Benefits Guide

For State of Florida Employees and Retirees

2016 Plan Year
This Benefits Guide is intended to assist plan members in selecting benefits offered under the State Group Insurance program. However, the benefits described herein are subject to change. The effective benefits provided under a particular plan are set forth in the plan document for each particular plan. Should any benefits described in this Benefits Guide conflict with the benefits described in a particular plan document, the benefits described in the particular plan document shall prevail.
What’s new for 2016 for current employees?

Open Enrollment starts Monday, Oct. 19, at 8 a.m. and ends Friday, Nov. 6, 2015, at 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time).

**Dependent Spouse and Child Life Insurance**

If you are enrolled in basic life insurance, you may enroll your legal spouse and eligible children in dependent life insurance coverage on a post-tax basis effective Jan. 1, 2016.

- **Spouse Life:** you may choose a $15,000 or $20,000 benefit amount. Coverage is guaranteed issue during this upcoming Open Enrollment or when you first get married; otherwise, medical underwriting is required. The cost is $4.50 per month for $15,000 and $6 per month for $20,000.
- **Child Life:** the benefit amount for eligible children is $10,000 and is always guaranteed issue. “Eligible children” means your child, adopted child, stepchild, foster child, legal ward, or child legally placed in your home for adoption. Eligible children remain covered through the end of the calendar year in which they turn age 26. The cost is $0.85 per month, regardless of the number of children covered.

If you have a qualifying event after open enrollment that will allow you to enroll in or change coverage (for example, you get married), you may make changes to your dependent spouse and dependent child life insurance elections.

**Optional Life Insurance**

If you are a salaried employee, Optional Life is additional term life insurance you may purchase on a post-tax basis. You may choose one to seven times your annual salary up to $1 million. Underwriting is required for six times or seven times your salary or for any benefit amount over $500,000. If you missed your opportunity to enroll in this benefit as a new hire:

This open enrollment only: you may enroll in optional life insurance for one times your annual salary, up to a $500,000 benefit maximum, guaranteed issue. To enroll after this open enrollment, you’ll have to pass medical underwriting.

**Aetna Now Owns Coventry**

Coventry members will be enrolled in Aetna for 2016. Questions? Please call Aetna at 877-858-6507.

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**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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.
5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.
What's new for 2016 for retirees?

Open Enrollment starts Monday, Oct. 19, at 8 a.m. and ends Friday, Nov. 6, 2015, at 6 p.m. Eastern Standard Time (5 p.m. Central Standard Time).

Retiree life insurance premiums are decreasing.

If you are a retiree enrolled in retiree life insurance, good news! Your monthly premium is going down. Starting with your December payment for January coverage, the $2,500 benefit premium is $4.83 per month and the $10,000 benefit premium is $19.33 per month.

Enrolled in the $2,500 benefit but want to increase? You must call People First during open enrollment to change your benefit level unless you have a life event, such as marriage, that would allow you to increase coverage.

This benefit is only available to retirees who enrolled in retiree life insurance upon retirement.

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Coventry members will be enrolled in Aetna for 2016. Questions? Please call Aetna at 877-858-6507.

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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 then Add to make updates.

5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.
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# Benefits Fair Schedule for the 2016 Plan Year

Fairs are open from 9 a.m. to 4 p.m. local time unless otherwise indicated. Some sites require paid parking and photo identification.

## TALLAHASSEE

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>October 19</td>
<td>The Betty Easley Center, 4075 Esplanade Way</td>
</tr>
<tr>
<td>Tuesday</td>
<td>October 20</td>
<td>Florida State University, Oglesby Union Ballroom, 75 N. Woodward Ave.</td>
</tr>
<tr>
<td>Wednesday</td>
<td>October 21</td>
<td>Donald L. Tucker Civic Center, 505 W. Pensacola St.</td>
</tr>
<tr>
<td>Thursday</td>
<td>October 22</td>
<td>Florida A&amp;M University, Jake Gaither Athletic Complex, 1835 Wahnish Way</td>
</tr>
<tr>
<td>Friday</td>
<td>October 23</td>
<td>Department of Revenue, 2450 Shumard Oak Blvd., Building 2, Room 1250</td>
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</tbody>
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## TAMPA BAY AREA / WEST COAST

<table>
<thead>
<tr>
<th>Day</th>
<th>Date</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Monday</td>
<td>October 19</td>
<td>Department of Children and Families, 9393 N. Florida Ave. (at I-275 and Busch Blvd.)</td>
</tr>
<tr>
<td>Tuesday</td>
<td>October 20</td>
<td>USF Tampa, Marshall Student Center Ballroom, 4202 E. Fowler Ave., MSC 2100</td>
</tr>
<tr>
<td>Wednesday</td>
<td>October 21</td>
<td>USF St Petersburg, University Student Center, 200 6th Ave., South (ends at 3 p.m.)</td>
</tr>
<tr>
<td>Thursday</td>
<td>October 22</td>
<td>Fort Myers Regional Service Center, 2295 Victoria Ave.</td>
</tr>
<tr>
<td>Friday</td>
<td>October 23</td>
<td>USF Sarasota-Manatee, Selby Auditorium, 8350 N. Tamiami Trail</td>
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## WEST FLORIDA

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<thead>
<tr>
<th>Day</th>
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<th>Location</th>
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<tbody>
<tr>
<td>Monday</td>
<td>October 26</td>
<td>Pensacola Bay Center, 201 E. Gregory St.</td>
</tr>
<tr>
<td>Tuesday</td>
<td>October 27</td>
<td>University of West Florida, 11000 University Parkway, Building 22 (10 a.m. to 3 p.m.)</td>
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## SOUTH FLORIDA

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<th>Date</th>
<th>Location</th>
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<tbody>
<tr>
<td>Tuesday</td>
<td>October 27</td>
<td>North Broward Regional Service Center, 1400 W. Commercial Blvd., Room 195</td>
</tr>
<tr>
<td>Wednesday</td>
<td>October 28</td>
<td>Florida Atlantic University, Live Oak Pavilion, 777 Glades Road, (east of I-95)</td>
</tr>
<tr>
<td>Thursday</td>
<td>October 29</td>
<td>Florida International University (S), Graham Center, 11200 S.W. 8th, St.</td>
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## GAINESVILLE

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<th>Date</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Wednesday</td>
<td>October 28</td>
<td>University of Florida, Touchdown Terrace, 157 Gale Lemerand Drive (ends at 3 p.m.)</td>
</tr>
<tr>
<td>Thursday</td>
<td>October 29</td>
<td>Tacachale, Agency for Persons with Disabilities, 1621 N.E. Waldo Road</td>
</tr>
</tbody>
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## CENTRAL FLORIDA / EAST COAST

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<th>Day</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday</td>
<td>October 30</td>
<td>University of Central Florida, Student Union, Pegasus Ballroom, 12715 Pegasus Drive (ends at 2 p.m.)</td>
</tr>
<tr>
<td>Monday</td>
<td>November 2</td>
<td>Volusia County Health Department, 1845 Holsonback Drive (off Bill France Blvd.)</td>
</tr>
<tr>
<td>Tuesday</td>
<td>November 3</td>
<td>Crowne Plaza Orlando Downtown, 304 W. Colonial Drive</td>
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</table>

## JACKSONVILLE AREA

<table>
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<th>Day</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>November 2</td>
<td>Department of Health, 1217 N. Pearl St., (off I-95)</td>
</tr>
<tr>
<td>Tuesday</td>
<td>November 3</td>
<td>Department of Children and Families, 5920 Arlington Expressway</td>
</tr>
<tr>
<td>Wednesday</td>
<td>November 4</td>
<td>John J. Crews Activity Center, 7487 S. State Road 121</td>
</tr>
</tbody>
</table>
## Contact Information

<table>
<thead>
<tr>
<th>State Group Insurance Plans</th>
<th>Plan Types</th>
<th>Phone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida Blue</td>
<td>PPO Plan (Medical)</td>
<td>800-825-2583</td>
<td><a href="http://www.floridablue.com/state-employees">www.floridablue.com/state-employees</a></td>
</tr>
<tr>
<td>Aetna (and formerly Coventry)</td>
<td>HMO Plan(Medical)</td>
<td>877-858-6507</td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>AvMed</td>
<td>HMO Plan (Medical)</td>
<td>888-762-8633</td>
<td><a href="http://www.avmed.org/go/state">www.avmed.org/go/state</a></td>
</tr>
<tr>
<td>Capital Health Plan</td>
<td>HMO Plan (Medical)</td>
<td>850-383-3311</td>
<td><a href="http://www.capitalhealth.com/state">www.capitalhealth.com/state</a></td>
</tr>
<tr>
<td>Florida Health Care Plans</td>
<td>HMO Plan (Medical)</td>
<td>877-615-4022</td>
<td><a href="http://www.fhcp.com">www.fhcp.com</a></td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>HMO Plan (Medical)</td>
<td>877-614-0581</td>
<td><a href="http://www.welcometouhc.com/florida">www.welcometouhc.com/florida</a></td>
</tr>
<tr>
<td>Minnesota Life</td>
<td>Basic and Optional Life</td>
<td>888-826-2756</td>
<td><a href="http://www.lifebenefits.com/florida">www.lifebenefits.com/florida</a></td>
</tr>
<tr>
<td>Ameritas Dental Preventive Plus</td>
<td>Indemnity with PPO</td>
<td>877-721-2224</td>
<td><a href="http://www.ameritasgroup.com/florida">www.ameritasgroup.com/florida</a></td>
</tr>
<tr>
<td>CIGNA Dental</td>
<td>Prepaid Dental</td>
<td>800-244-6224</td>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
</tr>
<tr>
<td>Humana Select 15, Schedule B</td>
<td>Prepaid Dental/Indemnity</td>
<td>866-879-3630</td>
<td><a href="http://www.humanadental.com/custom/fl">www.humanadental.com/custom/fl</a></td>
</tr>
<tr>
<td>UnitedHealthcare Dental Solstice 700</td>
<td>Prepaid Dental</td>
<td>800-980-0292</td>
<td><a href="http://www.myuhcdental.com/statefl">www.myuhcdental.com/statefl</a></td>
</tr>
<tr>
<td>Aflac</td>
<td>Cancer/Intensive Care</td>
<td>800-780-3100</td>
<td><a href="http://www.capitalins.com">www.capitalins.com</a></td>
</tr>
<tr>
<td>Cigna Health and Life Insurance Company</td>
<td>Hospitalization</td>
<td>800-780-3100</td>
<td><a href="http://www.capitalins.com">www.capitalins.com</a></td>
</tr>
</tbody>
</table>

### Additional Contact Information

<table>
<thead>
<tr>
<th>People First</th>
<th>Call for help or enroll online</th>
<th>866-663-4735</th>
<th>peoplefirst.myflorida.com</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fax documents to</td>
<td>800-422-3128</td>
<td></td>
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<tr>
<td></td>
<td>Mail documents to</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Mail payments to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Security Administration</td>
<td>To enroll or inquire about Medicare</td>
<td>800-633-4227</td>
<td><a href="http://www.medicare.gov">www.medicare.gov</a></td>
</tr>
<tr>
<td></td>
<td>To ask about an HSA bank account</td>
<td>877-367-4472</td>
<td><a href="http://www.talstatebank.com">www.talstatebank.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>850-576-1182</td>
<td></td>
</tr>
<tr>
<td>myBenefits Website</td>
<td></td>
<td></td>
<td><a href="http://mybenefits.myflorida.com">mybenefits.myflorida.com</a></td>
</tr>
</tbody>
</table>
Getting Started

- How to Use this Guide
- Open Enrollment Tips
- Program Overview and How to Enroll

Key Points

- Open Enrollment starts Monday, Oct. 19, 2015, at 8 a.m. and ends Friday, Nov. 6, 2015, at 6 p.m. EST (5 p.m. CST).
- 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. 6 deadline. Log in to PeopleFirst 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.
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 mybenefits.myflorida.com to carefully consider your personal benefit needs.

- Open Enrollment for the 2016 plan year starts Monday, Oct. 19, 2015 at 8 a.m. and ends Friday, Nov. 6, 2015, at 6 p.m. EST (5 p.m. CST).

- 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 ii 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:
  - Register them by entering their personal information, including Social Security numbers, in People First.
  - 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. EST (5 p.m. CST) 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 offer. Refer to each section of this guide to find out how these plans work and call the insurance company for specific plan information.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Options</th>
<th>Who's Eligible</th>
<th>What You Should Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health</strong></td>
<td>1. Standard PPO</td>
<td>Employees, Retirees, COBRA, Surviving Spouse, Laid-off Career Service Employees</td>
<td>Recurring medical and prescription needs and services, as well as what you may require next year</td>
</tr>
<tr>
<td></td>
<td>2. Standard HMO</td>
<td></td>
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<tr>
<td></td>
<td>3. Health Investor PPO</td>
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<tr>
<td></td>
<td>4. Health Investor HMO</td>
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<tr>
<td><strong>Life</strong></td>
<td>1. Basic</td>
<td>Employees, Retirees (basic), Laid-off Career Service Employees (basic,</td>
<td>Your family’s financial needs in the event of a death in the family</td>
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<tr>
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<td>2. Optional</td>
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<td></td>
<td>3. Dependent Spouse</td>
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<td></td>
<td>4. Dependent Child</td>
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<tr>
<td><strong>Dental</strong></td>
<td>Prepaid</td>
<td>Employees and all others if eligible to continue through COBRA</td>
<td>Recurring dental costs, anticipated dental work, which plans pay for orthodontia, and if the plan has dentists accepting new patients in your area</td>
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<td>Dental PPO</td>
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<td>Indemnity with PPO</td>
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<td></td>
<td>Indemnity</td>
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<tr>
<td><strong>Vision</strong></td>
<td>Exam Plus</td>
<td>Employees and all others if eligible to continue through COBRA</td>
<td>Next year’s needs, including eye exams, glasses or contacts; some coverage may be available under your health plan</td>
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<tr>
<td><strong>Other Supplemental Plans</strong></td>
<td>1. Accident</td>
<td>Employees and others may convert to an individual policy upon termination of employment.</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>2. Cancer</td>
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<td></td>
<td>3. Disability</td>
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<td>4. Hospital Intensive Care</td>
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<td></td>
<td>5. Hospitalization</td>
<td></td>
<td></td>
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<tr>
<td><strong>Tax-Favored Accounts</strong></td>
<td>1. Flexible Spending Accounts:</td>
<td>Employees (OPS/variable-hour employees who meet eligibility requirements are only eligible for the dependent care reimbursement account)</td>
<td>Out-of-pocket costs for eligible medical expenses or for care of qualified dependents while you work</td>
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<tr>
<td></td>
<td>• Medical Reimbursement</td>
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<td></td>
<td>• Limited Purpose Medical Reimbursement</td>
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<td></td>
<td>• Dependent Care Reimbursement</td>
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<tr>
<td></td>
<td>2. Health Savings Account</td>
<td></td>
<td>Out-of-pocket costs for eligible medical expenses if you’re enrolled in a Health Investor Health Plan</td>
</tr>
</tbody>
</table>

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.

Review your health plan’s [summary of benefits and coverage and summary plan description or certificate of coverage](#). If you prefer a paper copy, call your health plan.
Available Coverage Tiers by Plan

<table>
<thead>
<tr>
<th></th>
<th>Employee</th>
<th>Employee + Spouse</th>
<th>Employee + Children</th>
<th>Family</th>
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<tbody>
<tr>
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<td>✓</td>
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<tr>
<td>Life</td>
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<td></td>
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<tr>
<td>Dental</td>
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<tr>
<td>Vision</td>
<td>✓</td>
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<tr>
<td>Accident</td>
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<td>✓</td>
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</tr>
<tr>
<td>Disability</td>
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<td></td>
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<tr>
<td>Hospital Intensive Care</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

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

- Open Enrollment for the 2016 Plan Year: You must enroll or make changes by 6 p.m. EST (5 p.m. CST) on Friday, Nov. 6, 2015. Open Enrollment changes are effective Jan. 1 of the next calendar year.
- 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 45 for important new-hire information.
- 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. 19, 2015, 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.
- 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.
- 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.
• The State Group Insurance plan year is Jan. 1 through Dec. 31.
• The State of Florida is required to report minimum essential health insurance coverage information to the Internal Revenue Service (IRS). We are required to report the covered individual’s name, address and Social Security Number (SSN) or Taxpayer Identification Number (TIN). If we are unable to report a valid SSN or TIN for your employee’s dependents, the employee is subject to a $50 IRS penalty for each failure to provide a valid SSN or TIN.
• 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. 19, 2015, 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.
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;
- During the new hire measurement period, they experience an employment status change with an increase in work hours to an average of 30 hours or more per week;
- 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.

Employees who enroll in basic life insurance may be eligible to enroll in dependent spouse and dependent child 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 38 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.

Eligibility for retiree coverage
- 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 for health insurance and most supplemental insurance plans include:
- Your spouse – the person to whom you are legally married.
• 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 he or she turns age 26 through the end of the calendar year in which he or she reaches 30 if he or she is unmarried, has no dependents of his or her own, is dependent on you for financial support, lives in Florida or attends school in another state, and has 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 Suspends**

For employees, coverage will suspend on the last day of the month in which you do not make the required contributions for coverage including the months you are on leave without pay or suspension. Your coverage will not be reinstated until People First receives the total amount due, applies the remittance to your account and notifies the plan of the reinstatement.

**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 you are in layoff status. Payment is due the 10th day of the month before the month of coverage. For example, payment for July coverage is due June 10.

- On the last day of your health insurance coverage stability 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 end 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. EST (5 p.m. CST). 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:

- 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.
- 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 remain employed by the state. Other plans will end at the same time as your health insurance 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 ends 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.

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 4 – Spouse Program
Complete and sign the Spouse Program Election Form located at mybenefits.myflorida.com and list all eligible dependents;

- Enroll in the same health plan; and
- 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.

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**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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.
5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.
My Health

- How to Choose a Health Plan
- Preferred Provider Organization (PPO)
- Health Maintenance Organizations (HMO)
- Prescription Drug Plan

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 22.
- 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 38.
- See the My Resources section for important information about Medicare—Pages 40-49.
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:
   - Standard PPO Plan with worldwide coverage
   - Health Investor PPO Plan with worldwide coverage
   - Standard Health Maintenance Organization (HMO) Plan with coverage in a specific service area
   - Health Investor HMO 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 coverage under each of the different options.


5. Factor tax-favored accounts into your decision for costs insurance does not cover—Page 32.

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. For Health Investor (PPO and HMO):

- 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.

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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

<table>
<thead>
<tr>
<th></th>
<th>Standard Plans</th>
<th>Health Investor Health Plans¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO</td>
<td>HMOs</td>
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<tr>
<td><strong>Choice of Providers</strong></td>
<td>In or Out of Network²</td>
<td>Network only</td>
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<tr>
<td><strong>Open a Health Savings Account (HSA)³</strong></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Have a Reimbursement Account</strong></td>
<td>Yes – Active Employees Medical Reimbursement Account</td>
<td>Yes – Active Employees Limited Purpose Medical Reimbursement Account</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Lower</td>
<td>None</td>
</tr>
<tr>
<td><strong>How You Pay for Most Medical Care</strong></td>
<td>Network: set copayments or percentage of network allowed amount after deductible</td>
<td>Set copayments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-network: percentage of non-network allowance after deductible and any balance up to charges</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>Certain routine, preventive services and immunizations covered at 100%</td>
<td>Certain routine, preventive services and immunizations covered at 100%</td>
</tr>
</tbody>
</table>

Review your health plan’s summary of benefits and coverage and summary plan description or certificate of coverage. If you prefer a paper copy, call your health plan.

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 CVS/caremark administers prescription drug coverage for the PPO plans. See Page 22 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 https://www.floridablue.com/state-employees.

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:

<table>
<thead>
<tr>
<th>Plan</th>
<th>In-Network Annual Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard PPO Plan</td>
<td>$250 for individual coverage $500 for family coverage</td>
</tr>
<tr>
<td>Health Investor PPO Plan</td>
<td>$1,300 for individual coverage $2,600 for family coverage</td>
</tr>
</tbody>
</table>

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 https://www.floridablue.com/state-employees 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 United States Preventive Services Task Force.

A complete list of preventive services may be found at https://www.healthcare.gov/get-answers.

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 https://www.floridablue.com/state-employees and select 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

The State Employees’ PPO Plan limits the out-of-pocket amount you pay each year. Once you reach the maximum dollar amount in a calendar year, the PPO Plan pays 100 percent of the allowed amount for network covered services for the rest of the calendar year.

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.

Refer to the PPO plan document for specific information about the PPO plans.
State Employees’ Standard and Health Investor PPO Plans Comparison Chart

<table>
<thead>
<tr>
<th>Covers care received in or out of network</th>
<th>Standard PPO Plan</th>
<th>Health Investor PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Network</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANNUAL DEDUCTIBLE**

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network</td>
<td>$250</td>
<td>$500</td>
<td>$1,300</td>
<td>$2,600</td>
</tr>
<tr>
<td>Non-Network</td>
<td>$750</td>
<td>$1,500</td>
<td>$1,200</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

**COSTS FOR CARE**

<table>
<thead>
<tr>
<th></th>
<th>Standard PPO Plan</th>
<th>Health Investor PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor office visits</td>
<td>$15 per visit for PCP</td>
<td>40% of non-network allowance plus the amount between the charge and allowance</td>
</tr>
<tr>
<td></td>
<td>$25 per visit for specialists</td>
<td>20% of network allowed amount</td>
</tr>
<tr>
<td>Hospital stay</td>
<td>$250 per admission deductible then 20% of network allowed amount</td>
<td>$500 per admission deductible then 40% of non-network allowance plus the amount between the charge and allowance</td>
</tr>
<tr>
<td></td>
<td>$500 per admission deductible then 40% of non-network allowance plus the amount between the charge and allowance</td>
<td>20% of network allowed amount</td>
</tr>
<tr>
<td></td>
<td>$250 per admission deductible then 20% of network allowed amount</td>
<td>After meeting deductible, 40% of out-of-network allowance plus the difference between the charge and the allowance</td>
</tr>
</tbody>
</table>

**PRESCRIPTION DRUGS**

<table>
<thead>
<tr>
<th></th>
<th>Standard PPO Plan</th>
<th>Health Investor PPO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$7/retail-30 day; $14/mail/retail-90 day</td>
<td>Pay in full and file a claim; 30%</td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$30/retail-30 day; $60/mail/retail-90 day</td>
<td>Pay in full and file a claim; 30%</td>
</tr>
<tr>
<td>Non-Preferred Brand</td>
<td>$50/retail-30 day; $100/mail retail-90 day</td>
<td>Pay in full and file a claim; 50%</td>
</tr>
<tr>
<td>Preventive Care (coverage based on age and gender): Certain routine physical exams, health screenings, mammograms, and immunizations</td>
<td>100% of allowed amount; no deductible</td>
<td>100% of non-network allowance; you pay amount between charge and allowance; no deductible</td>
</tr>
<tr>
<td></td>
<td>100% of non-network allowance; you pay amount between charge and allowance; no deductible</td>
<td>100% of allowed amount; no deductible</td>
</tr>
<tr>
<td></td>
<td>100% of non-network allowance; you pay amount between charge and allowance; no deductible</td>
<td>100% of non-network allowance; you pay amount between charge and allowance; no deductible</td>
</tr>
<tr>
<td>Qualifies for an HSA</td>
<td>No</td>
<td>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</td>
</tr>
<tr>
<td>Qualifies for Medical FSA</td>
<td>Yes, Medical Reimbursement Account (MRA)</td>
<td>Yes, Limited Purpose MRA</td>
</tr>
</tbody>
</table>

Review your health plan’s [summary of benefits and coverage and summary plan description or certificate of coverage](#). If you prefer a paper copy, call your health plan.

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1. Prescriptions are included.
2. Before anything but preventive care is covered.
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 $1,300 (individual plan) or $2,600 (family plan) out of pocket, for covered in-network services.
- 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 38 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 $3,350 for individual coverage and $6,750 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):
    - Select the Health Investor PPO Plan as your health plan, and
    - Enroll in an HSA through People First, and
    - Open a personal HSA bank account at Tallahassee State Bank by completing the HSA bank account application before Jan. 1.

Health Maintenance Organizations (HMO)

- Except for 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 CVS/caremark administers prescription drug coverage, except for CHP and FHCP. See Page 22 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 change online via HMO’s website or call HMO to complete any necessary paperwork.

\[ ^1 \text{Tallahassee State Bank assesses a small monthly fee for accounts with less than } $2,500 \text{ after they have been open one full month.} \]
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 21.

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

HMO Preventive Care
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 https://www.healthcare.gov/prevention/.

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 discounts on gym memberships, smoking cessation classes, and health counseling and education. To compare these benefits see the Wellness Benefits Chart on the mybenefits website.

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.

Refer to the plan documents for specific information about the HMO or PPO plan.

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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.
5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.
### Standard and Health Investor HMO Plans Comparison Chart

<table>
<thead>
<tr>
<th>Covers care received only in the network</th>
<th>Standard HMO</th>
<th>Health Investor Health Plan HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANNUAL DEDUCTIBLE</strong> (you pay before anything but preventive care is covered)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Individual</td>
<td>No deductible</td>
<td>$1,300¹</td>
</tr>
<tr>
<td>• Family</td>
<td>No deductible</td>
<td>$2,600¹</td>
</tr>
<tr>
<td><strong>COSTS FOR CARE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Doctor office visits</td>
<td>$20 per visit for PCP</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>$40 per visit for specialists</td>
<td>20%</td>
</tr>
<tr>
<td>• Hospital stay</td>
<td>$250</td>
<td>20%</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS:</strong> Up to 30-day retail or up to 90-day mail order/retail prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>$7/retail; $14/mail order</td>
<td>30%</td>
</tr>
<tr>
<td>• Preferred Brand</td>
<td>$30/retail; $60/mail order</td>
<td>30%</td>
</tr>
<tr>
<td>• Non-Preferred Brand</td>
<td>$50/retail; $100/mail order</td>
<td>50%</td>
</tr>
<tr>
<td><strong>PREVENTIVE CARE</strong> (coverage based on age and gender):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Certain routine physical exams, health screenings, and immunizations</td>
<td>See the HMO’s Summary Plan Description (SPD) or Certificate of Coverage (COC)</td>
<td>Same as standard HMOs; no deductible required</td>
</tr>
<tr>
<td>Qualifies for HSA</td>
<td>No</td>
<td>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</td>
</tr>
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<td>Qualifies for Medical FSA</td>
<td>Yes—Medical Reimbursement Account (MRA)</td>
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</tr>
</tbody>
</table>

Review your health plan’s summary of benefits and coverage and summary plan description or certificate of coverage. If you prefer a paper copy, call your health plan.

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 $1,300 (individual plan) or $2,600 (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 38 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).

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- 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 Bank. To be sure you receive the state money you are entitled to and your own contribution (if any):
  - Select the Health Investor HMO Plan as your health plan, and
  - Enroll in an HSA through People First, and
  - Open a personal HSA bank account at Tallahassee State Bank 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 $1,300 ($2,600 for family) for all services and prescriptions out of pocket. After you meet your total annual deductible, you pay the coinsurance amount up to your total out-of-pocket maximum amount. See your plan document for details.

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1. Turn off the browser’s pop-up blocker and log in to peoplefirst.myflorida.com.
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1 Tallahassee State Bank assesses a small monthly fee for accounts with less than $2,500 after they have been open one full month.
<table>
<thead>
<tr>
<th>County</th>
<th>Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALACHUA</td>
<td>AvMed Capital Health Plan</td>
</tr>
<tr>
<td>BAKER</td>
<td>AvMed Capital Health Plan</td>
</tr>
<tr>
<td>BAY</td>
<td>UnitedHealthcare</td>
</tr>
<tr>
<td>BRADFORD</td>
<td>AvMed AvMed</td>
</tr>
<tr>
<td>BREVARD</td>
<td>Aetna* AvMed</td>
</tr>
<tr>
<td>BROWARD</td>
<td>AvMed AvMed</td>
</tr>
<tr>
<td>CALHOUN</td>
<td>Capital Health Plan</td>
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<tr>
<td>CHARLOTTE</td>
<td>UnitedHealthcare</td>
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<tr>
<td>CITRUS</td>
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<td>CLAY</td>
<td>AvMed AvMed</td>
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<td>AvMed AvMed</td>
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<td>AvMed AvMed</td>
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<td>DUVAL</td>
<td>AvMed AvMed</td>
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<td>ESCAMBIA</td>
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<tr>
<td>FLAGLER</td>
<td>AvMed Florida Health Care Plans</td>
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<td>FRANKLIN</td>
<td>Capital Health Plan</td>
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<td>UnitedHealthcare</td>
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<td>HARDEE</td>
<td>AvMed AvMed</td>
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<tr>
<td>HENDRY</td>
<td>Aetna* AvMed</td>
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<td>HERNANDO</td>
<td>AvMed AvMed</td>
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<td>AvMed AvMed</td>
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<td>HILLSBOROUGH</td>
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<td>Capital Health Plan</td>
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<td>ST. JOHNS</td>
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</tr>
<tr>
<td>ST. LUCIE</td>
<td>AvMed Aetna* AvMed</td>
</tr>
<tr>
<td>SUMTER</td>
<td>AvMed AvMed</td>
</tr>
<tr>
<td>SUWANNEE</td>
<td>AvMed AvMed</td>
</tr>
<tr>
<td>TAYLOR</td>
<td>UnitedHealthcare</td>
</tr>
<tr>
<td>UNION</td>
<td>AvMed AvMed</td>
</tr>
<tr>
<td>VOLUSIA</td>
<td>AvMed Florida Health Care Plans</td>
</tr>
<tr>
<td>WAKULLA</td>
<td>Capital Health Plan</td>
</tr>
<tr>
<td>WALTON</td>
<td>UnitedHealthcare</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>UnitedHealthcare</td>
</tr>
</tbody>
</table>

*Aetna (and formerly Coventry)*
State Employees’ Prescription Drug Plan

CVS/caremark is the pharmacy benefits manager for the prescription drug benefits for State Group Insurance health plans (except the CHP Retiree Advantage plan and the FHCP Medicare Advantage plan). This means the state pays prescription drug claims and CVS/caremark 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 CVS/caremark Member Services anytime (24/7/365) at 888-766-5490.

For general plan information, visit http://info.caremark.com/sofrxplan. Members should create an account at www.caremark.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 three options: a network of retail pharmacies, a mail order pharmacy, and 90-day retail pharmacies.

- Retail: Use your CVS/caremark prescription drug card at your local pharmacy for short-term medications and those that must be filled immediately.

- 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 or 90-day maintenance at retail for certain prescribed maintenance drugs2 after they have been filled three times at a retail pharmacy.

- 90-Day Maintenance at Retail: Take your prescriptions for maintenance medications1 to a retail pharmacy participating in the 90-day maintenance network and get up to a 90-day supply for the same cost as two 30-day fills. Ask your doctor to write your prescription for up to a 90-day supply with three refills to take advantage of the cost savings.

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.

- If you have a maintenance medication prescription for up to a 90-day supply, you may have it filled one of three ways:
  - Through the CVS/caremark mail order pharmacy;
  - At a CVS retail pharmacy; or
  - At any retail pharmacy that participates in the 90-day maintenance supply retail network established specifically for the State of Florida. The pharmacies in this network may or may not be in the regular retail network. Visit www.caremark.com/sofrxplan or call 888-766-5490 to find out if your retail pharmacy is participating in the 90-day maintenance supply retail network.

- Copays for a 90-day maintenance supply at a participating retail pharmacy are the same as for mail order: $14 for generic drugs, $60 for preferred brand drugs, and $100 for non-preferred brand drugs.

This chart shows the cost savings of using generic drugs and the mail order/90-day retail 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.)

<table>
<thead>
<tr>
<th>State Employees’ Prescription Drug Plan</th>
<th>Retail (up to a 30-day supply)</th>
<th>Mail Order/Retail (up to a 90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$7</td>
<td>$14</td>
</tr>
<tr>
<td>Preferred-Brand Drugs</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>Nonpreferred-Brand Drugs</td>
<td>$50</td>
<td>$100</td>
</tr>
</tbody>
</table>

Quarterly, CVS/caremark 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.caremark.com/sofrxplan for more information. Members can log into www.caremark.com.

For PPO plan members, CVS/caremark maintains a list of maintenance medications that must be filled through mail order or 90-day retail after three fills at 30-day retail pharmacy. Visit www.caremark.com/sofrxplan for general information; members can log in to www.caremark.com for member-specific information.
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.

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 or 90 days at retail 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 CVS/caremark ID card to be sure you are charged the appropriate copayment (Standard plans) or coinsurance (Health Investor plans).

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 CVS/caremark’s Preferred Drug List (PDL) periodically; it’s updated quarterly. 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.

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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.
5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.
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 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 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 Continuation Options

If you terminate employment and wish to continue your Basic Life coverage, portability and conversion options may be available to you. For more information, call Minnesota Life at 1-888-826-2756.

Dependent Spouse Coverage

If you are enrolled in the Basic Life insurance plan, you may elect Dependent Spouse coverage. You may choose either a $15,000 benefit or a $20,000 benefit. This is an employee paid, post-tax benefit. If your spouse is a benefits-eligible State employee, you may not enroll them in Dependent Spouse coverage.

If you elect this coverage during your initial eligibility period (Open Enrollment for plan year 2016, new hire period, marriage QSC event), it is guaranteed issue. If you wish to enroll in this coverage outside the initial eligibility period or if you wish to increase the benefit from $15,000 to $20,000, your spouse may be required to pass medical underwriting.

Dependent Child Coverage

If you are enrolled in the Basic Life insurance plan, you may elect Dependent Child coverage. The benefit for Dependent Child coverage is $10,000. Premiums are post-tax and paid by the employee. The Dependent Child premium is one fixed amount regardless of the number of eligible children enrolled. Dependent Child coverage is always guaranteed Issue.

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. Premium amounts are based on your benefit election, salary and age. If your salary changes or you change age bands during the plan year, your premiums will change accordingly at this time.

You may apply for one to seven times your annual salary in optional coverage. The maximum benefit is $1 million. If you choose a coverage tier that takes your benefit over $1 million, your premium is based on the $1 million cap and your benefit equals $1 million.

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.

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 evidence of insurability. Enrolling during Open Enrollment, increasing by more than one increment, choosing coverage of more than $500,000 or choosing six or seven times your salary requires evidence of insurability. Make changes online in People First, complete the Evidence of Insurability form and send it to Minnesota Life.

- 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. Call Minnesota Life at 888-826-2756 for more information.

Basic Life for Retirees

Upon retirement, retirees may choose to remain in the State’s life insurance plan by enrolling in either a $2,500 life insurance benefit or a $10,000 life insurance benefit. Premiums for this coverage are post-tax and retiree paid.

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 re-enroll 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. The beneficiary for Dependent Spouse and Child coverages is the employee. Payments made to an estate, however, may result in a reduction of total benefits due to taxes and probate costs.

Additional Life Insurance Plan Benefits

Accidental Death and Dismemberment
Basic and Optional Life insurance coverages include accidental death and dismemberment coverage. 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 life insurance coverage options include an accelerated death benefit. This 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. Upon death, the remainder of your life insurance benefit, if any, is paid to the named beneficiaries.

Repatriation Benefit
All life insurance coverage options include a repatriation benefit. If a plan participant passes away 75 miles or more away from their primary address, a benefit of up to $5,000 will be paid for costs associated with transportation of the deceased.

Continuation of Coverage Options
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 may be able to port or convert your coverage. Continuation options are guaranteed issue provided your request and premium payment are made to Minnesota Life within 31 days of group plan termination. Call Minnesota Life at 888-826-2756 for additional information, forms and applicable premium information.

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

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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.
5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. 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. Dentists can leave a network at any time. Provider preference is not a qualifying status change event for you to cancel or change dental plans.
- Dental plans offer various benefits. Compare plan benefits carefully and look at more than the monthly premium amount.
- 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 made available to you as a convenience. Upon retirement, retirees may continue dental or vision through COBRA. For supplemental plans other than dental and vision, continuation options may be available to you through the insurance company. To learn about a specific plan, see the appropriate section below or contact the insurance company. Contact information can be found on Page v.

You must make all changes to your supplemental products—adding coverage, adding or removing dependents, changing benefit levels, etc. through People First. If you attempt to make these changes through an insurance agent or company without going through People First, the changes will not take effect.

Some plans require medical underwriting. This means you must complete the company's medical underwriting application and pass the medical underwriting test before you are approved for coverage. To get coverage, enroll online through People First then contact an agent representing the insurance company for an application and instructions. Once you are enrolled and approved, your coverage will become effective once a full month's premium has been deducted.

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

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 29) to see how the plans work. Refer to the plan document or contact the plan providers directly for monthly premium rates and out-of-pocket costs.

---

<table>
<thead>
<tr>
<th>Available Coverage Tiers by Plan</th>
<th>Employee</th>
<th>Employee + Spouse</th>
<th>Employee + Children</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Vision</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Accident</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer1</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Intensive Care</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

---

To Choose a Dental Plan:

1. Compare the four dental plan options—prepaid, PPO, indemnity with PPO, and indemnity. See chart on the next page for a side-by-side comparison.

2. Check each plan's network directory to see dentists and specialists available in your area. Remember: providers may drop out of the plan at any time; this is not a qualifying status change (QSC) event to change plans.

3. Think about your likely dental care needs for the coming year and compare your current costs for that care and your cost for coverage under the different plan options. Remember: factor tax-favored accounts into your decision—Page 34.

4. Read the dental plan documents or call the insurance companies for specific questions you have about coverage.

---

1 Some plans only offer employee and family coverage.
## Dental Plans Comparison Chart

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Prepaid Dental Plan</th>
<th>Dental Preferred Provider Organization Plan (DPPO)</th>
<th>Dental Indemnity with a DPPO Network Plan</th>
<th>Dental Indemnity Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Network of dentists and specialists to keep your costs low. Does not cover out-of-network services.</td>
<td>You can use any provider but will receive a greater benefit amount on services with dentists or specialists in the network.</td>
<td>You can use any provider but receive discounted rates on services if you use dentists or specialists in the network.</td>
<td>Scheduled reimbursement amount (set fee) for covered services from any dentist or specialist.</td>
</tr>
<tr>
<td><strong>Choice of Providers</strong></td>
<td>Network only</td>
<td>In or out of network</td>
<td>In or out of network</td>
<td>Any you choose</td>
</tr>
<tr>
<td><strong>Preventive Care (No deductible)</strong></td>
<td>Most services covered at no charge to you.</td>
<td>No charge in network. You pay 20% of cost for out of network.</td>
<td>No charge or you pay cost above a set dollar amount.</td>
<td>You pay cost above a set dollar amount.</td>
</tr>
<tr>
<td><strong>Basic and Major Care</strong></td>
<td>Set copays or a percentage of cost</td>
<td>Percentage of cost</td>
<td>You pay cost above a set dollar amount or a percentage of cost</td>
<td>You pay cost above a set dollar amount</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>No</td>
<td>Yes, for basic and major care</td>
<td>Yes, for basic and major care</td>
<td>Yes, for basic and major care</td>
</tr>
<tr>
<td><strong>You Should Know</strong></td>
<td>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.</td>
<td>You pay any amount per year over the calendar year maximum If you see an out-of-network dentist or specialist, your benefits are lower.</td>
<td>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 may be higher.</td>
<td>You pay any amount per year over the calendar year maximum.</td>
</tr>
<tr>
<td><strong>People First Plan Code and Plan Name</strong></td>
<td>4004 Humana Network Plus 4014 UnitedHealthcare Dental Solstice S700 4025 Assurant Employee Benefits Prepaid 225 4034 CIGNA Dental 4044 Humana Select 15</td>
<td>4054 Humana Preferred Plus 4054 Humana Preferred Plus 4064 Ameritas Dental Preventive Plus 4074 Assurant Employee Benefits Freedom Advance</td>
<td>4084 Humana Schedule B</td>
<td></td>
</tr>
</tbody>
</table>
My Supplemental Plans

Vision Plan

The vision plan is an employee-pay-all, pretax plan. The chart below shows a summary of the vision plan benefits. Additional discounts for lens options may be available to you through network providers. You may have some coverage for vision services available under your health plan.

Vision Plan Chart

<table>
<thead>
<tr>
<th>Exam and Materials (People First Plan Code 3004)</th>
<th>Frequency (based on the date of service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam Every</td>
<td>12 months</td>
</tr>
<tr>
<td>Lenses Every</td>
<td>12 months</td>
</tr>
<tr>
<td>Frames Every</td>
<td>24 months</td>
</tr>
<tr>
<td>Benefits</td>
<td>In-Network</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>100% after $10 copay</td>
</tr>
<tr>
<td>Lenses</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>100% after $10 copay</td>
</tr>
<tr>
<td>Bifocal</td>
<td>100% after $10 copay</td>
</tr>
<tr>
<td>Trifocal</td>
<td>100% after $10 copay</td>
</tr>
<tr>
<td>Scratch Resistant Lenses</td>
<td>$25 allowance</td>
</tr>
<tr>
<td>Anti-Reflective Lenses</td>
<td>$50 allowance</td>
</tr>
<tr>
<td>Frames</td>
<td>$75 wholesale allowance</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td></td>
</tr>
<tr>
<td>Elective</td>
<td>$150 allowance</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>100%</td>
</tr>
</tbody>
</table>

LASIK

Participants receive a 25% discount off the usual and customary price or 5% off advertised promotions or specials for LASIK services provided by in-network providers. The discount includes consultations, laser procedure, follow-up visits and any additional necessary corrective procedures.

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. To prevent delay in receiving your future contact lens benefit in full, you should try to use your full contact lens allowance at once.

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 Plan
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:
1. Enroll online through People First; and
2. Contact an agent to complete an application.

The accident plan is guaranteed issue and offered by Colonial Life (People First plan code 5002).

Cancer Plans
Employee-pay-all, pretax cancer plans help offset some of the direct and indirect expenses for cancer diagnosis and treatment. Aflac and Colonial Life 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). 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 2/3 percent of your income, up to $3,480 per month. Be sure you pick a monthly benefit amount less than or equal to 66 2/3 percent of your monthly income.

To enroll in a supplemental disability plan you must:
1. Enroll online through People First; and
2. See a Colonial Life agent to complete a company application.

The disability plan is guaranteed issue and offered by Colonial Life (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 for an Aflac supplemental hospital intensive care insurance policy:
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)
My Wealth
• Changes for the 2016 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 36.
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 2016 Plan Year

• HSA contribution for family coverage (including any state contribution) is $6,750.

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 as follows.

Flexible Spending Accounts:

• 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).

• Limited Purpose Medical Reimbursement Account (LPMRA): Enroll in this option if you have a Health Savings Account and are a salaried employee (OPS/variable-hour employees are not eligible).

• 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.

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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.

5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.
## Tax-Favored Accounts Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>Medical Reimbursement Account (MRA)</th>
<th>Limited Purpose Medical Reimbursement Account (LPMRA)</th>
<th>Dependent Care Reimbursement Account (DCRA)</th>
<th>Health Savings Account (HSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How It Works</strong></td>
<td>You contribute pretax money to the account through payroll deductions. • Use the myMRA card; or • Pay out of pocket for medical expenses; then submit claims and get reimbursed for eligible expenses.</td>
<td>You contribute pretax money to the account through payroll deductions. • Use the myMRA card; or • Pay out of pocket for medical expenses; then submit claims and get reimbursed for eligible expenses.</td>
<td>You contribute pretax money to the account through payroll deductions. • Pay out of pocket for dependent care services; then submit claims and the state will reimburse you for eligible expenses.</td>
<td>The state contributes pretax money to the account. You can, too. Pay for health care expenses from the account at the time of service or purchase.</td>
</tr>
<tr>
<td><strong>State Contribution</strong></td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes—if you open an HSA bank account at Tallahassee State Bank: • $41.66/month for individual coverage (up to $500/year) • $83.33/month for family coverage (up to $1,000/year)</td>
</tr>
<tr>
<td><strong>Employee Contribution Limit</strong></td>
<td>Yes—$60 minimum/year $2,550 maximum/year</td>
<td>Yes—$60 minimum/year $2,550 maximum/year</td>
<td>Yes—$60 minimum/year $5,000 maximum/year/household</td>
<td>Yes—$3,350/year individual coverage $6,750/year family coverage (Limit includes the state contribution.)</td>
</tr>
<tr>
<td><strong>Health Plan</strong></td>
<td>Standard</td>
<td>Health Investor (high-deductible)</td>
<td>N/A</td>
<td>Health Investor (high-deductible)</td>
</tr>
<tr>
<td><strong>Enroll in Another Tax-Favored Account</strong></td>
<td>Yes— DCRA</td>
<td>Yes— HSA and DCRA</td>
<td>Yes— MRA or HSA and LPMRA</td>
<td>Yes— LPMRA and DCRA</td>
</tr>
<tr>
<td><strong>Payment Card Available</strong></td>
<td>Yes— myMRA card</td>
<td>Yes— myMRA card</td>
<td>No</td>
<td>Yes— from Tallahassee State Bank</td>
</tr>
<tr>
<td><strong>Money Available</strong></td>
<td>The lump sum of your annual deduction is available Jan. 1 (for Open Enrollment) or on the date you enroll (if you are a new-hire or have QSC event).</td>
<td>The lump sum of your annual deduction is available Jan. 1 (for Open Enrollment) or on the date you enroll (if you are a new-hire or have QSC event).</td>
<td>As it is deducted from your paycheck.</td>
<td>As it is deposited into your HSA bank account at Tallahassee State Bank.</td>
</tr>
<tr>
<td><strong>Deadline to Use Funds</strong></td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>How to Enroll</strong></td>
<td>1. 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. 2. Enter in the Annual Amount and click the Select button. 3. Enter your Password and select the Complete Enrollment button. Once you enter an amount you can only change during Open Enrollment or with a QSC event.</td>
<td>1. 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. 2. Enter in the Annual Amount and click the Select button. 3. Enter your Password and select the Complete Enrollment button. Once you enter an amount you can only change during Open Enrollment or with a QSC event.</td>
<td>1. 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. 2. Enter in the Annual Amount and click the Select button. 3. Enter your Password and select the Complete Enrollment button. Once you enter an amount you can only change during Open Enrollment or with a QSC event.</td>
<td>1. Enroll online through People First. Complete the Dependent Certification process, then select Click the Flex Spend Acct tab. 2. 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.) 3. Review Change Summary tab and click Complete Enrollment. 4. Open an HSA bank account at Tallahassee State Bank.</td>
</tr>
</tbody>
</table>
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 $2,550 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.

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.

<table>
<thead>
<tr>
<th>Balance in 2015 Account</th>
<th>Balance in 2016 Account</th>
<th>Claim</th>
<th>How Claim is Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50</td>
<td>$500</td>
<td>$10 dated January 2016</td>
<td>$10 comes out of the 2015 account, leaving $40 in the account</td>
</tr>
<tr>
<td>$40</td>
<td>$500</td>
<td>$50 dated February 2016</td>
<td>$40 comes out of the 2015 account, leaving a balance of zero and the other $10 now comes out of the 2016 account</td>
</tr>
<tr>
<td>$0</td>
<td>$490</td>
<td></td>
<td>New balances after claims are paid</td>
</tr>
</tbody>
</table>

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 accidently 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 2015 by April 15, 2016, 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, 2016, to use eligible services for your 2015 contributions. Remember, you must also file these claims by April 15, 2016. 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 2015 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 incurred in 2015 by April 15, 2016. If you do not, you will lose your money.

You must 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 2016 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 employee\(^1\) 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 $3,350 for individual coverage and $6,750 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;

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

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 Bank2 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 Bank2. To be sure you receive the state money you are entitled to and your own contribution (if any), open your account before Jan. 1.

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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.
5. Once you’ve confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.

2 Tallahassee State Bank assesses a small monthly fee for accounts with less than $2,500 after they have been open one full month.
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 43.
- You must provide a copy of your Medicare card to People First when you enroll in Medicare—Page 43.
- New employees should make elections carefully, as they remain in effect for the remainder of the plan year—Page 45.
- You can authorize someone else to discuss your insurance benefits with People First or your insurance company—Page 49.
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.

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:

1. Employees must be in a Health Investor HMO or PPO plan to contribute to an HSA.
2. They must open a personal HSA bank account at Tallahassee State Bank by completing the online HSA bank account application.
3. 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, which means the current month may still be unpaid.

**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 employee to make an insurance coverage or Flexible Spending Account change outside of the Open Enrollment period, as defined in the QSC Matrix.

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**How to Appeal a Decision**

The appeal process gives you an avenue to have your medical claim, prescription 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 v). 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 summary plan description 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 CVS/caremark.

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.
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 in Medicare Part B.

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 or not you enroll in Parts A and B. 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), 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 or 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
Fax: 800-422-3128

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.
Special Notice about the Medicare Part D Drug Program

Jan. 1, 2016

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. 5.

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 evidence of insurability to enroll in Optional Life insurance.
• If you’re enrolled in a prepaid dental plan, you may need to call your insurance provider to be added to your dentist’s roster before making any appointments.
• 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 calendar 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.

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 2016, 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 CVS/caremark (which provides third-party medical and pharmacy support to the self-insured plan); the notices describe how Florida Blue and CVS/caremark will satisfy the requirements. Members in an insured plan option will receive similar notices directly from their insurer or HMO.

It’s important to note 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 members’ 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, CVS/ caremark, 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...
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 CVS/caremark can be filed by following the procedures in the notices they provide. To file other complaints with the plans, contact 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 confirm dependent eligibility and register new dependents (Social Security Numbers required). Enter your People First password and select Certify to complete the dependent verification 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 then Add to make updates.
5. Once you've confirmed your choices, enter your People First password and click Complete Enrollment.

To see your confirmation statement, go to your home page and select Benefits Confirmation Statement in the My Quick Links section. Select 2016 for the Benefits Material Year, Confirmation Statement for the Benefits Material Type and then View Materials. To view or print your confirmation statement, select View Details.
Thank you for trusting Florida Blue to service the State Employees’ PPO Plan for more than 35 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.
Visit floridablue.com/state-employees
Stop in a Florida Blue Center near you. Check out floridablue.com for locations.

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!

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.

In the pursuit of health

Thank you for trusting Florida Blue to service the State Employees’ PPO Plan for more than 35 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.
Visit floridablue.com/state-employees
Stop in a Florida Blue Center near you. Check out floridablue.com for locations.

Florida Blue is an Independent Licensee of the Blue Cross and Blue Shield Association.
A healthier you
STARTS HERE.

When you choose AvMed, you’re choosing more than a healthcare Provider. You’re choosing a health partner, ready to help you make better choices every day—to live a healthier life. It’s all here for you:

• An extensive Network of doctors & hospitals
• No referrals necessary to see specialists
• 24/7 live-healthy support, including our Member Engagement Center dedicated to State Employees, and Nurse On Call
• Discounts on gym memberships, massage therapy, yoga and more
• Service that consistently ranks above our statewide competitors *

All this, from the Florida company that’s been specializing in Florida healthcare for more than 45 years — and caring for State of Florida employees and retirees for more than 30 of those years. To learn about our health plans visit www.AvMed.org/go/state.

*Highest overall rating of statewide plans reporting HMO and POS product data to the National Committee for Quality Assurance (NCQA) for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

When you choose AvMed, you’re choosing more than a healthcare Provider. You’re choosing a health partner, ready to help you make better choices every day—to live a healthier life. It’s all here for you:

• An extensive Network of doctors & hospitals
• No referrals necessary to see specialists
• 24/7 live-healthy support, including our Member Engagement Center dedicated to State Employees, and Nurse On Call
• Discounts on gym memberships, massage therapy, yoga and more
• Service that consistently ranks above our statewide competitors *

All this, from the Florida company that’s been specializing in Florida healthcare for more than 45 years — and caring for State of Florida employees and retirees for more than 30 of those years. To learn about our health plans visit www.AvMed.org/go/state.

*Highest overall rating of statewide plans reporting HMO and POS product data to the National Committee for Quality Assurance (NCQA) for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey.

LOCAL. TRUSTED.

We’re committed.

Captorsal Health Plan has served State of Florida employees and their families for over 30 years.

www.capitalhealth.com/state
Do you have a Coventry HMO plan?

If you do, mark this date on your calendar: January 1, 2016. That’s when you — and your HMO plan — join the Aetna family.

No referrals are necessary, plus you’ll now have access to Aetna’s national select network of providers. And a whole lot of new tools and support, too.

Visit www.aetnastateflorida.com or call 1-877-858-6507 to learn more. Member Services representatives are available Monday through Friday, from 7 a.m. to 7 p.m. ET.

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.

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2015132

GOOD HEALTH CARE BEGINS AT HOME.

Working for good health in Volusia and Flagler counties

Great providers, labs, pharmacies, health education classes, 24/7 Nurse Advice Line ... setting a high standard for excellent health care ... and health coverage in Volusia and Flagler counties

Preferred Fitness Network
Get fit at your choice of more nearly 60 gyms, fitness centers and YMCAs in Volusia and Flagler counties following completion of your online personal health risk assessment. They are all part of Florida Health Care Plans’ Preferred Fitness Network.

Same-Day Appointments
Florida Health Care Plans Members can get same-day appointments at FHCP’s extended hours centers. Simply call Central Scheduling and you will get medical attention when you need it.

Best Around for 24 Years
Florida Health Care Plans has been recognized as the Reader’s Choice Best Health Plan by the Daytona Beach News-Journal. FHCP won this award again in 2014, for the 24th year in a row.

855 Go2FHCP or visit FHCP.com
Health care: It’s about value.

You need to know the money spent on benefit coverage is giving you what you need. We offer:

- No referrals: See the specialist you want without hassles
- Statewide and national network: No preauthorizations, no county limits
- Discounts on fitness clubs and Jenny Craig®
- A program with personalized support for expectant moms
- 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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CVS/caremark

At your Convenience.

Get access to the State Employees’ Prescription Drug Plan benefits at the pharmacy, by phone, online or with our mobile app – it’s that convenient. We’re here to help manage your medicine while finding ways to save you time and money.

All the features below are available to current members. Starting on October 19, 2015, current and prospective plan members can visit www.caremark.com/sofrxplan or talk with CVS/caremark Customer Care toll-free at 1-888-766-5490 to learn more.

Nearby Network Retail Pharmacies
- Choose from a network of more than 59,000 retail pharmacies nationwide
- Pick up 90-day supplies of maintenance medicines at select retail pharmacies for the same low cost as mail service

Caremark.com
- Compare your drug costs versus generic drugs costs
- Set up mail service for 90-day supplies of maintenance medicines
- Find the Plan’s current preferred drug list

Toll-free Support 24/7 (1-888-766-5490)
- Talk to a CVS/caremark pharmacist or Customer Care representative anytime
- Set up mail service for 90-day supplies

CVS/caremark Mobile App (Download on Google Play or the App Store)
- Refill by scanning your prescription label
- Find a pharmacy, review orders and check costs

*A maintenance medication is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol. ©2015 CVS/caremark. All rights reserved. 106-34787a 061915
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!

How does the competition stack up? Compare how well the plans do with certain preventive procedures like cancer screenings, 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

NEW! Apply an additional layer of financial protection

Minnesota Life Insurance Company is proud to partner with the State of Florida to provide group term life insurance benefits to members. Below are new benefits for full-time active employees in 2016:

- **Spouse Life** - $15,000 or $20,000 of guaranteed coverage, no evidence of insurability (EOI) required during open enrollment
- **Child Life** - $10,000 of guaranteed coverage, EOI never required
- Employees that don’t currently participate in the Optional plan may elect 1x salary of guaranteed coverage, no EOI required during open enrollment

Affordable coverage. Excellent service. Call 1-888-826-2756 or visit www.lifebenefits.com/florida

Insurance products underwritten by Minnesota Life Insurance Company, a Securian Financial Group affiliate. 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 Rev 6-2015
A01973-0615
Apply an additional layer of financial protection

Take advantage of Group Term Life Insurance

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

- **Two coverage amounts:** $2,500 for $4.83/month or $10,000 for $19.33/month*
- **Local service from our Tallahassee branch office**

*Rates are subject to change.

Call 1-888-826-2756 or visit www.lifebenefits.com/florida

Insurance products underwritten by Minnesota Life Insurance Company, a Securian Financial Group affiliate. This product is offered under policy form series 07-30978.

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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.

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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.

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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 enrollees are administered by Ameritas Life. Billing and slighty for most plans with 25 or fewer enrollees are administered by HealthPlan Services, Inc.

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2016 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
- 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
- Access to over 6,200 unique dentists in Florida (and more than 100,000 nationwide)
- Coverage for up to 4 cleanings per year
- 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

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
Humana proudly offers dental benefit options

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

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

Network Plus Prepaid and Preferred Plus DPPO

Select 15 Prepaid and Schedule B Indemnity

Humana dental benefit options for the State of Florida

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

Please contact us at 866-879-3630 or visit our website at Humanadental.com/custom/fl
Imagine paying less for benefits. That’s the Solstice S700 Plan from UnitedHealthcare Dental.

Here’s what you get:

- Low premiums
- No primary dentist selection required EVER
- Preventive services including sealants for children covered at 100%
- No waiting periods OR claim forms to submit

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.

People First Plan Code 4014

Clearly Simple: Humana Vision

With Humana Vision Care Plan (VCP) Exam and Materials plan (3004) option, you get:

- 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

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

GCHHA7HHH 0116
For more information about our Cancer policy, please contact:

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

*Plan Codes: Cancer 6500-6501-6502-6503-6510-6511-6512-6513
Coverage is underwritten by American Family Life Assurance Company of Columbus.
WWHQ | 1932 Wynnton Road | Columbus, GA 31999

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

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

*Plan Codes: Hospital Intensive Care 7000
Coverage is underwritten by American Family Life Assurance Company of Columbus.
WWHQ | 1932 Wynnton Road | Columbus, GA 31999
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 costs for outpatient surgery and inpatient hospital facility charges. Each of the four plans offers different coverage levels, and each allows benefit payments to be sent to you or the hospital.

**Preferred Provider Plus:** People First Benefit Code 8100

**30/20 Plus:** People First Benefit Code 8110

**365 Plus:** People First Benefit Code 8130 for $100 a day, 8140 for $200 a day

**SIS:** People First Benefit Code 8120

Accidents can happen anytime, anywhere.

Accidents are usually followed by a series of bills. Even if you have good insurance, you may still have to cover out-of-pocket costs, such as:

- Doctor bills
- Ambulance fees
- Hospital expenses

Colonial Life’s Accident Insurance can help protect you, your spouse and your dependent children from the unexpected expenses of an accident.

**Important Features**

- You receive 24-hour coverage for on-job and off-job accidents.
- You’re paid 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.
- You can continue coverage with no increase in premium when you retire or change jobs.

Contact Colonial Life:
888-756-6701
VisitYouville.com/StateofFL

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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Cancer Insurance

If diagnosed with cancer, would you have the money to cover...
- Out-of-network treatments
- Experimental treatments
- Travel expenses
- Home health care needs
- Child care expenses

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

Important Features
- Coverage is guaranteed during open enrollment and for new hires for 2016.
- Treatment benefits include radiation and chemotherapy.
- Coverage includes cancer screening benefits, hospital intensive care benefits and more.
- Since cancer treatment is often prolonged, our plan offers very few lifetime limits.

Contact Colonial Life:
888-756-6701
VisitYouville.com/StateofFL

Disability Insurance

If you got sick or hurt and couldn’t work, how long could you go without a paycheck?

In today’s economy, it would be difficult losing just one paycheck. But a disability could have you out of work for days, weeks, months or even a year.

Colonial Life’s Disability Insurance replaces a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness.

Important Features
- You’re guaranteed to be issued coverage not to exceed 66 2/3% of your income, up to a maximum of $3,480 a month.
- Pregnancy, whether normal or complicated, is covered the same as any other covered sickness.
- You can continue coverage with no increase in premium when you retire or change jobs.

Contact Colonial Life:
888-756-6701
VisitYouville.com/StateofFL

This information is applicable to policy form DES1000-FL and is incomplete without the corresponding disclosure statement. Please see your Colonial Life benefits counselor for complete information.

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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!