

BENEFITS GUIDE

2014
Plan Year



Your Health | Your Decision



For State of Florida
EMPLOYEES AND RETIREES



FLORIDA DEPARTMENT OF MANAGEMENT SERVICES
**state group
insurance**
We serve those who serve Florida



FLORIDA DEPARTMENT of

management
SERVICES
We serve those who serve Florida

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Rick Scott, Governor

Craig J. Nichols, Agency Secretary

Dear Employees and Retirees:

Another year has passed quickly, bringing us to Open Enrollment – your opportunity to evaluate your coverage options and make needed changes for 2014. Despite what you might be hearing related to health care changes, State Group Insurance plans and tax-favored accounts remain relatively unchanged. Notable changes for 2014 include the following:

- Health insurance coverage will be offered to OPS/variable hour-employees who meet specific eligibility requirements.
- The pre-existing limitation provision of the state employees' PPO Plan will no longer be in force.
- Health savings account contributions limits, including the state's contribution, will increase to \$3,300 for a single plan and \$6,550 for family for active employees.

One of our 2014 goals is for all of our members to “know their numbers.” Knowing your blood pressure, cholesterol, glucose and body mass index can help you take appropriate steps to better health. Talk to your health care provider about the free preventive screenings available to you.

Use this benefits guide, visit myFlorida.com/myBenefits, or talk to an insurance company about other ways to make the most of your State Group Insurance benefits. The plans offered through our program provide needed protection for a variety of health issues, and we would like more members to take advantage of the available benefits.

As you consider your insurance needs for next year and make plans to know your numbers, please take this once-a-year opportunity to choose the best insurance options for you and your eligible dependents. Remember, it's your health and your decision.

Sincerely,

Barbara M. Crosier, Director
State Group Insurance

What's Important for 2014?

Open Enrollment starts Monday, Oct. 21, at 8 a.m. and ends Friday, Nov. 8, 2013, at 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time).

The following changes take effect Jan. 1, 2014.

- All health plan members: If you or a covered eligible dependent, regardless of age, have a pre-existing condition, you no longer have to provide proof of creditable coverage. Health plans are required to cover the condition without a waiting period.
- Health savings account contributions limits, including the state's contribution, will increase to \$3,300 for a single plan and \$6,550 for family plans for active employees.

Remember: to make Open Enrollment elections, you must certify the eligibility of your dependents, if any. Log in to People First for the easy certification process. You will need about 10 minutes and your dependent information – birth dates and Social Security numbers. See [Page 6](#) for eligibility requirements, including accurate Social Security numbers or a U.S. government-issued equivalent; then log in to People First during Open Enrollment to remove any dependents that are ineligible.

How to Make Changes in People First

In our continued effort to streamline processes, save state dollars and protect the environment, we are eliminating several paper election forms. You can easily make Open Enrollment changes in People First:

1. Turn off the browser's pop-up blocker and log in to peoplefirst.myflorida.com.
2. Select Start or the Open Enrollment link and then follow the simple steps to certify dependent eligibility and register new dependents (Social Security numbers required). Enter your People First password and select Certify to complete the dependent certification process.
3. Select Enroll Now to start. Your current benefits and what you will have next year are side-by-side so you can easily verify or change your elections.
4. Click Change, Add or Cancel to make updates.
5. Once you've confirmed your choices, enter your People First password and select Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section.

1. Select 2014 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials.
2. To view or print your confirmation statement, select View Details.

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Benefit Fair Schedule Open Enrollment for 2014

Fairs are open from 9 a.m. to 4 p.m. local time unless otherwise indicated. Some sites have security desks and photo identification is required to enter.

CENTRAL FLORIDA / EAST COAST			
Friday	Oct. 4	Orlando	<u>University of Central Florida, Student Union Ballroom, 12775 Pegasus Drive (ends at 2 p.m.)</u>
Monday	Oct. 21	Daytona Beach	<u>Volusia County Health Department, 1845 Holsonback Drive off Bill France Blvd.</u>
Tuesday	Oct. 22	Orlando	<u>Crowne Plaza Orlando Downtown, 304 West Colonial Drive</u>
TALLAHASSEE			
Monday	Oct. 21	Tallahassee	<u>The Betty Easley Center, 4075 Esplanade Way</u>
Tuesday	Oct. 22	Tallahassee	<u>Florida State University, Oglesby Union Ballroom, 75 N. Woodward Ave. (10 a.m. to 2 p.m.)</u>
Wednesday	Oct. 23	Tallahassee	<u>Tallahassee-Leon County Civic Center, 505 West Pensacola St.</u>
Thursday	Oct. 24	Tallahassee	<u>Department of Revenue, 2450 Shumard Oak Blvd., Building 1, Room 1820</u>
Friday	Oct. 25	Tallahassee	<u>Florida A&M University, Jake Gaither Athletic Complex, 1835 Wahnish Way (10 a.m. to 2 p.m.)</u>
SOUTH FLORIDA			
Wednesday	Oct. 23	Boca Raton	<u>Florida Atlantic University, Live Oak Pavilion, 777 Glades Road, east of I-95</u>
Thursday	Oct. 24	Miami	<u>Florida International University (S), Graham Center, 11200 Southwest 8th St.</u>
Friday	Oct. 25	Ft. Lauderdale	<u>North Broward Regional Service Center, 1400 West Commercial Blvd., Room 195</u>
WEST FLORIDA			
Monday	Oct. 28	Pensacola	<u>Pensacola Bay Center (Civic Center), 201 East Gregory St.</u>
Tuesday	Oct. 29	Pensacola	<u>University of West Florida, 11000 University Parkway, Building 22 (10 a.m. to 3 p.m.)</u>
TAMPA BAY AREA / WEST COAST			
Monday	Oct. 28	Tampa	<u>Department of Children & Families, 9393 N. Florida Ave. at I-275 and Busch Blvd.</u>
Tuesday	Oct. 29	Tampa	<u>USF, Marshall Student Center Ballroom, 4202 East Fowler Ave., MSC 2100</u>
Wednesday	Oct. 30	St. Petersburg	<u>USF St. Petersburg, Harbor Hall, 1000 3rd St. South (ends at 3 p.m.)</u>
Thursday	Oct. 31	Fort Myers	<u>Fort Myers Regional Service Center, 2295 Victoria Ave.</u>
Friday	Nov. 1	Sarasota	<u>USF Sarasota-Manatee, Selby Auditorium, 8350 North Tamiami Trail</u>
GAINESVILLE			
Wednesday	Oct. 30	Gainesville	<u>University of Florida, Touchdown Terrace, 157 Gale Lemerand Drive (ends at 3 p.m.)</u>
Thursday	Oct. 31	Gainesville	<u>Tacachale, Agency for Persons with Disabilities, 1621 Northeast Waldo Road</u>
JACKSONVILLE AREA			
Monday	Nov. 4	Jacksonville	<u>Department of Children & Families, 5920 Arlington Expressway</u>
Tuesday	Nov. 5	Jacksonville	<u>Department of Health, 1217 North Pearl St., off I-95</u>
Wednesday	Nov. 6	Macclenny	<u>John J. Crews Activity Center, 7487 South State Road 121</u>

Contact Information

Plans	Plan Types	Phone	Website
Florida Blue	State Employees' PPO Plan (Medical)	800-825-2583	www.bcbsfl.com or www.floridablue.com
Express Scripts	State Employees' Prescription Drug Plan	877-531-4793	www.medco.com/soflrxplan (non-members) www.medco.com (members log-in)
Aetna	HMO Plan (Medical)	877-858-6507	www.aetna.com
AvMed	HMO Plan (Medical)	888-762-8633	www.avmed.org/go/state
Capital Health Plan	HMO Plan (Medical)	850-383-3311	www.capitalhealth.com/state
Coventry Health Care of Florida	HMO Plan (Medical)	866-575-1875	http://state.chcflorida.com
Florida Health Care Plans	HMO Plan (Medical)	877-615-4022	www.fhpc.com
UnitedHealthcare	HMO Plan (Medical)	877-614-0581	www.welcometouhc.com/florida
Minnesota Life	Basic and Optional Life	888-826-2756	www.lifebenefits.com/florida
Ameritas Dental Preventive Plus	Indemnity with PPO	877-721-2224	www.ameritasgroup.com/florida
Assurant Employee Benefits Freedom Advance	Indemnity with PPO	800-442-7742	www.assurantemployeebenefits.com/STofFL
Assurant Employee Benefits Prepaid 225	Prepaid Dental	800-443-2995	www.assurantemployeebenefits.com/STofFL
CIGNA Dental	Prepaid Dental	800-244-6224	www.cigna.com
Humana Network Plus, Preferred Plus	Prepaid Dental, PPO	800-943-6880	www.humanadental.com/custom/fl/
Humana Select 15, Schedule B	Prepaid Dental/Indemnity	866-879-3630	www.humanadental.com/custom/fl/
UnitedHealthcare Dental Solstice 700	Prepaid Dental	800-980-0292	www.myuhcdental.com/statefl
Humana Vision	Materials Only/Exam Plus	800-939-5369	www.humanavisioncare.com/custom/fl
Aflac	Cancer/Intensive Care	800-780-3100	www.capitalins.com
Cigna Health and Life Insurance Company	Hospitalization	800-780-3100	www.capitalins.com
Colonial Life	Accident/ Cancer/ Disability	888-756-6701	www.coloniallife.com/florida
New Era	Hospitalization	800-277-2300	www.ssc-life.com
People First	Call for help or to enroll online	866-663-4735	https://peoplefirst.myflorida.com
	Fax documents to	800-422-3128	
	Mail documents to	P.O. Box 6830 Tallahassee, FL 32314	
	Mail payments to	P.O. Box 863477 Orlando, FL 32886-3477	
Social Security Administration	To enroll or inquire about Medicare	800-633-4227	www.medicare.gov
Tallahassee State Bank	To ask about an HSA bank account	877-367-4472 850-576-1182	www.talstatebank.com
MyBenefits Website			http://www.myflorida.com/mybenefits/

Getting Started

How to Use this Guide

Open Enrollment Tips

Program Overview and How to Enroll



Key Points

- Open Enrollment starts Monday, Oct. 21, at 8 a.m. and ends Friday, Nov. 8, 2013, at 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time).
- Open Enrollment is your once-a-year opportunity to make any changes you want to your State Group Insurance benefits.
- You can change your benefits as many times as you want before the Nov. 8 deadline. Log in to People First to make your choices and remember to select the green Complete Enrollment button when you are ready to save changes. For step-by-step instructions, go to [Page i](#).
- If you make Open Enrollment changes, look for a mailed confirmation statement in early December. Be sure all changes are correct, any eligible dependents are enrolled in coverage, and any ineligible dependents have been removed.

Getting Started

How to Use this Guide

This booklet is a summary of the State Group Insurance program plans, benefits descriptions and rules that govern the program. You will find the options for the new plan year—the calendar year that begins Jan. 1 and ends Dec. 31—that are available to eligible employees and retirees of the state. This guide does not change or replace the express written terms of any policy, plan or coverage, which are subject to change at any time.

The guide is divided into sections that group similar insurance coverage types together. If you are interested in enrolling in or changing your health insurance coverage, for example, you should read the entire My Health section to be sure you consider all your health insurance options. Be aware, however, that individual company plans differ, so you should contact the company for specific information about a service, medication or procedure.

Check out the Key Points feature at the beginning of each section. Read these to learn about the basics of our program and get answers to frequently asked questions.

Definitions, information for new employees, important information about Medicare, your right to privacy and more are in the My Resources section. Be informed. Take advantage of these additional resources.

Why Should I Make Elections Online?

Convenience

Night and weekend access
No phone hold time
No forms to complete, fax or mail
Make elections as often as you like during Open Enrollment

Efficiency

See all available options
Ensure your eligible dependents are enrolled
Confirm benefit elections instantly

Open Enrollment Tips

The Division of State Group Insurance (DSGI) is pleased to present this benefits package to you. You have a variety of benefits from which to choose, so review this guide and visit www.myflorida.com/mybenefits to carefully consider your personal benefit needs.

- Open Enrollment for the 2014 plan year starts Monday, Oct. 21, at 8 a.m. and ends Friday, Nov. 8, 2013, at 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time).
- Contact the insurance companies directly and be sure the plan you want has more than one provider you like. You cannot change plans if your doctor or dentist leaves the network, does not accept new patients, or does not have reasonable appointment times.
- Review your personalized benefits statement carefully. It includes important information about your benefit options for next year and the cost of each option.
- Know your People First password. If you have not logged in to People First in the last 90 days, the website will prompt you to change your password online. Visit dms.myflorida.com/pf to learn more.
- Avoid the rush—make changes early through People First. Making online changes is convenient and allows you to see all your available options at once. Go to Page i for step-by-step instructions.
- Select the right coverage level, such as individual or family, employee or employee plus spouse, etc.
- Enrolling eligible dependents is a two-step process. You must:
 1. Register them by entering their personal information, including Social Security numbers, in [People First](#).
 2. Enroll them by adding them to each plan you choose.
 - People First Service Center representatives are available weekdays from 8 a.m. to 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time) at 866-663-4735. TTY users should call 866-221-0268.

Program Overview

Review this chart for a quick overview of the insurance and other benefits we offer¹. Refer to each section of this guide to find out how these plans work and call the insurance company for specific plan information.

Benefits	Options	Who's Eligible ¹	What You Should Consider	Tools and Resources (See contact information for insurance companies on Page iv.)
Health	<ol style="list-style-type: none"> Standard PPO Standard HMO Health Investor PPO Health Investor HMO 	Employees, Retirees, COBRA, Surviving Spouse, Laid-off Career Service Employees	Recurring medical and prescription needs and services, as well as what you may require next year	www.myflorida.com/myBenefits www.myflorida.com/myBenefits/calculator/hpce.htm https://peoplefirst.myflorida.com www.floridahealthfinder.gov
Life	<ol style="list-style-type: none"> Basic Optional 	Employees, Retirees (basic), Laid-off Career Service Employees (basic)	Your family's financial needs in the event of your death	www.myflorida.com/myBenefits
Dental	<ol style="list-style-type: none"> Prepaid Dental PPO Indemnity with PPO Indemnity 	Employees and all others if eligible to continue through COBRA	Recurring dental costs, anticipated dental work, which plans pay for orthodontia, and if the plan has dentists accepting new patients in your area	www.myflorida.com/myBenefits www.myflorida.com/myBenefits/calculator/dpce.htm
Vision	<ol style="list-style-type: none"> Materials Only Exam Plus 	Employees and all others if eligible to continue through COBRA	Next year's needs, including eye exams, glasses or contacts; some coverage may be available under your health plan	www.myflorida.com/myBenefits
Other Supplemental Plans	<ol style="list-style-type: none"> Accident Cancer Disability Hospital Intensive Care Hospitalization 	Employees and others may convert to an individual policy upon termination of employment.	Your income-protection needs; most of these programs provide income benefits if you and/or covered family members suffer from illness or injury; some require underwriting	www.myflorida.com/myBenefits
Tax-Favored Accounts	<ol style="list-style-type: none"> Flexible Spending Accounts: Medical Reimbursement Limited Purpose Medical Reimbursement Dependent Care Reimbursement Health Savings Account 	<p>Employees (OPS/variable-hour employees who meet eligibility requirements are only eligible for the dependent care reimbursement account).</p> <p>Employees</p>	<p>Out-of-pocket costs for eligible medical expenses or for care of qualified dependents while you work</p> <p>Out-of-pocket costs for eligible medical expenses if you're enrolled in a Health Investor Health Plan</p>	www.myflorida.com/myBenefits www.myflorida.com/myBenefits/calculator/mrae.htm www.myflorida.com/myBenefits/calculator/lhfsae.htm www.myflorida.com/myBenefits/calculator/dcrae.htm www.myflorida.com/myBenefits/calculator/hpceE.htm

¹Benefit options vary depending on your employment status and whether you meet required eligibility criteria and pay monthly premiums on time. Some benefits are available for only for a limited time.

Available Coverage Tiers by Plan

	Employee	Employee + Spouse	Employee + Children	Family
Health	✓			✓
Life	✓			
Dental	✓	✓	✓	✓
Vision	✓	✓	✓	✓
Accident	✓	✓	✓	✓
Disability	✓			
Cancer ¹	✓		✓	✓
Hospital Intensive Care	✓		✓	✓
Hospitalization	✓			✓

How to Enroll

Make your benefit elections for any of the opportunities listed below through the People First website.

1. Open Enrollment for the 2014 Plan Year: You must enroll or make changes by 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time) on Friday, Nov. 8, 2013. Open Enrollment changes are effective Jan. 1 of the next calendar year.
2. New Hire: You have 60 days from your date of hire to enroll or 60 days from the start of a new term of office if you are an elected state official. See [Page 51](#) for important new-hire information.
3. Qualifying status change (QSC) event: You can make changes during the plan year only if you experience a QSC event. For all QSC events, you have 60 days from the date of the event to make allowable benefit changes. If you make changes to your benefits due to a QSC event that occurs on or after Oct. 21, 2013, and you also make changes during Open Enrollment, you should call the People First Service Center to be sure your elections are correct for the new plan year that starts Jan. 1.
4. Spouse Program: If you and your spouse are state employees, you can participate in the Spouse Program and receive health insurance at a reduced premium. To enroll or make changes, you must submit a completed Spouse Program Election Form

available on the mybenefits website and send it to the People First Service Center. Make online elections in People First to enroll, change or cancel any plan other than health insurance.

5. Surviving Spouse: If you are the surviving spouse of a state employee or retiree and you were covered under the plan at the time of your spouse's death, you have 31 days to enroll in health insurance coverage. People First will send you an enrollment package upon notification of the death. See [Page 10](#) for more information.

Important Reasons to Call People First:

Several important events may affect your coverage. Call People First within 60 days if you experience one of the following:

- You go off state payroll for any reason;
- You or your dependent becomes eligible for Medicare;
- Your dependent becomes ineligible for coverage; or
- Your spouse becomes employed by or ends employment with the state.

My Membership

Eligibility

Enrolling and Making Changes

Key Points

- Open Enrollment elections are effective Jan. 1, 2014.
- The State Group Insurance plan year is Jan. 1 through Dec. 31.
- You may be required to submit documentation to add or remove dependents from your plans, except during Open Enrollment.
- You are required to remove dependents immediately when they lose eligibility (due to divorce, for example).
- If you make changes to your benefits due to a qualifying status change (QSC) event that occurs on or after Oct. 21, 2013, and you also make changes during Open Enrollment, you should call the People First Service Center to be sure your elections are correct for the new plan year that starts Jan.1.

2014
Plan Year



Your Health | Your Decision



Eligibility

Part-time and full-time employees as defined in section 110.123(2)(c) and (f), Florida Statutes, are eligible for coverage under the State Group Insurance program.

Eligibility for health insurance coverage:

- Salaried employees who work .75 full-time equivalency (FTE) or more and OPS/variable-hour employees who work an average of 30 hours or more per week over the defined measurement period are considered full-time and eligible for the state contribution towards the monthly premium.

OPS/variable-hour employees are eligible for coverage if:

- At the point of hire, they are reasonably expected to work 30 hours or more per week on average;
- At the end of their 12-month new hire measurement period, their hours worked averaged 30 hours or more per week;
- At the end of the 12-month open enrollment measurement period, their hours worked averaged 30 hours or more per week.
- Salaried employees who work less than .75 FTE pay a prorated share of the employer premium based on their FTE plus the employee share.
- OPS/variable-hour employees who work less than 30 hours per week on average over the defined measurement period are not eligible for coverage.

Eligibility for life insurance coverage:

- Salaried employees who work 1.0 FTE are automatically enrolled in the \$25,000 basic life insurance and pay no monthly premium. They are also eligible to enroll in optional term life insurance.
- Salaried employees who work less than 1.0 FTE may enroll in the \$25,000 basic life insurance and pay a prorated share of the monthly premium. They are eligible to enroll in optional term life insurance.
- OPS/variable-hour employees who work an average of 30 hours or more each week over the defined measurement period may enroll in the \$25,000 basic life insurance and pay the entire monthly premium. They are not eligible for optional term life insurance.
- OPS/variable-hour employees who work less than 30 hours per week on average over the defined measurement period are not eligible for coverage.

In addition, employees who meet the eligibility requirements for health insurance (above) may enroll in:

- A health savings account (if enrolled in a health investor health plan) and receive the state contribution once the account is correctly established; (see [Page 43](#) for more information);
- Dental, vision and other supplemental insurance plans;
- A dependent care reimbursement account:

Only salaried employees are eligible to enroll in a medical or limited purpose medical reimbursement account.

State officers or state employees may continue to participate in the State Group Insurance program if they retire under a State of Florida retirement system or a state optional annuity or retirement program or go on disability retirement under the State of Florida retirement system. They must have been covered by the program at the time of retirement and receive retirement benefits immediately after retirement or maintained continuous coverage under the program from termination until receiving retirement benefits.

Employees thinking of retirement should review the State Group Insurance Benefits Package for New Retirees, available on the [mybenefits site](#) under Forms and Publications. Employees that do not continue health and life insurance coverage at the time of retirement will not be allowed to enroll in state health or life insurance at a later date.

Dependents Eligible for Coverage

If you are enrolled in the State Group Insurance plans, you may also cover your eligible dependents. You must:

1. Register your dependent online in [People First](#); and
2. Select the correct family coverage tier for each plan that is to cover your dependents; and
3. Enroll each dependent in the appropriate plan; and
4. Select the Complete Enrollment button in [People First](#).

In accordance with Chapter 60P, Florida Administrative Code, dependents must meet specific eligibility requirements to be covered under State Group Insurance plans. Eligible dependents include:

- Your spouse – a person of the opposite sex to whom you are legally married. See Section 741.212(3), Florida Statutes.
- Your child – your biological child, legally adopted child or child placed in the home for the purpose of adoption in accordance with applicable state and federal laws.
- Your child with a disability – your covered child who is permanently mentally or physically disabled. This child may continue health insurance coverage after reaching age 26 if you provide adequate documentation validating disability upon request and the child remains continuously covered in a State Group Insurance health plan. The child must be unmarried, dependent on you for care and for financial support, and can have no dependents of his/her own.
- Your stepchild – the child of your spouse for as long as you remain legally married to the child's parent.
- Your foster child – a child that has been placed in your home by the Department of Children and Families Foster Care Program or the foster care program of a licensed private agency. Foster children may be eligible to their age of maturity.
- Legal guardianship – a child (your ward) for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state and federal laws. Your ward may be eligible until his or her age of maturity.
- Your grandchild – a newborn dependent of your covered child. Coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered.
- Your over-age dependent – your child after the end of the calendar year in which they turned age 26 through the end of the calendar year in which they reach 30 if they are unmarried, have no dependents of their own, are dependent on you for financial support, live in Florida or attend school in another state, and have no other health insurance.

You may be required to provide documentation for your eligible dependents. If you fail to provide requested documentation, you may be liable for medical and prescription claims or premiums back to the date you enrolled. Fax documentation to 800-422-3128 or mail it to

People First Service Center, P.O. Box 6830, Tallahassee, FL 32314. Write your People First ID number on the top right corner of each page of your fax or other documentation.

Over-Age Dependent (ages 26-30) Coverage

This individual health coverage for your over-age dependent requires an additional monthly premium and you and your eligible over-age dependent must be enrolled in the same health plan. Call the People First Service Center for more information.

When Coverage Begins

See the [QSC Matrix](#) for the complete list of qualifying status change events that trigger a gain or loss of eligibility, as well as coverage effective dates.

When Coverage Ends

See the [QSC Matrix](#) for the complete list of qualifying status change events that cause a loss of eligibility. In summary, your coverage in State Group Insurance plans ends:

- When your employment is terminated. Active employees pay premiums one month in advance, so coverage ends on the last day of the month following the month you terminated employment. For example, if your last day of work is April 23, your coverage ends May 31.
- On the last day of the month in which you do not make the required premium payment for coverage, including the months when you are on leave without pay, suspension or layoff status. Payment is due the tenth of the month before the month of coverage. For example, payment for July coverage is due June 10.
- On the last day of your 12-month health insurance coverage period if you are an OPS/variable-hour employee and you did not meet the eligibility requirements (see the Eligibility section). In other words, life and supplemental insurance plans ends the same time as health insurance, regardless of the number of months enrolled.
- On the last day of the month in which you remarry, if you have coverage as a surviving spouse of an employee or retiree.

If your spouse is enrolled as your covered dependent, your spouse's coverage ends on the last day of the month in which:

- Your coverage is terminated.
- You and your spouse divorce. (You are required to notify People First within 60 days of the divorce.)
- Your spouse dies.

Your dependent children's coverage ends:

- On the last day of the month in which your coverage is terminated.
- The end of the calendar year in which your dependent turns age 26 (or 30 for over-age health coverage).
- On the last day of the month your dependent no longer meets the definition of an eligible dependent. (For example, if you divorce, you may no longer cover your stepchildren.)

When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they become ineligible, unless otherwise noted above. If your dependents become ineligible for coverage, go to the People First website to remove them from your plans or call the People First Service Center at 866-663-4735 within 60 days of the ineligibility. Service Center hours are 8 a.m. to 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time). Send required documentation to People First. If you fail to provide the required documentation, you risk paying for more coverage than you need.

Please note: Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the Florida Department of Financial Services Division of Insurance Fraud.

Chapter 60P, Florida Administrative Code, governs eligibility and enrollment for the State Group Insurance program. Additionally, our plans fall under Internal Revenue Code (IRC) cafeteria plan guidelines. Consequently, participants are required to stay in the plans they select. Per the IRC, participants can only make changes during Open Enrollment or if they have a qualifying status change (QSC) event, such as a birth, marriage, or change in employment status, only if it results in a gain or loss of eligibility for insurance. (Retirees may decrease or cancel coverage at any time. Those who cancel will not be allowed to reenroll.)

Enrolling and Making Changes

You could have as many as five options to enroll or change your coverage:

Option 1 – Hired as a New Employee

If you are a newly-hired¹, eligible employee (see the Eligibility section), you have 60 days from the date you were hired to enroll in State Group Insurance benefits. Enroll online at <https://peoplefirst.myflorida.com>. If you do not enroll within 60 days of your hire date, you can only enroll during the next Open Enrollment period or if you experience an appropriate qualifying status change (QSC) event. Choose your options carefully. Once you make your elections, you can only change them during the next Open Enrollment unless you have an appropriate QSC event (see below).

Your coverage begins on the first day of the month after the month in which the state deducts (or People First receives) a full month's premium. Coverage always begins on the first day of a month and continues for the rest of the calendar year, as long as you pay premiums on time and you remain eligible.

For example, assume you are a salaried employee hired on July 20. If People First receives your enrollment information before Aug. 1, your coverage begins Sept. 1, after one full month's premium is deducted from your paycheck. For health insurance only, you can elect an early effective date, provided you submit the full month's employee share by check. For example, if you are hired July 20, you can elect to have your health insurance start on Aug. 1. If you do, you must send a check for the full month's employee premium to People First.

If you are an OPS/variable-hour employee, the earliest health coverage will begin is the first day of the third month of employment. All other plans begin the first day of the month for which a full payroll deduction is taken.

¹ If you have a child over the age of 26 with a mental or physical disability who meets the above eligibility criteria, the first time you enroll in the State Group Insurance program, you may enroll that child in your plan.

Option 2 – Qualifying Status Change (QSC) Event

If you have a qualifying status change (QSC) event that results in a gain or loss of eligibility for coverage, you have 60 days (unless otherwise noted) from the date of the event to make changes to your benefits. Changes include enrolling or cancelling, increasing or decreasing coverage, or adding or removing dependents. See the [QSC Matrix](#) for the complete list of QSC events and documentation requirements.

If you have a QSC event and want to change your benefit elections:

1. Make the change online at the [People First website](#) within 60 days of the event. If your specific QSC event is not listed, call the People First Service Center within 60 days of the event. You should call People First within 60 days even if you do not yet have the supporting documentation; otherwise, you will have missed your election window and will be unable to make any changes.
2. Birth, adoption, divorce, death, Medicare disability and court orders require documentation before your QSC event can be processed. If you experience one of these events, send your documentation to People First within 60 days of the event; then call People First to make changes to your insurance. If you miss your window, you may pay more for insurance than you need to or be responsible for claims incurred (for ineligible dependents, for example).

If you enroll yourself or your eligible dependents during the year because of a QSC event, coverage begins on the first day of the month after the month in which the state deducts (or People First receives) a full month's premium. Coverage always begins on the first day of a month and, if you are a salaried employee, continues for the rest of the calendar year, as long as you pay premiums on time and you and your dependents remain eligible. If you are an OPS/variable-hour employee, your health insurance coverage is guaranteed for 12 months, as long as you remain employed by the state. Other plans will end at the same time as your health insurance if you no longer meet the eligibility requirements.

Active employees: If you go off the payroll, and do not cancel your coverage you must pay your share of the premium by personal check, cashier's check or money order to continue coverage. You may be required to pay the full premium cost—your share and the state's share, depending

on the reason you are not working. Call People First for more information.

If you do not want to continue your insurance coverage while you are off the payroll, call People First within 60 days of your leave date to cancel. This ensures you can enroll in coverage if you return to work. If you do not cancel and are later cancelled because you did not pay your premiums, you will only be allowed to enroll during the next Open Enrollment.

To make an enrollment change based on a qualifying status change (QSC) event, federal law requires the event to result in a gain or loss of eligibility for coverage, and your elections must meet general consistency rules. For example, if you have individual health insurance coverage and get married, you may change from individual to family coverage; however, you cannot change health insurance plans because the QSC event only changes the level of coverage eligibility. In this case, changing plans is not consistent with the nature of the QSC event.

Option 3 – Open Enrollment

Held in the fall, annual Open Enrollment gives you the opportunity to review available benefit plan options and make any changes you want for the next plan year, which starts Jan. 1 and goes through Dec. 31. Any changes you make remain in effect for the entire calendar year if you pay premiums on time and you remain eligible, unless you make changes because of a QSC event. OPS/variable-hour employees are only able to participate in Open Enrollment if they meet the requirements listed in the Eligibility section above.

Option 4 – Spouse Program

1. Complete and sign the Spouse Program Election Form located at myflorida.com/mybenefits and list all eligible dependents;
2. Enroll in the same health plan; and
3. Agree to notify the People First Service Center within 60 days of becoming ineligible for the Spouse Program. You and your spouse become ineligible for the Spouse Program if:
 - One or both of you end employment with the state, including retirement;
 - You divorce;
 - A spouse dies.

It is your responsibility to notify the People First Service Center if you become ineligible for the Spouse Program. If you fail to do so within 60 days of one of the listed events, you will be liable for claims or premiums back to the date you lost eligibility. Additionally, you may have to pay for a higher level of coverage than you need. For example, you may be required to pay for family coverage instead of individual coverage. Upon notification of ineligibility for the Spouse Program, the People First Service Center adds covered, eligible dependents to the primary spouse's plan, unless you request otherwise.

Eligible OPS/variable-hour employees are allowed to participate in the Spouse Program if they are married to a state employee and follow the steps above.

Option 5 – Surviving Spouse

Surviving spouses are also eligible for coverage. The term "surviving spouse" means the widow or widower of:

- A deceased state officer, state employee (including OPS/variable-hour employees) or retiree if the spouse was covered as a dependent at the time of the participant's death;
- An employee or retiree who died before July 1, 1979;
- A retiree who retired before Jan. 1, 1976, under any state retirement system and who is not eligible for any Social Security benefits.

The surviving spouse and dependents, if any, must have been covered at the time of the participant's death. To enroll, the surviving spouse has 60 days to notify the People First Service Center of the death and 31 days to enroll after receipt of the enrollment package. Coverage is effective retroactively once the enrollment form and premiums have been received. Coverage begins the first of the month following the last month of coverage for the deceased; in other words, coverage must be continuous.

Coverage for surviving spouses ends on the first of the month following remarriage; however, they are eligible to continue coverage under COBRA for a limited time, provided they provide a copy of the marriage certificate within 60 days of the marriage.

Please note: Falsifying documents, misrepresenting dependent status, or using other fraudulent actions to gain coverage may be criminal acts. The People First Service Center is required to refer such cases to the State of Florida.

Address Corrections: It is extremely important for you to keep your address updated in [People First](#). If your address is not current, you may not receive important information, such as benefit plan changes and proof of your insurance coverage. A current address ensures you receive your State Group Insurance information, including benefit plan documents and changes, member identification cards, proof of insurance coverage, etc. Log in to [People First](#) or follow your employer's process to update your address.

My Health

How to Choose a Health Plan

Preferred Provider Organization (PPO)

Health Maintenance Organizations (HMO)

Prescription Drug Plan

2014
Plan Year



Your Health | Your Decision



Key Points

- State Employees' PPO Plan members who use out-of-network providers have higher out-of-pocket expenses, even if they have no choice in the provider.
- Health Investor Health Plans are high-deductible plans. The monthly premium is lower than the Standard Plans, but you should consider your out-of-pocket costs carefully before choosing this plan.
- Prescription drug costs are lower if you use generics, mail order, and preferred brand-name drugs—[Page 24](#).
- If you are an active employee and you enroll in a Health Investor Health Plan, you should also enroll in a Health Savings Account (HSA) through People First and open an HSA bank account through Tallahassee State Bank. You will only receive the state's monthly contribution if you complete these two steps—[Page 43](#).
- See the My Resources section for important information about Medicare—[Pages 49-50](#).

My Health

One of the most important benefits available to you is health insurance. You should think about a number of things before selecting a health plan. Keep in mind, one plan is not better than another; each plan simply offers different benefits. Carefully consider your health care needs and review the comparisons and other materials available before making a decision.

How to Choose a Health Plan

1. Compare the four main types of options:
 - Health Investor PPO Plan with worldwide coverage
 - Standard Health Maintenance Organization¹ (HMO) Plan with coverage in a specific service area
 - Health Investor HMO¹ Plan with coverage in a specific service area
2. See which doctors, hospitals and specialists are available in each plan's provider network. (Providers may cancel their participation at any time without notice; this is not a qualifying status change event to change or cancel plans.)
3. Think about your likely medical care needs for the coming year. Compare your cost for that care and your cost for coverage² under each of the different options. Use the online Health Plan Cost Estimator at www.myflorida.com/mybenefits/calculator/hpce.htm.
4. Visit www.floridahealthfinder.gov to compare quality of care and patient satisfaction measures for Florida HMOs and PPOs.
5. Factor tax-favored accounts into your decision for costs insurance does not cover ([Page 38](#)).
6. Decide which option is best for you.

Differences between the Standard and Health Investor Plans

There are some important differences between Standard Plans and Health Investor plans. In both the Health Investor PPO and the Health Investor HMO plans:

- You must meet a higher deductible, which includes medical and prescription costs, than for the Standard PPO Plan or Standard HMO plans.
- You pay less to buy coverage.
- You must open a Health Savings Account to get the state contribution and pay for eligible health care expenses with pretax dollars.
- You can also open a Limited Purpose Medical Reimbursement Account for certain dental, vision and preventive care expenses.

Associated with either the Health Investor PPO or HMO plans, the HSA account allows you to use pretax dollars to pay your share of the cost for eligible health care expenses that are not covered by your health, dental or vision plans. Any unused HSA funds at the end of a year carry forward to the next year.

Active employees may also take unused HSA balances with them if they stop working for the state. When employees are eligible for an HSA and have completed the necessary steps, the state makes a contribution to their health savings bank account, and employees may also add their own pretax contributions to their HSA. To participate, active employees must:

1. Be in a Health Investor PPO or Health Investor HMO plan.
2. Enroll in an HSA through [People First](#).
3. Open a personal HSA bank account at Tallahassee State Bank by completing the [HSA bank account application](#). The state contribution to your HSA can only be deposited if you open your HSA bank account at Tallahassee State Bank. To be sure you do not forfeit any state money or have your contribution, if any, returned to you post-tax through payroll, open your HSA before Jan. 1 or before your effective date of coverage. Tallahassee State Bank charges a small monthly fee to manage your HSA bank account.

¹ To enroll in an HMO, you must live in its contracted service area. Active employees may also enroll in an HMO based on their work county. HMOs have specific provider networks you must use; if you use a provider outside of the plan's network, you may have no coverage.

² For active employees, premium rates for all Standard Plans are the same and rates for all Health Investor plans are the same. Part-time salaried employees pay rates based on their full-time equivalency (FTE). Retiree HMO premiums may differ. Log in to [People First](#) for premium rates. Premium rates are subject to change at any time due to legislative action.

Health Plans Comparison Chart

	Standard Plans		Health Investor Health Plans ¹	
	PPO	HMOs	PPO	HMOs
Choice of Providers	In or Out of Network ²	Network only	In or Out of Network ²	Network only
Open a Health Savings Account (HSA) ³	No	No	Yes – Active Employees	Yes – Active Employees
Have a Reimbursement Account	Yes – Active Employees Medical Reimbursement Account		Yes – Active Employees Limited Purpose Medical Reimbursement Account	
Annual Deductible	Lower	None	Higher ⁴	Higher ⁴
How You Pay for Most Medical Care	<p>Network: set copayments or percentage of network allowed amount after deductible</p> <p>Non-network: percentage of non-network allowance after deductible and any balance up to charges</p>	Set copayments	<p>Percentage of cost after deductible</p> <p>You must meet the deductible (\$1,250 for individual, \$2,500 for family) before anything but certain preventive care services are covered</p>	
Preventive Care	Certain routine, preventive services and immunizations covered at 100%			
Annual Out-of-Pocket Maximum	Lower	Lowest	Higher	Higher

¹ High-deductible plans.

² You pay much higher out-of-pocket costs when using out-of-network providers.

³ If you enroll in a Health Investor Health Plan and you are an active employee, you should open an HSA to receive state contributions, as long as you have no other health coverage. Your HSA balance earns interest, carries forward year to year and is portable if you leave state employment.

⁴ You pay all medical and prescription costs before your plan covers anything but some preventive care.

Difference between an HMO and a PPO

While the core benefits between the State Employees' PPO Plan and the HMO plans are similar, there are differences. Preferred Provider Organization coverage may give you broader access to doctors, hospitals and other medical providers. Health Maintenance Organization coverage may give you more predictability regarding your medical costs.

Both plans contract with networks of providers to deliver services. Health Maintenance Organization plans require you to use an exclusive network of providers for services with very few options for using non-network providers (generally, only for emergency care). In the State Employees' Standard and Health Investor PPO Plans, you can use out-of-network providers, but you pay more.

The PPO Plans allow you to self-refer, or visit specialists without referral from a primary care physician (PCP); however, you should get pre-authorization for some services, such as advanced imaging, to ensure coverage. Some HMO plans require you to first obtain a referral from your PCP to have your treatment by a specialist covered under the plan.

All Standard HMO plans charge copayments for visits. A copayment is a fee you pay to visit a provider. The Standard PPO Plan has deductibles, coinsurance and copayments, depending on the service and the provider's network status. Health Investor PPO and Health Investor HMO plans have higher deductibles and coinsurance.

To enroll in an HMO you must live in its contracted service area county. Active employees may also enroll in an HMO based on their work county. Health Maintenance Organization plans have specific provider networks you must use; if you use a provider outside of the plan's network, you may have no coverage. Health Maintenance Organization plans typically provide care through regional provider networks; these plans cover out-of-network care only in emergencies. The State Employees' Standard and Health Investor PPO Plans use a worldwide network and offer out-of-state coverage through the BlueCross and BlueShield BlueCard® Program. If you spend time traveling, do not live in Florida, or have an eligible dependent that does not live in your county, the State Employees' Standard or Health Investor PPO Plans may be more suitable.

You should select a plan with multiple providers that you would feel comfortable using in the event that your

current provider's relationship with a plan ends. Health care providers can leave a health plan's network at any time and without notice. Be sure you select a plan with providers who are accepting new patients. The plan you choose now will be in effect for the entire plan year.

Preferred Provider Organization (PPO)

The State Employees' Standard and Health Investor PPO Plans are self-insured health plans. This means the state pays medical and prescription drug claims. Florida Blue (BlueCross and BlueShield of Florida, Inc.) administers medical coverage, and Express Scripts (Medco) administers prescription drug coverage for the PPO plans. See Page 24 for more information about the State Employees' Prescription Drug Plan.

As the medical administrator, Florida Blue processes health claims, develops and maintains the preferred provider network, and provides customer service. To learn more about Florida Blue, call 800-825-2583 or visit www.bcbsfl.com or www.FloridaBlue.com.

Charges for the Standard PPO Plan and Health Investor PPO Plans

Pre-Negotiated Fees: Florida Blue negotiates reduced fees with all network providers; these fees are lower than the providers' actual charges, so if you stay in the network, you take advantage of these lower fees.

Annual Deductible: A yearly amount, based on the allowed amount, you must pay for certain services before the plan starts paying. The deductible varies based on the network status of the provider (a network or non-network provider), the type of plan (either individual or family), and whether you are enrolled in the Standard or Health Investor PPO Plan:

In-Network Annual Deductible	
Standard PPO Plan	\$250 for individual coverage \$500 for family coverage
Health Investor PPO Plan	\$1,250 for individual coverage \$2,500 for family coverage

Once you meet your deductible, you typically only pay your coinsurance or copayment for eligible services. To meet a deductible means you pay all medical costs (and prescription drug costs in the Health Investor PPO Plan) before your plan covers anything but office visit copays and some preventive care. If you are enrolled in the State Employees' PPO Plan and you see a non-network PPO provider, the amount you pay increases significantly. Additionally, deductible costs are much higher when you go out of network.

- **Coinsurance:** A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible. This includes prescription drug costs under the Health Investor PPO Plan.
- **Copayment:** A per-visit fee for office visits, emergency room services, and prescription drugs if you are enrolled in the Standard PPO Plan.

The State Employees' Standard PPO Plan and Health Investor PPO Plan rely on a statewide network of providers contracted with Florida Blue and a nationwide and worldwide network through the BlueCard® Program. When you need to see a provider, you can choose to visit a network provider or a non-network provider.

Network providers include physicians, hospitals and other health care providers who agree to accept pre-negotiated fees for covered services. These fees are generally lower than the providers' actual charge and you do not pay more than the pre-negotiated fee. Choosing a network provider saves you money.

Non-network providers do not participate in the preferred provider network. Hospital-based physicians, such as hospitalists, radiologists, pathologists, anesthesiologists and emergency room physicians, may be non-network even if the hospital is in-network. When you receive covered services from a non-network provider, you pay higher non-network deductibles and coinsurance costs. For these services, the provider bills you directly for the difference between the amount your plan pays and the provider's charge. When you receive care from a non-network provider—even if you had no choice—the plan pays the provider a formula-determined amount based on the type

of service provided. The non-network provider's actual charges are typically much higher than these amounts. You will experience much higher out-of-pocket costs than those associated with services from a network provider.

Check to see if your provider is part of the Florida Blue or BlueCard® network before you receive services; otherwise, you may have to pay more than you expected. Go to www.bcbsfl.com or www.FloridaBlue.com to check the provider's network status. If your provider is outside of Florida or the United States, you can find the network status through the BlueCard® Program at www.bluecares.com or 800-810-BLUE (2583). Even if you travel outside of Florida or the United States, you receive the same coverage you receive in Florida, as long as the provider or hospital is part of the network.

Both the Standard and Health Investor PPO Plans cover preventive medical services, health, care and immunizations that are age and gender based in accordance with the current grade A and B recommendations of the U.S. Preventive Services Task Force. A complete list of preventive services may be found at <http://www.healthcare.gov/law/features/rights/preventive-care/index.html>.

In addition to the preventive care coverage under the PPO Plan, Florida Blue offers a discount program for eye exams, eye glasses, mail order contact lenses, and laser vision care. To access the discounted services, all you need is your Florida Blue (BCBSF) member identification card. For more information about these services and for participating providers, go to www.bcbsfl.com or www.FloridaBlue.com and click For Members. Go to Member Resources and select View Discounts for the Blue365 Program or call 800-825-2583.

Maximum Annual Out-of-Pocket Expenses for Coinsurance

The State Employees' PPO Plan limits the out-of-pocket amount you pay for coinsurance each year. Only your coinsurance amounts count toward this limit. Once you reach the maximum dollar amount in a calendar year, the PPO Plan pays 100 percent of the coinsurance allowed amount for covered services for the rest of the calendar year. In the State Employees' Standard and Health Investor PPO Plans, deductibles, office visit and emergency room copayments, non-covered services and/or supplies, per admission fees and provider charges exceeding the plans' allowed amounts do not count toward the annual out-of-pocket maximum.

	Standard PPO Plan	Health Investor PPO Plan	
	Combined In and Out of Network	In Network	Out of Network
Annual Out-of-Pocket Maximum	\$2,500 for individual coverage \$5,000 for family coverage	\$3,000 for individual coverage \$6,000 for family coverage	\$7,500 for individual coverage \$15,000 for family coverage

Money Saving Tips:

- Using network providers makes your coverage more affordable.
- The State Employees' PPO Plans pay 100 percent of the allowed amounts for most preventive care services, including mammograms.
- You can save money by using the prescription drug mail order program and/or generic drugs when available.

How to Make Changes in People First

In our continued effort to streamline processes, save state dollars and protect the environment, we are eliminating several paper election forms. You can easily make Open Enrollment changes in People First:

1. Turn off the browser's pop-up blocker and log in to peoplefirst.myflorida.com.
2. Select Start or the Open Enrollment link and then follow the simple steps to certify dependent eligibility and register new dependents (Social Security numbers required). Enter your People First password and select Certify to complete the dependent certification process.
3. Select Enroll Now to start. Your current benefits and what you will have next year are side-by-side so you can easily verify or change your elections.
4. Click Change, Add or Cancel to make updates.
5. Once you've confirmed your choices, enter your People First password and select Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section.

1. Select 2014 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials.
2. To view or print your confirmation statement, select View Details.

State Employees' Standard and Health Investor PPO Plans Comparison Chart

Covers care received in or out of network	Standard PPO Plan		Health Investor PPO Plan	
	Network	Non-Network	Network	Non-Network
Annual Deductible <ul style="list-style-type: none"> Individual Family 	\$250 \$500	\$750 \$1,500	\$1,250 ^{1,2} \$2,500 ^{1,2}	\$2,500 ^{1,2} \$5,000 ^{1,2}
Costs for Care <ul style="list-style-type: none"> Doctor office visits Hospital stay 	\$15 per visit for PCP \$25 per visit for specialists \$250 per admission deductible then 20% of network allowed amount	40% of non-network allowance plus the amount between the charge and allowance \$500/per admission deductible then 40% of non-network allowance plus the amount between the charge and allowance	20% of network allowed amount for all medical care and hospital stays	40% of non-network allowance plus the amount between the charge and allowance for all medical care and hospital stays
Prescription Drugs: Up to 30-day retail or up to 90-day mail order prescription <ul style="list-style-type: none"> Generic Preferred Brand Non-Preferred Brand 	\$7/retail; \$14/mail order \$30/retail; \$60/mail order \$50/retail; \$100/mail order	Pay in full and file a claim Pay in full and file a claim Pay in full and file a claim	30% 30% 50%	Pay in full and file a claim Pay in full and file a claim Pay in full and file a claim
Preventive Care (coverage based on age and gender): Certain routine physical exams, health screenings, mammograms, and immunizations	100% of allowed amount; no deductible	100% of non-network allowance; you pay amount between charge and allowance; no deductible	100% of allowed amount; no deductible	100% of non-network allowance; you pay amount between charge and allowance; no deductible
Annual Coinsurance and Out-of-Pocket Maximum³ <ul style="list-style-type: none"> Individual Family 	\$2,500 network and non-network combined \$5,000 network and non-network combined		\$3,000 ¹ \$6,000 ¹	\$7,500 ¹ \$15,000 ¹
	No		Yes, after you open an HSA account at Tallahassee State Bank, the state contributes up to \$500 for individual coverage or up to \$1,000 for family coverage each year	
Qualifies for Medical FSA	Yes, Medical Reimbursement Account (MRA)		Yes, Limited Purpose MRA	

¹ Prescriptions are included.

² Before anything but preventive care is covered.

³ After your out-of-pocket coinsurance costs reach these maximums, the plan pays 100 percent for covered coinsurance in most cases, up to the allowed amount or allowance for the rest of the calendar year. This does not include deductible, copayments, cost of care not covered by plan, hospice care, charges greater than the non-network allowed amount, charges greater than plan limitations, and preadmission certification penalties.

Health Investor Preferred Provider Organization (PPO)

While the Health Investor PPO Plan covers all the same services and supplies as the Standard PPO Plan, there are some key differences. Under the Health Investor PPO:

- If you are a Career Service (or equivalent) employee or a retiree, your monthly insurance premiums are lower.
- You must meet the plan deductible for all services and prescriptions except certain preventive services before the plan pays anything. This means you pay the first \$1,250 (individual plan) or \$2,500 (family plan) out of pocket.
- Active employees:
 - If you or your covered dependents do not have other health coverage (including Medicaid and Medicare), you may open a Health Savings Account (HSA) and make pretax contributions to it. You can use the HSA to pay out-of-pocket expenses, such as your deductible and coinsurance, even if you leave state employment. See Page 43 for more information about the HSA.
 - If you enroll in an HSA and open an HSA bank account at Tallahassee State Bank, the state contributes \$41.66 per month for full-time employees with individual coverage (up to \$500 annually) or \$83.33 per month for family coverage (up to \$1,000 annually).
 - In addition to the state's contribution to your HSA bank account, you can contribute your own additional pretax funds to the account to reach the maximum limit (including state contribution) of \$3,300 for individual coverage and \$6,550 for family coverage. If you are 55 or older, you can contribute an additional \$1,000.
 - This money rolls over each year and you can take it with you if you leave state employment.
 - The state can deposit money only after you open your HSA bank account at Tallahassee State Bank. To be sure you receive the state money you are entitled to and your own contribution (if any):
 1. Select the Health Investor PPO Plan as your health plan, and
 2. Enroll in an HSA through [People First](#), and
 3. Open a personal HSA bank account at Tallahassee State Bank¹ by completing the [HSA bank account application](#) before Jan. 1.

¹ Tallahassee State Bank assesses a small monthly fee for accounts with less than \$2,500 after they have been open one full month.

Wellness Benefits Comparison Chart

Wellness Benefits	PPO PLAN	HMO PLANS					
	Florida Blue	Aetna	AvMed	Capital Health Plan	Coventry	Florida Health Care Plans	UnitedHealthcare
Online Information, Tools and Member Discounts	www.bcbsfl.com or www.FloridaBlue.com	Members www.aetna.com Prospective (Coming Soon) http://www.aetnastateflorida.com/	www.avmed.org	www.capitalhealth.com	http://state.chcflorida.com	www.fhcp.com FHCP Member Portal: Offers secure access to the Health Portal, Member Resources, and Documents Portal	Members www.myuhc.com Prospective www.welcometouhc.com/florida
Health Assessments	Provided	Provided	Provided	Provided	Provided	Welcome to Wellness: An online health assessment that is provided through the Health Portal	Provided
Fitness Memberships	20% - 60% discount at participating facilities	Discounts at participating facilities through partnership with Globalfit. www.globalfit.com/fitness or 1-800-298-7800	Up to 30% discount at participating facilities	Discounts available at participating facilities and up to \$150 annual reimbursement (per household)	Discounts at participating facilities	Preferred Fitness: Free access to participating gyms upon completion of the Health Assessment for State of Florida Employees and their Eligible Dependents. Free access to participating gyms for Medicare members	Up to 50% off enrollment fee and up to 10% off monthly fee at participating facilities
Smoking Cessation	Help from eMindful	Online Simple Steps to a Healthier Life quit smoking program: Breathe	Reimbursement for Smokers booklet/CD when you quit AHEC Smoking Cessation	Health Information Line 850-383-3400 Florida Quit Line 877-822-6669 Freedom from Smoking: www.ffsonline.org Quit Smoking Now 850-224-1177	Breathe, online digital coaching program. More information at http://state.chcflorida.com	QuitSmart Program: FHCP pays the \$110 program fee and the member pays a \$20 supply fee Freedom from Smoking: Free online program Florida Quit Line: Free telephone counseling Quit Smoking Now: Free community six-week class	QuitSmart Program; smoking treatment plan and discounts on nicotine replacement products
Weight Management	Discounts available through Jenny Craig, and Nutri-Systems	Program discounts available through ediets, Jenny Craig, and Nutrisystem, online weight management tools and resources	Reimbursement for up to one year of fees once you reach goal weight	Health Information Line 850-383-3400; and online tools at www.capitalhealth.com Some reimbursement through Fitness Reimbursement. See website www.capitalhealth.com	Weight Watchers and Jenny Craig programs in addition to Online Health and Wellness Tools	Halifax Lighter Lifestyles Management Program Child-Weight Loss Classes Eat-right Move-right Weight Loss Classes Weight Loss Classes for Adults	Discount on Jenny Craig; online weight management program
Nutritional Counseling	Health Coach 877-789-2583	Discounts available for nutritional resources, including dietetic counseling; discounts on books and other products	Up to 30% discount for network dieticians and nutritionists	Health Information Line 850-383-3400	Up to 30% discount at participating practitioners and online nutrition program and tools at http://state.chcflorida.com	Customized Individual consultation and/or group classes with an FHCP Registered Dietician. Nutrition Courses: Pre-Diabetes, Healthy Heart Eating, and Nutrition Game Plan for Diabetes	Health coaching online including nutrition program support; discounts on books and products
Nutritional Supplements		Save 15% on over 2,400 OTC vitamins and other homeopathic remedies	Discounts available		Discounts available through My Online Services		Discounts on vitamins and foods
Health Counseling	Health Dialog 877-789-2583	Informed HealthLine at 1-800-556-1555, available 24/7; disease management nurse contact, and medical consultations online with medical doctors with a 20-50% discount.	Nurse On Call 888-866-5432 24/7 specialized disease management education services available.	Health Information Line 850-383-3400; and online tools at www.capitalhealth.com	Health and Wellness Coaching http://state.chcflorida.com	24 Hour Nurse Advice Line: Speak with a Registered Nurse 24x7 in English or Spanish to help understand a condition or symptom, ask a confidential question, or find advice on where to go for care. Welcome to Wellness: Online health guidance and counseling, Health Education Services & Programs: Diabetes, Pre-Diabetes, Heart Disease, Heart Failure, Asthma, COPD, High Blood Pressure, Depression, Osteoporosis, and Case Management	NurseLine, Nurse Chat, and Health Coach online
Prenatal Education	Healthy Addition Prenatal Program 800-955-7635, option 6	Prenatal and postpartum care programs through Beginning Right Maternity Management	Prenatal and Postpartum Care Program	www.capitalhealth.com Health Information Line 850-383-3400	Prenatal and Postpartum Care programs	Halifax Healthy Families	Healthy Pregnancy Program
Massage and Acupuncture		At least 25% discount at participating locations	Discounts available		Up to 30% discount at participating locations	Complementary and Alternative Medicine Program offering 20% discount on services available for Employees and Medicare members	Discounts available
Meditation and Guided Imagery		Discounts available	Discounts available	www.capitalhealth.com CHP Connect	Up to 30% discount at participating locations	May be offered by participating gyms as part of the Preferred Fitness Program. (Check with selected gyms for details (yoga, meditation, etc.))	Discounts available
Exercise Classes (e.g., yoga, pilates)	Discounts available	Discounts available at participating locations on yoga equipment, books, DVDs through Pranamaya	Discounts available	Discounts available	Up to 30% discount at participating locations	Matter of Balance Fall Prevention Program Acute Neck and Low Back Pain Program Preferred Fitness: Each gym has unique exercise class and weight training programs. Contact the participating gym for details.	Included at participating locations
Fitness Equipment, Apparel and Footwear	Discounts available	Discounts available			Discount and awards available through My Online Services	Discounts available through Blue365	Discounts available

Health Maintenance Organizations (HMO)

Except for Medicare Advantage Plans through Capital Health Plan (CHP) and Florida Health Care Plans (FHCP), each HMO is a self-insured health plan. This means the state pays medical and prescription drug claims. Each HMO administers medical coverage and Express Scripts administers prescription drug coverage, except for CHP and FHC. See [Page 24](#) for more information about the State Employees' Prescription Drug Plan.

Health Maintenance Organizations provide health services for active employees who live or work for the state within the HMO's contracted service area and for retirees if they live in the HMO's contracted service area. There is limited or no coverage for services outside the HMO service areas except in emergencies. Carefully consider the HMO's policy, especially if you have dependents that do not live in the service area.

Do not choose your HMO plan only because a particular physician, physician group, hospital or other health care provider participates in a plan. At any point providers can leave the HMO provider network. If this happens, you must choose a new provider from the network. If you use a provider who is not part of the network, you may have to pay up to the entire amount for services. If your doctor leaves the network, you can only change or cancel health plans during the next Open Enrollment period or if you have an appropriate qualifying status change (QSC) event; in other words, your doctor leaving the network it is not a QSC event to change plans.

Health Maintenance Organization plans focus on prevention, early detection, and treatment of illnesses to reduce expensive and inconvenient hospital stays. There are no pre-existing condition exclusions or waiting periods.

For some HMOs, you must choose a primary care physician (PCP) within the HMO provider network. A PCP is the provider you visit for most of your health care needs. If you decide to change your PCP, you must contact the HMO and complete any necessary paperwork.

If you need to see a specialist for a specific concern, you may need a referral from your PCP. (You do not need a referral to see dermatologists, gynecologists for well-woman checkups, chiropractors, podiatrists or for emergency care.) Some participating HMOs do not require referrals from your PCP, but you must use specialists in the HMO network.

Primary care physicians and other providers vary among HMOs and the list can change. You should contact the HMO or review the list of network providers on the HMOs' websites.

To see which HMO offers coverage in your county, see the HMO Service Areas by County chart on [Page 23](#).

Charges for Standard HMO Plans

Copayment: A payment for physician services, urgent care, emergency room visits and hospital admissions fees.

HMO Preventive Features

Both Standard and Health Investor HMO plans provide preventive care (including items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved; immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; care and screenings provided by the Health Resources and Services Administration (HRSA) with respect to infants, children and adolescents; and well-woman exams (with no member cost share). A complete list of preventive services may be found at <http://www.healthcare.gov/law/resources/regulations/prevention/index.html>.

Both Standard HMO plans and Health Investor HMO plans also provide routine eye exams with the appropriate copay or coinsurance, respectively. Health Maintenance Organizations plans may also offer significant discounts on glasses, contact lenses and some corrective surgeries. Contact your local HMO to get details on the vision care discounts they offer.

Other preventive features may include gym discounts, smoking cessation classes, and health counseling and education. To compare these benefits see the Wellness Benefits Chart on [Page 19](#). Other preventive features may include gym discounts, smoking cessation classes, and health counseling and education. To compare these benefits see the Wellness Benefits Chart on [Page 19](#).

Moving Out of Your HMO's Service Area

If you have Standard or Health Investor HMO coverage and move so that you neither live nor work for the state in the service area, and you lose eligibility, you have 60 days to notify People First to change your plan. If you move out of state, you can only continue coverage through the State Employees' PPO Plan.

Standard and Health Investor HMO Plans Comparison Chart

Covers care received only in the network	Standard HMO	Health Investor Health Plan HMO
Annual Deductible (before anything but preventive care is covered) <ul style="list-style-type: none"> • Individual • Family 	No deductible No deductible	\$1,250 ¹ \$2,500 ¹
Costs for Care <ul style="list-style-type: none"> • Doctor office visits • Hospital stay 	\$20 per visit for PCP \$40 per visit for specialists \$250	20% 20% 20%
Prescription Drugs: Up to 30-day retail or up to 90-day mail order prescription <ul style="list-style-type: none"> • Generic • Preferred Brand • Non-Preferred Brand 	\$7/retail; \$14/mail order \$30/retail; \$60/mail order \$50/retail; \$100/mail order	30% 30% 50%
Preventive Care (coverage based on age and gender): Certain routine physical exams, health screenings, and immunizations	See the HMO's Certificate of Coverage (COC) or Summary Plan Document.	Same as standard HMOs; no deductible required
Annual Out-of-Pocket Maximum <ul style="list-style-type: none"> • Individual • Family 	\$1,500 \$3,000	\$3,000 ¹ \$6,000 ¹ After you reach your out-of-pocket maximum, the plan pays 100% up to allowable cost for most covered care for the rest of the calendar year
Qualifies for HSA	No	Yes, after you open an HSA account at Tallahassee State Bank, the state contributes up to \$500 for individual coverage or up to \$1,000 for family coverage each year
Qualifies for Medical FSA	Yes—Medical Reimbursement Account (MRA)	Yes—Limited Purpose MRA

¹ Prescriptions are included.

Health Investor HMO Plans

While the Health Investor HMO plans cover all the same services and supplies as the Standard HMO plans, there are some key differences. Under the Health Investor HMO:

- If you are a Career Service (or equivalent) employee or a retiree, your monthly insurance premiums are lower.
- You must meet the plan deductible for all services and prescriptions except certain preventive services. This means you pay the first \$1,250 (individual plan) or \$2,500 (family plan) out of pocket.
- Active employees:
 - If you or your covered dependents do not have other health coverage, you may open a Health Savings Account (HSA) and make pretax contributions to it. You can use the HSA to pay out-of-pocket expenses, such as your deductible and coinsurance, even if you leave state employment. See Page 43 for more information about the HSA.
 - If you enroll in an HSA and open an HSA bank account at Tallahassee State Bank, the state contributes \$41.66 per month for full-time employees with individual coverage (up to \$500 annually) or \$83.33 per month for family coverage (up to \$1,000 annually).
 - In addition to the state's contribution to your HSA bank account, you can contribute your own additional pretax funds to the account to reach the maximum limit (including state contribution) of \$3,300 for individual coverage and \$6,550 for family coverage. If you are 55 or older you can contribute an additional \$1,000.
 - This money rolls over and you can take it with you.
 - The state can deposit money only after you open your HSA bank account at Tallahassee State Bank¹. To be sure you receive the state money you are entitled to and your own contribution (if any):
 1. Select the Health Investor HMO Plan as your health plan, and
 2. Enroll in an HSA through People First, and
 3. Open a personal HSA bank account at Tallahassee State Bank¹ by completing the HSA bank account application before Jan. 1.

Charges for the Health Investor HMO Plans

- Coinsurance: A percentage of the medical and pharmacy costs you are required to pay after your annual deductible is met.
- Annual deductible: This is a yearly amount you are required to pay before anything except some preventive care is covered. You pay the first \$1,250 (\$2,500 for family) for all services and prescriptions out of pocket. After you meet your total annual deductible, you pay the coinsurance amount.

¹ Tallahassee State Bank assesses a small monthly fee for accounts with less than \$2,500 after they have been open one full month.

HMO Service Areas by County

ALACHUA

AvMed

BAKER

AvMed

BAY

UnitedHealthcare

BRADFORD

AvMed

BREVARD

Aetna

BROWARDAvMed
Coventry**CALHOUN**

Capital Health Plan

CHARLOTTE

UnitedHealthcare

CITRUS

AvMed

CLAY

AvMed

COLLIER

UnitedHealthcare

COLUMBIA

AvMed

DESOTO

UnitedHealthcare

DIXIE

AvMed

DUVAL

AvMed

ESCAMBIA

Coventry

FLAGLERAvMed
Florida Health Care Plans**FRANKLIN**

Capital Health Plan

GADSDEN

Capital Health Plan

GILCHRIST

AvMed

GLADES

UnitedHealthcare

GULF

UnitedHealthcare

HAMILTON

AvMed

HARDEE

AvMed

HENDRY

Coventry

HERNANDO

AvMed

HIGHLANDS

AvMed

HILLSBOROUGH

AvMed

HOLMES

UnitedHealthcare

INDIAN RIVER

AvMed

JACKSON

UnitedHealthcare

JEFFERSON

Capital Health Plan

LAFAYETTE

UnitedHealthcare

LAKE

AvMed

LEE

UnitedHealthcare

LEON

Capital Health Plan

LEVY

AvMed

LIBERTY

Capital Health Plan

MADISON

Coventry

MANATEE

AvMed

MARION

AvMed

MARTIN

AvMed

MIAMI-DADEAvMed
Coventry**MONROE**

UnitedHealthcare

NASSAU

AvMed

OKALOOSA

UnitedHealthcare

OKEECHOBEE

UnitedHealthcare

ORANGE

AvMed

OSCEOLA

AvMed

PALM BEACHAvMed
Coventry**PASCO**

AvMed

PINELLAS

AvMed

POLK

AvMed

PUTNAM

UnitedHealthcare

SANTA ROSA

Coventry

SARASOTA

UnitedHealthcare

SEMINOLE

AvMed

ST. JOHNS

AvMed

ST. LUCIEAvMed
Coventry**SUMTER**

AvMed

SUWANNEE

AvMed

TAYLOR

UnitedHealthcare

UNION

AvMed

VOLUSIAAvMed
Florida Health Care Plans**WAKULLA**

Capital Health Plan

WALTON

UnitedHealthcare

WASHINGTON

UnitedHealthcare

State Employees' Prescription Drug Plan

Express Scripts is the pharmacy benefits manager for the prescription drug benefits for State Group Insurance health plans (except the CHP and the FHCP Medicare Advantage plans). This means the state pays prescription drug claims and Express Scripts is the pharmacy benefit management company that provides your comprehensive prescription benefit management services. If you have questions about your prescription drug costs, available generic alternatives, specialty medications, using mail order or finding a network pharmacy, call Express Scripts (Medco) Member Services anytime (24/7/365) at 877-531-4793

For general plan information, visit www.medco.com/sofrxplan. Members should create an account at www.medco.com to see prescription drug history, check for generic alternatives, order refills for mail order maintenance drugs, check the status of an order and use many other features. Both websites provide drug cost information, the most up-to-date preferred drug list and a sample of the tools available to members of the State Employees' Prescription Drug Plan.

All health insurance options include comprehensive prescription drug coverage with two parts: a network of retail pharmacies and a mail order pharmacy.

1. Retail: Use your Medco prescription drug card at your local pharmacy for short-term medications and those that must be filled immediately.
2. Mail Order: Send your prescriptions for maintenance medications¹ to the mail order pharmacy and get up to a 90-day supply for the same cost as two 30-day fills at a retail pharmacy—which is like getting one free fill at retail. To use the mail order program, ask your doctor to write your prescription for up to a 90-day supply with three refills. This allows you to take advantage of the mail order savings. State Employees' PPO Plan members are required to use mail order for certain prescribed maintenance drugs¹ after they have been filled three times at a retail pharmacy, which went in to effect Jan. 1, 2011.

This chart shows the cost savings of using generic drugs and the mail order pharmacy for maintenance medications. All copays are for members of Standard HMO or PPO health plans only. (See the next page for Health Investor Health Plan member information.)

State Employees' Prescription Drug Plan	Retail (up to a 30-day supply)	Mail Order (up to a 90-day supply)
Generic Drugs	\$7	\$14
Preferred-Brand Drugs	\$30	\$60
Nonpreferred-Brand Drugs	\$50	\$100

Twice a year, Medco updates its Preferred Drug List as a guide (not an all-inclusive list) for you and your health care providers. Non-members can visit www.medco.com/sofrxplan for more information. Members can log in to www.medco.com.

For PPO plan members, Medco maintains a list of maintenance medications that must be filled through mail order after three fills at retail pharmacy which went in to effect Jan. 1, 2011. Non-members may visit www.medco.com/sofrxplan for more information; members can log in to www.medco.com.

Health Investor Health Plan Members

If you are a Health Investor Health Plan member, you must first satisfy the appropriate individual or family annual deductible. After paying this deductible out of pocket, your coinsurance for retail and mail order drugs is 30 percent for generic and preferred brand-name drugs and 50 percent for non-preferred brand-name drugs. There are no copays for members of these health plans.

Medicare Advantage Plans

If you are a CHP Retiree Advantage or FHCP Medicare Advantage Plan member, call the customer service department or visit the HMO's website for prescription drug information.

¹ Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, ongoing use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Save Money on your Prescription Costs

There are several easy things you can do to save money on prescription drugs:

- Use generics whenever possible or choose a preferred brand-name drug if a generic is not available.
- Use mail order to reduce your copays and receive up to a 90-day supply at the same cost as two retail refills.
- At retail pharmacies, show your Medco ID card to be sure you're charged the appropriate copayment (Standard plans) or coinsurance (Health Investor plans).
- Check your local pharmacy outlets. Some retail pharmacies, grocery stores and warehouse clubs offer frequently prescribed generic drugs for \$4 or for free. To take advantage of these prices, you cannot use your insurance plan. In other words, do not show your Medco ID card.

Important

In the plans described above, if you request a brand-name drug when a generic is available, you must pay the difference between the generic cost and the brand-name cost, plus the appropriate copayment or coinsurance. If your physician writes on the prescription that the brand-name drug is medically necessary or "dispense as written" and the reason why, you only have to pay the appropriate copayment or coinsurance.

Prescription Drugs—What's the Difference?

Generic medications may look different, but they provide the same level of quality, safety and effectiveness as the brand-name medicine for a lower price.

Often two brand-name drugs (non-generic) can be used for the same medical condition. One may be less expensive than the other or have superior clinical results. The less-expensive or clinically superior drug becomes a preferred brand-name drug and the other becomes non preferred brand-name drug. Check Medco's Preferred Drug List (PDL) periodically; it's updated twice a year. Sometimes a drug moves from the PDL to the non-preferred brand name list. If this happens, ask your doctor to prescribe a preferred brand-name drug or generic drug that would cost less money and work just as well.

My Life

Basic Life

Optional Life

Additional Plan Benefits



Key Points

- You can fill out your beneficiary form online.
- Life insurance plans include additional benefits.
- Minnesota Life provides [additional legal and planning services](#) for members.

My Life

The state offers term life insurance, including an accidental death and dismemberment benefit underwritten by Minnesota Life, to full-time and part-time employees and to State of Florida retirees. To learn more about Minnesota Life, call 888-826-2756 or visit www.lifebenefits.com/florida.

Basic Life for Active Employees

The state offers Basic Life insurance to all eligible employees. The benefit is \$25,000, regardless of employee classification or age. Part-time employees receive the same benefit if they enroll, but pay a low monthly premium that is prorated based on their full-time equivalency (FTE). Eligible OPS/variable-hour employees pay must enroll and pay the full monthly premium for coverage.

Enrollment in Basic Life insurance is automatic for all full-time, salaried employees upon hire. If you do not want this coverage, you can waive it during your first 60 days of employment, during Open Enrollment or with an appropriate qualifying status change event. Part-time employees and OPS/variable-hour employees must enroll through People First if they want Basic Life insurance coverage.

Basic Life Conversion Option

If you terminate employment, you can convert your Basic Life policy to an individual plan. To do so, call Minnesota Life at 1-888-826-2756 within 31 days from the date coverage ends.

Optional Life for Active Employees

If you are enrolled in the Basic Life insurance plan and you are a salaried employee (OPS/variable-hour employees are not eligible), you can purchase additional term life insurance, which is an employee-pay-all, post-tax benefit. You may apply for one to seven times your annual salary in optional coverage. The maximum limit is \$1 million. If you choose a coverage tier that takes you over \$1 million, your premium is based on the \$1 million cap and your benefit equals \$1 million.

If you are currently enrolled in Optional Life (meaning you currently have at least one times your annual salary), you can increase your coverage amount during Open Enrollment or with an appropriate qualifying event. If you increase by one increment up to the lesser of \$500,000 or five times your annual salary, you do not have to provide proof of good health. Enrolling during Open Enrollment,

increasing by more than one increment, choosing coverage of more than \$500,000 or choosing six or seven times salary requires proof of good health. Make changes online in [People First](#), complete the Evidence of Insurability form and send it to Minnesota Life.

If you are a newly hired employee, you can enroll in this optional coverage on a guaranteed issue basis up to the lesser of \$500,000 or five times annual salary. This means you can choose one to five times your annual salary, as long as the coverage amount is less than \$500,000, without providing proof of good health. Coverage over \$500,000 or for six or seven times salary requires proof of good health. You must enroll in coverage through [People First](#) within 60 days of being hired.

Optional Life Portability Option

If you leave state employment other than by retiring, you may be able to continue your Optional Group Life insurance up to age 70 by paying premiums directly to Minnesota Life. Group rates still apply to ported coverage, but are higher than those for active employees. Call Minnesota Life at 888-826-2756 for more information.

Basic Life for Retirees

Upon retirement, retirees have two options to continue basic term life insurance through the state:

1. \$2,500 benefit - your monthly cost is \$7.41
2. \$10,000 benefit - your monthly cost is \$29.65

You can change your coverage level during open enrollment or with an appropriate qualifying status change event; however, if you cancel your life insurance coverage, you will be unable to reenroll later as a retiree.

Beneficiaries

If you have not done so, complete your Beneficiary Designation and Change Request form as soon as possible. To designate or change your beneficiary online, go to www.lifebenefits.com/florida or get a form at the [mybenefits website](#) and send it to Minnesota Life's Tallahassee branch office at the address on the form. If you do not designate a beneficiary in writing, Minnesota Life pays the proceeds according to the default beneficiary provisions of the policy in this order: your spouse, children, parents and the personal representative of your estate. Payments made to an estate, however, may result in a reduction of total benefits due to taxes and probate costs.

Additional Plan Benefits

Accidental Death and Dismemberment - All Members

Both Basic and employee Optional Life insurance coverage include accidental death and dismemberment coverage. Significant benefits may be available in the event of accidental death or injury. Payment amounts vary from 25 percent to 100 percent of your coverage.

Accelerated Death Benefit - All Members

The Accelerated Death Benefit, or “living benefit option,” provides you with an advanced benefit if you are diagnosed with a terminal illness and have less than 12 months to live. You may be eligible for up to 100 percent of your life insurance benefits (\$1 million maximum). Upon death, the balance of the life insurance benefit, if any, is paid to the named beneficiaries.

Conversion Privileges - All Members

You lose your life insurance coverage if you leave state employment, become ineligible for coverage or neglect to pay the premium. If you lose your coverage, you can convert some or all of the life insurance to an individual contract. Regardless of your age or health, you can purchase an individual life insurance policy, provided the conversion request and premium payment are made to Minnesota Life within 31 days of group plan termination. Call Minnesota Life at 888-826-2756 for the conversion forms and applicable premium information.

Waiver of Premium - Active Employees

If you become disabled before age 60, Minnesota Life may waive your premiums. Call Minnesota Life at 888-826-2756 for more information on the Waiver of Premium option.

How to Make Changes in People First

In our continued effort to streamline processes, save state dollars and protect the environment, we are eliminating several paper election forms. You can easily make Open Enrollment changes in People First:

1. Turn off the browser’s pop-up blocker and log in to peoplefirst.myflorida.com.
2. Select Start or the Open Enrollment link and then follow the simple steps to certify dependent eligibility and register new dependents (Social Security numbers required). Enter your People First password and select Certify to complete the dependent certification process.
3. Select Enroll Now to start. Your current benefits and what you will have next year are side-by-side so you can easily verify or change your elections.
4. Click Change, Add or Cancel to make updates.
5. Once you’ve confirmed your choices, enter your People First password and select Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section.

1. Select 2014 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials.
2. To view or print your confirmation statement, select View Details.

My Supplemental Plans

Dental
Vision
Accident
Cancer
Disability
Hospital Intensive Care
Hospitalization



Key Points

- Supplemental plans offer varying coverage levels. Some offer only individual and family; others offer more options. Be sure you enroll in the correct coverage level.
- Some dental plans have provider networks, and dentists can leave at any time. Provider preference is not a qualifying status change event for you to cancel or change dental plans.
- Dental plans offer various rates and benefits. Compare plan benefits carefully and look at more than the monthly premium amount – [Page 32](#).
- All enrollments and changes must go through People First, not the insurance company; however, some companies require a separate application before your enrollment is complete.

Supplemental Plans

The state offers active employees the opportunity to participate in optional, employee-pay-all, supplemental insurance plans. These plans are called employee-pay-all because employees pay the entire premium; the state does not contribute. Like the health plans, the state deducts premiums for these plans from your paycheck on a pretax basis (before taxes are taken out). These plans are made available to you as a convenience. Retirees may only continue dental or vision through COBRA upon retirement. To learn about a specific plan, see the contact information on Page iv.

Most of these supplemental plans offer a variety of benefit and premium levels. Some cover services and some pay you cash if you need hospitalization, are treated for cancer, spend time in a hospital intensive care unit, have an accident, or become disabled. For most plans, you can choose different levels of coverage for different premium amounts.

You must make all changes to your supplemental products—adding coverage, adding or removing dependents, changing benefit levels, etc. through [People First](#). If you make these changes through only the insurance agent or company, the changes will not take effect.

Some of the cancer and all hospital intensive care insurance plans require medical underwriting. This means you must complete the company's medical underwriting application before you are approved for coverage. To get coverage enroll online through [People First](#) then see a company agent for an application to send directly to the insurance company. Once you are enrolled and approved, the state withholds one full month's premium from your paycheck. Only then does your coverage take effect.

Enroll in the supplemental plans through the [People First website](#) during Open Enrollment or as permitted by a qualifying status change event or when you are first hired. For some accident, disability, cancer and hospital intensive care plans, you must also submit separate applications to the insurance companies.

Be sure you choose the correct coverage tier. Different products offer different levels of coverage.

Available Coverage Tiers by Plan	Employee	Employee + Spouse	Employee + Children	Family
Dental	✓	✓	✓	✓
Vision	✓	✓	✓	✓
Accident	✓	✓	✓	✓
Cancer ¹	✓		✓	✓
Disability	✓			
Hospital Intensive Care	✓		✓	✓
Hospitalization	✓	✓	✓	✓

Dental Plans

The state offers employee-pay-all, pretax dental plans. Each plan offers different payment rates, services and provider networks. Review these plans closely to determine which one best fits your needs. You may enroll in only one dental plan. Read the dental plans comparison chart ([Page 30](#)) to see how the plans work. The dental plan rate chart on [Page 32](#) compares each plan by monthly premium costs and out-of-pocket costs for the most common dental procedures. Use the [dental plan cost estimator](#) on the [mybenefits website](#) to compare plan costs based on your dental needs for next year. Contact the plans directly to learn more.

Follow These Steps to Choose a Dental Plan:

1. Compare the four dental plan options—prepaid, PPO, indemnity with PPO, and indemnity plans. See chart below for a side-by-side comparison.
2. Check to see which dentists and specialists are available in each plan. Providers may drop out of the plan at any time; this is not a qualifying status change (QSC) event to change plans.

Think about your likely dental care needs for the coming year and compare your cost for that care and your cost for coverage under the different options. An easy way to do this is to use the [dental plan cost estimator](#).

3. Read the dental plan document or call the insurance company for specific questions you have about coverage.
4. Factor tax-favored accounts into your decision [Page 38](#).
5. Decide which option is best for you.

¹ Some plans only offer employee and family coverage.

Dental Plans Comparison Chart

Plan Type	Prepaid Dental Plan	Dental Preferred Provider Organization Plan (DPPO)	Dental Indemnity with a DPPO Network Plan	Dental Indemnity Plan
Definition	Network of dentists and specialists to keep your costs low. Does not cover out-of-network services.	Discounted rates on services if you use dentists or specialists in the network.	Discounted rates on services if you use dentists or specialists in the network, but you can use any provider you choose.	Scheduled reimbursement amount (set fee) for covered services from any dentist or specialist.
Choice of Providers	Network only	In or out of network	Any you choose	Any you choose
Preventive Care (No deductible)	Most services covered at no charge to you.	No charge in network. You pay 20% of cost for out of network.	No charge or you pay cost above a set dollar amount.	You pay cost above a set dollar amount.
Basic and Major Care	Set copays or a percentage of cost	Percentage of cost	Cost above a set dollar amount or a percentage of cost	Cost above a set dollar amount or a percentage of cost
Calendar Year Maximum	No	Yes	Yes	Yes
Deductible	No	Yes, for basic and major care	Yes, for basic and major care	Yes, for basic and major care
You Should Know	Your dentist could leave the network at any time. This is not a qualifying status change (QSC) event to cancel or change dental plans or coverage levels.	If you see an out-of-network dentist or specialist, your out-of-pocket costs are much higher.	You pay any amount per year over the calendar year maximum. If you see an out-of-network dentist or specialist, your out-of-pocket costs are much higher.	You pay any amount per year over the calendar year maximum.
People First Plan Code and Plan Name	4004 Humana Network Plus 4014 UnitedHealthcare Dental Solstice S700 4025 Assurant Employee Benefits Prepaid 225 4034 CIGNA Dental 4044 Humana Select 15	4054 Humana Preferred Plus	4064 Ameritas Dental Preventive Plus 4074 Assurant Employee Benefits Freedom Advance	4084 Humana Schedule B

Dental Plans Rate Chart

Your dental plan may limit the number of visits and/or services (frequency)

		Prepaid Dental Plans (In-Network Only)					Dental PPO Plan		Indemnity with Dental PPO Plans		Indemnity Plan
		Humana Network Plus	UnitedHealthcare Solstice S700	Assurant Employee Benefits Prepaid 225 Plan	CIGNA Dental	Humana Select 15	Humana Preferred Plus		Ameritas Dental	Assurant Employee Benefits Freedom Advance	Humana Schedule B
People First Plan Code		4004	4014	4025	4034	4044	4054		4064	4074	4084
MONTHLY PREMIUM											
Employee Only		\$23.58	\$10.91	\$14.93	\$27.38	\$12.64	\$31.76		\$10.20	\$41.48	\$14.74
Employee + Spouse		\$46.48	\$23.95	\$25.17	\$49.22	\$21.20	\$58.76		\$20.76	\$79.63	\$21.96
Employee + Child or Children		\$55.42	\$29.90	\$33.26	\$57.92	\$23.00	\$65.66		\$27.00	\$93.84	\$23.30
Employee + Family		\$70.80	\$41.98	\$43.54	\$70.26	\$32.98	\$95.32		\$37.56	\$124.14	\$37.10
Calendar Year Deductible		\$0	\$0	\$0	\$0	\$0	In Network	Out-of-Network Individual: \$50 Family: \$100; Waived for Type I-Diagnostic & Preventive Services	\$50 Calendar Year Waived on Type 1	\$50/person; \$100/family waived on Type 1 and IV	Individual: \$50 Family: \$150; Waived for Type I-Preventive Services
Calendar Year Maximum		\$0	\$0	\$0	\$0	\$0	\$1,200/person		\$1,000/person ⁸	\$1,250/person	\$1,000/person
							In Network	Out of Network			
ADA Code	EXAMS	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay	You Pay
D0120	Periodic Oral Evaluation	\$0 ¹⁻⁹	\$0	\$0	\$0	\$0	\$0 ¹	20% ¹	Cost above \$14	\$0	Cost Above \$11.70 ¹
D0140	Limited Oral Evaluation - problem focused	\$0 ¹⁻⁹	\$0	\$0	\$0	\$0	\$0 ¹	20% ¹	Cost above \$15	\$0	Cost Above \$15.30 ¹
D0150	Comprehensive Oral Evaluation	\$0 ¹⁻⁹	\$0	\$0 ¹	\$0	\$0	\$0 ¹⁶	20% ¹⁶	Cost above \$22	\$0	Cost Above \$15.30 ¹
X-RAYS											
D0210	Intraoral - Complete Series, including bitewings	\$0 ¹⁴	\$0	\$0	\$0	\$0	\$0 ¹⁶	20% ¹⁴	Cost above \$45	20% ¹⁶	Cost Above \$30.60 ¹⁴
D0220	Intraoral - Periapical first film	\$0 ⁹	\$4	\$0	\$0	\$0	\$0 ¹⁷	20% ¹⁷	Cost above \$8	20% ¹⁷	Cost Above \$6.30
D0230	Intraoral - Periapical each additional film	\$0 ⁹	\$2	\$0	\$0	\$0	\$0 ¹⁷	20% ¹⁷	Cost above \$6	20%	Cost Above \$6.30
D0272	Bitewings - two films	\$0 ¹⁻⁹	\$0	\$0	\$0	\$0	\$0 ¹⁸	20% ¹⁸	Cost above \$13	\$0 ¹⁴	Cost Above \$12.60 ¹
D0274	Bitewings - four films	\$0 ¹⁻⁹	\$0	\$0	\$0	\$0	\$0 ¹⁸	20% ¹⁸	Cost above \$20	\$0 ¹⁴	Cost Above \$16.20 ¹
D0330	Panoramic film	\$0 ¹⁴	\$50	\$0	\$0	\$0	\$0 ¹⁴	20% ¹⁵	Cost above \$36	20%	Cost Above \$23.40 ¹⁴
PREVENTIVE SERVICES											
D1110	Prophylaxis - adult cleaning	\$0 ¹⁻⁹	\$0 ¹	\$0 ¹	\$0	\$0 ¹	\$0 ¹	20% ¹	Cost above \$30	\$0 ¹	Cost Above \$18.90 ¹
D1120	Prophylaxis - child cleaning	\$0 ¹⁻⁹	\$0 ¹⁻²	\$0 ¹	\$0	\$0 ¹	\$0 ¹	20% ¹	Cost above \$21	\$0 ¹	Cost Above \$18.00 ¹
D1203	Fluoride - child	\$0 ⁹	\$0 ²	\$0	\$0	\$0 ²	\$0 ²⁻¹⁵	20% ²⁻¹⁵	Cost above \$11	\$0 ³	Cost Above \$15.30 ¹⁻²
D1351	Sealant - per tooth	\$0 ¹⁴	\$0 ²	\$0	\$11	\$7	\$0 ²⁻¹⁴	20% ²⁻¹⁴	Cost above \$17	\$0 ²	Cost Above \$6.30 ¹⁵
SILVER FILLINGS											
D2140	Amalgam, 1 surface, primary or permanent	\$6 ⁹	\$0	\$10	\$0	\$0	20%	50%	Cost above \$25	20%	Cost Above \$11.70
D2150	Amalgam, 2 surfaces, primary or permanent	\$8 ⁹	\$0	\$15	\$0	\$0	20%	50%	Cost above \$32	20%	Cost Above \$18.00
WHITE FILLINGS, FRONT TEETH											
D2330	Anterior Composite, 1 surface	\$8 ⁹	\$30	\$25	\$0	\$30	20%	50%	Cost above \$30	20%	Cost Above \$15.30
D2331	Anterior Composite, 2 surfaces	\$10 ⁹	\$37	\$35	\$0	\$37	20%	50%	Cost above \$38	20%	Cost Above \$22.50
ONLAYS AND CROWNS											
D2740	Crown, All Porcelain	\$280 ⁹	\$245 ⁵	\$225 ⁵	\$490 (all inclusive)	75%	50%	70%	Cost above \$161	50%	Cost Above \$95.40
D2950	Core Build Up	\$59 ⁹	\$70	\$75	\$130 (includes Pins)	\$40	50%	70%	Cost above \$32	50%	Cost Above \$36.00
PERIODONTAL CARE (for gums)											
D4341	Periodontal Therapy, 4+ teeth/quadrant	\$14 ^{9,15}	\$50	\$75 ⁹	\$83	\$45	20% ¹⁶	50% ¹⁶	Cost above \$52	50%	Cost Above \$14.40 ¹
D4910	Periodontal Maintenance	\$9 ¹⁻⁹	\$50	\$45	\$50	\$45	20%	50%	Cost above \$32	50% ¹⁵	Cost Above \$19.80 ¹
EXTRACTIONS											
D7140	Extraction, erupted tooth or exposed root	\$8 ⁹	\$20	\$18	\$12	\$0	20%	50%	Cost above \$28	20%	Cost Above \$14.40
D7210	Surgical removal of erupted tooth	\$14 ⁴	\$30	65 ⁴	\$50	\$25	20%	50%	Cost above \$54	50%	Cost Above \$26.10
ORTHODONTIA CARE ⁶											
D8080	Comprehensive orthodontic treatment of adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	\$1,580	\$2,250	\$2,000	\$2,045	75%	50% (up to \$1,500 lifetime max reimbursement per person)	Not Covered	Not Covered	50%; \$1,000 lifetime max benefit	Not Covered
D8090	Comprehensive orthodontic treatment of adult dentition (full treatment case up to 24 months - including fixed removable appliances)	\$1,580	\$2,350	\$2,200	\$2,385	75%	50% (up to \$1,500 lifetime max reimbursement per person)	Not Covered	Not Covered	Not Covered	Not Covered
None	Bracketing (for above procedures D8080 or D8090)	Included	Included	\$300	\$515	Included	Included	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered
D8660	Pre-orthodontic treatment visit (consult/records/exam)	\$80	\$35	\$100	\$67	75%	50% (up to \$1,500 lifetime max reimbursement per person)	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$250	\$300	\$250	\$345	75%	50% (up to \$1,500 lifetime max reimbursement per person)	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered
D8999	Unspecified Orthodontic Procedure - By Report (Orthodontic Treatment Plan and Records)	Included	\$250	Included under D8660	\$195	Included	Included	Not Covered	Not Covered	Subject to limits in Code D8080	Not Covered

Use this rate chart to compare dental plan costs. The rows show the monthly premium and the amount or percentage you pay for the common dental services listed. The columns list the costs by plan. "Cost above" means you pay any dollar amount that is higher than the amount shown. Use the online cost estimator to compare your likely total costs under each plan at www.myflorida.com/mybenefits.

All fees listed here are approximate and are based on the services of a general dentist. Refer to the plan documents or contact the plans directly for payment information, limitations and treatment schedules related to your specific needs. Where plan documents differ from the information on this chart, they shall take the place of this chart.

¹ Limited to once every six months

² Only for children under age 16

³ Only for children under age 14

⁴ Only for children under age 13

⁵ Services require separate payment of laboratory charges

⁶ Copays do not include pre-exam and retention

⁷ 75% during first year; 50% for second and subsequent years of continuous coverage

⁸ Plan payments for covered preventive procedures are not deducted from your annual maximum benefit.

⁹ Copayment for General Dentist or Specialist is the same

¹⁰ No more than one time in any 12 months in a row

¹¹ Once every six months (frequencies combined with routine dental cleanings)

¹² No more than one time in any 60 months in a row

¹³ No more than 4 x-rays in any 12 months in a row

¹⁴ Limited to one per 36 months

¹⁵ Limited to one per 12 months

¹⁶ Limited to one per 24 months

¹⁷ Limited to four per 12 months; includes D0220/D230

¹⁸ Limited to one set per 12 months; includes D0272/D274

Vision Plans

Humana Vision, offers two employee-pay-all, pretax vision plans: the full coverage Exam Plus plan and the Materials Only plan. Review the benefits comparison chart, keeping in mind that you may have some coverage of vision services available under your health plan. Then make the choice that is best for you.

Vision Plans Comparison Chart

	Exam Plus (People First Plan Code 3004)		Materials Only (People First Plan Code 3006)	
Monthly Member Rates				
Employee Only	\$5.85		\$4.36	
Employee + Spouse	\$11.56		\$8.60	
Employee + Children	\$11.44		\$8.50	
Family	\$17.98		\$13.38	
Frequency (based on the date of service)				
Exam Every	12 months		N/A	
Lenses Every	12 months ¹		12 months ¹	
Frames Every	24 months		24 months	
Copayments				
Exam	\$10		N/A	
Lenses and/or Frames	\$10		\$10	
Benefits	In Network	Out of Network²	In Network	Out of Network²
Eye Exam	100% after copay	\$50 allowance	N/A	N/A
Lenses				
Single	100% after copay	\$40 allowance	100% after copay	\$40 allowance
Bifocal	100% after copay	\$60 allowance	100% after copay	\$60 allowance
Trifocal	100% after copay	\$80 allowance	100% after copay	\$80 allowance
Frames	\$75 wholesale	\$60 retail	\$75 wholesale	\$60 retail
Contact Lenses³				
Elective	\$100 allowance	\$100 allowance	\$100 allowance	\$100 allowance
Medically Necessary ⁴	100%	\$200 allowance	100%	\$200 allowance
LASIK	Members receive a 10% discount off usual, customary, and reasonable charges at preferred LASIK provider locations and pay no more than \$1,800 per eye for the Conventional LASIK procedure and \$2,300 per eye for Custom LASIK. Members receive benefits where TLC Truvision network providers are available, with the following preferred rates: <ul style="list-style-type: none"> • Silver Package: \$895/eye for Conventional LASIK • Gold Package: \$1,295/eye for Custom LASIK • Platinum Package: \$1,895/eye for Custom LASIK plus Bladeless LASIK (using Intralase technology) 			
Calendar Year Deductible	None, after plan copayments			
Calendar Year Max Benefit	Up to plan limits			
Lifetime Maximum Benefit	Unlimited			
Waiting Periods	None			

¹ You can purchase either glasses or contact lens. Coverage applies to one or the other.

² The amounts shown are maximum benefits. The actual benefit amount the plan will reimburse to a plan member for non-network doctors will be the least of the maximum shown in the schedule, the amount actually charged, or the amount a doctor usually charges a private patient.

³ This allowance is paid with the same frequency as lenses, in the place of the lens and frame benefit.

⁴ Medically necessary (prior authorization required) is defined as 1) following cataract surgery without intraocular lens; 2) correction of extreme visual acuity problems not correctable with glasses; 3) anisometropia greater than 5.00 diopters and asthenopia or diplopia, with spectacles; 4) Keratoconus; or 5) monocular aphakia and/or binocular aphakia where the doctor certifies contact lenses are medically necessary for safety and rehabilitation to a productive life.

Accident Plans

The employee-pay-all, pretax accident plan offers worldwide coverage 24/7 and pays a lump-sum benefit to cover some of the expenses you may have as a result of an accident or injury. To enroll in the supplemental accident plan you must complete these two steps:

1. Enroll online through [People First](#); and
2. See an agent to complete a company application.

Colonial Life offers a guaranteed issue accident plan (People First plan code 5002).

Cancer Plans

Employee-pay-all, pretax cancer plans help offset some of the direct and indirect expenses not covered by your health insurance for cancer diagnosis and treatment. Aflac and Colonial offer cancer plans.

The People First plan codes for Aflac's cancer plans are 6500-6513 and 7000. You must complete these two steps to apply for Aflac supplemental cancer insurance policies:

1. Enroll online through [People First](#); and
2. See an agent to complete a company application, which requires medical underwriting. The company will notify People First if approved, at which time your payroll deductions begin. Your effective date of coverage will be the month following a full payroll deduction.

Coverage is underwritten by American Family Life Assurance Company of Columbus.

Colonial Life offers a guaranteed issue cancer plan (People First plan code 6601). You can enroll yourself and your dependents without passing medical underwriting (pre-existing limitations may apply). If you are currently enrolled in a Colonial Life cancer plan, you may continue your plan as is. If you want to make changes to your current plan, such as adding family coverage, you must cancel it and enroll in another cancer plan. If you change to the new cancer policy, benefits will be paid according to the policy in effect at the time a diagnosis is made. This may be important to you if you already have cancer. See an agent to learn about the options that are best for you.

For this cancer plan, enroll online through [People First](#). A separate application to the company is not required.

Disability Plans

Disability plans are designed to replace income if you are unable to work as a result of a covered accident or illness (including maternity). Depending on the monthly benefit you select, you are guaranteed coverage at 66 ⅔ percent of your income, up to \$3,480 per month. Be sure you pick a monthly benefit amount less than or equal to 66 ⅔ percent of your monthly income.

To enroll in a supplemental disability plan you must complete these two steps:

1. Enroll online through [People First](#); and
2. See an agent to complete a company application.

Colonial Life offers a guaranteed issue disability plan (People First plan code 5020).

Hospital Intensive Care Plans

Hospital intensive care plans help offset some out-of-pocket expenses for stays in a hospital intensive care unit.

You must complete these two steps to apply Aflac supplemental hospital intensive care insurance policies:

1. Enroll online through [People First](#); and
2. See an agent to complete a company application, which requires medical underwriting. The company will notify People First if approved, at which time your payroll deductions begin. Your effective date of coverage will be the month following a full payroll deduction.

Aflac offers hospital intensive care plans (People First plan codes 6500-6513 and 7000).

Coverage is underwritten by American Family Life Assurance Company of Columbus.

Hospitalization Plans

Employee-pay-all, pretax hospitalization plans pay for some of the hospital expenses not covered by your health insurance. These charges may include the hospital deductible, non-covered room and board charges, copayments, and out-patient surgical center charges. You may buy more than one hospitalization plan, but be sure you are fully informed before choosing multiple plans of the same insurance type.

The following companies offer hospitalization plans:

- CIGNA Health and Life Insurance Company (CHLIC) represented by Capital Insurance Agency, Inc. (People First plan codes 8100-8140)
- New Era Insurance represented by State Securities Corporation (People First plan codes 8160, 8170 and 8180)

How to Make Changes in People First

In our continued effort to streamline processes, save state dollars and protect the environment, we are eliminating several paper election forms. You can easily make Open Enrollment changes in People First:

1. Turn off the browser's pop-up blocker and log in to peoplefirst.myflorida.com.
2. Select Start or the Open Enrollment link and then follow the simple steps to certify dependent eligibility and register new dependents (Social Security numbers required). Enter your People First password and select Certify to complete the dependent certification process.
3. Select Enroll Now to start. Your current benefits and what you will have next year are side-by-side so you can easily verify or change your elections.
4. Click Change, Add or Cancel to make updates.
5. Once you've confirmed your choices, enter your People First password and select Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section.

1. Select 2014 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials.
2. To view or print your confirmation statement, select View Details.

My Wealth

Changes for the 2014 Plan Year

Tax-Favored Accounts

Flexible Spending Accounts

Health Savings Account



Key Points

- Tax-favored accounts are for active employees.
- Unless you make changes, current tax-favored account contributions roll over to the new plan year that begins Jan. 1.
- Flexible Spending Accounts have two deadlines: one to use services and one to submit claims. If you miss those deadlines, you lose your money—[Page 40](#).

My Wealth

Tax-favored accounts, such as Flexible Spending Accounts (FSAs) and the Health Savings Account (HSA), help stretch your active employee income by letting you pay for certain eligible health and/or dependent care expenses using pretax dollars. Tax-favored accounts offer tax savings because you pay for out-of-pocket expenses with pretax money. Without a tax-favored account, you pay for those same expenses, but you use money left in your employee paycheck after the state deducts federal and other taxes. Using tax-favored accounts can save you up to 40 percent or more. (Actual savings vary based on your individual tax situation.)

Changes for the 2014 Plan Year

- Health savings account contributions limits, including the state's contribution, will increase to \$3,300 for a single plan and \$6,550 for family.

Tax-Favored Accounts

If you are an eligible employee, the state deducts money on a pretax basis to fund any tax-favored account you choose, reducing your federal income tax liability. When you sign up, you decide how much you want held in your account for the plan year (Jan. 1 through Dec. 31). The state offers these tax-favored account options for you to set aside a portion of your income to pay for eligible medical and/or dependent care expenses:

- Flexible Spending Accounts:
 1. Medical Reimbursement Account (MRA): Enroll in this option if you have a Standard PPO or HMO Plan and are a salaried employee (OPS/variable hour employees are not eligible).
 2. Limited Purpose Medical Reimbursement Account (LPMRA): Enroll in this option if you have a Health Investor HMO plan or the Health Investor PPO Plan and a Health Savings Account and are a salaried employee (OPS/variable-hour employees are not eligible).

3. Dependent Care Reimbursement Account (DCRA): Enroll in this account if you have a qualified dependent that needs care.
- Health Savings Account: Enroll in this option if you have a Health Investor HMO Plan or the Health Investor PPO Plan.

How Pretax Helps Active Employees

The IRS allows you to pay certain expenses with tax-free dollars using tax-favored accounts, such as Flexible Spending Accounts (FSA) or a Health Savings Account (HSA). In other words, the state deducts your insurance premiums and tax-favored account contributions before deducting taxes from your paycheck. These pretax deductions mean your taxable income is lower, so you save money because you pay less income tax.

When you use one of the FSAs or an HSA, your paycheck is reduced by the amount you choose to pay to that account. You don't pay income tax on that money, and it is there for you to use when you have eligible expenses for health care or dependent care.

Tax-Favored Accounts Comparison Chart

	Medical Reimbursement Account (MRA)	Limited Purpose Medical Reimbursement Account (LPMRA)	Dependent Care Reimbursement Account (DCRA)	Health Savings Account (HSA)
How It Works	You contribute pretax money to the account through payroll deductions. <ul style="list-style-type: none"> Use the myMRA card; or Pay out of pocket for medical expenses; then submit claims and get reimbursed for eligible expenses. 	You contribute pretax money to the account through payroll deductions. <ul style="list-style-type: none"> Use the myMRA card; or Pay out of pocket for medical expenses; then submit claims and get reimbursed for eligible expenses. 	You contribute pretax money to the account through payroll deductions. <ul style="list-style-type: none"> Pay out of pocket for dependent care services; then submit claims and the state will reimburse you for eligible expenses. 	The state contributes pretax money to the account. You can, too. <p>Pay for health care expenses from the account at the time of service or purchase.</p>
State Contribution	No	No	No	Yes—if you open an HSA bank account at Tallahassee State Bank: <ul style="list-style-type: none"> \$41.66/month for individual coverage (up to \$500/year) \$83.33/month for family coverage (up to \$1,000/year)
Employee Contribution Limit	Yes \$60 minimum/year \$2,500 maximum/year	Yes \$60 minimum/year \$2,500 maximum/year	Yes \$60 minimum/year \$5,000 maximum/year/ household	Yes \$3,300/year individual coverage \$6,550/year family coverage (Limit includes the state contribution.)
Health Plan	Standard	Health Investor (high-deductible)	N/A	Health Investor (high-deductible)
Enroll in Another Tax-Favored Account	Yes – DCRA	Yes – HSA and DCRA	Yes – MRA or HSA and LPMRA	Yes – LPMRA and DCRA
Payment Card Available	Yes – myMRA card	Yes – myMRA card	No	Yes – from Tallahassee State Bank
Money Available	The lump sum of your annual deduction is available January 1 (for Open Enrollment) or on the date you enroll (if you are a new-hire or have QSC event).	The lump sum of your annual deduction is available January 1 (for Open Enrollment) or on the date you enroll (if you are a new-hire or have QSC event).	As it is deducted from your paycheck.	As it is deposited into your HSA bank account at Tallahassee State Bank.
Deadline to Use Funds	Yes—grace period to use funds ends March 15 and you must submit all claims by April 15 of the next plan year; otherwise, you forfeit any money left in your account.	Yes—grace period to use funds ends March 15 and you must submit all claims by April 15 of the next plan year; otherwise, you forfeit any money left in your account.	Yes—grace period to use funds ends March 15 and you must submit all claims by April 15 of the next plan year; otherwise, you forfeit any money left in your account.	No—the HSA works just like a savings account. The balance rolls over from year to year and you can take it with you if you leave state employment.
How to Enroll	<ol style="list-style-type: none"> Enroll online through People First. Complete the Dependent Certification process, then select Change or Add in the Make a Change column for the plan type. Enter in the Annual Amount and click the Select button. Enter your Password and select the Complete Enrollment button. <p>Once you enter an amount you can only change during Open Enrollment or with a QSC event.</p>	<ol style="list-style-type: none"> Enroll online through People First. Complete the Dependent Certification process, then select Change or Add in the Make a Change column for the plan type. Enter in the Annual Amount and click the Select button. Enter your Password and select the Complete Enrollment button. <p>Once you enter an amount you can only change during Open Enrollment or with a QSC event.</p>	<ol style="list-style-type: none"> Enroll online through People First. Complete the Dependent Certification process, then select Change or Add in the Make a Change column for the plan type. Enter in the Annual Amount and click the Select button. Enter your Password and select the Complete Enrollment button. <p>Once you enter an amount you can only change during Open Enrollment or with a QSC event.</p>	<ol style="list-style-type: none"> Enroll online through People First. Complete the Dependent Certification process, then select Click the Flex Spend Acct tab. Enter your annual contribution amount, if any. You can change this amount at any time. (The state contribution is automatic unless you waive it or fail to open your HSA account.) Review Change Summary tab and click Complete Enrollment. Open an HSA bank account at Tallahassee State Bank.

Flexible Spending Accounts

Flexible Spending Accounts are tax-favored accounts for active employees that reimburse members for eligible expenses. The state offers three kinds:

- **Medical Reimbursement Account (MRA):** use this account for eligible medical, dental or vision services or products, as well as eligible pharmacy products.
- **Limited Purpose Medical Reimbursement Account (LPMRA):** you may have an HSA; you can only use this account for eligible dental, vision, and preventive care expenses not covered by your health plan. Use the HSA for all other medical expenses.
- **Dependent Care Reimbursement Account (DCRA):** You must have a qualified dependent. Use this account to reimburse yourself for eligible expenses, such as daycare, that you pay to take care of a qualified dependent. You cannot use this account for health care expenses.

Medical and Limited Purpose Medical Reimbursement Accounts

For both the MRA and the LPMRA, the minimum annual contribution to open the account is \$60 per year, and the maximum is \$2,500 per year. The entire amount in your account is available at the beginning of the plan year (Jan. 1), so you can use your myMRA card or submit a claim before the regular contribution is withheld from your paycheck. For example:

- In January, you contribute \$100 from your paycheck to your MRA.
- You pay \$120 for prescriptions using your myMRA card.
- The cost is covered, even though there is only \$100 in your account.

Claims

MRA and LPMRA paper claims work on a first in, first-out basis. This means that the first claim received is the first claim paid, regardless of the service date. The myMRA card transactions occur at the time of service.

Month of Eligible Service	When You Submit Claim	Order Claim is Paid
August 2014	October 2014	1
November 2014	March 2014	4
December 2014	January 2014	2
February 2014	You used your myMRA card	3

In addition, during the grace period, the state pays all claims from prior plan year funds until they are exhausted before funds in the new plan year are touched.

Balance in 2013 Account	Balance in 2014 Account	Claim	How Claim is Paid
\$50	\$500	\$10 dated January 2014	\$10 comes out of the 2013 account, leaving \$40 in the account
\$40	\$500	\$50 dated February 2014	\$40 comes out of the 2013 account, leaving a balance of zero and the other \$10 now comes out of the 2014 account
\$0	\$490		New balances after claims are paid

Eligible Health Care Expenses (MRA only)

When deciding how much money to set aside each year, it's important to know which expenses are eligible for reimbursement under the MRA. Remember, if you don't use all the money in your MRA, you lose it. Following is a partial list of medically necessary eligible MRA expenses:

- Deductibles you pay as part of your health care insurance plan
- Copayments for eligible medical bills after you meet plan deductibles, if any
- Any qualifying amount you pay for eligible expenses after your maximum benefit has been paid
- Acupuncture
- Ambulance services
- Contraceptive devices
- Dentures
- Eye examinations, eyeglasses, and contact lenses and supplies
- Hearing aids and batteries
- Obstetric care
- Orthodontia (braces)
- Oxygen
- Guide dogs
- Smoking cessation programs and prescription drugs
- Hearing impaired equipped telephone
- Wheelchair
- Certain over-the-counter items

Eligible Health Care Expenses (LPMRA)

Following is a partial list of medically necessary eligible LPMRA expenses:

- Corrective contact lenses
- Dental fees
- Eyeglasses
- Immunizations
- Guide dogs
- Optometrist fees
- Orthodontic treatment
- Cancer screening

What is use-it-or-lose-it?

Section 125 of the IRS Code allows you to put some of your salary into a nontaxable benefit, such as an FSA. Use-it-or-lose-it refers to the IRS requirement that if you do not spend all the money you have contributed to your FSA account(s), you lose any money in the FSA you have not used by March 15 and claimed by April 15 of the next year. The law does not allow the state to roll it over or refund it to you. Since you never receive your FSA contributions as part of your paycheck, you cannot be taxed on the amount. If you were able to get unused amounts out of your FSA at the end of the benefit period, you would be receiving deferred compensation, which section 125 expressly prohibits.

Ineligible Expenses (both MRA and LPMRA)

Ineligible expenses cannot be reimbursed through the MRA. Following is a partial list of expenses ineligible for reimbursement:

- Insurance premiums
- Warrantees
- Weight-loss programs and appetite suppressants (unless prescribed for a specific medical condition)
- Anti-hair-loss drugs
- Cosmetics and toiletries
- Dental procedures to whiten teeth (bleaching)

Once you become an MRA or LPMRA member, you can log in to [People First](#), select FSA Information to see a more inclusive guide to eligible expenses.

Your Annual Contribution

Carefully estimate how much money you might need in your MRA or LPMRA. If you make your election during Open Enrollment, your contribution amount is for the plan year (Jan. 1 through Dec. 31). If you are a new hire or enroll in an account as the result of an appropriate qualifying status change (QSC) event, your account starts the date you make your election through the end of the calendar year. If you already have an MRA or LPMRA and experience a QSC event, you may increase to the maximum limit or decrease to the amount that has already been deposited, depending on the type of QSC event. Be aware that if you increase your contribution limit during the middle of the plan year, you can only submit claims against the new amount if they are incurred on or after your new effective date.

You must incur eligible expenses by March 15 of the next plan year or lose unused money. In addition, you must submit claims for the plan year by the April 15 tax filing deadline for the entire amount you had withheld or lose the unclaimed money. Use the cost estimator at the [mybenefits website](#) to determine how much you should withhold for the plan year. You can only change the amount during Open Enrollment or with an appropriate QSC event.

Medical FSA elections roll over from plan year to plan year. You can change or cancel your election in [People First](#) during Open Enrollment.

The myMRA Card and Filing Claims

The myMRA card is a convenient way to pay for eligible health care expenses – instead of paying out of pocket and waiting for a reimbursement. At your doctor's office and the pharmacy, the card knows where you are and what you're buying. When you use it at one of these two places to pay your regular copays, nothing else is required of you.

When you go to the dentist's or vision care office, the card knows you're in a health care facility and so it will work, but it may not know what you're paying for. (there are no barcodes for items or services). This means you can pay for eligible expenses (office copays and crowns, for example), but you can also accidentally pay for ineligible expenses such as teeth whitening and specialty toothbrushes. Consequently, when you use the card at places like this, you may be asked to submit documentation to prove you paid for an eligible health care expense as defined by the Internal Revenue Code. You still have the benefit and convenience of no out-of-pocket costs.

If the expense is not eligible for reimbursement, you can substitute another claim for an eligible expense that you paid for out of pocket, as long as you meet all due dates. If the expense is not eligible for reimbursement and you do not have another claim to substitute, you must send a personal payment (check, money order, or cashier's check) to State of Florida-DIV, P.O. Box 864684, Orlando, FL 32886-4684.

When you participate in a tax-favored account like an MRA, you must comply with the Internal Revenue Code. The State of Florida is required to take steps to protect your pretax status and to keep the state account balanced.

If you don't have your myMRA card or you're buying an over-the-counter medication, you may send your claim form and documentation to People First for a reimbursement

of eligible expenses. Additionally, over-the-counter medications require a doctor's prescription or letter of medical need before the claim can be reimbursed. Remember, you must submit all eligible claims for 2014 by April 15, 2014, or you will lose your money.

Grace Period: You have a grace period to use services and/or purchase eligible medical and pharmacy products and claim them on the previous year's FSA. The grace period gives you until March 15 of each year to use the amount in your FSA from the previous year; for example, you have until March 15, 2014, to use eligible services for your 2013 contributions. Remember, you must also file these claims by April 15, 2014. Receipts with service dates after March 15 are applied to the current year's account.

Leaving State Employment

If you stop working for the state, you can only be reimbursed for eligible services and purchases made before your last payroll deduction unless you make arrangements with the People First Service Center to continue the account through the end of the plan year.

Learn More

For more information about MRAs and LPMRAs, including eligible expenses, read the 2014 Tax-Favored Accounts Reference Guide located under Forms and Publications on the [mybenefits website](#). Also see IRS Publication 502, Medical and Dental Expenses, at www.irs.gov. Publication 502 lists expenses you can deduct from your income taxes; however, some items listed are not eligible for reimbursement through your MRA.

Dependent Care Reimbursement Account

A Dependent Care Reimbursement Account (DCRA) reimburses you for eligible expenses, such as daycare, that you pay to take care of a qualified dependent, but not for health care expenses. The minimum to open the account is \$60 per year; the maximum is \$5,000 per year, per household.

At any given time, you can only be reimbursed for dependent care expenses up to the current balance available in your account. Unlike MRAs, only the amount you have contributed to the account, minus any claims paid, is available at any given time. In other words, the entire annual deduction amount is not available for reimbursement at the beginning of the plan year.

Before you enroll, carefully compare the potential tax savings from this plan to the federal income tax credits available. In the following instances, you will generally reduce the amount of taxes you pay by enrolling in this plan if:

- You file a federal IRS income tax form 1040 EZ. Because there is no line to deduct dependent care expenses, the only way to get a tax benefit for dependent care expenses is through a DCRA.
- You and your spouse file taxes as “married, filing separately” because the IRS only allows a tax credit for those filing as “single, head of household” or “married, filing jointly.”
- Your expenses are more than \$2,400 for one dependent or \$4,800 for two or more dependents.

Qualified Dependents

Most people use a DCRA for childcare expenses for children under age 13; however, a qualified dependent may be any person you take care of who lives in your home and depends on you for support. To see if your dependents qualify read IRS Publication 503, Dependent Care Expenses, at www.irs.gov.

If you are divorced and your dependent lives with you, you can claim work-related dependent or child care expenses. This is true even if you do not claim the dependent on your tax return.

Once your dependent loses eligibility, you must call the People First Service Center to stop monthly deductions.

Eligible Expenses

Eligible expenses are expenses for the care of dependents so you (and your spouse, if married) can work, look for work, or attend school. Qualified expenses include:

- Licensed childcare center for either children or adults
- Before or after school or summer programs
- Neighbor who cares for the children before or after school
- Individual who provides care in his/her home
- Individual who provides care in your home, for example:
 - Live-in nanny
 - Licensed practical nurse or assisted care provider for an adult
 - Babysitter

Ineligible Expenses

Fees paid to the following providers do not qualify:

- School tuition
- Someone who can be claimed as the employee’s dependent
- Overnight camp
- Charges for materials, transportation and other charges not directly related to the care of the individual

Your Annual Contribution

Carefully estimate how much money you need in the DCRA for the year (Jan. 1 through Dec. 31), because what you do not use by March 15 of the next plan year, you lose. In addition, if you do not submit claims for the plan year by the April 15 tax filing deadline for the entire amount you had withheld, you lose the unclaimed money.

Use the cost estimator at the [mybenefits website](#) to determine how much you should withhold for the plan year.

Dependent Care Reimbursement Account elections roll over from plan year to plan year. You can change or cancel your election in [People First](#) during Open Enrollment or with an appropriate qualifying event.

Filing Claims

If you have a Dependent Care Reimbursement Account, you must send all receipts and claim forms to People First for processing. Claim forms are available on the [mybenefits website](#). You must submit all claims for 2014 by April 15, 2014. If you do not, you will lose your money.

You need to supply the federal tax identification number or Social Security number of the dependent care provider when you file claims for dependent care expenses, and your account must have adequate funds for you to be reimbursed.

Leaving Employment

If you stop working for the state, you can only be reimbursed for eligible services incurred before leaving employment.

Learn More

For more information about qualified dependent care expenses and other FSA provisions, read the 2014 Tax-Favored Accounts Reference Guide located under Forms and Publications on the [mybenefits website](#). Also see IRS Publication 503, Dependent Care Expenses, at www.irs.gov.

Health Savings Account

If you are an active employee¹ enrolled in a Health Investor Health Plan (high-deductible plan) and you and your covered dependents do not have other health coverage, you should enroll in a Health Savings Account (HSA) through [People First](#). You must then open an HSA bank account with Tallahassee State Bank to get the state contribution and the tax-favored benefits of this account. You can use the HSA to pay out-of-pocket expenses, such as medical and prescription drug costs, deductibles, coinsurance, and dental and vision services that aren't covered under your insurance. Unlike MRAs, the money in your HSA is still available to you if you leave state employment.

Annual Contributions

If you enroll in an HSA and open an HSA bank account at Tallahassee State Bank, the state contributes \$41.66 per month for full-time employees with individual coverage (up to \$500 annually) or \$83.33 per month for family coverage (up to \$1,000 annually).

In addition to the state's contribution to your HSA bank account, you can contribute your own pretax funds to the account to reach the maximum annual limit (including the state contribution) of \$3,300 for individual coverage and \$6,550 for family coverage. If you are an employee 55 or older, you can contribute an additional \$1,000 each year.

Caution: The FSA Grace Period Can Adversely Impact HSA Eligibility IRS tax laws do not allow you to be enrolled in a Medical Reimbursement Account (MRA) and a Health Savings Account (HSA) at the same time. If you currently have an MRA and you plan to enroll in the HSA for next year, you will be ineligible for the HSA until April 1 of the following year to allow you the full grace period through March 15.

Eligibility

Who is eligible for an HSA? Anyone who:

- Is enrolled in a Health Investor Health Plan, and
- Is not covered by any other health insurance, and
- Is not enrolled in Medicare, and
- Cannot be claimed as a dependent on someone else's tax return. (Children cannot establish their own HSAs. If eligible, spouses can establish their own HSAs.)

What other health coverage is allowed for me to still be eligible for an HSA?

- Specific disease or illness insurance and accident, disability, dental care, vision care, and long-term care insurance
- Employee Assistance Programs, disease-management programs, or wellness programs (these programs must not provide significant benefits in the nature of medical care or treatment)
- Drug discount cards
- Veterans Administration benefits (unless you actually received VA health benefits in the last three months)

Using HSA Funds

When can I use the money in my HSA?

- You must incur qualified medical expenses on or after the date you establish the HSA.
- You can use HSA distributions to reimburse previous years' expenses as long as you incurred them on or after the date you establish the HSA.
- There is no time limit on when distribution must occur.

HSA and Medicare

How does Medicare affect my HSA?

- You must stop making contributions once you are enrolled in any type of Medicare.
- You are not eligible for an HSA nor can you continue to make contributions to an HSA after you enroll in Medicare.
- When you enroll in Medicare, you can keep the money in your HSA and use it to pay for medical expenses, including your Medicare premiums (except Medigap premiums) and out-of-pocket expenses, such as deductibles, copays and coinsurance under any part of Medicare.

¹Retirees may have a Health Savings Account through the financial institution of their choice, but they are not eligible for the state contribution.

To Enroll

Enroll in an HSA through [People First](#) by enrolling in a Health Investor Health Plan on the health link. Enter any annual contribution amount you want in addition to the state contribution, and then open an HSA bank account at Tallahassee State Bank¹ by completing the [HSA bank account application](#).

Leaving Employment

Unlike FSAs, you can take your HSA funds with you when you leave state employment.

The state can deposit money only after you open your HSA bank account at Tallahassee State Bank¹. To be sure you receive the state money you are entitled to and your own contribution (if any), open your account before Jan. 1.

¹ Tallahassee State Bank assesses a small monthly fee for accounts with less than \$2,500 after they have been open one full month.

How to Make Changes in People First

In our continued effort to streamline processes, save state dollars and protect the environment, we are eliminating several paper election forms. You can easily make Open Enrollment changes in People First:

1. Turn off the browser's pop-up blocker and log in to peoplefirst.myflorida.com.
2. Select Start or the Open Enrollment link and then follow the simple steps to certify dependent eligibility and register new dependents (Social Security numbers required). Enter your People First password and select Certify to complete the dependent certification process.
3. Select Enroll Now to start. Your current benefits and what you will have next year are side-by-side so you can easily verify or change your elections.
4. Click Change, Add or Cancel to make updates.
5. Once you've confirmed your choices, enter your People First password and select Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section.

1. Select 2014 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials.
2. To view or print your confirmation statement, select View Details.

My Resources

Definitions
How to Appeal a Decision
Active Employees Eligible for Medicare
Retirees Eligible for Medicare
Special Notice about Medicare Part D
What New Hires Need to Know
Privacy Notice
Making Elections in People First

Key Points

- If you are a retiree eligible for Medicare, the state pays your health insurance claims as the secondary insurance, even if you choose not to enroll in Medicare Part B—[Page 49](#).
- You must provide a copy of your Medicare card to People First when you enroll in Medicare—[Page 49](#).
- New employees should make elections carefully, as they remain in effect for the remainder of the plan year—[Page 51](#).
- You can authorize someone else to discuss your insurance benefits with People First or your insurance company—[Page 56](#).



Definitions

Annual Maximum: Total dollar amount a plan pays during a calendar year toward the covered expenses of each person enrolled.

Annual Out-of-Pocket Coinsurance Maximum: The maximum amount of coinsurance a PPO plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire coinsurance amount for covered services for the remainder of the calendar year. Non-coinsurance expenses such as copays, deductibles, hospital admission fees, non-covered services, charges in excess of the non-network allowance for services provided by non-network providers, and charges in excess of any plan limitations do not apply to the annual out-of-pocket maximum.

Annual Out-of-Pocket Copay Maximum: The limit on the total copayments that you pay during a benefit year for covered services. You may be responsible for providing documentation to your HMO of the total copayment amount paid.

Coinsurance: A percentage of the medical costs, based on the allowed amount, you must pay for certain services after you meet your annual deductible. This includes prescription drug costs under a Health Investor Health Plan.

Copayment: A set dollar amount you pay for network doctors' office visits, emergency room services and prescription drugs.

Deductible: Total dollar amount, based on the allowed amount, you must pay out of pocket for covered medical expenses each calendar year before the State Employees' Standard PPO Plan, the Health Investor PPO Plan or a Health Investor HMO plan pays for most services. The deductible does not apply to network preventive care and any services where you pay a copayment rather than coinsurance. Some of your dental options also have an annual deductible, generally for basic and major dental care services.

Dependent Care Reimbursement Account (DCRA): A type of Flexible Spending Account for active employees that allows them to reimburse themselves with pretax dollars for eligible expenses they pay to take care of a qualified dependent.

Election: The choice for insurance benefits you make as a new hire, during Open Enrollment, or as the result of a qualifying status change event.

Flexible Spending Account (FSA): An account for active employees that allows them to reimburse themselves with pretax dollars for eligible out-of-pocket health care costs and/or the costs associated with caring for a qualified dependent. With these accounts, employees decide the annual amount they want to contribute before the start of a plan year. They must submit claims for the plan year by April 15 of the following year for the entire amount withheld so they do not lose the unused money. Flexible Spending Accounts include Dependent Care Reimbursement Accounts, Limited Purpose Medical Reimbursement Accounts and Medical Reimbursement Accounts.

Grace Period: The period of time from Jan. 1 until March 15 in which active employees can continue to incur eligible FSA expenses and claim them under the previous plan year's election.

Health Investor HMO and PPO: The state's name for two of its health insurance options where you pay a higher deductible in exchange for:

- Lower premiums than the State Employees' Standard PPO or a Standard HMO.
- The opportunity to have a Health Savings Account to pay eligible health care expenses with pretax dollars, partially funded by the state (for active employees).

Health Maintenance Organization (HMO): A prepaid medical plan limited to restricted contracted service areas (where you live or work) and a specific network of providers.

Health Savings Account (HSA): An account associated with the Health Investor HMO and PPO Plans that allows active employees to use pretax dollars to pay their share of the cost for eligible medical, prescription, dental or vision care services not covered by their insurance plans. When employees are eligible for an HSA and have completed the appropriate steps, the state contributes money to their account; they may also add their own pretax contributions to the HSA. The HSA differs from an FSA in three ways:

- Employees must be in a Health Investor HMO or PPO plan to contribute to an HSA.
- They must open a personal HSA bank account at Tallahassee State Bank by completing the online HSA bank account application.

- Any unused HSA funds at the end of a year carry forward to the next year and employees may take unused HSA balances with them if they stop working for the state.

Limited Purpose Medical Reimbursement Account

(LPMRA): A type of Flexible Spending Account that allows active employees to reimburse themselves for dental, vision and preventive care expenses not covered by their high-deductible health plan. They may also have an HSA.

Maintenance Drugs: Prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Medical Reimbursement Account (MRA): A type of Flexible Spending Account that allows active employees to reimburse themselves with pretax dollars for eligible out-of-pocket health care costs. If they have an HSA, they cannot enroll in an MRA.

Pre-Determination of Benefits (dental plan): A request you can submit to find out in advance how much the dental plan will pay for recommended dental care. This feature can be particularly useful in the PPO or indemnity dental plans because you pay a percentage of the cost. The process is not required but can help avoid surprises.

Preferred Provider Organization (PPO): A plan offering discounted rates on services if you use providers in the network. If you use providers outside of the network, your out-of-pocket expenses will be much greater.

Premium: The monthly or biweekly amount you pay for your insurance coverage.

Pretax Plan: A plan for active employees that is paid for with pretax money. The IRS allows for certain expenses to be paid for with tax-free dollars. The state takes premiums out of your check before taxes are calculated, increasing your spendable income and reducing the amount you owe in income taxes. Consequently, the IRS has tax laws that require you to stay in the plans you select for a full plan year (January through December). You can only make changes during Open Enrollment or if you have a qualifying status change event.

Prepaid Plans: All plans in the State Group Insurance program are prepaid, which means you pay for your coverage one month in advance; for example, you pay for July coverage in June. If you are underpaid for any reason, future premium payments are applied to the month that is underpaid.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists.

Provider: Any type of health care professional or facility that provides services under your plan.

Provider Network: A group of health care providers, including dentists, physicians, hospitals and other health care providers, that agrees to accept pre-determined rates when serving members.

Qualifying Status Change (QSC) Event: An occurrence that qualifies the subscriber to make an insurance coverage or Flexible Spending Account change outside of the Open Enrollment period, as defined in the [QSC Matrix](#).

How to Appeal a Decision

The appeal process gives you an avenue to have your medical claim or enrollment issues reviewed if you disagree with the original decision. Following this process maintains your right to a hearing, where a final determination can be made.

To Appeal Eligibility and Enrollment Decisions

If you have worked with the People First Service Center and disagree with an eligibility or enrollment decision, you may send a written explanation of your concern as a Level I Appeal to the People First Service Center (see contact information Page iv). People First will send you a written response to your appeal, including where to send a Level II Appeal, if needed.

To Appeal Medical Claims

State Employees' PPO Plan Members: If your medical claim is totally or partially denied, you may send a written appeal to Florida Blue (BlueCross and BlueShield of Florida). You have a limited time to submit these appeals.

Refer to Section 12 of the State Employees' PPO Plan Booklet and Benefits Document for specific instructions.

HMO Plan Members: If your medical claim is totally or partially denied, you may call or send a written appeal (recommended) to your HMO's appeal department. Refer to your HMO policy or call the number on the back of your insurance card for help. You have a limited time to submit these appeals. Refer to your plan document for specific instructions.

All Health Plan Members: If your prescription drug claim is totally or partially denied, you may send your State Employees' Prescription Drug Plan appeal to Express Scripts. You have a limited time to submit these appeals. Refer to your plan document for specific instructions. (Medicare Advantage Plan members should submit prescription drug claim appeals to their HMO.)

To Appeal Other Insurance Claims

Supplemental Plan Members: You may submit a written grievance and appeal to the company for further claims review. Refer to your policy or call the number on the back of your insurance card for help.

How to Make Changes in People First

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1. Turn off the browser's pop-up blocker and log in to peoplefirst.myflorida.com.
2. Select Start or the Open Enrollment link and then follow the simple steps to certify dependent eligibility and register new dependents (Social Security numbers required). Enter your People First password and select Certify to complete the dependent certification process.
3. Select Enroll Now to start. Your current benefits and what you will have next year are side-by-side so you can easily verify or change your elections.
4. Click Change, Add or Cancel to make updates.
5. Once you've confirmed your choices, enter your People First password and select Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section.

1. Select 2014 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials.
2. To view or print your confirmation statement, select View Details.

Important Information for Active Employees Eligible for Medicare

If you, as an active state employee, and/or your dependents become eligible for Medicare, your State Group Insurance health plan continues to be your primary insurance coverage. Medicare coverage pays as secondary (after the plan pays) only if you enroll.

Most people are eligible for premium-free Medicare Part A (hospital insurance). Medicare Part B (medical insurance) requires you to pay a monthly premium.

Because you are an active employee and the plan is the primary payer, you should discuss with Medicare your option to delay your Medicare Part B coverage. You qualify for a special enrollment period with Medicare, which means you can choose to delay enrollment in Medicare Part B without penalty. After you stop working, you have eight months to enroll in Medicare Part B without a Medicare premium penalty. To delay enrollment in Medicare Part B, contact Medicare at www.medicare.gov or 800-Medicare (800-633-4227). TTY users call 877-486-2048.

Once you or your dependents become eligible for Medicare, you must send a copy of the Medicare card to People First (include your People First ID number) to:

People First Service Center
P.O. Box 6830
Tallahassee, FL 32314
Fax: 800-422-3128

If you delayed Medicare Part B as an active employee, you should elect it as soon as you retire. This is in your best financial interest, even though Medicare gives you up to eight months to enroll without a Medicare premium penalty. If you are enrolled in Capital Health Plan or Florida Health Care Plans, you must complete a separate application process for the Medicare Advantage plan. Contact your HMO for more information.

Once you are eligible for either Medicare Part A or Part B as a retiree, the Plan pays secondary, whether you enroll in Parts A and B or not. Medicare becomes the primary payer for your health care services. As a retiree, if you do not elect your Medicare Part B coverage right away, you must pay the first 80 percent of your health care expenses, and the plan pays secondary. Failure to enroll in Medicare Part B as soon as you retire will make you responsible for expensive medical bills.

Important Information for Retirees Eligible for Medicare

Once you and/or your dependents become eligible for Medicare Part A and Part B due to age (65) or disability, you should contact the Social Security Administration (SSA) about Medicare benefits. Enrollment in Medicare is time sensitive and you may be subject to substantial financial penalties if you fail to meet federal deadlines. Contact your local SSA office, call 800-MEDICARE (800-633-4227), or visit www.medicare.gov for more information. TTY users call 877-486-2048.

When you or your dependents become eligible due to age (65) and for your convenience, People First will automatically enroll you in the appropriate State Group Insurance Medicare secondary plan for a reduced monthly premium.

Paying Health Insurance Claims

At that time, Medicare will be available to you to pay claims as your primary insurance and the state plan will pay claims as your secondary insurance. If you choose not to enroll in Medicare, the state plan will still be your secondary insurance and you will be required to pay the portion of your claims (approximately 80 percent) that Medicare would have paid. If you choose to continue your state health insurance coverage once you're eligible for Medicare, you should elect your Medicare Part B coverage. Although Medicare does not require you to purchase Part B, it is in your financial interest to do so.

Medicare Identification (ID) Card

For proper enrollment and to ensure coordination of benefits with Medicare, you must send People First a copy of your Medicare card within 60 days of receipt. Write your People First ID number on your copy and fax it to 800-422-3128 or mail it to:

People First Service Center
P.O. Box 6830
Tallahassee, FL 32314

If You Are Not Eligible for Medicare

If you are not eligible for Medicare, please send a copy of your Medicare ineligibility letter to People First immediately. People First will reverse your enrollment to the state's primary plan with the higher monthly premium. If you delay, you may have an underpayment and risk cancellation of coverage, as well as have high claims costs.

Medicare Part D Drug Program

See the next page for a special notice about this prescription drug coverage to help you decide if you should enroll.

Special Notice about the Medicare Part D Drug Program

Jan. 1, 2014

Please read this notice carefully. It explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll in Medicare Part D.

Medicare prescription drug coverage (Medicare Part D) became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage.

All approved Medicare prescription drug plans must offer a minimum standard level of coverage set by Medicare. Some plans may offer more coverage than required. As such, premiums for Medicare Part D plans vary, so you should research all plans carefully.

The Florida Department of Management Services has determined that the prescription drug coverage offered by the State Employees' Health Insurance Program (State Health Program) is, on average, expected to pay out as much as or more than the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your State Health Program coverage, be aware that you and your dependents will be dropping your hospital, medical and prescription drug coverage. If you choose to drop your State Health Program coverage, you will not be able to re-enroll in the State Health Program.

If you enroll in a Medicare prescription drug plan and do not drop your State Health Program coverage, you and your eligible dependents will still be eligible for health and prescription drug benefits through the State Health Program. However, if you are enrolled in a state-sponsored HMO offering a Medicare Advantage Prescription Drug Plan, you may have to change to the State Employees' PPO Plan to get all of your current health and prescription drug benefits.

If you drop or lose your coverage with the State Health Program and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. Additionally, if you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage, and you may have to wait until the following November to enroll.

Additional information about Medicare prescription drug plans is available from:

- www.medicare.gov
- Your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number)
- (800) MEDICARE or (800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, payment assistance for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA). To contact your local SSA office, call 800-772-1213, or www.socialsecurity.gov for more information. TTY users call 800-325-0778.

For more information about this notice or your current prescription drug plan, call the People First Service Center at 866-663-4735.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether you have maintained creditable coverage and, therefore, whether you are required to pay a higher premium amount (a penalty).

What New Hires Need to Know

If you are a new employee with the State of Florida, take note of the following:

- The plan year is a calendar year—Jan. 1 through Dec. 31.
- Our plans are pretax, which means you save money, and you can only make future changes to your elections during Open Enrollment or if you have a qualifying status change (QSC) event. Choose your new-hire elections carefully.
- You have 60 calendar days from your hire date to make your State Group Insurance elections. If you miss this deadline, you can only enroll during the next Open Enrollment or if you have an appropriate QSC event.
- Once you make an election within your 60 days, you can only change it during Open Enrollment or if you have an appropriate QSC event. For example, if you make your election for health insurance on day five of employment, you cannot cancel or change to another health insurance company or plan type during your 60 days; however, you can make a new election for another type of plan, such as dental, at a later time within the 60 days.
- If you are a salaried employee, your effective date of coverage is always the first of the month following your election and receipt of full month’s premium. You can elect an early effective date for health insurance, provided you make the election on time and you and your employer submit the full month’s premium. If you are an OPS/variable-hour employee, the earliest coverage will begin is the first day of the third month of employment.

- Correct Social Security numbers, birthdates and documentation are required to enroll eligible dependents in your plans.
- Health Investor Health Plans are high-deductible plans with corresponding Health Savings Accounts. See the My Health and My Wealth sections for more information.
- New hires are not required to provide proof of good health to enroll in Optional Life insurance.
- If you’re enrolled in a prepaid dental plan, call your insurance provider to be added to your dentist’s roster. (United Solstice members can make an appointment without being added to a roster.)
- Flexible Spending Accounts (Medical, Limited Purpose Medical and Dependent Care Reimbursement Accounts) and the HSA have annual contribution amounts, not monthly premiums. This means that whatever dollar amount you elect to contribute will be divided by the number of payrolls left in the plan year. You may want to choose a lower amount for a partial plan year and then raise the amount during Open Enrollment for the next plan year.
- For example, if you are hired in October and elect a \$5,000 contribution amount, the \$5,000 will be divided by the number of payrolls left in the calendar year, and that amount will be taken out of your paycheck and put in your account. In this scenario, you could have more than \$1,000 taken out of each paycheck.
- You may need to take an additional step for your Flexible Spending Account(s) for the new plan year, depending on when you make your new-hire election. See the chart below for details.

When did you make new hire election?	Does annual FSA amount roll over to new plan year?	Make a new election for the new plan year?	How do you make the new election?
Before Oct. 21, 2013	Yes	Only if you want to change the dollar amount	In People First during Open Enrollment
On or after Oct. 21, 2013 through Nov. 8, 2013	No	Yes, if you want to keep the account	In People First during Open Enrollment
On or after Nov. 11, 2013	No	Yes, if you want to keep the account	Call People First at 866-663-4735

If you are a new hire during the Open Enrollment period, you must first make your new-hire elections for the current plan year. If you want to make changes for 2014, you must make Open Enrollment elections for the next plan year. Call the People First Service Center at 866-663-4735 for assistance.

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information.

This information, known as protected health information, includes virtually all individually identifiable health information held by plans—whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices for the State of Florida’s Flexible Spending Account, and discusses administrative activities performed by the state for the State of Florida Employees’ Group Health Self-Insurance Plan (the self-insured plan) and for insurance companies and HMOs in the State Group Insurance Program (the insured plans).

The plans covered by this notice, because they are all sponsored by the State of Florida for its employees, participate in an “organized health care arrangement.” The plans may share health information with each other to carry out Treatment, Payment, or Health Care Operations (defined below).

The plans’ duties with respect to health information about you

The plans are required by law to maintain the privacy of your health information and to provide you with a notice of the plans’ legal duties and privacy practices with respect to your health information. Participants in the self-insured plan will receive notices directly from Florida Blue (BlueCross and BlueShield of Florida) and Express Scripts (Medco) (which provides third-party medical and pharmacy support to the self-insured plan); the notices describe how Florida Blue and Express Scripts will satisfy the requirements. Participants in an insured plan option will receive similar notices directly from their insurer or HMO.

It’s important to note that these rules apply only with respect to the health plans identified above, not to the state as your employer. Different policies may apply to other state programs and to records unrelated to the plans.

How the plans may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail: Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the plans may share health information about you with physicians who are treating you.

Payment includes activities by these plans, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as behind-the-scenes plan functions such as risk adjustment, collection, or reinsurance. For example, the plans may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

Health Care Operations include activities by these plans (and in limited circumstances other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health Care Operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the plans may use information about your claims to review the effectiveness of wellness programs.

The amount of health information used or disclosed will be limited to the “Minimum Necessary” for these purposes, as defined under the HIPAA rules. The plans may also contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the plans may share your health information with the state

The plans will disclose your health information without your written authorization to the state for plan administration purposes. The state needs this health information to administer benefits under the plans. The state agrees not to use or disclose your health information other than as permitted or required by plan documents and by law.

The plans may also disclose “summary health information” to the state if requested, for purposes of obtaining premium bids to provide coverage under the plans, or for modifying, amending, or terminating the plans. Summary health information is information that summarizes participants’ claims information, but from which names and other identifying information has been removed.

In addition, the plans may disclose to the state information on whether an individual is participating in the plans or has enrolled or dis-enrolled in any available option offered by the plans.

The state cannot and will not use health information obtained from the plans for any employment-related actions. However, health information collected by the state from other sources is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the chance to agree or object to these disclosures; (although exceptions may be made, for example, if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The plans are also allowed to use or disclose your health information without your written authorization for uses and disclosures required by law, for public health activities, and other specified situations, including:

- Disclosures to Workers’ Compensation or similar legal programs, as authorized by and necessary to comply with such laws;
- Disclosures related to situations involving threats to personal or public health or safety;
- Disclosures related to situations involving judicial proceedings or law enforcement activity;
- Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death and to funeral directors to carry out their duties;
- Disclosures related to organ, eye or tissue donation and transplantation after death;
- Disclosures subject to approval by institutional or private privacy review boards and subject to certain assurances by researchers regarding the necessity of using your health information and treatment of the information during a research project. Certain disclosures may be made related to health oversight activities, specialized government or military functions and U.S. Department of Health and Human Services investigations.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization for a plan that has taken action relying on it. In other words, you cannot revoke your authorization with respect to disclosures the plan has already made.

Your individual rights

You have the following rights with respect to your health information the plans maintain. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right for the Flexible Spending Account and for the state activities relating to the self-insured plan and insured plans. Contact the Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL 32314-5450 to obtain any necessary forms for exercising your rights. The notices you receive from Florida Blue, Express Scripts, and your insurer or HMO (as applicable) will describe how you exercise these rights for the activities they perform.

Right to request restrictions on certain uses and disclosures of your health information and the plans' right to refuse

You have the right to ask the plans to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the plans to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the plans to restrict use and disclosure of health information to notify those persons of your location, general condition, or death—or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request must be in writing.

The plans are not required to agree to a requested restriction. And if the plans do agree, a restriction may later be terminated by your written request, by agreement between you and the plans (including an oral agreement), or unilaterally by the plans for health information created or received after you're notified that the plans have removed the restrictions. The plans may also disclose health information about you if you need emergency treatment, even if the plans had agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the plans will accommodate reasonable requests to receive communications of health information from the plans by alternative means or at alternative locations.

If you want to exercise this right, your request to the plans must be in writing and you must include a statement that disclosure of all or part of the information could endanger you. This right may be conditioned on your providing an alternative address or other method of contact and, when appropriate, on your providing information on how payment, if any, will be handled.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a Designated Record Set. This may include medical and billing records maintained for a health care provider; enrollment, payment,

claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the plans use to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. In addition, the plans may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the plans will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request.

The plans may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The plans also may charge reasonable fees for copies or postage. If the plans do not maintain the health information but know where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the plans amend your health information in a Designated Record Set. The plans may deny your request for a number of reasons. For example, your request may be denied if the health information is not accurate and complete; was not created by the plans (unless the person or entity that created the information is no longer available); is not part of the Designated Record Set; or is not available for inspection (for example, psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the plans will:

- Make the amendment as requested;

- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the plans have made of your health information. This is often referred to as an accounting of disclosures. You generally may receive an accounting of disclosures if the disclosure is required by law in connection with public health activities or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a limited data set (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request must be in writing. Within 60 days of the request, the plans will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the

delay and the date by which the plans expect to address your request. You may make one request in any 12-month period at no cost to you, but the plans may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the plans upon request

You have the right to obtain a paper copy of this Privacy Notice upon request.

Changes to the information in this notice

The plans must abide by the terms of the Privacy Notice currently in effect. This notice took effect on April 14, 2003. However, the plans reserve the right to change the terms of their privacy policies as described in this notice at any time and to make new provisions effective for all health information that the plans maintain. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to a plan's privacy policies as described in this notice, you will be provided with a revised Privacy Notice through posting on the dms.myflorida.com/dsgi or mailed to your last known home address.

Complaints

If you believe your privacy rights have been violated, you may complain to the plans and to the U.S. Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. Complaints about activities by your insurer or HMO, or by Florida Blue or Express Scripts can be filed by following the procedures in the notices they provide. To file other complaints with the plans, contact the DSGI for a complaint form. It should be completed, including a description of the nature of the particular complaint, and mailed to the Division of State Group Insurance, P.O. Box 5450, Tallahassee, FL 32314-5450.

Contact

For more information on the privacy practices addressed in this Privacy Notice and your rights under HIPAA, contact the Division of State Group Insurance at P.O. Box 5450, Tallahassee, FL 32314-5450.

Authorization to Disclose Protected Health Information (PHI)

If you want to give People First or your insurance company permission to disclose PHI to an individual, you must submit an authorization form to each party. For example, if you want your spouse to be able to call People First to discuss your monthly premiums, you must send People First an authorization form; otherwise, representatives will be unable to talk to your spouse per the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines. Call People First or your insurance company for more information.

How to Make Changes in People First

In our continued effort to streamline processes, save state dollars and protect the environment, we are eliminating several paper election forms. You can easily make Open Enrollment changes in People First:

1. Turn off the browser's pop-up blocker and log in to peoplefirst.myflorida.com.
2. Select Start or the Open Enrollment link and then follow the simple steps to certify dependent eligibility and register new dependents (Social Security numbers required). Enter your People First password and select Certify to complete the dependent certification process.
3. Select Enroll Now to start. Your current benefits and what you will have next year are side-by-side so you can easily verify or change your elections.

4. Click Change, Add or Cancel to make updates.
5. Once you've confirmed your choices, enter your People First password and select Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section.

1. Select 2014 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials.
2. To view or print your confirmation statement, select View Details.

Choose Wisely: Use FloridaHealthFinder.gov



“When I chose a health plan, I used FloridaHealthFinder.gov to help me find the health plan that ranked highest in overall member satisfaction, because that was important to me. FloridaHealthFinder.gov made it easier.”

Choosing the health plan that best serves you and your family’s needs is important. FloridaHealthFinder.gov can help! When choosing among your health insurance options, you can access and compare recent quality of care and patient satisfaction measures for Florida HMOs and PPOs. You can also locate and compare various health care facilities in your area. [Visit FloridaHealthFinder.gov today!](http://FloridaHealthFinder.gov)

How does the competition stack up? Compare how well the plans do with certain preventive procedures like breast cancer screening, well child visits, diabetes care and more.

What are health plan members saying? Review how current members evaluated their plans on how quickly and easily they receive care, communication with doctors and overall satisfaction.

Which health care facility should you use? FloridaHealthFinder.gov helps you locate and compare health care facilities across the state, so you ensure you choose the facility that is best for you and your family.

Where does it hurt? The *Symptom Navigator* and the *Look Up a Medical Condition* interactive tools allow you to research symptoms and medical conditions.

www.FloridaHealthFinder.gov

1-888-419-3456



In the pursuit of health

Thank you for trusting Florida Blue to service the State Employees’ PPO Plan for more than 33 years. Continue to count on us for help with your overall health care needs:

- Preferred doctors and hospitals throughout the United States
- Your secure member website for personal health information and more
- Personalized care support and programs to help you stay healthy
- A Customer Service team dedicated to State Employees’ PPO Plan members

Have questions? We’re here to help.



1-800-825-2583 to talk to a service representative, Monday - Friday, 8 a.m. to 5 p.m. EST.



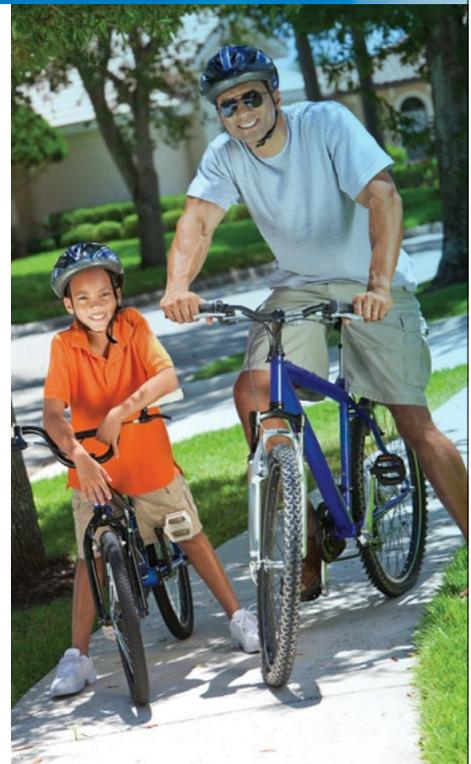
Visit **floridablue.com** and click on Members and then State Employees.



Stop in a **Florida Blue Center** near you. Check out floridablue.com for locations.

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- Dedicated customer service team available from 7 a.m. to 7 p.m.

Visit AetnaStateFlorida.com or call **1-877-858-6507** to learn more.

For self-funded accounts, benefits coverage is offered by your employer, with administrative services only provided in Florida by Aetna Health Inc. and/or Aetna Life Insurance Company.

Health benefits and health insurance plans contain exclusions and limitations. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. For more information about Aetna plans, refer to www.aetna.com.

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Capital Health Plan members enjoy:

- > Access to the Physician Group of Capital Health Plan and the Capital Health Plan Urgent Care Center.
- > CHPConnect for secure online access to your personal health record.
- > Health/Fitness Reimbursement; receive up to \$150 each year per household.
- > Retiree Advantage (HMO) for Medicare eligible State retirees and their dependents.

Local Member Services

Available by phone at:

850-383-3311 or 1-877-392-1532
Monday – Friday: 7 a.m. to 7 p.m.

Or, visit us IN PERSON at:

1545 Raymond Diehl Road
Monday – Friday: 8 a.m. to 5 p.m.



www.capitalhealth.com/state

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- ✓ **No referral** for specialists
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- ✓ **Preventive vision care**
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For more information, please call **866-575-1875**

Visit us online at chcflorida.com

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WORKING FOR GOOD HEALTH IN VOLUSIA AND FLAGLER COUNTIES

Preferred Fitness Network

Get fit at your choice of 45 gyms, fitness centers or YMCAs in FHCP's Preferred Fitness Network in Volusia and Flagler counties, following your personal health risk assessment.

Extensive Provider Network

One of the area's most extensive provider networks that routinely adds new providers. Visit fhcp.com for complete information.

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Recognized as the "Best Around" Health Care Plan by *Daytona Beach News-Journal* readers for the past 22 years in a row!

Great providers, labs, pharmacies, clinics, seminars, 24/7 live information-on-call... setting the standard for excellent health care...and health care coverage in Volusia and Flagler counties.



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- Discussion with a nurse, 24/7

By offering the right combination of value, benefits, extras, and access, we're dedicated to keeping you and your family healthy and well taken care of – now, and for years to come.

Learn more. Call 1-877-614-0581 or visit welcometouhc.com/florida



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A Prescription Drug Plan to Simplify Your Life

Express Scripts is committed to helping millions of Americans like you with access to medications and the services needed to help you stay healthy. Here's just a sampling of what your prescription benefit offers:

- Up to a **90-day supply of maintenance medication** through the Medco Pharmacy® (now a part of the Express Scripts family of pharmacies) for the same cost as two 30-day fills at retail. That's like getting a refill for free!
- A **pharmacist available 24/7** by phone who can answer questions about medications, drug interactions or any side effects you may experience.
- Access at **Express-Scripts.com/sofrxplan** to price medications, search for lower-cost drugs, locate a participating retail pharmacy and much more. (Members should register at **Express-Scripts.com**.)



The person shown is for illustrative purposes only and may not be an actual employee.

Additional questions? Call 877.531.4793 and speak to a Member Services representative.



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Choose Wisely: Use FloridaHealthFinder.gov



"When I chose a health plan, I used FloridaHealthFinder.gov to help me find the health plan that ranked highest in overall member satisfaction, because that was important to me. FloridaHealthFinder.gov made it easier."

As a state retiree, you are offered an extensive selection of benefits options for all of your health care needs. Choosing the health plan that best serves you and your family's needs is important. FloridaHealthFinder.gov can help! When choosing among your state health insurance options, you can access and compare recent quality of care and patient satisfaction measures for Florida HMOs and PPOs. You can also locate and compare various health care facilities in your area. [Visit FloridaHealthFinder.gov today!](http://FloridaHealthFinder.gov)

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Where does it hurt? The *Symptom Navigator* and the *Look Up a Medical Condition* interactive tools allow you to research symptoms and medical conditions.

www.FloridaHealthFinder.gov

1-888-419-3456



Apply an additional layer of financial protection

Minnesota Life is proud to partner with the State of Florida to provide **group term life insurance** benefits to members. Your plan offers these benefits to all full-time active employees:

- **Basic Plan** - \$25,000 coverage automatically provided
- **Optional coverage** - one to seven times your salary, up to \$1,000,000 (*Evidence of Insurability may be required*)
- **Local service** from our Tallahassee office

Affordable coverage. Excellent service. Call **888-826-2756** or visit www.lifebenefits.com/florida.



Minnesota Life Insurance Company
A Securian Company

This product is offered under policy form series 07-30978.

Group Insurance - Tallahassee Office
1909 Hillbrooke Trail, Suite 2, Tallahassee, FL 32311-4289
1-888-826-2756 • 850-878-0048 Fax • www.LifeBenefits.com
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MINNESOTA LIFE

Apply an additional layer of financial protection

Take advantage of your Group Term Life plan.

As a State of Florida retiree, you have access to the following **group life insurance** benefits:

- **Two coverage amounts:** \$2,500 for \$7.41/month or \$10,000 for \$29.65/month*
- **Local service from our Tallahassee branch office**

Call **888-826-2756** or visit www.lifebenefits.com/florida.



Minnesota Life Insurance Company
A Securian Company

*Rates are subject to change.

This product is offered under policy form series 07-30978.

Group Insurance - Tallahassee Office
1909 Hillbrooke Trail, Suite 2, Tallahassee, FL 32311-4289
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F66890-1 Rev 4-2013
A01291-0413

MINNESOTA LIFE



Indemnity With PPO (People First Plan 4064)

Our Highlights

For Ameritas, our story is about more than just providing quality benefits. It's about protecting the smiles, sights and sounds of a lifetime. We don't have a one-size-fits-all plan. We understand that people have different needs, so we tailor our programs to fit just right. To find out more about this plan, designed specifically for employees of The State of Florida, contact Ameritas at 877-721-2224, or online at ameritasgroup.com/florida.



GR 6190 Rev. 5-13

Q: How does the plan work?

A: The Ameritas dental plan is an insurance plan that pays specific dollar amounts for each covered procedure. With preventive plus, plan payments for covered preventive dental procedures are not deducted from the plan member's annual maximum benefit, saving the entire annual maximum for other covered services.

Q: What are the benefits of the Ameritas dental plan?

A: You can visit the dentist of your choice and know exactly what your insurance company may pay (subject to plan deductibles, limitations and maximums).

Q: Can I continue to see my current dentist?

A: Yes. You are free to visit the dentist of your choice.

Q: What if my dentist is not in the PPO network?

A: Your benefits remain the same whether your dentist is a member of the PPO network or not. If you see a dentist who is not in the network, your out of pocket expense may be higher than if you visit a PPO dentist, who has agreed to charge reduced contracted fees.

Q: Will I need a referral to visit a specialist?

A: No. You can see the specialist of your choice without a referral.

Q: Do my family members need to visit the same dentist that I choose?

A: No. Each member is free to see the dentist of his or her choice.

Q: How do I locate a PPO provider?

A: Visit our website, ameritasgroup.com. Click on "Find a Provider" and follow the easy step-by-step instructions to locate PPO dentists in your area.

Q: If my dentist isn't a member of the PPO network, can he or she join?

A: You are welcome to nominate your dentist to our PPO network. Nominate your dentist online at ameritasgroup.com, or call our Provider Relations Department toll free at 800.755.8844.

This information is provided by Ameritas Life Insurance Corp. (Ameritas Life), Group dental, vision and hearing care products (9000 Rev. 03-08, dates may vary by state) and individual dental and vision products (Indiv. 9000 Ed. 11-09) are issued by Ameritas Life. Some plan designs are not available in all areas. Some states require that producers be appointed with Ameritas Life before soliciting its products. To become appointed with Ameritas Life, please call 800-659-2223. Most plans for groups with 26 or more enrolled lives are administered by Ameritas Life. Billing and eligibility for most plans with 25 or fewer enrolled lives are provided by HealthPlan Services, Inc.

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Offering State of Florida employees...2014 benefit options

NO CHANGE TO YOUR PREMIUMS FOR 2014! TWO DENTAL PLANS – Look at these plan features!

2014 Dental Plan Highlights

Prepaid Dental Series 225 with Ortho Copays Plan (People First Plan Code: 4025)

- "No charge" for 35 procedures including oral exams, x-rays, routine cleanings, fluoride treatments, and sealants; 250+ procedures covered by set copayments
- No deductibles or claim forms, annual benefit maximum, or waiting periods
- Pre-existing dental conditions are covered
- Each family member may choose their own Plan dentist
- 30 common specialty procedures provided by member's selected Plan dentist or Plan Specialist for same copayment
- An implant benefit
- Set copayments for child and adult orthodontic treatments
- Vision Discount Program included



Indemnity with PPO Insured Plan/ Freedom Advance

(People First Plan Code: 4074)

- Freedom to choose any dentist or specialist
- In- and out-of-network coinsurance is the same; no penalty for using out-of-network dentist
- **NEW!** Calendar year deductible (waived for Type I): \$50/individual and \$100/per family, in- or out-of-network
- **NEW!** Major services (Type III) covered at 50% in the first year with no waiting periods
- Access to over 6,200 unique dentists in Florida (and almost 102,000 nationwide) offering up to 30% off their usual fees
- Coverage for **up to 4 cleanings per year**
- 100% coverage for preventive services such as cleanings and X-rays
- Coverage for composite resins (white fillings) on back teeth
- Vision Discount Program included

For more information please call State Securities Corporation at 800.277.2300 or 850.386.2300 (Tallahassee) www.assurantemployeebenefits.com/SToffl

Assurant Employee Benefits is the brand name for insurance products underwritten and prepaid products provided by Union Security Insurance Company. See plan documents for complete details including all limitations, exclusions and restrictions. Contact us for costs and complete details.

Cigna Dental Promotes Wellness



Regular dental visits may do more than brighten your smile. Preventive dental care often catches minor problems before they become major and expensive to treat.

- No annual dollar maximums, deductibles, or waiting periods.
- No hidden charges! Copays listed on the Patient Charge Schedule include the full cost for covered procedures – even for specialty care.
- No referrals needed to visit a network orthodontist or for children under age 7 to visit a network pediatric dentist.
- More than 5,000 network general dentist and specialist locations.
- Access to Cigna Healthy Rewards® Program: A program offering discounts on an array of services, including vision, chiropractic, weight management and smoking cessation programs, and much more.

The following features further promote preventive care and overall health (some copays may apply):

Brush Biopsy and ViziLite™: To aid in the early detection of oral cancer.

– **Sealants:** There is no age limit on sealants, which help prevent tooth decay.

– **Prescriptions:** Up to 50% off average retail prices on certain prescription dental products.

People First Plan Code 4034

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Get connected to myCigna

It's easy to get things done with myCigna, our secure customer website. If you've just enrolled, simply register at www.myCigna.com.

Then, check your coverage & more:

- View your personalized dental plan information
- Enjoy discounts on a variety of health and wellness products and services
- Use our interactive tools to learn more about your oral health

MARKETED & SERVICED BY: Capital Insurance Agency, Inc. 800-780-3100 □
www.capitalins.com



Cigna.

Humana proudly offers dental benefit options

Network Plus Prepaid and Preferred Plus DPPO

Dental Plan Highlights

Preferred Plus DPPO People First Plan Code #4054

- In-and-out of network benefits
- Child and adult orthodontia
- Endodontics (root canals), periodontics (gum treatment), and oral surgery covered as type II - basic services
- In-network benefits not subject to balance billing over PPO provider's contracted fee
- Enhanced out-of-network benefits based on the 90th percentile of usual, customary, and reasonable charge

Network Plus Prepaid People First Plan Code #4004

- Includes 330 covered dental procedures at fixed copayments
- Orthodontic coverage at fixed copayments for both children and adults
- Copayments applicable with both general and specialist dentists
- No specialty referral pre-authorization required; members may "self refer" to specialists
- Large network of providers with over 4,000 general dentists statewide
- No office visit fee
- No waiting periods, annual maximums, deductibles, or claim forms to file

Humana.

Please contact us at 800-943-6880 or visit our website at Humanadental.com/custom/fl

GCHHA7GHH 0413

Humana dental benefit options for the State of Florida

Select 15 Prepaid and Schedule B Indemnity

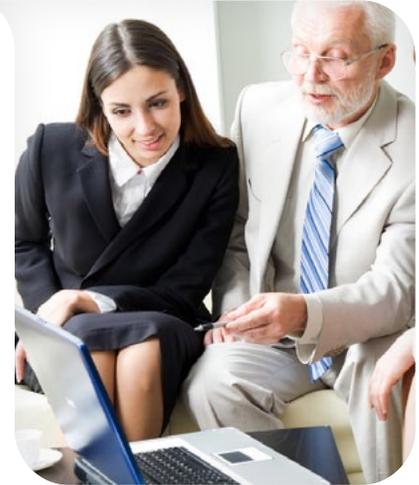
Dental Plan Highlights

Prepaid/Select 15 People First Plan Code #4044

- Choose your own dentist from a list of participating general dentists
- Many “no charge” benefits
- Savings on every procedure
- No deductibles
- No maximum benefit limitations
- No waiting periods
- No claim forms
- Child and adult orthodontia

Indemnity/Schedule B People First Plan Code #4084

- Freedom to see any dentist
- Coverage for type I, II and III services
- Claims paid according to a stated benefit schedule
- \$50 calendar year deductible (waived for type I services)
- No waiting periods
- \$1000 calendar year maximum benefit



Humana®

Please contact us at 866-879-3630 or visit our website at Humanadental.com/custom/fl

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Dental Care Clear and Simple

Imagine paying less for benefits.
That's the Solstice S700 Plan
from UnitedHealthcare Dental.

Our plan offers you:

- Low premiums
- No primary dentist selection required EVER
- Preventive services including sealants for children at no charge
- No waiting periods OR claim forms to submit
- Children can see their network pediatric dentist up to the age of 16
- Cosmetic procedures (teeth whitening, bonding and veneers) are included at a copayment level
- 7,242-plus provider network

People First Plan Code 4014

The Solstice S700 Dental Plan offers you savings, freedom and choices.
For more information, call **1-800-980-0292**
or visit www.myuhcdental.com/statefl.



UnitedHealthcare Dental plans are administered by Dental Benefit Providers, Inc. Offered by Dental Benefit Providers of Illinois, Inc., a licensed Prepaid Limited Health Service Organization; Chapter 636 F.S.

Clearly Simple: Humana Vision

With Humana Vision VCP options, you get:

- A choice between the Vision Care Plan (VCP) Exam and Materials plan (3004), or the Materials Only plan (3006)
- Access to one of the largest vision networks in the United States, with more than 35,000 participating optometrists, ophthalmologists and national retail locations including LensCrafters®, Pearle Vision®, Sears® Optical, Target® Optical, and JCPenney® Optical
- Comprehensive eye health examination
- Annual contact lens allowance
- Wholesale pricing on frames, avoiding high retail markups
- Access to **HumanaVisionCare.com/custom/fl**, where you can access provider networks, view benefits, check eligibility, and use other automated services
- Discounts on Lasik and PRK procedures

Humana®

Please contact us at 800-939-5369 or visit our website at HumanaVisionCare.com/custom/fl

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**OUT-OF-POCKET
MEDICAL EXPENSES**

Deductibles | Copayments



**EVERYDAY LIVING
EXPENSES**

Mortgage | Rent | Groceries



**LOSS OF
INCOME**

Salary | Hourly Wages

For more information about our
Cancer* policy, please contact:



Capital Insurance Agency, Inc.
1-800-780-3100
www.capitalins.com

Aflac®

We've got you under our wing.™

*Plan Codes: Cancer 6500-6501-6502-6503-6510-6511-6512-6513

Coverage underwritten by American Family Life Assurance Company of Columbus

Z120270

4/12



**OUT-OF-POCKET
MEDICAL EXPENSES**

Deductibles | Copayments



**EVERYDAY LIVING
EXPENSES**

Mortgage | Rent | Groceries



**LOSS OF
INCOME**

Salary | Hourly Wages

**For more information about our Hospital
Intensive Care* policy, please contact:**



Capital Insurance Agency, Inc.
1-800-780-3100
www.capitalins.com



We've got you under our wing.*

*Plan Codes: Hospital Intensive Care 7000

Coverage underwritten by American Family Life Assurance Company of Columbus

Z120271

4/12

NO ONE CAN PREDICT A HOSPITAL STAY. But you can plan for the expenses.

**A supplemental
hospital plan
can help take care
of some of the
out-of-pocket
hospital facility
costs.**



Marketed and serviced by:
Capital Insurance Agency, Inc.
800.780.3100
www.capitalins.com

There are four supplemental plans available this year, underwritten by Cigna Health and Life Insurance Company (CHLIC):

- **Preferred Provider Plus (PPP):** People First Benefit Code 8100
- **30/20 Plus:** People First Benefit Code 8110
- **365 Plus:** People First Benefit Codes 8130 for \$100 a day or 8140 for \$200 a day
- **SIS:** People First Benefit Code 8120

Each offers different levels of coverage.

Benefit payment can be sent to you or the hospital.

Contact Capital Insurance Agency for more information.

GO YOU[®]



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Accident Insurance

In your lifetime, which of these accidental injuries have happened to you or someone you know?

- Sports-related accidental injury
- Broken bone
- Burn
- Concussion
- Laceration
- Back or knee injuries

Accidents happen more often than you think. Thankfully, Colonial Life's accident insurance can help prepare and see you and your family through the unexpected.



Contact Colonial Life:
888.756.6701
connect.coloniallife.com/florida

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4-13



Important Features

- 24-hour coverage for accidents that occur on- and off-the-job.
- Benefit payments regardless of workers' compensation or any other insurance you may have with other insurance companies.
- Benefits are paid directly to you, unless you specify otherwise.
- With most plans, you can continue coverage with no increase in premium when you retire or change jobs.

Enroll online through People First or contact a Colonial Life benefits counselor.

Accident Insurance People First Benefit Plan Code 5002

This information is applicable to policy form ACCPOL- FL and is not complete without the corresponding outline of coverage. Please see your Colonial Life benefits counselor for complete information.

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Making benefits count.

NS-10357-10

Cancer Insurance

If diagnosed with cancer, would you have the money to cover...

- Out-of-network treatments
- Experimental treatments
- Home health care needs
- Travel expenses to and from treatment centers
- Childcare expenses

Cancer Insurance helps guard against financial difficulties if you or a loved one is diagnosed with cancer.



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Important Features

- Coverage is **guaranteed** if enrolled during the annual open enrollment period.
- Treatment benefits include radiation and chemotherapy.
- Includes cancer screening benefits, hospital intensive care benefits and more.
- Cancer insurance has few lifetime limits. This is an important feature because cancer treatment is often prolonged.

Enroll online through People First or contact a Colonial Life benefits counselor.

Cancer Insurance People First Benefit Plan Code 6601

THIS IS CANCER ONLY INSURANCE. Applicable to certificate form GCAN-C-FL. This coverage has exclusions and limitations that may affect benefits payable. Please see the outline of coverage or your Colonial Life benefits counselor for complete details.

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Making benefits count.

NS-10357-10

Disability Insurance

If you get sick or hurt and can't work, which of these bills could you continue to pay?

- Medical Bills
- House Payment
- Car Payment
- Groceries
- Utilities

Disability Insurance helps protect your income so you can still pay your bills.



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4-13

Important Features

- You're **guaranteed** to be issued coverage at 66 ⅔% of your income, up to \$3,480 a month.
- Covers pregnancy the same as any other covered sickness.
- With most plans, you can continue coverage with no increase in premium when you retire or change jobs.

Enroll online through People First or contact a Colonial Life benefits counselor.

Disability Insurance People First Benefit Plan Code 5020

This information is applicable to policy form DIS1000-FL and is incomplete without the corresponding disclosure statement. Please see your Colonial Life benefits counselor for complete information.



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Featuring Some of the Lowest Rates Available in Florida's Pre-tax Program

Hospital Income Plan

A pre-tax insurance plan for employees with the State of Florida

HOSPITAL INCOME HOME HEALTH CARE CONVALESCENT CARE EXTENDED CARE

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Benefits Paid Directly to You!
Your Choice!
Benefits may be applied to your out-of-pocket expenses or paid directly to the hospital.

Choices of coverage

- \$100 a day
- \$200 a day
- \$100 a day with ECR

People First Plan Codes

- #8160
- #8170
- #8180

Extra benefits included in the plan:

- Home Health Care
- Convalescent Care
- Extended Care



Affordable premiums that have not been increased for over 10 years!

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