BENEFITS GUIDE

Take Time. Take Action.

2018 Plan Year

For State of Florida Employees and Retirees

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Note: We intend for this benefits guide to help you choose benefits offered under the State Group Insurance Program, but it is not representative of all plan provisions or rules that govern the program. Please refer to each plan document that fully describes its benefits, Part I of Chapter 110, Florida Statutes, and Chapter 60P, Florida Administrative Code. Plan documents, statutory provisions, and rules prevail if there are any discrepancies with this benefits guide.

Introduction

The State of Florida offers a comprehensive insurance benefits package through the State Group Insurance Program as part of your total compensation package. The program allows you to choose benefit plans that best suit your individual needs. We offer coverage to current eligible employees, retirees, spouses and other dependents, and surviving spouses, as identified in subsection 110.123(2)(c), (f), (h), and (o), Florida Statutes, as well as COBRA members.

We continually foster a culture of health through our health plans' wellness and disease management programs, publication of our monthly Wellness Wire e-newsletter, and promotion of the state's employee assistance program (EAP) (If eligible, you are automatically enrolled in this free benefit; click the EAP link on your People First home page). We offer the tools and resources to help you make positive lifestyle choices for a healthier you.

The overview contained in this benefits guide contains links to online materials that further explain the benefits, limits and exclusions, and how to access services.

1. Read this guide to learn about all of your options.
2. Review online information while asking yourself what's most important to you.
3. Go to a vendor's website to learn about coverage, network access and other plan benefits.
4. Enroll or make changes in People First before open enrollment ends or during the year within 60 days of a qualifying status change event.

Accurate Numbers for Tax Reporting

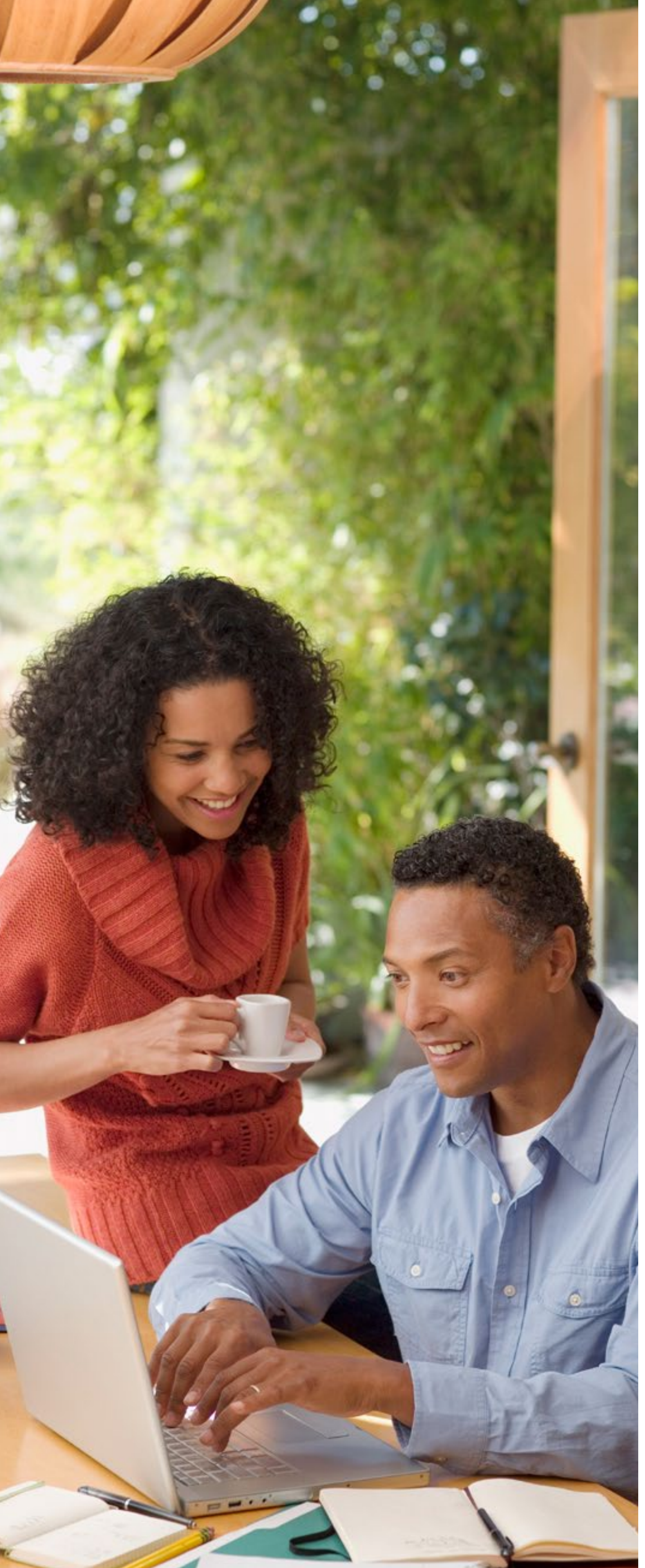
As part of federal tax reporting requirements, we must report to the Internal Revenue Service (IRS) the covered person's name, address, and Social Security number (SSN) or Taxpayer Identification Number (TIN). To ensure proper reporting of your minimum essential health insurance coverage to the IRS and to avoid paying an IRS penalty, please be sure your dependents, if any, have a valid SSN or TIN.

Health Insurance Mandates

Since 2014, the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, as amended) requires most people to maintain health insurance coverage (called minimum essential coverage) or potentially pay a penalty for noncompliance. Minimum essential coverage is a term defined in the ACA and its implementing regulations, and the health insurance offered through the State Group Health Insurance Program meets the ACA's requirement.

We must offer this coverage to all eligible employees and their dependents and report on a month-by-month basis to the IRS those who were offered coverage and those who enrolled in coverage.

For this tax reporting year, we will submit the required forms to the IRS indicating that we offered health insurance coverage to you and your dependents and noting who enrolled.



What Is Open Enrollment?

Open enrollment is your once-a-year opportunity to make changes to your state group insurance benefits. Make changes online in People First or call the People First Service Center weekdays from 8 a.m. to 6 p.m. Eastern time (ET) at 866-663-4735 or TTY 866-221-0268.

- Avoid the rush—make changes early and online whenever it's convenient for you.
- Review your personalized benefits statement carefully. It shows what you are enrolled in this plan year and your options for the next year plan year, including the monthly cost.
- Change elections as many times as you would like during open enrollment; elections become final at 6 p.m. Eastern time on the last day of the open enrollment period.
- If you don't make changes during open enrollment, all of your elections will continue to the new plan year, including the dollar amount deductions toward your healthcare flexible spending account (FSA), dependent care FSA, and/or health savings account (HSA).

If you make changes, look for your mailed confirmation statement in November or view your confirmation statement online in People First by selecting the Benefits Confirmation Statement link in the My Quick Links section on your home page. Be sure all changes are correct. Confirm you've enrolled your eligible dependents and removed those who are now ineligible (e.g., as a result of divorce).

Open enrollment starts at 8 a.m. Monday, October 16, and ends promptly at 6 p.m. Friday, November 3, 2017, (all times Eastern).

What's New?

- Your **HMO Plan** option for 2018 may have changed. Please verify that your current HMO is available in your area for the 2018 plan year by visiting mybenefits.myflorida.com. In the event your HMO Plan option has changed and you fail to make an election, you will be automatically enrolled into the HMO plan available based upon your home mailing address.
- **Assurant** is now Sun Life. This name change does not impact the coverage offered.
- **Dental Options** have changed. Several dental plans are ending. Those plans include: Ameritas Plan (4064), Humana Plan (4004), Humana Plan (4054), and UnitedHealthcare plan (4014). If you have any of those plans you will need to make a new plan choice. New dental plans will be available through Ameritas and MetLife. Each company will offer three different levels of PPO coverage. The plans were designed to ensure open network access and a range of coverage options for state employees and their eligible dependents.

Take time. Take action.
Be an active open enrollment participant!

- **Occupational Therapy** services are a covered benefit beginning January 1, 2018. Services must be for conditions resulting from a physical or mental illness, injury, or impairment. For the State Employees' PPO Plan, coverage is limited to 21 treatment days during any six-month period; for the State Employees' HMO Plan, coverage is limited to 60 visits per injury.
- **Medication Synchronization** (Med Sync) allows you to save time and reduce the number of trips to your retail pharmacy by requesting that your retail pharmacist "synchronize" all your medication refills so you can pick them all up on the same day. Med Sync is optional, not required and allowed once per year.
- **Vision Premiums** have changed. New premiums are included in your Annual Benefits Statement.
- At the end of 2018, members will be allowed to **carryover up to $500** of unused **healthcare flexible spending account (FSA)** and **limited purpose FSA** money into the next plan year. The "Grace Period" for incurring claims into the next calendar year will be eliminated for the healthcare FSA and limited purpose FSA. Please note that the change to allow a carryover does not apply to the dependent care FSA, and the dependent care FSA will still have the "Grace Period" for incurring claims into the next calendar year.
- For 2018, the **health savings account (HSA) contribution** maximum for employees enrolled in single coverage is $3,450, including the state's contribution. The family coverage HSA contribution is $6,900. That is an increase of $50 for individual limits and $150 for family limits for the 2018 plan year.
- **New Live Chat** feature is available in the FSA & HSA Information Portal in People First. Now, with a click of your mouse you can chat with a Chard Snyder customer service representative. Anything you might call in or email about, you can also take care of using Live Chat Representatives, who are available to chat 8 a.m. to 5 p.m. Easter time Monday through Friday
- **OPS employees** are now eligible to enroll in the healthcare FSA and the limited purpose FSA.
- The Division of State Group Insurance (DSGI) is contracting with a private company to perform a **Dependent Eligibility Verification Audit (DEVA)** to determine whether dependent(s) are eligible to participate in the State Group Insurance Program. The audit will begin on December 1, 2017, and will require subscribers to respond to any requests for documentation to verify dependent(s) eligibility. Enrollees may remove ineligible dependents at any time prior to December 1, 2017, by calling People First at 866-663-4735 or online during Open Enrollment.
- Beginning January 1, 2018, DSGI will begin a **Weight Management Pilot** for eligible members of the Florida Blue, AvMed, Aetna, and UnitedHealthcare plans. This year-long pilot will enroll members in a wellness program and give them access to prescription drugs for chronic weight management.

Contact Information

Need help? Call the insurance company if you have questions about what's covered or about network providers and other plan benefits. Call People First about premiums, eligibility or enrollment, and call Chard Snyder for information about FSAs and HSAs.

State Group Insurance Plans	Plan Types	Phone	Website
Health and Life			
Florida Blue	State Employees' PPO Plan (Medical)	800-825-2583	www.floridablue.com/state-employees
CVS/caremark	State Employees' Prescription Drug Plan	888-766-5490	www.caremark.com (members register and log in) www.caremark.com/sofrxplan (general information)
Aetna	HMO Plan (Medical)	877-858-6507	www.aetnastateflorida.com
AvMed	HMO Plan (Medical)	888-762-8633	www.avmed.org /state
Capital Health Plan	HMO Plan (Medical)	850-383-3311	www.capitalhealth.com/state
UnitedHealthcare	HMO Plan (Medical)	877-614-0581	www.florida.welcometouhc.com
Securian (formerly Minnesota Life)	Basic and Optional Life	888-826-2756	www.lifebenefits.com/florida
Dental			
Ameritas	Preventive PPO, Standard PPO and PPO w/ Indemnity	877-721-2224	www.ameritas.com/group/olbc/florida
Sun Life Financial (formerly Assurant)	Indemnity with PPO	800-442-7742	www.sunlife.com/us/Microsites/State+of+Florida
Sun Life Financial (formerly Assurant) Employee Benefits Prepaid 225	Prepaid Dental	800-443-2995	www.sunlife.com/us/Microsites/State+of+Florida
Cigna Dental	Prepaid Dental	800-244-6224	www.capitalins.com
Humana Select 15, Schedule B	Prepaid Dental/Indemnity	866-879-3630	www.humanadental.com/custom/fl/
MetLife	Preventative PPO, Standard PPO and PPO w/ Indemnity	844-222-9104	www.metlife.com/StateofFL
Supplemental Plans			
Humana Vision	Exam Plus	800-939-5369	www.compbenefits.com/custom/state-of-fla-vision/
Aflac	Cancer/Intensive Care	800-780-3100	www.capitalins.com
Cigna Health and Life Insurance Company	Hospitalization	800-780-3100	www.capitalins.com
Colonial Life	Accident/Cancer/Disability	888-756-6701	www.visityouville.com/stateoffl
New Era	Hospitalization	800-277-2300	www.ssc-life.com
Other			
People First	Call for help or enroll online	866-663-4735	www.peoplefirst.myflorida.com
People First **E4 Health (EAP)** **(If eligible, you are automatically enrolled in this free benefit.)**	Fax documents to	800-422-3128	www.peoplefirst.myflorida.com For more information, click the EAP link on your People First home page.
	Mail documents to	P.O. Box 6830 Tallahassee, FL 32314	
	Mail payments to	P.O. Box 863477 Orlando, FL 32886	
	Employee Assistance Program (EAP) #BlueChat for Teens	844-208-7067	
Chard Snyder	Healthcare FSA, Limited Purpose FSA, Dependent Care FSA, Health Savings Account	855-824-9284	www.mybenefits.myflorida.com
Social Security Administration	To enroll in or inquire about Medicare	800-633-4227	www.medicare.gov
myBenefits Website	N/A	N/A	www.mybenefits.myflorida.com

Stay in Touch with Mobile Apps

Download free mobile apps in the App Store or Google Play to complete these tasks from the palm of your hand.

Health insurance plan (if app is available)

- Find a doctor in your network.
- Look up symptoms, conditions and medications.
- Email the message center.
- Search claims.
- Check benefits and coverage.
- View your member ID card and use at your doctor's office.
- Estimate your payment.
- Find an urgent care center.

CVS/caremark for prescription drugs

- Refill mail order prescriptions without registering or signing in (Easy Refill).
- Submit a photo of your paper prescription.
- Scan a prescription for refill.
- See the number of refills due and orders in progress without signing in.
- Check order status.
- Renew or request new mail service prescriptions.
- Check drug costs and coverage.
- View prescription history.
- Find a pharmacy in your network.
- View your member ID card and use at a retail pharmacy.
- Identify unknown pills.
- Check for potential drug interactions.

Chard Snyder for spending and savings accounts

- View your account balances.
- View transaction details.
- File claims and attach receipts.
- Add receipts to claims already submitted on the website.
- View receipts and claims.
- Receive text alerts by submitting your phone number.
- Email questions to FloridaAskPenny@chard-snyder.com.

View Chard Snyder's Mobile App Overview Video.

Moving? Remember to keep your address current in People First.

How Do You Make Changes in People First?

Make changes online in People First—it's easy.

Know your People First password. Passwords expire every 90 days for your protection. See Frequently Asked Questions, question 8, on how to reset your password quickly, if needed.

1. Turn off the browser's pop-up blocker and log in to People First.

2. Select Start or the Open Enrollment link. Enter your People First password and select Certify to complete the dependent cerification process. Register new, eligible dependents by entering their personal information in People First (have Social Security numbers nearby).

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.

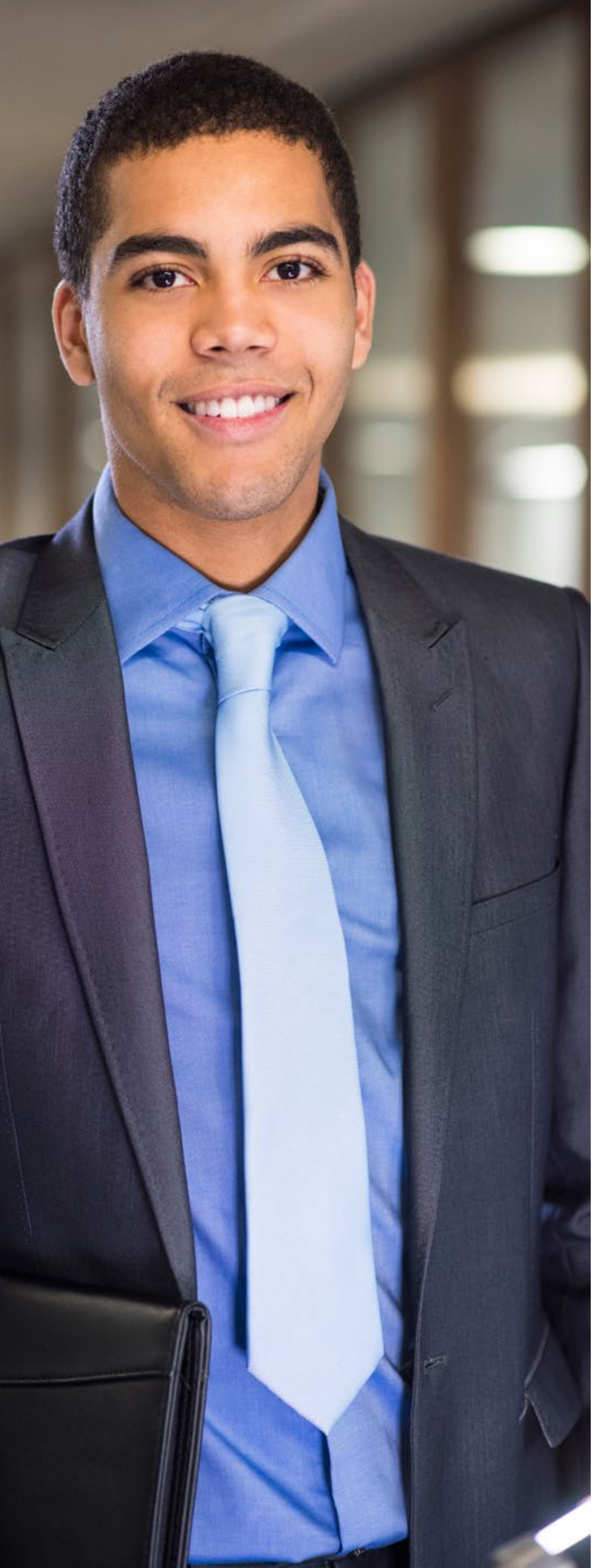
4. Click Change or Add to make updates. Select the correct family coverage tier level for each insurance plan. Then add dependents to each insurance plan you choose.

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

To be sure your selections are correct, select the Benefits Confirmation Statement link in the My Quick Links section on your People First home page.

As a Reminder

Elect to receive your Form 1095-C electronically. Log in to People First and follow this trail: Employee Information > Personal Information > Contact Information. Then select Notification Email. If you don't have a notification email in People First, enter one. Check the appropriate box to receive your 1095-C electronically. Otherwise, we will mail the 1095-C to the mailing address listed in People First. Please keep all addresses current. Safeguard your Form 1095-C to prove you had minimum essential health insurance coverage during the plan year. Speak with your tax preparer if you have questions about what you are required to report.



What Is a Cafeteria Plan?

Simply defined, a cafeteria plan is a program employers can use to offer a variety of benefits (like options on a cafeteria menu) to employees who use pretax payroll dollars to pay for the benefits they select. Employees have more take-home pay, and employers save FICA taxes.

Cafeteria plans have specific enrollment requirements under the Internal Revenue Code that employees must follow in exchange for pretax savings. Choose your plans carefully. Once enrolled, you must remain in the selected plans unless you have a qualifying status change (QSC) event during the year.

Getting married or divorced? Having a baby or adopting? Is your spouse changing jobs? For many major life QSC events, you may be allowed to enroll in or cancel your insurance coverage within 60 days of the life event. If you miss the 60-day window, you must wait until you experience another life event or until the next open enrollment to make a change.

Cafeteria plans also have specific dependent eligibility requirements. For example, you can enroll your legal spouse but not your domestic partner or fiancé(e). You can also enroll your children, legally adopted children, and legally appointed foster children. To cover stepchildren, you must be married to their parent. To cover grandchildren over the age of 18 months, nieces, nephews, and other children, you must be the legally appointed guardian.

If dependent eligibility changes, you must notify People First within 60 days of the change. For example, if you and your spouse divorce, you must send a copy of the divorce decree to People First within 60 days of the divorce. By following this timeline, you will not have to repay the state for claims an ineligible dependent incurred or pay COBRA premiums to cover that ineligible dependent. If you're in the spouse program, you won't have to pay back premiums for underpaid months (up to $165 per month). Enjoy the pretax benefits of a cafeteria plan, but make sure you understand your responsibilities. Visit mybenefits.myflorida.com or call People First to learn about your options.

Eligibility

Read this section to increase your understanding of the rules that govern this program, including important deadlines, changes allowed during the plan year, and dependent eligibility. We cover eligible state employees, retirees, surviving spouses, former employees who continue insurance through COBRA, and eligible dependents.

Employee Eligibility

To be eligible to participate in the State Group Insurance Program (program), you must be a full-time or part-time employee as defined in s.110.123(2)(c) and (f), Florida Statutes. Upon hire, your position or expected hours of service will determine if you are eligible to participate in the program.

- **Full-time** – includes salaried career service and select exempt service/senior management service (SES/SMS) positions working 0.75 full-time equivalency (FTE) or more and Other Personal Services (OPS) employees expected to work an average of 30 or more hours per week. Employees in these positions are eligible to participate in all plans offered under the program upon hire (exception: OPS employees are not eligible for optional life).
- **Part-time** – includes salaried career service and SES/SMS positions working less than 0.75 FTE. Employees in these positions are eligible to participate in all plans offered under the program upon hire but pay a pro-rated share of the health and life insurance employer premium based on the FTE plus their employee share.

OPS employees expected to work less than 30 hours per week on average are not eligible to participate in the program upon hire.

Seasonal – includes positions for which the customary annual employment is six months or less and begins each year at approximately the same time of year, such as summer or winter. Employees in these positions are not eligible to participate in the program upon hire.

Eligibility is determined at the point of hire, and eligibility for subsequent plan years is determined using a look-back measurement method. The look-back measurement method is based on IRS final regulations under the ACA. Its purpose is to provide greater predictability for eligibility determinations. Effective October 3, 2014, the State of Florida began using a 12-month look-back measurement method to determine who is a full-time employee for purposes of program eligibility.

The 12-month look-back measurement method involves three different periods:

1. **Measurement Period** – counts hours of service to determine eligibility

   a. New Hire Measurement Period

   If you are not a full-time employee at the point of hire, your hours of service from the first day of the month following your date of hire to the last day of the twelfth month of employment will be measured.

   An example: Assume you are hired October 5, 2018, and you are not employed full time. Your initial measurement period will run from November 1, 2018, through October 31, 2019.

   If your hours worked during the new hire measurement period average 30 hours or more per week, you are eligible to enroll in the program with an effective date of December 1, 2019.

   b. Open Enrollment Measurement Period

   - If you have been employed long enough to work through a full (12 months) measurement period, you are considered an ongoing employee. Your hours of service are measured during the open enrollment measurement period. This period runs from October 3 through the following October 2 of each year and will determine eligibility for the plan year that follows the measurement period.
   - If you are a new employee who is reasonably expected to work an average of 30 hours or more per week upon hire, you are eligible. Eligibility will continue until your hours are measured during the next or second (depending on your date of hire) open enrollment measurement period to determine eligibility for the next plan year.
   - **An example:** Assume you are hired January 5, 2018, in an OPS position and are expected to work an average of at least 30 hours per week. You are eligible to enroll in the program at your point of hire and will continue program eligibility through December 31, 2019. You will then be measured on October 3, 2019, to determine your eligibility for the 2020 plan year.

2. **Stability Period** – follows a measurement period. Your hours of service during the measurement period determine whether you are a full-time employee who is eligible for coverage during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is "locked in" for the stability period, regardless of how many hours you work during the stability period as long as you remain an employee of the State of Florida.

   There are exceptions to this general rule for employees who experience certain changes in employment status. For ongoing employees, the stability period lasts 12 consecutive months. Newly hired full-time employees may have a stability period longer than 12 months depending on their date of hire.

3. **Administrative Period** – the time between the measurement period and the stability period when administrative tasks, such as determining eligibility for coverage and facilitating enrollment, are performed. If you are determined to be eligible, a benefits package showing your available options, costs and effective dates will be mailed to the mailing address on file in People First, the system of record.

Special rules apply when employees are rehired by the State of Florida. If you are an OPS employee who experiences a break in service of at least 13 weeks (26 weeks for employees of academic institutions), you will be treated as a new hire upon your return. If you return to state employment in fewer than 13 weeks (26 weeks for employees of academic institutions), you will automatically be enrolled in the plans you had before you left employment.

The rules for the look-back measurement method are very complex, and this is a general overview of how the rules work. More complex rules may apply to your situation. The State of Florida intends to follow the IRS final regulations (including any future guidance issued by the IRS) when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, call the People First Service Center at 866-663-4735 weekdays from 8 a.m. to 6 p.m. Eastern time.

Retiree Eligibility

You are eligible to continue health and life insurance if you were a state officer or state employee and you:

1. Retire under a State of Florida retirement system or a state optional annuity or state retirement program or go on disability retirement under the State of Florida retirement system, as long as you were covered under health and life insurance at the time of your retirement and you begin receiving retirement benefits immediately after you retire; or

2. Retire under the Florida Retirement System Investment Plan, and you

   - Meet the age and service requirements to qualify for normal retirement as set forth in s. 121.021(29), Florida Statutes; or have attained the age specified by s. 72(t)(2)(A)(i), Internal Revenue Code, and you have 6 years of creditable service; and
   - Take an immediate distribution; and
   - Maintained continuous coverage under the program from termination until receiving your distribution (you must continue health insurance coverage through COBRA until you take your immediate distribution); or

3. Retired before January 1, 1976, under any state retirement system and you are not eligible to receive any Social Security benefits.

If you do not continue health insurance coverage at retirement or drop retiree coverage after retiring, you will not be allowed to elect state health insurance at a later date as a retiree.

If you are a retiree that returns to active employment as a full-time equivalent (FTE) or other personnel services (OPS) employee and you are enrolled in health insurance coverage at the time of retirement, you will automatically be enrolled in active employee health insurance coverage. When you later terminate employment or return to retirement you will be allowed to continue retiree coverage, provided you have had continuous coverage under the program.

To learn more, see the benefits package for new retirees.

COBRA Eligibility

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows qualified participants to continue coverage of health, dental, and vision benefits through their employer's group insurance plan for limited periods of time under certain circumstances, including the following:

- Voluntary or involuntary job loss.
- Reduction in hours worked.
- Transition between jobs.
- Death.
- Divorce.
- Other life events.

People First will mail a COBRA package to you or your dependents to your address on record in People First when one of these events is reported. COBRA enrollees pay the entire monthly premium plus a 2 percent administrative fee. You and/or your dependents lose eligibility for COBRA when you become eligible for other group insurance, including Medicare, or if you fail to pay the premium by the last day of the coverage month.

Dependent Eligibility

The following dependents are eligible for coverage:

- **Your spouse** – the person to whom you are legally married.
- **Your child** – your biological child, child with a qualified medical support order, legally adopted child, or child placed in the home for the purpose of applicable state and federal laws through the end of the calendar year in which the child turns age 26.
- **Your stepchild** – the child of your spouse for as long as you remain legally married to the child's parent through the end of the calendar year in which the child turns age 26.
- **Legal guardianship** – a child for whom you have legal guardianship in accordance with an Order of Guardianship pursuant to applicable state or federal laws or a child for whom you are grant court-ordered temporary or other custody through the end of the calendar year in which the child turns age 26.
- **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 through the end of the calendar year in which the child turns age 26.
- **Newborn child of a covered dependent (health insurance only)** – a newborn child of an enrollee's eligible child who is covered under state group health insurance at the time of the newborn child's birth. Coverage ends at 18 months or when the parent of the child terminates coverage, whichever is earlier.
- **Eligible children of an enrollee's surviving spouse** through the end of the calendar year in which the child turns age 26.
- **Children of law enforcement, probation, or correctional officers** who were killed in the line of duty and who are attending a college or university beyond their 18th birthday.
- **Children over the age of 26 with permanent intellectual or physical disabilities if** –
    - They were enrolled before they turned 26 and remain covered or they were over the age of 26 at the time of the enrollee's initial enrollment; and
    - They are incapable of self-sustaining employment because of the intellectual or physical disability; and
    - They are dependent on the enrollee for care and financial support.
- **Children between the ages of 26 and 30 (health insurance only)** – eligibility begins the year after an eligible child turns 26 and ends on December 31 the year he or she turns 30. To be eligible and remain eligible, the child must be unmarried, have no dependents, not be enrolled in other health insurance coverage, and must either be a resident of Florida or be a full-time or part-time student.

NOTICE: As prohibited by the rules of the program, the following acts will be treated as fraud or misrepresentation of material fact:

- Falsifying dependent information.
- Falsely certifying ineligible persons as eligible.
- Falsifying dependent documentation.
- Falsely enrolling ineligible persons in coverage.
- Falsifying the occurrence of QSC events.
- Falsifying QSC event documentation.

Such acts will require you to reimburse the plan for any fraudulent claims incurred or, if you're still within the COBRA election window, for paying COBRA premiums for any months that ineligible persons were covered.

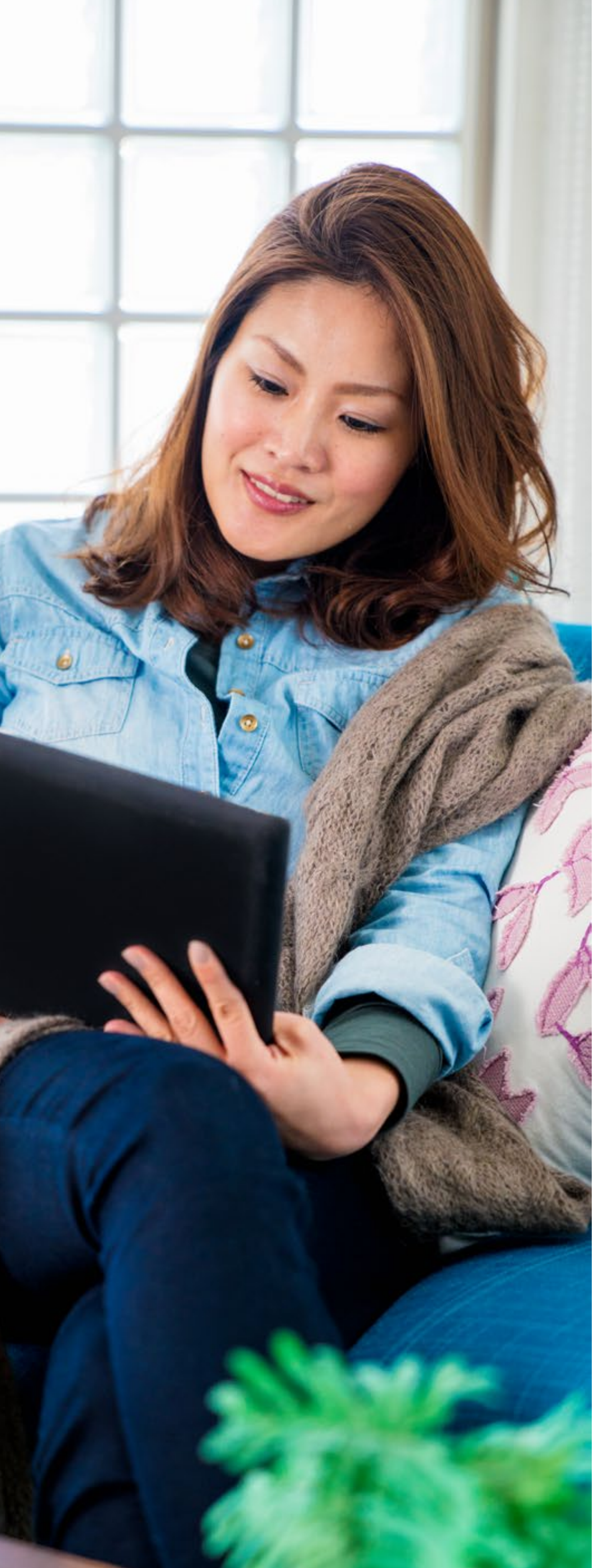
Dependent Eligibility Verification

Dependent Eligibility Verification Audit. During the 2017 Legislative Session, the Florida Legislature directed the Division of State Group Insurance (DSGI) to conduct an audit to ensure that dependents covered under the State Group Insurance Program meet eligibility requirements. The audit will begin on December 1, 2017, and applies to nearly 93,000 subscribers with approximately 193,000 actively enrolled dependents.

What does this mean to me? During the audit, you may be requested to provide documentation of your dependent(s) eligibility. It is important that you comply with any request from the audit vendor. If you do not send legible documents within the requested timeframe or if the documents provided do not support eligibility, insurance coverage will be terminated for the dependent(s).

What should I do now? If you are covering an ineligible dependent, an amnesty period will occur now through November 30, 2017. This means that if you remove ineligible dependents from coverage before December 1, 2017, you will be held harmless for past claims for the ineligible dependent(s). You may remove ineligible dependents at any time by calling People First at 866-663-4735 or online during Open Enrollment from October 16, 2017 through November 3, 2017.

Where do I find more information? More information will be provided in your Open Enrollment package which you will receive in October 2017. You may also visit the Dependent Eligibility Verification webpage. The webpage provides detailed descriptions of eligible dependents.



Enrollment

You may enroll when you first become eligible for coverage; for example, when you're hired or when you experience a QSC event during the year or during open enrollment. Common QSC events include marriage, divorce, birth, and change in employment status. All eligible state employees, enrolled retirees, surviving spouses, and COBRA participants may participate in open enrollment.

Make your state group insurance elections online in People First. You'll have convenient access at just about any time with no forms to complete (except for spouse program members) and no phone hold time. You can see all available options, enroll your eligible dependents, and confirm your benefit selections instantly.

Enrollment Tips

- Watch for your benefits package. It will show all your options, costs, and explain possible effective dates of coverage.
- Enroll online in People First during open enrollment or within 60 days of your QSC event. If you miss either of these deadlines, you must wait until the next open enrollment unless you have another QSC event during the year that allows you to make a change.
- Have correct Social Security numbers, birth dates and required documentation to enroll your eligible dependents.
- Choose your options carefully. Once you make an election during open enrollment or within the 60-day QSC event window, you cannot cancel or change to another plan (i.e., switch health insurance). However, you may elect other plans such as dental within that same 60-day window. For employees, state group insurance plan premiums are deducted from your paycheck before calculating payroll taxes to save you money. Because of these pretax tax savings, the IRS determines when you may make changes—either annually during open enrollment or during the plan year if you have a QSC event.
- The plan year means a calendar year (January 1 through December 31).

What New Hires Need to Know

- Optional life insurance is guaranteed issue up to 5 times salary ($500,000 max) when you are an eligible new hire. If you miss this opportunity to enroll, or want to enroll for up to 7 times salary ($1million max), you will have to complete the medical underwriting process if you decide to enroll later.
- Dependent spouse life insurance is also guaranteed issue if you are married when you are an eligible new hire or if you later marry. Your spouse will have to complete the medical underwriting process if you decide to enroll later.

- The state group insurance program offers prepaid dental plans, which have a limited network. Be sure the plan you want has plenty of dentists in your area and the offices are accepting new patients. You won't be able to change dental plans because you don't like the dentists or because your dentist leaves the network.
- Health saving accounts and flexible spending accounts (healthcare, limited purpose healthcare, and dependent care accounts) contributions are based on your plan year (January to December) election. Be careful—especially if you're enrolling mid-year. You may want to choose a lower annual amount now and then increase it during open enrollment for the next year. For example, if you are hired in October and you choose a $5,000 annual contribution amount, that amount is divided by the number of payrolls left in the plan year and that amount will be deducted from each paycheck (i.e. you elect $5,000, there are 5 pay periods remaining in the year, $1,000 will be deducted from each paycheck).
- If you are hired during open enrollment, make new hire elections for the current year first, and then make open enrollment changes for the next plan year.

Spouse Program Health Insurance

The spouse program provides family health insurance for two state employees married to each other. Each pays $15 per month for family coverage. To enroll, you and your spouse must complete and sign the Spouse Program Election Form and send it to People First at the address on the form.

You have 60 days to enroll. You become eligible for the spouse program either when you or your spouse works for the state and the other starts working for the state, as well, or when you marry another state employee and you're already employed by the state. If you miss your opportunity to enroll when you are first eligible, you must wait until open enrollment to enroll.

Notify People First within 60 days if either one or both of you ends state employment, including through retirement, or if you divorce. If you delay in notifying People First, your account will become underpaid because your coverage will be changed to the correct level starting with the first day of the month you are no longer eligible for the spouse program. If this occurs, your health insurance coverage will be suspended until you pay the underpayment.

Surviving Spouse Health Insurance

If you are the employee or retiree and your spouse dies, send a copy of the death certificate to People First and ask to be enrolled in single coverage if you have no other covered dependents.

If you were covered by your spouse's health insurance at the time of his or her death, you are entitled to continue health insurance coverage by paying the full premium for the rest of your life, unless you remarry. To enroll, call People First to receive an enrollment package by mail. You will need to send the completed application with a copy of the death certification within 60 days of receiving People First's Enrollment package. Coverage must be continuous, so you may have to pay underpayments if enrollment is delayed.

If you remarry, call People First immediately. If you provide your marriage certificate, you and your new spouse may continue health insurance coverage through COBRA for a limited time.

You Are Not Allowed to Be Covered by Two Plans. Chapter 60P, Florida Administrative Code, does not permit an enrollee or dependent to be covered under two state group health plans simultaneously. Examples of what is not allowed include the following:

- Two married employees each enroll in a health plan and cover each other and/or their children under the other's plan.
- A child who is covered under her parent's health plan goes to work for the state and enrolls in her own health plan.

If you or your dependents are covered by two different state group health plans, please call People First to correct the enrollment. One plan does not act as secondary insurance to the other, so you receive no added benefit by being dually enrolled and you may be paying more than you should.

When Coverage Is Effective

Enrollment and changes made during open enrollment are effective January 1 of the next year. Payroll deductions for most plans begin the preceding December. Enrollment and permitted changes made as a result of a QSC event are effective as follows:

- Health insurance may be effective as soon as the first day of the month following the month you elect coverage in People First. You will be required to send payment for the health insurance premium if payroll has already run. For births and adoptions, call People First to request coverage for the child effective on his or her date of birth or on the date that he or she is placed in the home for adoption, respectively.
- Basic life is effective on the first day that a full-time salaried employee is actively at work or the first day of the month following the payroll deduction after a part-time salaried or an eligible OPS employee elects coverage.
- Optional life, dependent spouse life, and certain supplemental plans are effective on the first day of the month after completion of the medical underwriting process, if required, and after a full payroll deduction is taken. Plans that do not require medical underwriting, such as dependent child life, are effective the first day of the month for which a full payroll deduction is taken.
- Healthcare and dependent care FSAs start on your enrollment date.
- Your HSA becomes active on the date you deposit money through payroll deduction and/or the state deposits money into your HSA.

When Coverage Suspends

Premium payments for state group insurance plans are made one month in advance of the coverage month (e.g., you pay for July coverage in June). If your account becomes underpaid, the next month's premium payment will first be applied to the underpaid month, leaving the coverage month underpaid. For example, on June 23, you elect an early effective date for health insurance and coverage is to begin July 1. Payroll for July coverage has already run, so you must send a check for $180 because your account is underpaid. If you do not send your payment, the payroll deductions for August coverage will be applied to July. Consequently, August becomes underpaid. This monthly process repeats until you send your payment.

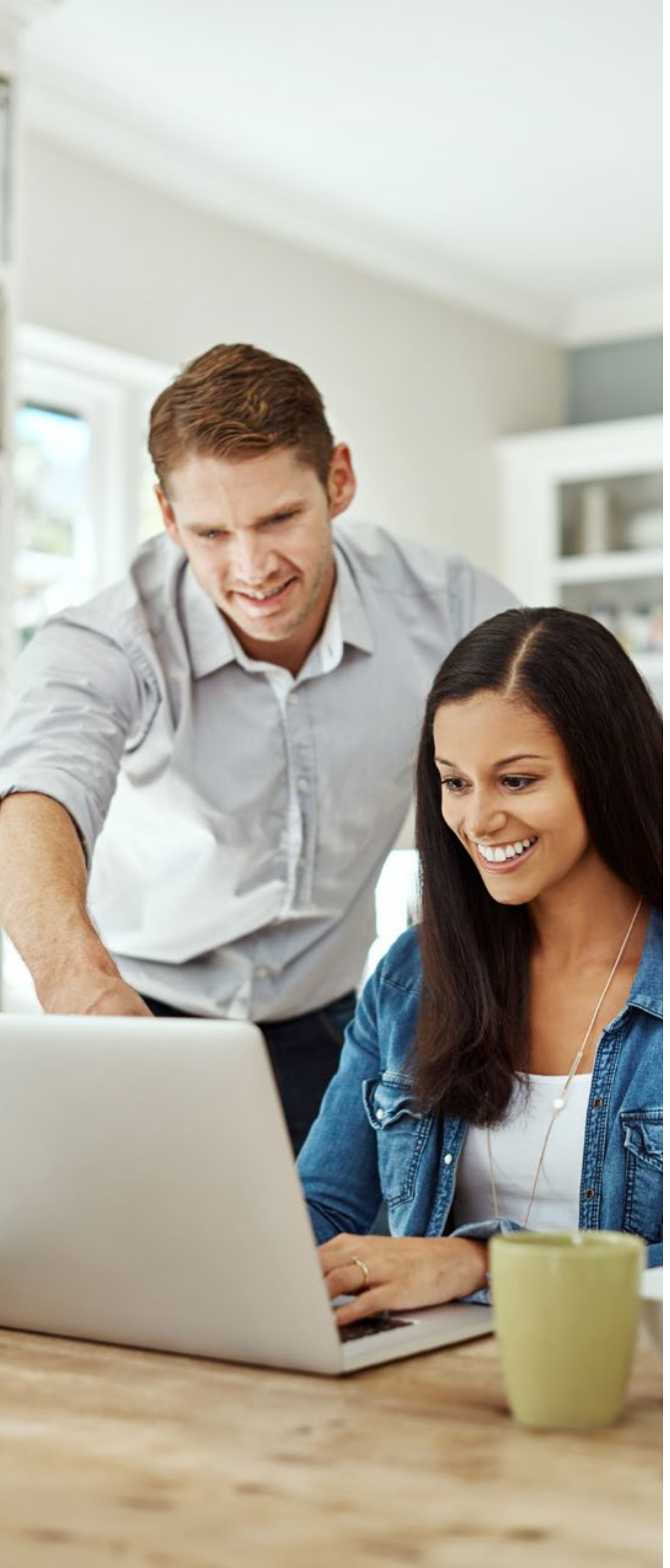
Any time your insurance premium is underpaid, coverage will be suspended. This means that your insurance is temporarily unavailable. If you go to the doctor's office or the pharmacy, you will have to pay out of pocket for services and prescriptions. Once you pay the underpayment, you can submit eligible insurance claims for reimbursement.

Avoid this situation by keeping your address updated in People First, reading notices from People First and taking quick action to pay any underpayments.

When Coverage Ends

All coverage ends as follows, unless you elect COBRA (health, dental, vision):

- Employees: When you end employment with the state, coverage ends for you and any covered dependents the last day of the month following the month of termination. For example, if your last day of work is June 23, coverage ends July 31.
- Retirees, COBRA participants, layoff participants, and surviving spouses: You have until the last day of the coverage month to pay the premium. If you have made no payment, coverage will end and you will not be permitted to re-enroll. Avoid this situation by mailing your payment to People First by the tenth day of the month before next month's coverage. For example, mail July's payment before June 10.
- COBRA participants may have coverage for up to 18, 29 or 36 months depending on your event; layoff participants may have coverage for up to 24 months.
- Surviving spouse: If you remarry, coverage ends the last day of the month of your marriage. You and your new spouse may continue health insurance through COBRA for a limited time.
- Dependents: Coverage ends for dependents when your coverage ends or when they lose eligibility—the last day of the month of a divorce (ex-spouse and ex-stepchildren), their death, or when they meet the age limits.
- OPS employees: Coverage ends on the last day of your stability period if you do not continue to meet eligibility requirements.



Health and Wellbeing

Your total health is important to us. We offer a variety of benefits to keep you physically and mentally healthy. Take time to read about your options so that you can make informed decisions about the state group insurance plans that are best for you.

Regardless of which plan you select, you should select a primary care provider to manage your care, and you should take advantage of free preventive services to monitor your health.

Health Insurance Plans

We offer four health insurance plans in each Florida county. Each plan provides comprehensive major medical and prescription drug coverage as well as preventive care benefits and wellness programs page 20.

1. The standard preferred provider organization (PPO), administered by Florida Blue, provides coverage in and out of network. You must meet a deductible and pay coinsurance and copayments. You can self-refer to most specialists, and you have access to a nationwide network and the BCBS Global™ Core Program.

2. The high deductible PPO works like the standard PPO except you have a higher deductible to meet before anything except certain preventive services is covered. Once you meet your deductible, you pay coinsurance for all services and prescription drugs. Enroll in an HSA to help offset your out-of-pocket costs.

3. Standard health maintenance organization (HMO) services are provided by Aetna, AvMed, Capital Health Plan, and UnitedHealthcare. An HMO is offered in each county in the State of Florida. HMOs cover only in-network services, except in certain emergency situations. You pay copayments for services provided in the HMO's network, and you may be required to have a primary care provider and referrals to some specialists.

4. The high deductible HMO has the same in-network requirements as the standard HMO. You must meet a high deductible before anything except certain preventive services are covered and, once you meet your deductible, you pay coinsurance for all services and prescription drugs. Enroll in an HSA to help offset your out-of-pocket costs.

Learn More

- Compare these four plans side-by-side.
- Review the health plan's online provider directory to ensure that your desired doctors and specialists are in the network.
- Read your health plan's specific plan booklet and benefits document for detailed coverage information and exclusions.

Health Savings Account

An HSA is a tax-advantaged account you should have if you enroll in a high deductible health plan. You don't pay taxes on any money you deposit into it, and you won't pay taxes when you use money from the account to pay for eligible healthcare expenses like deductibles and coinsurance. Once enrolled and your HSA Advantage bank account is opened through Chard Snyder, you will receive the state's monthly deposit of $41.66 for single coverage and $83.33 for family coverage ($500 and $1,000 annually, respectively). Unused funds roll over each year, and you can take your HSA with you when you leave state employment.

Money Savers

- Choose a primary care provider and use network healthcare providers. Confirm your provider participates in your health plan's network and accepts the state group insurance health plan.
- Pay a $25 copayment for network urgent care instead of $100 at an emergency room, (always go to the ER if you have a life-threatening emergency). Your primary care provider may be part of an urgent care center; be sure to ask.
- Get fit and take advantage of your health plan's gym membership reimbursement and other discounts page 20.
- Pay nothing for your annual physical and certain preventive screenings. Track your biometric numbers to see positive movement.
- Ask for generic drugs. If no generic drug is available, ask for preferred brand drugs over non-preferred ones. See the Preferred Drug List.
- Use 90-day retail at participating pharmacies or mail order for your maintenance prescription drugs; you'll pay only two copayments for a three months' supply, saving you a copayment. Ask your prescribing provider to write your maintenance drug's prescription for up to a 90-day supply with three refills.
- Take advantage of all the resources your health plan has to offer:
    - Information about events.
    - Healthy recipes.
    - Resources to help you understand food nutrition labels.
    - Resources to help with quitting smoking.
    - Tips to prevent chronic disease or management and education programs if you have a chronic disease.
    - Information about where to go for urgent care instead of the emergency room.
    - If you're eligible, call E4 Health for six free counseling sessions per incident instead of paying out-of-pocket copayments through your health plan.

Use Emergency Rooms for Emergencies

You know that going to an emergency room costs you four times as much as going to urgent care, but did you know that it can cost the plan 10 times more, sometimes higher? A procedure that costs your health plan $100 in an urgent care facility can cost more than $1,000 at an emergency room. Why should you care? When costs for the plan increase, premiums increase. You may not see the cost as an employee, but you will see it as a retiree.

Help keep costs low. If you have a primary care provider, you can often schedule an office visit the same day. Urgent care centers have extended hours for whenever the unexpected occurs. Save money, and save the emergency room visit for life-threatening illnesses and accidents.

Prescription Drug Plan

CVS/caremark administers prescription drug benefits for all health insurance enrollees (except CHP Medicare Advantage members). Prescription drug costs differ depending on your health plan and whether you buy generic, preferred brand or non-preferred brand drugs.

Call 888-766-5490 or visit www.caremark.com/sofrxplan to learn about the preferred drug list (updated quarterly), maintenance medications list, specialty medications, mail order process and 90-day maintenance at retail pharmacies. You can create an account at www.caremark.com/wps/portal/REGISTER_ONLINE to see your prescription drug history, order refills and check the status of your mail order drugs.

Health Plan Summary Comparison Chart

Your Costs:	Standard – HMO: Network Only	Standard – PPO: Network	Standard – PPO: Out of Network	High Deductible (Pair with Health Savings Account) – HMO and PPO: Network	High Deductible (Pair with Health Savings Account) – PPO Only: Out of Network
Annual Deductible (You pay this amount first before the plan pays anything, except for preventive care.)	None	$250 l $500 Single l Family	$750 l $1,500 Single l Family	$1,350 l $2,700 Single l Family	$2,500 l $5,000 Single l Family
Global In-Network Annual Out-of-Pocket Maximum	$7,350 l $14,700 per indiv. l per family (combined pharmacy and medical)	$7,350 l $14,700 per indiv l per family (combined pharmacy and medical)	N/A	$4,300 l $8,700 per indiv. l per family (combined pharmacy and medical)	N/A
Preventive Care[1]	Free	Free; no deductible	Amount between charge and out-of-network allowance; no deductible	Free; no deductible	Amount between charge and out-of-network allowance; no deductible
Primary Care	$20 copayment	$15 copayment	40% of out-of-network allowance plus the amount between the charge and the out-of-network allowance	Deductible then 20% of network allowed amount	Deductible then 40% of out-of-network allowance plus amount between charge and out-of-network allowance
Specialist	$40 copayment	$25 copayment		Deductible then 20% of out-of- network allowance	
Urgent Care	$25 copayment	$25 copayment	$25 copayment		Deductible then 20% of out-of-network allowance
Emergency Room	$100 copayment	$100 copayment	$100 copayment		
Hospital Stay	$250 copayment	20% after $250 copayment	40% after $500 copayment plus the amount between charge and out-of-network allowance	Deductible then 20% of network allowed amount	Deductible, $1,000 copay, then 40% of out-of-network allowance plus the amount between charge and out-of-network allowance
Generic Drugs l Preferred Brand l Non-Preferred Brand	$7 l $30 l $50 Network Retail (up to 30-day supply) $14 l $60 l $100 Mail Order or Participating 90-Day Retail (up to 90-day supply)		Pay in full; file claim for reimbursement	After paying deductible, 30% l 30% l 50% Network Retail and Mail Oder	Pay in full; file claim for reimbursement

Monthly Premiums: We Deduct Your Premium a Month in Advance (i.e., December 2017 for January 1, 2018, Coverage)

Monthly Premiums:	Standard HMO	Standard PPO	High Deductible HMO and PPO (Network)	High Deductible PPO Only (Out of Network)
Career Service/OPS	$50.00 Single	$180.00 Family	$15.00 Single	$64.30 Family
Select Exempt Service/ Sr. Management Service	$8.34 Single	$30.00 Family	$8.34 Single	$30.00 Family
Spouse Program	$30.00 ($15 each employee)		$30.00 ($15 each employee)	
Over-age Dependents (age 26 - 30)	$692.84 Each		$616.18 Each	
COBRA	$706.70 Single	$1,590.79 Family	$628.50 Single	$1,387.78 Family
Retiree < Age 65	$692.84 Single	$1,559.60 Family	$616.18 Single	$1,360.57 Family

Medicare Tiers[2]:	Medicare I	Medicare II	Medicare III	Med I	Med II	Med III
Retiree ≥ Age 65 or on SSI Disability	$388.38	$1,119.85	$776.76	$292.76	$917.13	$585.51
Capital Health Plan	$282.62	$945.62	$565.24	$257.23	$852.80	$514.46

[1] Preventive care based on age and gender.

[2] Medicare I = single coverage for retired participant eligible for Medicare. Medicare II = family coverage for two or more and at least one is Medicare eligible. Medicare III = family coverage for retiree and one dependent, and both are Medicare eligible.

Wellness Benefits Comparison Chart

Benefits	PPO PLAN	HMO PLANS			
	Florida Blue	Aetna	AvMed	Capital Health Plan	UnitedHealthcare
Online Information, Tools and Member Discounts	www.floridablue.com/state-employees	Members: www.aetna.com Prospective Members: www.aetnasstateflorida.com	www.avmed.org/go/state	www.capitalhealth.com/state	Members: www.myuhc.com Prospective Members: www.florida.welcom-etouhc.com Rally wellness portal: https://werally.com/client/stateoffl/register/
Health Assessments	Provided.	Provided.	Provided.	Provided.	Provided through the Rally wellness portal.
Fitness Memberships	5%–20% discount at participating facilities.	Discounts at participating facilities through partnership with GlobalFit. Learn more at www. globalfit.com/ fitness or call 800-298-7800.	Members have access to more than 12,000 fitness clubs and exercise centers that offer free trials and discounted monthly dues and initiation rates. Learn more on AvMed's website in the Health & Wellness section or call 877-335-2746.	Discounts available at participating facilities and up to $150 annual reimbursement per household.	Health Allies provides up to 50% off enrollment fees and up to 10% off monthly fees at participating facilities.
Smoking Cessation		The online Breathe program of the "Simple Steps to a Healthier Life" initiative offers a smoking ces- sation plan that gives enrollees tailored strategies for overcoming barriers and effective steps for managing withdrawal.	Easy-to-follow methods available for kicking the smoking habit. Learn more on AvMed's website or call 888-762-8633 to get started.	Health Information Line: 850-383-3400 Florida Quit Line: 877-822-6669 Freedom from Smoking: www.ffsonline.org Quit Smoking Now: 850-224-1177 Tools to Quit: 877-784-8486 (NE Florida AHEC) or 850-224-1177 (Big Bend AHEC) CHPConnect: Healthy Conversations topics	Living Free Program: Smoking cessation treatment plan and discounts on nicotine replacement products.
Weight Management	Discounts available through Jenny Craig and Retrofit.	Program discounts available through eDiets, Jenny Craig, and Nutrisystem online weight management tools and resources.	Weight Watchers reimbursement for up to one year of fees once you reach your goal weight. Learn more on AvMed's website.	Referral to a network registered dietician. Talk with local nurses 24/7 via the Health Information Line at 850-383-3400 or use online tools at capital-health.com. Limited annual fitness reimbursement.	Discounts on Jenny Craig, Nutrisystem, and Think Light! online weight manage-ment program.
Nutritional Counseling	Health Coach: 877-789-2583	Discounts available for nutritional resources, includ- ing dietetic counsel-ing, books and other products.	Get 25% off on services offered by a regis-tered dieti- tian. Learn more on AvMed's website in the Health & Wellness section or call 877-335-2746.	Referral to a network registered dietician. Talk with local nurses via the Health Information Line 24/7 at 850-383-3400 or by email via the CHP Wellness Inbox through CHPConnect, an interactive website with streaming media pre-sentations covering many health and wellness topics.	Health coaching online including nutrition program support and discounts on books and products. Pro- vider may offer discounts on nutritional counseling.
Nutritional Supplements		Save 15% on more than 2,400 over-the-counter vitamins and other homeopathic remedies.	Members receive discounted prices on a broad choice of health and wellness supplements and products. Learn more on AvMed's website in the Health & Well-ness section or call 877-335-2746.	Members receive discounted prices on a broad choice of health and wellness supplements and products.	Discounts on vitamins and foods at GNC stores and Step One Foods.
Health Counseling	Health Dialog: 877-789-2583	24/7 Informed Health® Line: 800-556-1555 Disease management nurse contact and online medical consultations with medical doctors with a 20-50% discount.	Available Programs 1. Chronic condition management for illnesses including asthma, coronary artery disease, COPD, diabetes, and heart failure. 2. Complex case management for situations dealing with wound care, transplants, kidney disease, and maternity. 3. 24/7 Nurse On-Call support: Speak confidentially with a registered nurse about a health concern or learn more about surgery. 4. Call 888-762-8633 24/7.	Talk with local nurses via the Health Information Line 24/7 at 850-383-3400 or by email via the CHP Wellness Inbox through CHPConnect. Healthwise is a searchable online health encyclope- dia with embedded shared decision-making tools for those weigh-ing decisions about their healthcare.	Nurse Line at 877-614-0581. Nurse Chat available via myuhc.com and Health Coach online. Case management provides clinical counseling ser- vices and disease management for COPD, asthma, diabetes, coronary artery disease, and congestive heart failure.
Prenatal Education	Healthy Addition Prenatal Program: 800-955-7635, option 6	Prenatal and postpartum care programs through Beginning Right Maternity management.	Prenatal and postpartum care available. Case management programs available for more complex maternity care needs. For more information about these programs, call 888-762-8633.	Member's obstetrician provides prenatal education. Talk with local nurses via the Health Information Line 24/7 at 850-383-3400 or by email via the CHP Wellness Inbox through CHPConnect.	Healthy Pregnancy Program
Massage and Acupuncture		Discounts available, up to 25% with some providers.	Get 25% off on services offered by a registered acupuncturist or massage therapist. Learn more in the Health & Wellness section on AvMed's website or call 877-335-2746.		Discounts from local providers, where available.
Meditation and Guided Imagery		Discounts available.	Discounts available.	Explore CHPConnect, accessed through capital- health.com.	Discounts available.
Exercise Classes (e.g., yoga, Pilates)	Discounts available.	Discounts available, including yoga equipment, books and DVDs through Pranamaya.	Discounts available.	Discounts available and up to $150 annual reim- bursement per household available at participating facilities.	Included at participating gym locations.
Fitness Equipment, Apparel and Footwear	Discounts available.	Discounts available.	Discounts available.		Discounts available (e.g., Body Media, NordicTrack, Altra running footwear).

Weight Management Pilot

The Department of Management Services (Department) will offer a Weight Management Pilot Program (Pilot) for the 2018 Plan Year to provide coverage for the treatment and management of obesity and related conditions. The Pilot will cover medical services provided by treating physicians and all Federal Drug Administration-approved medications for prescribed chronic weight management. Pilot participants will be responsible for all applicable medical and prescription drug copayments, coinsurance, deductibles and out-of-pocket expenses.

Who is eligible?

The Pilot is open to 2,000 enrollees and their dependents in the State Group Health Insurance Program who meet **ALL** of the following eligibility criteria:

1. Enrolled in Aetna, AvMed, Florida Blue or United Healthcare in the 2017 and 2018 plan years;
2. Body Mass Index (BMI) of 27 or higher and at least one weight-related comorbid condition (e.g., hypertension, high cholesterol, type 2 diabetes) or BMI of 30 without a comorbid condition;
3. 18 years or older;
4. Completed a health risk assessment in 2017;
5. Consent to provide personal and medical information to the Department;
6. Referred and supervised by a licensed physician in-network with the health plan during the 2017 plan year;
7. Agree to enroll in a Department-approved wellness program during the 2018 plan year.

Who is not eligible?

The following enrollees or their dependents covered under the State Group Health Insurance Program are not eligible to participate in the Pilot:

- Enrollees and their dependents enrolled in Capital Health Plan or Florida Health Care Plans during the 2017 and 2018 plan years;
- Enrollees or dependents under the age of 18;
- Enrollees in COBRA;
- Women who are pregnant, plan to become pregnant, or are nursing;
- Enrollees or dependents who do not meet all of the Pilot's eligibility criteria.

Participant Responsibilities

- Pilot participants will be required to follow the treatment plan prescribed by their physician, engage in a Department-approved wellness program, and submit two progress reports to the Department during the 2018 plan year.
- The first progress report is due no later than May 30, 2018, and must document any reduction in BMI and weight, and any change in comorbid conditions, if applicable. The report must be signed by the participant's supervising physician.
- The second report is due no later than October 31, 2018, and must document any reduction in BMI and weight, and any change in comorbid conditions if applicable. The report must be signed by the participant's supervising physician.

Employee Assistance Program

E4 Health administers the state's Employee Assistance Program. If eligible, you will see an EAP link in the upper right-hand corner of your People First home page, or you can check with your human resources office.

E4 Health offers free support, resources and counseling for your total wellbeing: work-life balance, child and elder care referral and location services, financial and legal concerns, family and relationship challenges and depression and substance abuse.

You, your family and your household members are automatically enrolled in this free benefit, and you can receive up to six counseling sessions per issue, per year at no cost. E4 Health also supports teenagers with their life challenges, such as cyberbullying and peer pressure.

Look for monthly e-newsletters on topics to help you better manage life's unexpected turns. Help is available any time and is always confidential. Visit E4 Health today by logging on to People First.

Flexible Spending Accounts

Chard Snyder is the administrator of three types of reimbursement accounts, called flexible spending accounts, or FSAs, that give you a tax break on eligible out-of-pocket expenses. Use the prepaid Benny® card at the time of service as a convenient payment option wherever most credit cards are accepted.

- Healthcare FSA—Deposit up to $2,600 each plan year on a pretax basis and use to pay for eligible healthcare expenses.
- Limited purpose FSA—Deposit up to $2,600 each plan year on a pretax basis and use to pay for eligible dental and vision expenses (can be paired with a health savings account).
- Dependent care FSA—Deposit up to $5,000 each plan year on a pretax basis and use to pay for eligible dependent care expenses for children under age 13 and adults whom you can claim on your tax return.

For the healthcare FSA and limited purpose FSA, December 31, 2018, is the last day to incur claims for the 2018 plan year, and you must submit all claims by April 15, 2019. Otherwise, if you have funds remaining at the end of 2018, a maximum of $500 will carryover to the next plan year while any funds in excess of $500 will be forfeited.

For the dependent care FSA, March 15, 2019, is the last day to incur claims for the 2018 plan year, and you must submit all claims by April 15, 2019. Otherwise, you lose any remaining money.

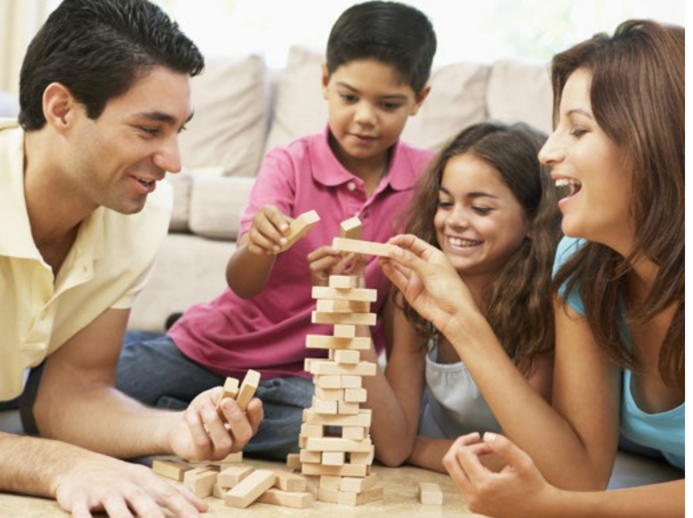
Find out how each account works or see chart.

Money Savers

- Deduct money from your paycheck before payroll taxes are calculated; you save money because you pay less income tax.
- Access the lump sum of your healthcare or limited purpose FSA on January 1; it essentially works like an interest-free, tax-free loan.
- Pay for predictable costs like orthodontic braces with healthcare FSA funds (annual limits and participation rules apply).
- Estimate how much you can save on your taxes with the Tax-Savings Calculator.

Spending and Savings Accounts Comparison Chart

	Flexible Spending Accounts (FSA)			Health Savings Account (HSA)
	Healthcare FSA	Limited Purpose FSA	Dependent Care FSA	
How It Works	• You deposit pretax money into the account through payroll deductions to pay for eligible medical, dental, vision, preventive, and prescription drug expenses. • Use the Benny® prepaid benefits card to pay for eligible services and items, • Pay your provider directly from your online account, or • Pay out of pocket for eligible medical expenses; then submit claims to be reimbursed.	• You deposit pretax money into the account through payroll deductions to pay for eligible dental, vision, and preventive care expenses that are not covered by your high deductible health plan. • Use the Benny® prepaid benefits card to pay for qualified services and items, • Pay your provider directly from your online account, or • Pay out of pocket for ok eligible expenses; then submit claims to be reimbursed.	• You deposit pretax money into the account through payroll deductions. You get reimbursed for eligible services (non-healthcare related) to care for children under age 13 that you can claim on your tax return or age 13 or older who lives with you at least 8 hours a day and needs supervised care, such as an elderly parent or spouse with a disability. • Use the Benny® prepaid benefits card to pay for qualified dependent care services, • Pay your provider directly from your online account, or • Pay out of pocket for eligible dependent care expenses; then submit claims to be reimbursed.	• The state contributes pretax money to your personal account each month for you to pay for eligible health expenses and save for future costs. You may also deposit pretax money. • Pay for eligible expenses from this savings account at time of service or purchase, • Pay your provider directly from your online account, or • Pay out of pocket for eligible expenses; then submit claims to be reimbursed.
Who Is Eligible	Benefits-eligible employees.	• Benefits-eligible employees • Must enroll in a high deductible plan with an HSA.	Benefits-eligible employees.	Employees enrolled in a high deductible health plan.
State Contribution	No.	No.	No.	• Yes. Must enroll in an HSA online in People First, which enrollment automatically opens your HSA Advantage™ account. The state contributes the following: • $41.66/month for single coverage (up to $500/year) • $83.33/month for family coverage (up to $1,000/year)
Employee Contribution Limit	• Yes. • $60 minimum/year • $2,600 maximum/year	• Yes. • $60 minimum/year • $2,600 maximum/year	• Yes. • $60 minimum/year • $5,000 maximum/year/household	• Yes. • $3,450/year for single coverage • $6,900/year for family coverage • (Limits include the state's contribution.) • Employees age 55+ may contribute an additional $1,000 each year (catch up).
When Money Is Available	The total amount of your annual election is available Jan. 1 (for open enrollment) or on your enrollment date for new hires or individuals who have an appropriate qualifying status change (QSC) event.	The total amount of your annual election is available Jan. 1 (for open enrollment) or on your enrollment date for new hires or individuals who have an appropriate QSC event.	Money is added to your account after each payroll deduction. You may use only the amount you have in your account at that time.	As the state deposits money into your Chard Snyder HSA Advantage™ personal savings account.
Payment Card	Yes. Benny® prepaid benefits card.	Yes. Benny® prepaid benefits card.	Yes. Benny® prepaid benefits card.	Yes. Benny® prepaid benefits card.
Deadline to Use Funds	December 31, 2018, is the last day to incur claims for the 2018 plan year, and you must submit all claims by April 15, 2019. Otherwise, a maximum of $500 will carryover for use in the next plan year and any funds in excess of $500 will be forfeited.	December 31, 2018, is the last day to incur claims for the 2018 plan year, and you must submit all claims by April 15, 2019. Otherwise, a maximum of $500 will carryover for use in the next plan year and any funds in excess of $500 will be forfeited.	March 15, 2019, is the last day to incur services for the 2018 plan year, and you must submit all claims by April 15, 2019. Otherwise, you lose any remaining money.	No deadline. HSA works just like your savings account. The balance rolls over from year to year; take the money with you if you leave state employment.
Health Plan Option	Standard PPO or HMO, but enrollment not required.	High deductible PPO or HMO enrollment not required.	N/A	High deductible PPO or HMO enrollment required.
Enroll in Another Spending Account	Yes. Dependent care FSA.	Yes. HSA and dependent care FSA.	Yes. Healthcare FSA, or HSA and limited purpose FSA.	Yes. Limited purpose FSA and dependent care FSA.
How to Enroll	• Enroll online in People First. Complete the Dependent Certification process; then select Change or Add in the Make a Change column for the account type. • Enter the Annual Amount and click the Select button. Enrolling during the year? Be careful. We divide this annual dollar amount by the remaining number of payrolls left in the year and subtract accordingly from your pay. You may want to choose a lower annual amount today and raise it during open enrollment for next year. • Enter your password and select the Complete Enrollment button. Once you enter an amount, you can change only during open enrollment or during the year with a QSC event.			• Enroll online in People First. • Complete the Dependent Certification process. • Enroll in a high deductible health plan. • If you want to contribute money in addition to the state's contribution, enter your contribution amount (you may change this amount anytime). • Enter your password and select the Complete Enrollment button. • We automatically enroll you in the HSA, which starts the state's contribution.



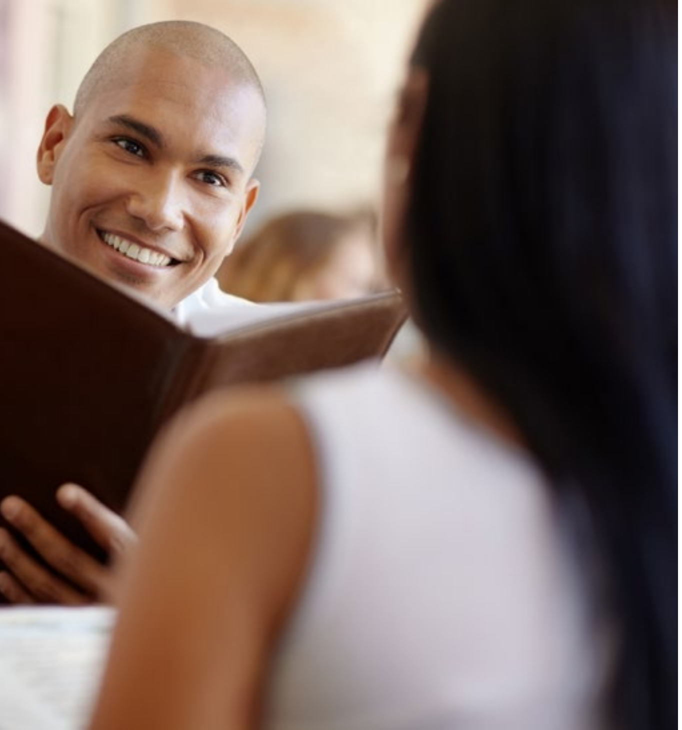
Life Insurance

Securian offers group term life insurance to eligible employees and retirees. Designate your beneficiary or beneficiaries at the time you enroll and review your designations periodically to account for changes. Learn about some of the available plan features.

Life Insurance Options			
Type	**Benefit Amount**	**Enrollment**	**Monthly Premium**
Basic Life	$25,000	• Salaried, full-time employees automatically enrolled • Part-time and OPS employees must enroll	• Salaried, full-time: no premium • Part-time: pro-rated premium • OPS: $3.58
Optional Life (salaried employees only)	One to seven times your base annual earnings ($1 million max)	Guaranteed issue for new hires up to 5x salary ($500,000 max); up to 7x if you qualify ($1 million max)	Varies by coverage level, salary and age
Dependent Spouse	$15,000 | $20,000	Guaranteed issue if you enroll when first hired or you marry	$4.50 | $6.00
Dependent Child	$10,000 per each child	Guaranteed issue	$0.85 (covers all eligible children)
Basic Life for Retirees	$2,500 | $10,000	Continue life insurance when you retire	$4.83 | $19.33

Additional Life Benefits	
Benefit	**Coverage**
Accidental Death and Dismemberment	Varies between 25% to 100% of coverage (employees only)
Accelerated Death (advanced life insurance funds in certain situations)	Up to 100% of your life insurance including your optional life coverage
Repatriation (Covers the cost of transporting the deceased home if death occurred 75+ miles away)	Up to $5,000
Legal Services	Phone access to a national network of attorneys
Legacy Planning Services	Help with end-of-life issues when dealing with a loss or planning for one's passing
Beneficiary Financial Counseling	Counseling to beneficiaries who receive at least $25,000

Find out why optional life insurance may be important for you.



Supplemental Insurance

The State Group Insurance Program offers dental, vision, and other supplemental insurance plans to eligible employees on a pretax basis. You pay the full premium for all supplemental plans; and the state does not contribute. You may continue dental or vision through COBRA upon termination of employment, including retirement, or convert other plans by calling the insurance company directly.

Dental Plans

The state group program's dental options will change beginning in the 2018 plan year. Review the dental plan options carefully. Some have limited networks and pay only for services performed by network dental care providers. Some give you in- and out-of-network benefits. Be sure the plan you want has plenty of dentists in your area who are accepting new patients. You can't change dental plans because you don't like the dentists or because your dentist leaves the network.

Dental Plans Comparison Chart

	Prepaid Dental	Dental Preferred Provider Organization (DPPO)	Dental Indemnity with a DPPO Network Plan	Dental Indemnity Plan
Definition	Must use only network dental providers. No coverage for out-of-network services.	May use any dental provider, but you pay less when using network dental providers.	May use any dental provider, but pay discounted rates when using network dental providers.	May use any dental provider, but you pay first and then get reimbursed a set fee (scheduled amount) for covered services.
Choice of Providers	Network only.	In-or-out of network.	In-or-out of network.	Any you choose.
Preventive Care (no deductible)	No charge for most preventive services.	No charge in network; you pay 20% of costs for out of network.	You pay cost above set dollar amount.	You pay cost above set dollar amount.
Deductible	No.	Yes, for basic and major care.	Yes, for basic and major care.	Yes, for basic and major care.
Basic and Major Care	You pay set copays or a percentage of cost.	You pay a percentage of cost.	You pay cost above a set dollar amount or a percentage of cost.	You pay cost above a set dollar amount.
Calendar Year Maximum	No.	Yes.	Yes.	Yes.
You Should Know	Your dentist could leave the network at any time. This is not a qualifying status change (QSC) event to cancel or change dental plans or coverage levels.	You pay all charges above the annual maximum each calendar year. Thus, your costs will be higher if you see an out-of-network dental provider.		You pay all charges above the annual maximum each calendar year. Dentist fee are not negotiated by insurer and dentists may charge any amount they choose per procedure.
People First Plan Code and Plan Name	4025 Sun Life Prepaid 225 4034 Cigna Dental 4044 Humana Select 15	4054 Humana Preferred Plus 4022 Ameritas Standard PPO 4023 Ameritas Preventative PPO 4032 MetLife Standard PPO 4033 MetLife Preventative PPO 4074 Sun Life Freedom Advance	4021 Ameritas Indemnity w/PPO 4031 MetLife Indemnity w/PPO	4084 Humana Schedule B

Dental Plan Monthly Premiums

People First Plan Code	Plan Name	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
4021	Ameritas Indemnity w/PPO	$37.96	$70.40	$80.16	$115.76
4022	Ameritas Standard PPO	$31.50	$59.04	$66.08	$96.22
4023	Ameritas Preventative PPO	$22.84	$43.20	$46.24	$67.76
4031	MetLife Indemnity w/PPO	$45.50	$84.16	$94.04	$136.52
4032	MetLife Standard PPO	$32.08	$59.34	$66.32	$96.28
4033	MetLife Preventative PPO	$21.98	$40.64	$45.42	$65.94
4025	Sun Life Prepaid 225	$14.93	$25.17	$33.26	$43.54
4074	Sun Life Freedom Advance	$43.55	$ 83.61	$ 98.83	$130.35
4034	Cigna Prepaid	$ 29.43	$ 52.91	$ 62.26	$75.53
4044	Humana Select 15	$ 12.64	$ 21.20	$ 23.00	$ 32.98
4084	Humana Schedule B	$ 14.74	$ 21.96	$ 23.30	$ 37.10

Money Savers

- Review your dental plan's plan documents for benefit limits and exclusions, especially if you currently need major dental work.
- Confirm your dentist and dental specialists participate in your plan's network and accept the specific plan.
- Search your dental plan's online provider directory for dentists accepting new patients. Call the dentist's office to confirm it has a reasonable appointment schedule, especially for first-time patients.
- Before making an appointment, call your prepaid dental insurance company to be added to your dentist's roster of patients; otherwise, you will have no coverage when you go.
- Ask your dentist for prior-treatment cost evaluation to avoid expensive surprises.
- Talk to the dental plan about prior authorization requirements and other special processes.

Vision Plan

Humana offers eye exams and materials coverage.

Vision Plan Chart

Exam and Materials		
	Benefit Frequency (based on the service date and not per calendar year)	
Exam Every	12 months	
Lenses Every	12 months	
Frames Every	24 months	
Benefits	**In Network**	**Out of Network**
Eye Exam	100% after you pay $10 copay	$40 allowance
Lenses:		
Single	100% after you pay $10 copay	$40 allowance
Bifocal	100% after you pay $10 copay	$60 allowance
Trifocal	100% after you pay $10 copay	$80 allowance
Scratch Resistance Lenses	$25 allowance	Not Covered
Anti-Reflective Lenses	$50 allowance	Not Covered
Frames	$75 wholesale allowance	$60 retail allowance
Contact Lenses		
Elective	$150 allowance	$75 allowance
Medically Necessary	100%	$100 allowance
LASIK	Receive a 25% discount off the usual and customary price or 5% off advertised promotions or specials for LASIK services from in-network providers. Discount covers consultations, laser procedure, follow-up visits and any additional necessary corrective procedures.	

Monthly Premium	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
	$6.96	$13.74	$13.60	$21.36

Other Supplemental Plans

The following supplemental plans pay benefits directly to you, in addition to the coverage you receive from your health plan. Certain requirements apply before these plans pay. Some plans require you to complete their medical underwriting process and may also exclude coverage if you have pre-existing conditions.

Supplemental Plans Comparison Chart

Plan	Benefit Examples	Offered By
Accident	• Specified benefit amount(s) payable directly to insured for covered accidents in which a doctor's office or hospital is visited for treatment of an accidental injury. • Additional payments for follow-up visits and when crutches, wheelchairs or other covered medical aids are needed for covered accidental injuries. • Covers work and non-work related accidental injuries.	Colonial Insurance Company (888) 756-6701
Cancer	• Specified benefit amount(s) payable directly to insured for cancer screenings, diagnosis and treatment. • Utilize benefit payments as needed. • Benefit amounts dependent upon coverage level selected.	Aflac* (through Capital Insurance Agency) (800) 780-3100 Colonial Insurance Company (888) 756-6701
Disability	• Supplements income loss during short-term disability to help pay living expenses. • Can choose elimination period for accident and sickness related disabilities based upon need.	Colonial Insurance Company (888) 756-6701
Hospitalization	• Specified payment amounts directly to covered individual when hospitalized. • Additional payments, depending on coverage selected, for ancillary services related to hospitalization.	Cigna Health and Life Insurance Company (CHLIC), through Capital Insurance Agency (800) 780-3100 New Era (800) 277-2300
Hospital Intensive Care	Daily benefit for confinement in a hospital intensive care or a sub-acute intensive care unit.	Aflac* (through Capital Insurance Agency) (800) 780-3100
*Both the Aflac Cancer and Aflac Intensive Care policies require submission of a paper application. Upon completion of an election in People First, please access the Aflac brochure on the MyBenefits website, complete it and mail to the address listed at the top of the application. Contact Aflac or Capital Insurance Agency directly for application related questions.		

Important Information

Take time to review these important notices:

- State Group Insurance Program Privacy Notice
- Employees and Their Dependents Eligible for Medicare
- Retirees and Their Dependents Eligible for Medicare
- Medicare Part D Notice

Learn more about Medicare.

Dependent Care FSA Nondiscrimination Testing

Employee classification testing must occur to ensure IRS Code nondiscrimination requirements related to the dependent care FSA are met. If any issues are discovered through testing, your contribution amount for the dependent care FSA may be adjusted; otherwise, you may be taxed on the amount of benefits you receive. We will notify you if this situation occurs. For more information, visit www.ire.gov to access Title 26, subsection 129, dependent care assistance programs, of the Internal Revenue Code.