Department of
MANAGEMENT
SERVICES
Division of State Group Insurance

BENEFITS GUIDE

2021

PLAN YEAR

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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.

6 REASONS TO PAY ATTENTION DURING OPEN ENROLLMENT

Open Enrollment is the one time of the year when all eligible employees have the opportunity to sign up for or change their health, life, dental, vision, or other insurance coverage. Many people think Open Enrollment is only for those who are either starting their coverage or know they want to make a change to their plans, but Open Enrollment is important for everyone. Here are six reasons you should check your benefits during Open Enrollment every year:

1

Check to see if there are changes in your plan.

The Florida Legislature meets each spring and often passes legislation that affects health insurance coverage. The changes implemented may be big or small and could affect your insurance and/or benefits. Checking during Open Enrollment gives you the opportunity to learn about upcoming changes and make sure your current plan is still the best choice for you.

2

Check the dollar amounts in your Savings and Spending Accounts.

Flexible spending accounts (FSAs) are continuous until cancelled. Therefore, if you have an active FSA this year and don't make changes, the same contribution amount will be made for the following year. Make sure your contributions accurately reflect your need for the following year so that you'll be reimbursed for all the money you put into the account. Keep in mind the FSA now has the carryover. If you had a carryover, you may need to decrease your annual contribution. Pay close attention to deadlines to spend these funds and submit claims.

3

Make sure your dependents are still eligible.

There are specific rules for which dependents are eligible for benefits and for how long. Continually enrolling a dependent who is no longer eligible is considered fraud. Make sure that all of your dependents are still eligible and know when they will lose eligibility so you can make other arrangements.

4

Explore new programs and opportunities.

The State Group Insurance Program is constantly working to roll out new benefits and opportunities to better serve Florida's state employees and retirees. Various pilots and programs are offered throughout the year, and by closely reviewing Open Enrollment materials, you can take advantage of amazing opportunities.

5

Browse other plans.

As you move through different stages of life, you will have different needs, and your insurance plans should always help to cover them. The plan you were on last year may have worked for you then, but you and your family may have experienced a life changing event, and your current plan may not be the best fit anymore. Be sure that you're on the plan that will do the most for you during this stage of your life.

6

Earn rewards and save money by utilizing the Shared Savings Program.

Earn tax free money to pay for out-of-pocket medical, dental, vision, and prescription costs. This program is available to all State Group Insurance health plan enrollees and their dependents.

Healthcare BlueBook- Members can earn rewards by searching online and having their medical procedures completed at high quality, low cost facilities. Download the Healthcare Bluebook Mobile App Today!!! Access code: SOF

SurgeryPlus- Having a planned, non-emergency surgery? By using SurgeryPlus for your procedure, you can earn a reward and share in the savings.

Earned rewards are credited to your FSA, HSA, or HRA. Learn more about the Shared Savings Program by visiting mybenefits.myflorida.com/health/shared_savings_program.

Beginning Oct. 1, 2020, visit mybenefits.myflorida.com to learn what's new this Open Enrollment period and check out the 2021 Benefit Guide. You can make changes to your benefits online in People First beginning Oct. 19. All changes are effective Jan. 1, 2021.

OPEN ENROLLMENT CHECKLIST FOR 2021

Use this checklist to help make your benefit choices for 2021 in People First. To learn more about each plan go to mybenefits.myflorida.com/health.

Health	☐ Individual	☐Family		
State Employees' PPO Plan - Florida Blue			☐ Standard PPO	☐ High Deductible PPO
Aetna (must live or work in service area)			☐ Standard HMO	☐ High Deductible HMO
AvMed (must live or work in service area)			☐ Standard HMO	☐ High Deductible HMO
Capital Health Plan (must live or work in service area)			☐ Standard HMO	☐ High Deductible HMO
UnitedHealthcare (must live or work in service area)			☐ Standard HMO	☐ High Deductible HMO
☐ Health Savings Account (if enrolling in a High Deductible Health Plan)				$
Chard Snyder will automatically open the HSA Advantage™ account after HSA enrollment in PeopleFirst.				

Life

Basic Coverage			
Basic Term Life	○ Career Service and SES/SMS employees (automatically enrolled) ○ OPS / Variable hour class employees ($3.58/month - employee-elected and employee-paid) ○ $25,000 Policy		
Employee-elected coverage (for employees enrolled in basic term life)			
Optional Term Life Coverage Level **(medical underwriting may be required)**	☐1x ☐2x ☐3x ☐4x ☐5x ☐6x ☐7x (annual salary) ○ Maximum coverage: $1,000,000 ○ Includes matching AD&D benefit ○ OPS/Variable hour class employees are not eligible		
Spouse Optional Life **(underwriting required if not first time eligible)**	Elect one of the below: ☐ $15,000 ($5.18/month) ☐ $20,000 ($6.90/month)		
Child Optional Life **(covers all registered dependent children for $0.85/month)**	☐ $10,000 ($0.85/month)	○ Children are eligible from live birth to age 26 ○ Elections are guaranteed without answering health questions	

Savings and Spending Accounts (annual amounts)

Healthcare FSA	Applies to benefit-eligible employees	$	
Limited Purpose FSA	Applies to benefit-eligible employees	$	
Dependent Care FSA	Applies to benefit-eligible employees	$	
Health Savings Account (HSA)	Employees enrolled in an HDHP	$	
Health Reimbursement Account (HRA) and Post-Deductible HRA	Enrollees who have a State Group Insurance health plan are eligible. If you enroll in an HDHP, you are only eligible for the Post-Deductible HRA. Your HRA becomes active once your first reward has been credited to the account (for Shared Savings Program rewards only).		$

Dental

Ameritas	☐ Indemnity with PPO	☐ Standard PPO	☐ Preventive PPO	
CIGNA	☐ Prepaid			
Humana	☐ Prepaid HD205			
Indemnity Humana	☐ Schedule B 4084			
MetLife	☐ Indemnity with PPO	☐ Standard PPO	☐ Preventive PPO	
Sun Life	☐ Prepaid	☐ Indemnity with PPO		

Vision

☐ **Humana Vision Plan -Exam and Materials (Plan 3004)**			

Other Supplemental

Aflac	☐ Cancer	☐ Hospital Intensive Care			
CHLIC	☐ PPP Plan	☐ 30/20 Plan	☐ 365 Plus $100/Day Plan	☐ 365 Plus $200/Day Plan	☐ SIS Plan
Colonial	☐ Cancer	☐ Accident	☐ Disability		
New Era	☐ $100 Per Day	☐ $200 Per Day	☐ $100/Day/ECR		

CONTACT INFORMATION

Need help? Contact the insurance carrier if you have questions about what's covered, network providers, and other plan benefits. Contact People First about premiums, eligibility, or enrollment. Contact Chard Snyder about FSAs, HSAs, and HRAs. Contact Healthcare Bluebook or SurgeryPlus for questions related to their services.

State Group Insurance Plans	Plan Types	Phone	Website
Health, Prescription, and Life Plans			
Florida Blue	State Employees' PPO Plan (Medical)	800-825-2583	www.floridablue.com/state-employees
Aetna	HMO Plan (Medical)	877-858-6507	www.aetnastateflorida.com
AvMed	HMO Plan (Medical)	888-762-8633	www.avmed.org /state
Capital Health Plan Capital Health Plan MA-PD	HMO Plan (Medical) HMO Plan (Medical)	850-383-3311	www.capitalhealth.com/state
UnitedHealthcare	HMO Plan (Medical)	877-614-0581	www.florida.welcometouhc.com
UnitedHealthcare MA-PD	PPO Plan (Medical)	877-352-7794, TTY 711	https://www.uhcretiree.com/myflorida/home.html
Humana MA-PD	HMO Plan (Medical)	800-555-7997, TTY 711	our.humana.com/sof
CVS Caremark	State Employees' Prescription Drug Plan	888-766-5490	www.caremark.com (members register and log in) www.caremark.com/sofrxplan (general information)
Securian Financial	Basic, Optional, and Dependent Life	888-826-2756	www.lifebenefits.com/florida
Dental Plans			
Ameritas	Preventive PPO, Standard PPO, and PPO w/ Indemnity	877-721-2224	www.ameritas.com/group/olbc/florida
MetLife	Preventative PPO, Standard PPO, and PPO w/ Indemnity	844-222-9104	www.metlife.com/stateoffl
Sun Life Financial	Indemnity PPO	800-442-7742	www.sunlife.com/STofFL
Sun Life Financial Employee Benefits	Prepaid Dental	800-443-2995	www.sunlife.com/STofFL
Cigna Dental	Prepaid Dental	800-244-6224	www.capitalins.com
Humana Dental	Prepaid Dental/Indemnity	866-879-3630	https://www.compbenefits.com/custom/stateofflorida/
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	https://peoplefirst.myflorida.com/peoplefirst
	Mail documents to or Submit documents online in People First	P.O. Box 6830, Tallahassee, FL 32314	https://peoplefirst.myflorida.com/peoplefirst
	Mail payments to	P.O. Box 863477, Orlando, FL 32886	
Healthcare Bluebook	Online Transparency Portal	800-513-6118	www.healthcarebluebook.com/cc/sof
SurgeryPlus	Bundled Surgical Services	844-752-6170	www.florida.surgeryplus.com
KEPRO	Employee Assistance Program (EAP)	1 (833) 746-8337 TTY: 1 (877) 334-0499	For more information, click the EAP link on your People First home page. www.MyLifeExpert.com Company Code: FLORIDA
Chard Snyder	Healthcare FSA, Limited Purpose FSA, Dependent Care FSA, Health Savings Account, Health Reimbursement Account, and Post-Deductible HRA	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 software applications (apps) in the App Store or Google Play to complete these tasks from the palm of your hand.

Your health insurance plan (if mobile app is available)

- Find a doctor in your network.
- Email the message center.
- Search claims.
- Check benefits and coverage.
- View your member ID card and use it 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).
- Scan a prescription for refill.
- See the number of refills due and orders in progress without signing in.
- Check the 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.

Healthcare Bluebook

Members can earn rewards by searching online and having their medical procedure completed at a high quality, low cost facility.

Look for the "Go Green to Get Green" tile.

- View the cost and quality of healthcare providers and facilities.
- Search rewards that may be available at designated healthcare procedures.
- Enter Zip Code – Click My Employer Provides Bluebook.
- Enter Access Code – SOF.
- Log in with your PF information or personal Bluebook Code.

  Note: Not all procedures are rewardable based on cost and quality.

Chard Snyder for spending and savings accounts

- View your account balances.
- View transaction details.
- Scan items to see if they are eligible expenses.
- 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.
- For questions, you can chat with a customer service representative using the Live Chat feature.

INTRODUCTION

The State of Florida offers a comprehensive insurance benefits package through the State Group Insurance Program (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, surviving spouses, and COBRA participants, as identified in subsection 110.123(2)(b), (c), (f), (h), and (o), Florida Statutes.

We continually foster a culture of health through our health plans' wellness and disease management programs, publication of our Wellness Wire e-newsletter, and promotion of the state's Employee Assistance Program (EAP) that is offered to employees of qualifying State Agencies or non-BENO members. If eligible, you are automatically enrolled in this free benefit. Click the EAP link on your People First home page to determine if you are eligible. We offer 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 benefit plan'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 calendar days of a qualifying status change event.

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"). 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 Federal Internal Revenue Service (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.

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

WHAT IS OPEN ENROLLMENT?

Open enrollment is your once-a-year opportunity to make changes to your State Group Insurance benefits and learn about new benefits or changes to your current benefits.*

Open enrollment starts at 8 a.m. ET, Monday, October 19, and ends at 6 p.m. ET, Friday, November 6, 2020.

The Division of State Group Insurance is partnering with vendors to host online webinars. Check them out here.

Make changes online in People First or call the People First Service Center weekdays from 8 a.m. to 6 p.m. 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. The benefits statement shows your current selection and options for the next plan year, including the monthly cost.
- Make changes as many times as you would like during open enrollment. Elections become final at 6 p.m. ET on the last day of the open enrollment period.
- If you don't make changes during open enrollment, all of your elections will continue into the new plan year, including the dollar amount deductions toward your healthcare flexible spending account (FSA), limited purpose FSA, dependent care FSA, and/or health savings account (HSA).

If you make changes, you will receive a confirmation statement in the mail, or you may view your confirmation statement online in People First. Select the Insurance Benefits tile on your home page, then Confirmation Statement. 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).

How Do You Make Changes in People First?

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

1. Know your People First password. Passwords expire every 90 days for your protection.
2. Turn off the browser's pop-up blocker and log in to People First.
3. Select the "Complete Open Enrollment Now" task in your Inbox.
4. Review your covered dependents and elected plans.
5. If you are enrolled in a health plan for 2021, make your Shared Savings Program selections.
6. Enter your password and select "Complete Enrollment."

* Remember that you can make changes to your elections during Open Enrollment as many times as you want. However, once Open Enrollment ends, a qualifying status change (QSC) event is required to make election changes to your benefits. However, if you are participating in the Shared Savings Program, you can select an account for your reward payments at any time during the year.

Where do I submit documents?

To submit documents to People First, log into your People First account and upload the documents, or you can mail them to the below address.

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

WHAT'S NEW FOR 2021?

PRESCRIPTION DRUGS (RX)

CVS Caremark was selected to continue as the Division of State Group Insurance's Pharmacy Benefits Manager effective for the 2021 Plan Year. For information regarding the prescription drug plan, visit www.caremark.com/sofrxplan. Create your CVS Caremark account at www.caremark.com to monitor your prescriptions and access other important account and health care information.

IMMUNIZATIONS

Effective July 1, 2020, covered members may receive routine immunizations, including flu shots, at no-cost from any participating retail pharmacy in the State Group Insurance's Pharmacy Benefit Manager's network. Before you go, call the pharmacy to make sure that the immunization you need is available and if an appointment is required. Go to www.Caremark.com/sofrxplan or log in at www.Caremark.com for more information.

TELEHEALTH

Effective Jan. 1, 2021, telehealth services are covered for members when receiving primary care benefits. Telehealth services are provided remotely through a two-way interactive electronic device that includes both audio and visual communication. Telehealth services may be provided through a telehealth vendor, or through a virtual visit with your network or non-network provider (PPO plan only). Contact your health plan to learn more about what telehealth services they cover.

OPTIONAL LIFE RATE INCREASE

Securian Optional life insurance plan rates will increase for the 2021 Plan Year. Please check your annual benefits statement.

DENTAL RATE INCREASE

MetLife and Ameritas dental plan rates will increase for the 2021 Plan Year. Please check your annual benefit statement.

EMPLOYEE ASSISTANCE PROGRAM

As of July 1, 2020, your State of Florida Employee Assistance Program (EAP) vendor has changed from New Directions Behavioral Health, LLC (New Directions) DBA E4, LLC, to KEPRO. With this change, employees will continue to have access to essential EAP services found in the Employee Summary of Services below. Benefit information will be available via the People First portal at peoplefirst.myflorida.com/peoplefirst.

If you have any questions regarding this change, please contact the KEPRO toll-free member services line at (833) 746-8337.

HSA CONTRIBUTION & COVERAGE LIMITS FOR 2021

Please check https://www.mybenefits.myflorida.com/health/savings_and_spending_accounts, for updated rates for the 2021 Plan Year.

MEDICARE ADVANTAGE AND PRESCRIPTION DRUGS (MA-PD) PLAN CHANGES

Lower premiums and more benefit? Yes, please! Our Humana HMO MA-PD plan has been enhanced to offer even lower out of pocket costs AND lower premiums! Similarly, our UnitedHealthcare PPO MA-PD plan also lowered their monthly premium for the 2021 Plan Year. We encourage our retirees to research all of our MA-PD options by visiting our website at mybenefits.myflorida.com/health. For coverage and participating provider questions, we encourage you to contact the plan or plans of your choosing directly. Contact information for each MA-PD plan is also available on our website.

WHAT'S NEW FOR 2021?

HEALTHCARE AND LIMITED PURPOSE FSA, HEALTH REIMBURSEMENT ACCOUNT, AND HEALTH SAVINGS ACCOUNT

The CARES Act permanently reinstated coverage of eligible over-the-counter drugs and medicines, that normally would require a prescription, as eligible for reimbursement from healthcare FSA, HRA and HSA without the need for a prescription. Menstrual hygiene products may also now be purchased or reimbursed through these plans. You may use your Healthcare FSA, HRA and HSA funds for eligible over-the-counter medications and menstrual hygiene products as of Jan. 1, 2020. This new law also has no expiration date, meaning you may continue to purchase these items with your Healthcare FSA, HRA or HSA funds.

The carryover limit for healthcare and limited purpose FSA was increased from $500 to $550 (which is an increase of 20% of the maximum contribution limit). The increase starts with the 2020 plan year carryover.

WEIGHT MANAGEMENT PROGRAM

This year marks the fourth year for the Weight Management Program. Members of Aetna, AvMed, Florida Blue and UnitedHealthcare are provided with lifestyle coaching, CDC-approved curriculum, and FDA-approved medications (as approved by your physician). See other eligibility requirements. Participants are responsible for all applicable medical and Rx co-payments, co-insurance, deductibles, and out-of-pocket expenses.

BENEFITS STATEMENT

In addition to mailing Benefits Statements for this year's Open Enrollment, Benefits Statements will also be stored in People First. To view your Benefits Statement, log in to People First, select the Insurance Benefits tile and select the Insurance Benefits Statement icon. Benefits statements for new hires and new retirees will also be located on this screen.

For more information on selecting your benefits, please visit mybenefits.myflorida.com/health.

STAY IN THE KNOW

Important! Set up your notification email. In People First, follow this trail: Employee Information > Personal Information > Contact Information. Select Notification Email and enter your email address. To receive your tax Form 1095-C electronically, check the box.

If you move, remember that you must update your home and mailing address in People First to ensure you receive timely and important information such as benefit changes and insurance cards.

Open Enrollment packets are mailed out in October each year, which contains important information about your benefits changes. Check your mail to ensure you receive your Open Enrollment packet.

WHAT IS A CAFETERIA PLAN?

A cafeteria plan, per the Internal Revenue Code, is a program that employers can use to offer a variety of benefits (like options on a cafeteria menu) to employees, who may use pretax payroll dollars to pay for the benefits they select. By using benefits offered under a cafeteria plan, 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 plan(s) unless you experience an eligible qualifying status change (QSC) event during the year. For example: Getting married or divorced? Having a baby or adopting? Spouse changing jobs? For many major-life QSC events, you may be allowed to enroll in or cancel your insurance coverage within 60 calendar days of the QSC event. If you miss the 60-day window, you must wait until you experience another major-life QSC 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 your dependent's eligibility changes, you must notify People First within 60 calendar 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 at 866-663-4737 to learn about your options.

FOR MORE INFORMATION

Read more on the Cafeteria plan here!

ELIGIBILITY

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

EMPLOYEE ELIGIBILITY

To be eligible to participate in the Program, you must be a full-time or part-time employee as defined in section 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.
- Part-time – includes salaried career service and SES/SMS positions working fewer 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-rata share of the health and life insurance employer premium based on the FTE, plus their employee share.

OPS employees expected to work fewer than 30 hours per week on average are not eligible to participate in the Program upon hire. Similarly, seasonal employees 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), 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. The State of Florida uses a 12-month look-back measurement method to determine who is a full-time employee for purposes of Program eligibility.

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.

ELIGIBILITY MEASUREMENT PERIODS

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.

    Example:

    Assume you are hired on Oct. 5, 2020, and you are not employed full time. Your initial measurement period will run from Nov. 1, 2020, through Oct. 31, 2021.

    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 Dec. 1, 2021.

    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 Oct. 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, 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.

    Example:

    Assume you are hired Jan. 5, 2020, 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 Dec. 31, 2021. You will then be measured on Oct. 2, 2021, to determine your eligibility for the 2022 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 specific 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, if those plans are still available.

The rules for the look-back measurement method are very complex, and this is a general overview of how the rules work. More complex restrictions 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. ET.

RETIREE ELIGIBILITY

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

    a. 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 six years of creditable service; and

    b. Take an immediate distribution; and

    c. Either

        i. 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

        ii. Retired before Jan. 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 cancel retiree coverage, you will not be allowed to reenroll in state health insurance at a later date as a retiree.

If you are a retiree that returns to active employment in a benefits eligible position and you are enrolled in health insurance coverage at the time of retirement, you will 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.

To see your premium rates for 2021, visit the Premium Rate Table.

CHECK YOUR ELIGIBILITY BEFORE CHOOSING A PLAN

Before you choose a plan and complete your Open Enrollment selections, check your eligibility here.

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 adoption in accordance with applicable state and federal laws through the end of the calendar year in which he/she 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 he/she 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 he/she 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 granted court-ordered temporary or other custody through the end of the calendar year in which he/she turns age 26.
- **Your over-age dependent –** After the end of the calendar year in which he/she turns 26 through the end of the calendar year in which he/she turns 30 – if he/she is unmarried, has no dependents of his/her own, is a resident of Florida or a full- or part-time student, and has no other health insurance.
- **Your over-age dependent with a disability:** Your unmarried children with intellectual or physical disabilities are eligible to continue coverage after they reach age 26 if:

  a. they are enrolled in the Plan before they turn age 26; and

  b. they are incapable of self-sustaining employment because of intellectual or physical disability; and

  c. the required documentation supporting the intellectual or physical disability has been reviewed and confirmed by the health plan prior to their 26 birthday; and

  d. they are chiefly dependent on you for care and financial support.

  e. upon your initial enrollment in a State Group Insurance health plan, you have a child over the age of 26 with an intellectual or physical disability who meets the above eligibility criteria, you may enroll that child as a dependent under your coverage at that time. If you do not enroll the child at your initial enrollment, you will not be able to add the child to your coverage at a later date.

- **Newborn dependent of a covered dependent –** A newborn child born to a dependent while the dependent is covered under the plan. The newborn must have been added within 60 days of the birth. Coverage may remain in effect for up to 18 months of age as long as the newborn's parent remains covered.
- **Children of law enforcement, probation, or correctional officers –** 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.

- **Surviving spouse and dependents –** The widow or widower of a deceased state officer, state employee, or retiree if the spouse was covered as a dependent at the time of death; or an employee or retiree who died before July 1, 1979; or a retiree who retired before Jan. 1, 1976, under any state retirement system who is not eligible for any Social Security benefits. Upon remarriage, the widow or widower is no longer considered a surviving spouse. A surviving spouse shall report remarriage within 60 days of the remarriage. The surviving spouse and dependents, including any eligible children of a surviving spouse, if any, must have been covered at the time of the enrollee's death and the coverage must have been continuous.

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

MORE ON ELIGIBILITY

Use the camera on your smart phone to capture the QR code to the left to find out more!

ELIGIBILITY UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

COBRA allows qualified participants to continue coverage of their healthcare FSA, HRA, and health, dental, and vision benefits through their employer's group insurance plan for a limited period 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 your address on record in People First when one of these events is reported. COBRA enrollees pay the entire monthly premium plus a two 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.

If you are the spouse of an enrollee and have been dropped from coverage in anticipation of a divorce, please report this event to the People First Service Center. You may be eligible to enroll in COBRA at the time your divorce is finalized.

To see your premium rates for 2021, visit the Table.

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 open enrollment. Common QSC events include marriage, divorce, birth, or 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 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 statement online or in the mail. 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.
- Obtain 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 (e.g., switch health insurance plans). 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 (Jan. 1 through Dec. 31).

WHAT NEW HIRES NEED TO KNOW

- Optional life insurance is guaranteed issue up to five 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 seven times salary ($1 million max), you will have to complete the medical underwriting process if you decide to enroll later. Use Securian Financial's Benefit Scout to help you determine the amount of life insurance you need.
- 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 dentists in your area, and the offices are accepting new patients. You won't be able to change (until the next Open Enrollment or a Qualifying Status Change event) dental plans because you don't like the dentists or because your dentist leaves the network.
- If you enroll in a State Group Insurance health plan, you and your dependents are eligible to participate in the Shared Savings Program. Visit the Shared Savings Program page, to learn how you can earn rewards.

- 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 five 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. One spouse serves as the primary account holder. Each pays $15 per month for family coverage. To enroll, you and your spouse must complete and sign the Spouse Program Election Form and submit the form online through People First or send it to People First at the address on the form.

You have 60 days to enroll after you become eligible. You become eligible for the Spouse Program when you or your spouse works for the state, and the other starts working for the state, 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.

If you and your spouse elect enrollment under the Spouse Program, you will be enrolled in a family health plan. You and your spouse will be required to designate a "primary" and "secondary" for your account. The primary spouse is considered the enrollee while the secondary spouse and dependents are covered under the family health plan as dependents.

If the family is enrolled in a high deductible health plan (HDHP), the primary and secondary spouse should individually enroll in a health savings account (HSA). Each spouse will receive the individual state contribution.

Rewards earned through participation in the Shared Savings Program will be deposited in the Savings and Spending Account as designated by the primary spouse.

SURVIVING SPOUSE HEALTH INSURANCE

If you are the employee or retiree and your spouse dies, contact 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 as a surviving spouse by paying the full premium for the rest of your life or until you remarry. To enroll, call People First to request an enrollment package. The completed application with a copy of the death certification, must be returned within 60 calendar days of receipt of Enrollment package. Health insurance coverage must be continuous, and you may be required to pay underpayments if your enrollment is delayed.

If you remarry, call People First within 60 calendar days. If you provide your marriage certificate, you and your new spouse may continue health insurance coverage through COBRA for a limited time.

COVERAGE

WHEN COVERAGE IS EFFECTIVE

Enrollment and changes made during open enrollment are effective Jan. 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. 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 insurance 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 eligible OPS employee elects coverage.
- Optional life insurance, dependent spouse life insurance, 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 insurance, are effective the first day of the month for which a full payroll deduction is taken.
- Healthcare, limited purpose, 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.
- Your HRA becomes active on the date that you receive a reward payment through the Shared Savings Program.

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 underpayment will be deducted from your next payroll (up to $180 for employees paid bi-weekly or up to $360 for employees paid monthly) in addition to your regular monthly premium payroll, and payroll deductions will continue each payroll cycle until the outstanding balance is paid in full. In addition to, or in lieu of payroll deductions, you may coordinate payment with People First.

Any time your insurance premium is underpaid by more than one month, 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 in full, you can seek reimbursement from your health insurance provider for eligible insurance claims that were incurred during the period of suspension.

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 for a COBRA-eligible benefit (e.g., 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 submitting your payment to People First by the tenth day of the month before next month's coverage. For example, submit 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 your death, or the last day of the calendar year in which they meet the age limits (see page 8). Dependent grandchildren lose coverage at the end of the month in which they or if their parent ceases to be covered under the plan turn 18 months of age, or if their parent ceases to be covered under the plan.

TAKE NOTES

There are notes sections throughout the guide for your convenience.

NOTES

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 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.

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 or pay copayments. You can self-refer to many specialists, and you have access to a nationwide network (BlueCard Program®) and the international BCBS Global® Core Program.

2. The high deductible PPO works like the standard PPO, except you have a higher deductible to meet before the plan pays for anything (except for certain preventive services). Once you meet your deductible, you pay coinsurance for all services and prescription drugs. You may enroll in an HSA if you meet eligibility requirements to help offset your out-of-pocket costs.

3. Standard health maintenance organization (HMO) services are provided by Aetna, AvMed, Capital Health Plan, and United Healthcare. One of these HMO plans 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 deductible before the plan pays for anything (except for certain preventive services). Once you meet your deductible, you pay coinsurance for all services and prescription drugs. You may enroll in an HSA if you meet eligibility requirements to help offset your out-of-pocket costs.

$0 Copay

Check with your provider about available telehealth opportunities.

aetna™ AvMed Embrace better health.® Capital Health Plan An independent Licensee of the Blue Cross and Blue Shield Association United Healthcare Florida Blue In the pursuit of health®

USE EMERGENCY ROOMS FOR EMERGENCIES

Did you know that going to an emergency room costs you four times as much as going to urgent care? Did you also 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 in 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 on 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.

$0 Copay

Check with your provider about available telehealth opportunities.

LEARN MORE

Compare these side-by-side.

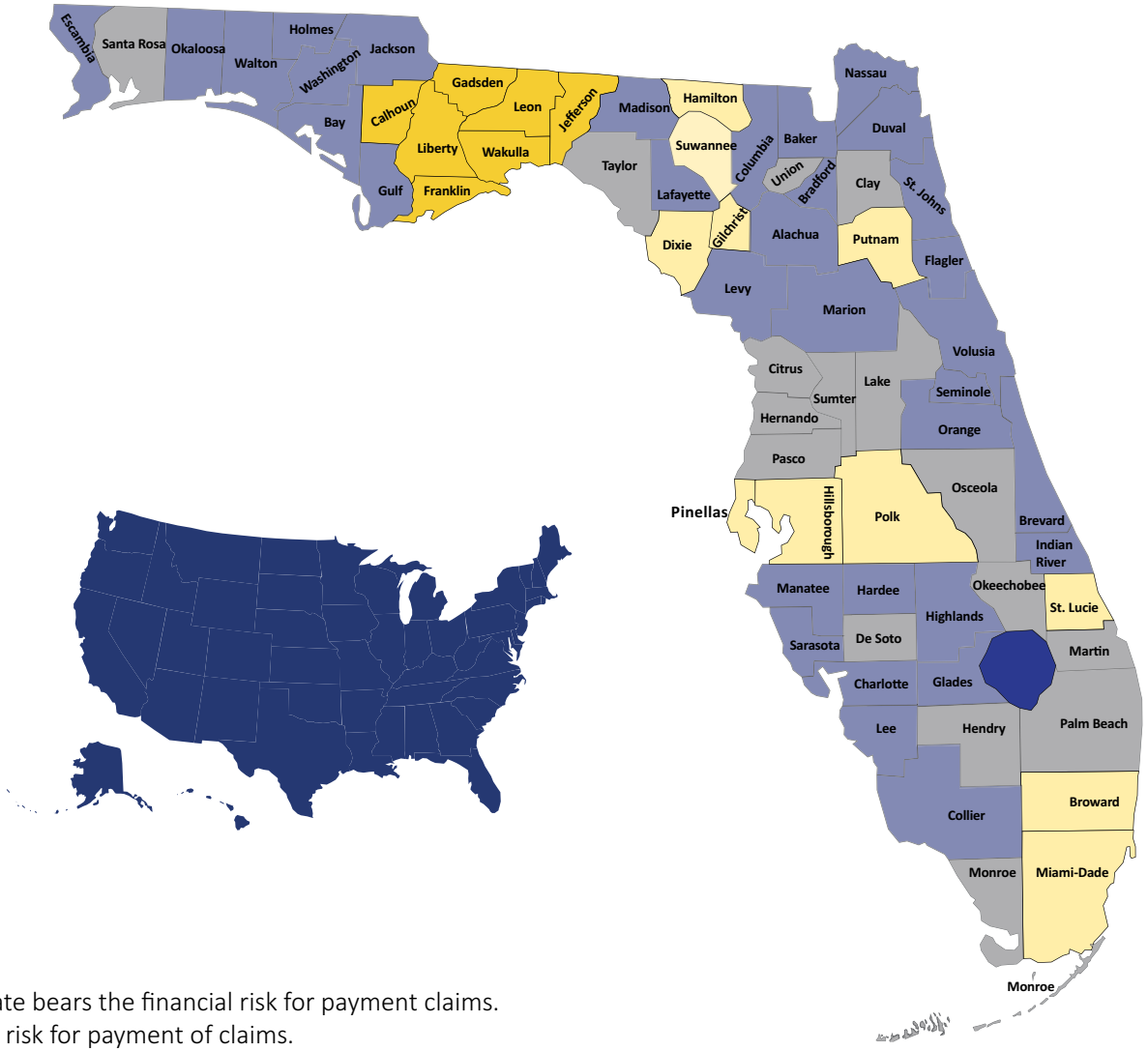
- Review the online provider directory to ensure that your desired doctors and specialists are in the network.
- Read your health plan's specific for detailed coverage information and exclusions.

To see a comparison of the wellness benefits of each plan, view the Wellness Benefits Comparison Chart.

NOTES

Department of MANAGEMENT SERVICES
Division of State Group Insurance

2021 CONTRACTED SERVICE AREAS



HMO
- Capital Health Plan[2]
- AvMed[1]
- UnitedHealthcare[1]
- Aetna[1]

PPO
- Florida Blue

PRESCRIPTION DRUG PROGRAM[1]
- CVS Caremark

[1]Self-insured/third party administrator: the State bears the financial risk for payment claims.
[2]Fully insursured: the HMO bears the financial risk for payment of claims.

HEALTH PLAN SUMMARY COMPARISON CHART (EXCLUDING MA-PD PLANS)

	Standard			High Deductible (Pair with Health Savings Account)	
	HMO	PPO		HMO and PPO	PPO Only
Your Costs:	Network Only	Network	Out of Network	Network	Out of Network
Annual Deductible (You pay this amount first before the plan pays anything, except for preventive care.)	None	$250 | $500 Single | Family	$750 | $1,500 Single | Family	$1,400 | $2,800 Single | Family	$2,500 | $5,000 Single | Family
Global In-Network Annual Out-of-Pocket Maximum	$8,550 | $17,100 per indiv. | per family (combined pharmacy and medical)	$8,550 | $17,100 per indiv | per family (combined pharmacy and medical)	N/A	$4,400 | $8,800 (PPO) $3,000 | $6,000 (HMO) per indiv. | per family (combined pharmacy and medical)	N/A
Preventive Care[1]	No charge	No charge; no deductible	Amount between charge and out-of-network allowance; no deductible	No charge; 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			
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 | Preferred Brand | Non-Preferred Brand	$7 | $30 | $50 Network Retail (up to 30-day supply) $14 | $60 | $100 Mail Order or Participating 90-Day Retail (up to 90-day supply)		Pay in full; file claim for reimbursement	After paying deductible, 30% | 30% | 50% Network Retail and Mail Oder	Pay in full; file claim for reimbursement
Monthly Premiums:	We Deduct Your Premium a Month in Advance (e.g., December 2020 for January 1, 2021, coverage)				
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)	$813.46 Each			$736.80 Each	
COBRA	$829.73 Single	$1,867.70 Family		$751.54 Single	$1,664.69 Family
Retiree < Age 65	$813.46 Single	$1,813.08 Family		$736.80 Single	$1,632.05 Family
Medicare Tiers[2]:	Medicare I	Medicare II	Medicare III	Med I	Med II	Med III
Retiree ≥ Age 65 or on SSI Disability	$430.18	$1,243.63	$860.35	$324.26	$1.061.06	$648.52
Capital Health Plan	$282.62	$1,054.31	$565.24	$257.23	$950.54	$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.

MEDICARE ADVANTAGE & PRESCRIPTION DRUG PLANS

At the direction of Governor DeSantis, the Division of State Group Insurance is offering Medicare-eligible retirees three qualified group Medicare Advantage and Prescription Drug Plans (MA-PDs) for 2021.

- Capital Health Plan (CHP) MA-PD
- Humana MA-PD
- UnitedHealthcare MA-PD

An MA-PD is a Medicare Advantage plan that includes Part A (hospitalization coverage), Part B (medical coverage), and Part D (prescription drug coverage). You keep your Medicare Parts A & B and you will continue to pay your Medicare Part B premium.

Along with lower monthly premiums, MA-PD plans offer:

- defined out-of-pocket costs for preventative care, specialist visits, and home health services;
- expanded benefits for routine vision, hearing, and dental services; and
- access to fitness programs and caregiver support.

Enrollment in a new MA-PD plan is optional and you can enroll year-round. If you enroll in a MA-PD plan during Open Enrollment, your effective date of coverage is Jan. 1, 2021. Please see the service area map on the following page, and links to the available MA-PDs that provide coverage in specific service areas. To see premium rates for 2021, see the MA-PD Premium Rate Table.

NOTES

Humana.

Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

United Healthcare

Department of MANAGEMENT SERVICES
Division of State Group Insurance

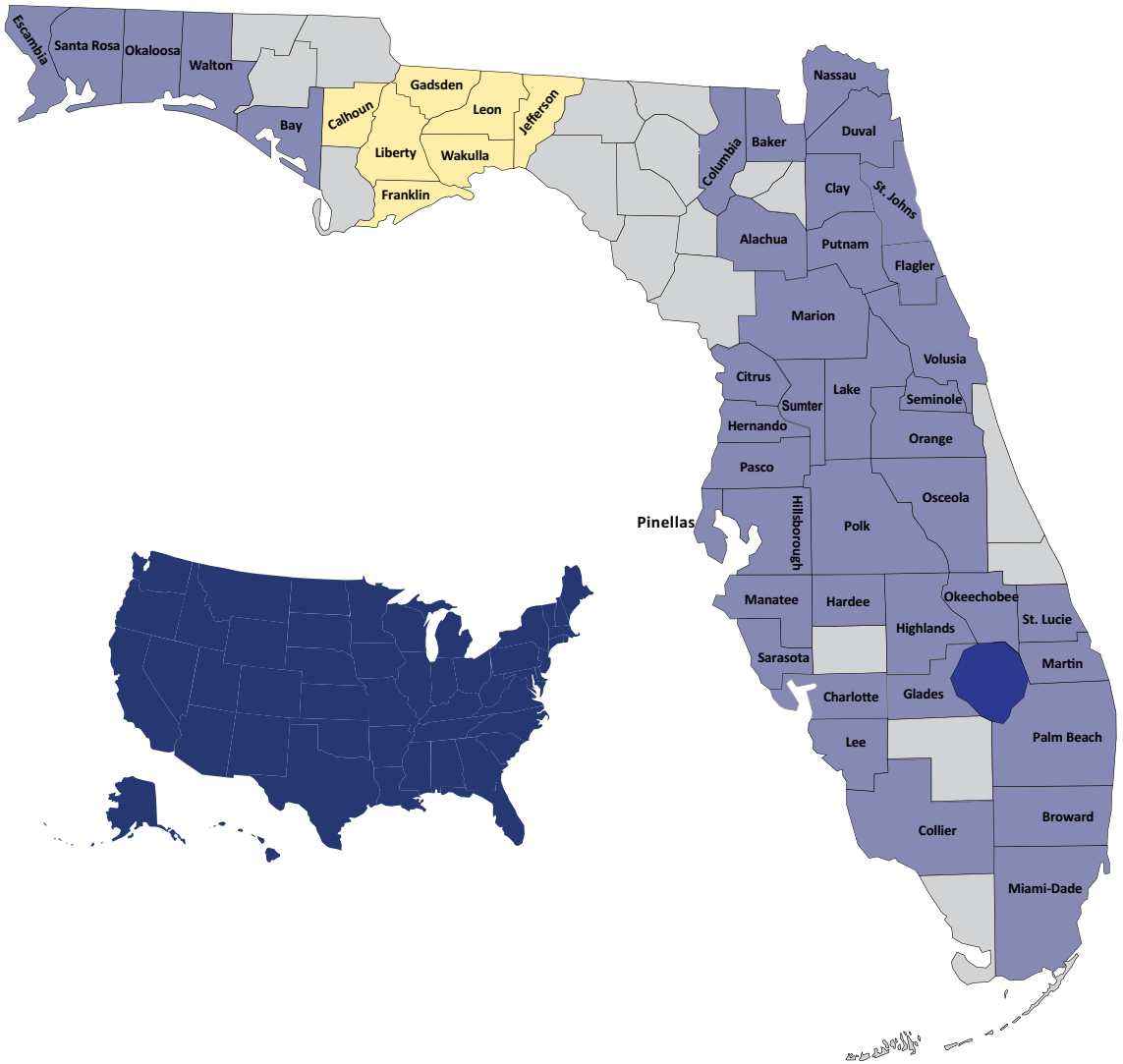
2021 CONTRACTED MEDICARE ADVANTAGE & PRESCRIPTION DRUG (MA-PD) PLAN SERVICE AREAS

HMO

- Capital Health Plan (MA-PD HMO Plan
- Humana (MA-PD HMO Plan)
- Counties with no MA-PD HMO Plans

PPO

- UnitedHealthcare (MA-PD PPO Plan)[1]



[1]Available naitonwide, including all 67 counties in FL.

CVS caremark®

PRESCRIPTION DRUG PLAN

CVS Caremark administers prescription drug benefits for all health insurance enrollees (except Medicare Advantage members). Prescription drug costs can differ depending on your health plan, the number of days' supply, and whether you buy generic, preferred brand, or non-preferred brand drugs.

You and your covered family members can get your no-cost routine vaccinations, including flu shots, at any In-Network pharmacy participating in the CVS Caremark Broad Vaccination Network. Before you go, call the pharmacy to make sure that the immunization you need is available and if an appointment is required. Retail pharmacies practice within the parameters of state and federal laws and regulations; it is possible that not all vaccinations will be available for everyone, i.e., some pharmacies may not be legally allowed to vaccinate children.

To locate an In-Network retail pharmacy participating in the Broad Vaccination Network, go to www.Caremark.com/sofrxplan or log in at www.Caremark.com; click on Find a Pharmacy or Pharmacy Locator; enter the applicable zip code or city and state; click on Advanced Options; and click on Vaccine Network. Pharmacies that participate in the Broad Vaccination Network are identified with a syringe icon.

You can create an account at www.Caremark.com to see your prescription drug history, order refills, and check the status of your mail-order drugs. CVS Caremark offers an online transparency tool to allow employees to see the cost of their prescription drugs, find out about generic options, and get the best value for their medications. You can access this tool by logging into your CVS Caremark account online or via the CVS Caremark App.

GO MOBILE

Download CVS Caremark's smartphone app to manage your account, see your ID card and more.

TELEHEALTH

Beginning January 1, 2021, telehealth services are covered when members receive primary care benefits. Telehealth services are provided remotely through a two-way interactive electronic device, and must include both audio and visual communication.

Telehealth options include visits through:

- a telehealth vendor using the vendor's network of providers, or
- a virtual visit with your network/non-network (non-network for PPO plan only) doctor using their selected technology.

The benefits of using telehealth:

- no co-pay when a telehealth vendor is used,
- increased access, and
- convenient…easy to schedule and no travel necessary.

Contact your plan/provider to learn more about covered telehealth services.

TELEHEALTH VENDOR		
	Standard	**HDHP**
FL Blue (PPO)	Network: $0; Non-Network: N/A	Network: No Per Visit Fee, subject to Calendar Year Deductible; Non-Network: N/A
Aetna, AvMed & UHC	$0	Network: No Per Visit Fee, subject to Calendar Year Deductible; Non-Network: N/A
CHP	$0	Network only: No Per Visit Fee, subject to Calendar Year Deductible

PROVIDER VIRTUAL/TELEHEALTH VISIT		
	Standard	**HDHP**
FL Blue (PPO)	Network: $15 (PCP), $25 (Spec, per applicable, approved Spec); Non-Network: Coinsurance 40% plus 100% of amount over the allowance (balance bill)	Network: Calendar Year Deductible and Coinsurance of 20%; Non-Network: Calendar Year Deductible and Coinsurance of 40% plus 100% of amount over the allowance (balance bill)
Aetna, AvMed & UHC	$20 Network (PCP)	Network only: 20% coinsurance, subject to Calendar Year Deductible
CHP	$20 Network (PCP)	Network only: 20% coinsurance, subject to Calendar Year Deductible

WEIGHT MANAGEMENT PROGRAM

The Department of Management Services (Department) will offer the fourth year of a Weight Management Program (WMP) for the 2021 Plan Year. The WMP will give participants access to a lifestyle change wellness program, cover medical services provided by in-network physicians, and provide coverage for all Federal Drug Administration-approved medications prescribed for chronic weight management. WMP participants will be responsible for all applicable medical and prescription drug copayments, coinsurance, deductibles, and out-of-pocket expenses

The application period for this program is Oct. 5, 2020 - Nov. 16, 2020.

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

1. Enrolled in Aetna, AvMed, Florida Blue, or UnitedHealthcare (does not include the MA-PD Plan) in the 2019 and 2020 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 2020;
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 2020 plan year; and
7. Agree to enroll in a Department-approved wellness program during the 2021 plan year;
8. If enrollees participated in year three of this program, they must have submitted a completed Mid-Year Progress Report and end of Year Progress Report to be considered for year four.

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

- Enrollees and their dependents enrolled in Capital Health Plan during the 2019 and 2020 plan years;
- Enrollees in the following Medicare Advantage and Prescription Drug Plans:
  - Humana MA-PD
  - UnitedHealthcare MA-PD
  - Capital Health Plan MA-PD
- 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 WMP's eligibility criteria.

For more information about participant responsibilities and how to apply to participate in the WMP, visit the mybenefits website.

Kepro™

EMPLOYEE ASSISTANCE PROGRAM

KEPRO EAP will be available to provide free services to all benefits-eligible employees. The EAP has an abundance of resources to help you manage everyday challenges or significant life events through a robust support network of local resources.

Please see KEPRO's contact information below, to learn more about your EAP or to request services.

Call Toll-Free: 1 (833) 746-8337
TTY: 1 (877) 334-0499
www.MyLifeExpert.com
Company Code: FLORIDA

The Employee Assistance Program is available to provide:

24 hours a day, 7 days a week, 365 days a year, confidential counseling and support. Any time of the day or night, weekends, and holidays, you will be able to reach an EAP professional. The EAP offers counseling sessions, and all discussions between you and your EAP professional are confidential.

Legal and financial consultations.
You can schedule a free, first-time consultation (up to 30 minutes) with an attorney or financial consultant on a variety of legal and money management concerns.

GO MOBILE

Online and mobile access to resources and referrals. The EAP website and mobile app allows you to connect to a robust offering of childcare, eldercare, and daily living resources in addition to other useful information and self-assessment tools.

SHOP SELECT SAVE

Earn rewards for making informed and cost effective decisons about your healthcare.

FLORIDA DEPARTMENT OF MANAGEMENT SERVICES
shared savings.

Shop. Select. Save.

The Shared Savings Program, administered by the Division of State Group Insurance, allows State Group Insurance enrollees to earn rewards by shopping for and selecting high quality, lower-cost healthcare services. This benefit, available to all State Group Insurance health plan enrollees and their eligible dependents at no additional cost has generated approximately $5.8 million in net savings for the state and approximately $1.4 million in rewards to state employee participants since January 2019.

Learn more at myBenefits.MyFlorida.com.

$5.8 MILLION* IN NET SAVINGS & $1.4 MILLION* IN REWARDS

*Totals for Jan. 2019 through June 30, 2020.

Healthcare Bluebook™ SurgeryPlus

To learn more about the Shared Savings Program, visit mybenefits.myflorida.com/health/shared_savings_program.

SAVINGS AND SPENDING ACCOUNTS

HEALTH REIMBURSEMENT ACCOUNT (HRA)

Chard Snyder is the administrator of two types of HRAs that reimburse you for eligible out-of-pocket expenses. Use the prepaid Chard Snyder Benefit Card at the time of service as a convenient payment option wherever most credit cards are accepted.

- HRA— is a pretax account available to you if you are enrolled in a standard health plan. You can use the funds to pay for eligible medical, dental, and vision expenses.
- Post-deductible HRA— is a pretax account that is available to you if you are enrolled in a high deductible health plan. After you meet the annual, federal deductible, you can use the funds to pay for eligible medical, dental, and vision expenses.

For the HRA and post-deductible HRA, December 31, 2020, is the last day to incur claims for the 2020 plan year, and you must submit all claims by April 15, 2021. However, unlike an FSA, if you have funds remaining at the end of 2020, all funds will carry over to the next plan year. The HRA is employer-funded only, which means you cannot contribute to the account. There is no limit on the amount of funds in an HRA.

As long as you are enrolled in a State Group Insurance health plan, you may continue your HRA. This applies to COBRA coverage, retiree coverage, and surviving spouse coverage.

Find out how each account works or visit the chart.

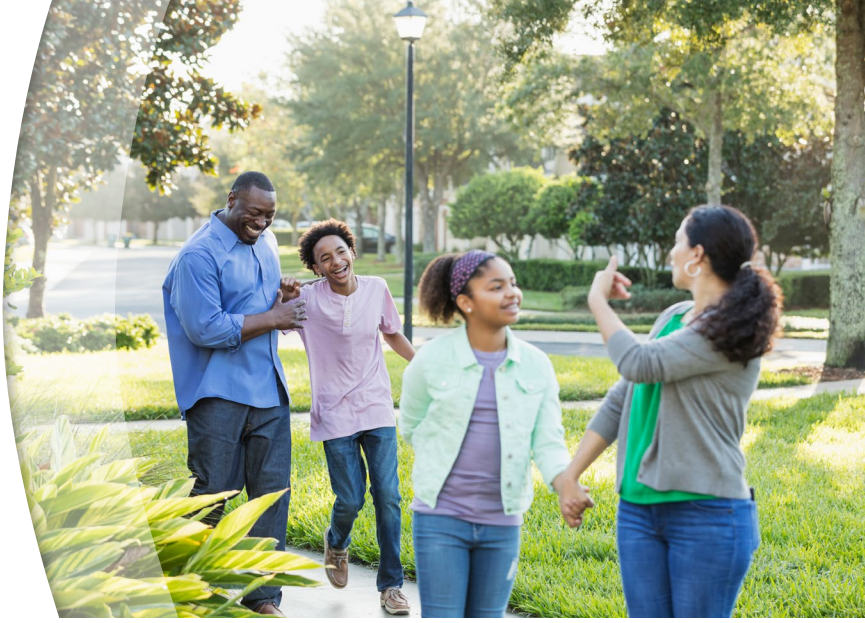
FLEXIBLE SPENDING ACCOUNT (FSA)

Chard Snyder is the administrator of three types of Flexible Spending Accounts (FSA) that give you a tax break on eligible out-of-pocket expenses. Use the prepaid Chard Snyder Benefit Card at the time of service as a convenient payment option wherever most credit cards are accepted. Employees must contribute a minimum of $60 per year to initiate an FSA.

- Healthcare FSA—you contribute up to $2,700 each plan year on a pretax basis to pay for eligible healthcare expenses.
- Limited purpose FSA—you contribute up to $2,700 each plan year on a pretax basis to pay for eligible dental and vision expenses (can be paired with a health savings account).
- Dependent care FSA—you contribute up to $5,000 each plan year on a pretax basis to pay for the care of your natural, adopted, and foster children who have not reached their 13th birthday, and family members who cannot physically or mentally care for themselves.

For the healthcare FSA and limited purpose FSA, December 31, 2020, is the last day to incur claims for the 2020 plan year, and you must submit all claims by April 15, 2021.

SAVINGS AND SPENDING ACCOUNTS



Otherwise, if you have funds remaining at the end of 2020, a maximum of $550 will carry over to the next plan year, while any funds in excess of $550 will forfeit.

For the dependent care FSA, March 15, 2021, is the last day to incur claims for the 2020 plan year, and you must submit all claims by April 15, 2021. Otherwise, you lose any remaining money.

HEALTH SAVINGS ACCOUNT (HSA)

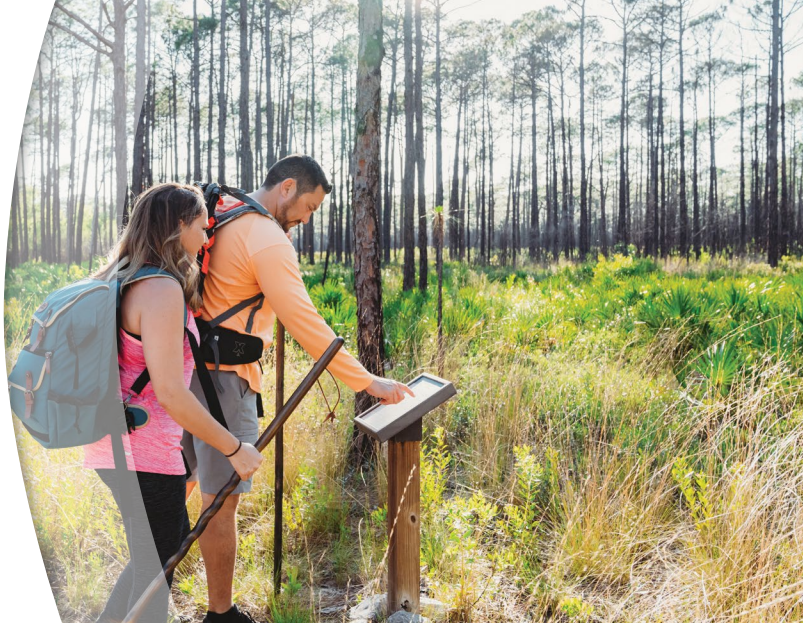
An HSA is a tax-advantaged account available to you if you enroll in a high deductible health plan. You don't pay taxes on any money you deposit into it, and you won't pay taxes when you use money from the account to pay for eligible healthcare expenses like deductibles and coinsurance. Once enrolled 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.

Find out how this account works or visit the comparison chart.

2021 SAVINGS AND SPENDING ACCOUNTS COMPARISON CHART

Flexible Spending Accounts (FSA)			Health Savings Account (HSA)	Health Reimbursement Account (HRA) and Post-Deductible HRA
Healthcare FSA	Limited Purpose FSA	Dependent Care FSA		
When Is Money Available				
The total amount of your annual election is available Jan. 1 (for open enrollment) or on your enrollment date (for new hires or if you 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 if you 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 the time.	As the state dependents amounts into your Chard Snyder HSA Advantage™ personal savings account.	HRA funds will be available within five business days of the reward notification to Chard Snyder. If you choose a Post-Deductible HRA, the funds are available for use after you have met the deductible. Single deductible is $1,400 and Family deductible is $2,800.
Payment Card				
Yes. The Chard Synder Benefit Card.	Yes. The Chard Synder Benefit Card.	Yes. The Chard Synder Benefit Card.	Yes. The Chard Synder Benefit Card.	Yes. The Chard Synder Benefit Card.
Deadline to Use Funds				
Yes. Use funds by December 31 and submit all claims by April 15 of the next plan year. If any funds are remaining up to $550 will be carried over into the following plan year. Amounts over $550 will be forfeited.	Yes. Use funds by December 31 and submit all claims by April 15 of the next plan year. If any funds are remaining up to $550 will be carried over into the following plan year. Amounts over $550 will be forfeited.	Yes. The grace period to use funds ends March 15 of the next plan year and you must submit all claims by April 15 of the next plan year. Otherwise, you will lose any remaining money.	No. HSA works just like your savings account. The balance rolls over from year to year. Be sure to take the money with you if you leave state employment.	Yes. Incureligible expenses by December 31. Claims for eligible products or services received during the plan year (1/1-12/31) must be filed no later than April 15 of the next plan year. Balance rolls over from year to year.
Health Plan				
N/A	High Deductible PPO or HMO.	N/A	High Deductible PPO or HMO.	Any health plan offered by the State.
Enroll In Another Savings or Spending Account				
Yes. Dependent Care FSA and HRA.	Yes. HSA, Dependent Care FSA, and Post-Deductible HRA.	Yes. Healthcare and Limited Purpose FSA, HSA, HRA, or Post-Deductible HRA.	Yes. Limited Purpose FSA, Dependent Care FSA, and Post-Deductible HRA.	Yes. Healthcare FSA, Limited Purpse FSA, and Dependent Care FSA. If enrolled in an HDHP, you must choose the Post-Deductible HRA.
How to Enroll				
1. Enroll online in People First. 2. Complete the ***Dependent Verification*** process. 3. Complete the ***Choose Plan*** step by selecting the Change or Add Icon in the Change column for the spending account type. 4. Enter the Annual Election Amount and click the ***Save*** button. Enrolling during the year? Be careful. We divide the 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. 5. Complete the ***Dependent Summary, Plan Summary,*** and ***Shared Savings Program***™ screens. 6. 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.			1. Enroll online in People First. 2. Complete the Dependent Verification process. 3. Enroll in a high deductible health plan. 4. If you want to contribute money in addition to the State's contribution, enter your contribution amount. You may change this amount at any time. 5. Enter your password and select the ***Complete Enrollment*** button. 6. We automatically enroll you in the HSA, which starts the State's contributions.	You do not need to enroll in the HRA. At the time of enrollment into your benefit plans, you can select the HRA as your account of choice for rewards earned through the Shared Savings Program. (There will be prompts to walk you through the process after you complete your benefits enrollment.) You may update your account selection at any time by logging into People First and clicking on the ***Shared Savings Quick Link***.

securian FINANCIAL



LIFE INSURANCE

Securian Financial offers group term life insurance to eligible employees and retirees. Designate your beneficiary or beneficiaries when 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	$5.18 | $6.90
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	$5.32 | $21.26

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

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. The state does not contribute. You may continue dental or vision through COBRA upon the termination of employment, including retirement, or convert other plans by calling the insurance company directly.

DENTAL PLANS

Take control of your total health. 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 (HMO)	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 for the Standard plan. However, for the Preventive plan you will pay the full negotiated rate for major care.	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 HD205	4022 Ameritas Standard PPO 4023 Ameritas Preventive PPO 4032 MetLife Standard PPO 4033 MetLife Preventive PPO	4021 Ameritas Indemnity w/PPO 4031 MetLife Indemnity w/PPO 4074 Sun Life Indemnity 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	$43.46	$80.60	$91.78	$132.54
4022	Ameritas Standard PPO	$36.06	$67.60	$75.64	$110.16
4023	Ameritas Preventive PPO	$26.16	$49.46	$52.94	$77.58
4031	MetLife Indemnity w/PPO	$49.44	$91.48	$102.20	$148.38
4032	MetLife Standard PPO	$34.86	$64.50	$72.06	$104.64
4033	MetLife Preventive PPO	$23.88	$44.18	$49.36	$71.66
4025	Sun Life Prepaid 225	$14.93	$25.17	$33.26	$43.54
4074	Sun Life Indemnity PPO	$43.55	$ 83.61	$ 98.83	$130.35
4034	Cigna Prepaid	$ 24.01	$ 47.31	$ 56.41	$72.06
4044	Humana HD205	$ 12.64	$ 21.20	$ 23.00	$ 32.98
4084	Humana Schedule B	$ 14.74	$ 21.96	$ 23.30	$ 37.10

Ameritas fulfilling life. Cigna. Sun Life MetLife Humana.

Humana®

VISION PLAN

Humana offers eye exams and materials coverage.

Caring for your eyes is an essential part of your overall health and wellness. That's why the State offers you competitive vision coverage at affordable rates through Humana Vision. Coverage is also available to retirees through COBRA and COBRA participants if they were enrolled prior to termination. Find out if you are eligible for these benefits.

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. Specific 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 the 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 the 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.

Capital Insurance Agency, Inc. Cigna Colonial Life New Era Health Plans

MONEY SAVERS

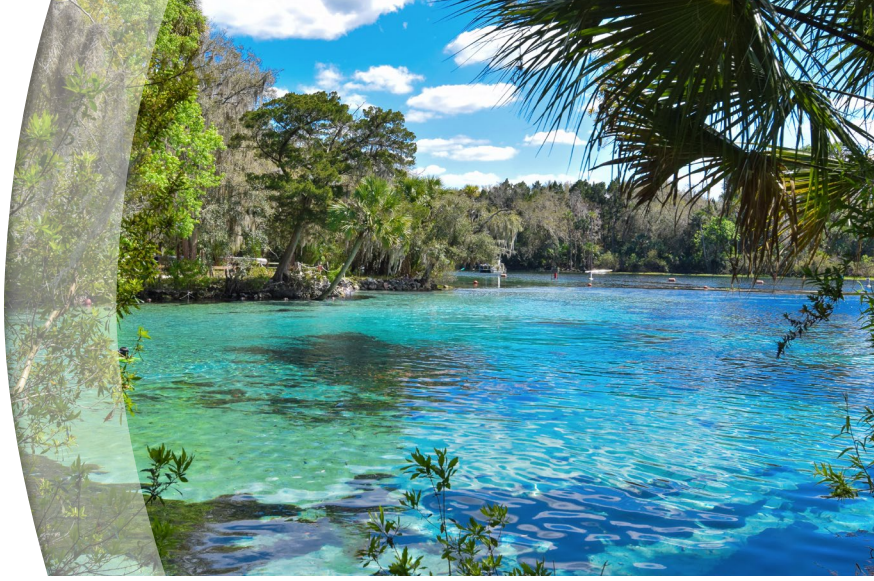
HEALTH AND WELLNESS MONEY SAVERS

- Earn financial rewards by shopping for healthcare services through Healthcare Bluebook and SurgeryPlus.
- Learn more about your prescription drug costs by using CVS Caremark's online transparency tool.
- Ask for generic drugs. If no generic drug is available, ask for preferred brand drugs over non-preferred ones. See the Preferred Drug List.
- 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 any gym membership reimbursement.
- Pay nothing for your annual physical and certain preventive screenings. Track your biometric numbers to see positive movement.
- For your maintenance prescription drugs, use 90-day retail fills at participating pharmacies or mail order. You'll pay only two copayments for 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.
  - Management and education programs if you have a chronic disease.

SAVINGS AND SPENDING ACCOUNT 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 Jan. 1.
  - Your FSA essentially works like an interest-free, tax-free loan.
- Pay for predictable costs like orthodontic braces with funds in your healthcare/limited purpose FSA (annual limits and participation rules apply).
- Estimate how much you can save on your taxes with the Tax-Savings Calculator.

MONEY SAVERS



DENTAL MONEY SAVERS

- Review your dental plan's plan documents for benefit limits and exclusions, based on your needs, including:
- Confirming your dentist and dental specialists participate in-network for your specific plan;
- If looking for a dentist:
  - 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.
- Talking to the dental plan about prior authorization requirements and other special processes.

NOTES

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.

NONDISCRIMINATION TESTING

Employee classification testing must occur to ensure IRS Code nondiscrimination requirements related to the dependent care FSA, HRA, and post-deductible HRA are met. If any issues are discovered through testing, contribution amounts may be adjusted; otherwise, you may be taxed on the amount of benefits you receive. For more information, visit www.irs.gov and review 26 U.S.C. §129(d)(2), for dependent care assistance programs, and 26 U.S.C. §105(h)(2)(A) for HRAs.

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