

benefits guide

for state retirees

effective january 1, 2008



Department of Management Services
Division of State Group Insurance

Dear State of Florida Benefits Participant:

I am pleased to greet you as a participant in the State of Florida Group Insurance program. As a state retiree, your public service played a vital role in improving the lives of Florida's citizens. YOU had the power to make a change!

You also have the power to best care for yourself and your loved ones through the State of Florida Group Insurance Program. Each year, the Department of Management Services (DMS) Division of State Group Insurance offers an Open Enrollment period. During this period, you have the power to choose the most appropriate benefit plans for you and your family. Throughout the rest of the year, you will need to meet the criteria for a Qualifying Status Change (QSC) to change your coverage. A few examples of QSCs include a marriage or divorce.

In this year's Open Enrollment packet, we are including this Benefits Guide which provides information on the health and life insurance plans. Please take time to carefully review this information. Decisions regarding benefit plans affect you and your loved ones. To help you make the best decision, you will find the following items in this package:

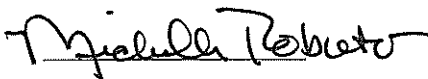
- Your Summary of Benefits - showing you the benefits you will have in 2008 UNLESS you make a change during Open Enrollment.
- This Benefits Guide, which answers many of your questions about the types of coverage available to you as a valued state retiree. It includes important news for 2008

For assistance and information on benefit options, DMS offers the following resources:

- Visit www.MyFlorida.com/myBenefits for a complete guide of insurance options, including a cost calculator, plan details and plan comparisons.
- Visit the People First Web site to take advantage of the self-service option, which is the easiest way to make your benefit elections. You will need your People First user ID and password to log in. Select the "Health and Insurance" tab for enrollment information and opportunities.
- Call the People First Service Center, toll-free, at (866) 663-4735. Representatives are available Monday through Friday from 8:30 a.m. to 5:30 p.m. EDT. TTY users may call toll-free, (866) 221-0268.

We take pride in serving you while carrying out our mission to "Serve Those Who Serve Florida." We encourage you to take an active role in making decisions regarding your benefits.

Sincerely,



Michelle Robleto, Director
Division of State Group Insurance

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Important News for 2008

The Division of State Group Insurance (DSGI) is extremely proud to present this benefits package to you. You have an impressive selection of benefits to choose from; review this book and carefully consider your personal benefit needs. Your benefits are a valuable part of your state retirement.

For 2008, we are pleased to offer a new life insurance carrier in addition to the already extensive list of insurance choices.

- Minnesota Life Insurance Company will be the new carrier for life insurance effective January 1, 2008. **The benefits remain the same, but you must submit a new Beneficiary Designation form to Minnesota Life identifying who your beneficiaries are.** Forms are available on the People First Web site and at www.minnesotalife.com.

This guide summarizes your choices and explains the steps to sign up for coverage. For more information call the People First Service Center at (866) 663-4735 (TTY users 866-221-0268) or visit www.MyFlorida.com/myBenefits. This guide also provides contact information for the different carriers, and you are encouraged to call them directly with your questions or talk to company representatives at the Benefit Fairs scheduled during open enrollment.

The plans and benefits descriptions included in this booklet are summaries and describe the options available to you. These are not intended to change or replace the express written terms of any policy, plan or coverage.



Making the Most of myBenefits

Address Corrections

One of the most important ways to get the most out of your benefit options is to make sure that we have your current address. It is extremely important for you to update your address and personal information on the People First Web site at <https://PeopleFirst.MyFlorida.com>. If your address is not up-to-date, you may not receive important information, such as notification of Open Enrollment, benefit plan changes and documentation of proof of coverage.

The Importance of Choice

This year we have a new tool to help you review and understand your insurance options. The informational Web site, www.MyFlorida.com/myBenefits, provides easy access to publications, forms, information about coverage, descriptions of benefit plans, provider links, and other important information to make your choices easy to understand.

2008 Enrollment Readiness Checklist

Use this checklist to help you make your benefit choices for 2008. Step 3 includes important information about enrollment deadlines.

Step 1: Review Your Medical Plan Options

Through the state, you and your family have a variety of medical plans available. To decide what's best for you:

► Consider the medical and prescription drug needs you and your family may have in 2008

1. Make a note of any care you will need in 2008, such as an annual physical, suggested surgery, or prescription drugs you take regularly.
2. Consider the medical and prescription drug care you received in 2007. Will any of that care be repeated in 2008? What did it cost?
3. If you're currently in the Standard or Health Investor PPO, review your claims for the last year by logging on to the "myBlueService" page on the BlueCross BlueShield of Florida's (BCBSF) Web site. You need your user BCBSF ID and PIN to log in. If you haven't received one, register using your Social Security number and birth date. If covered dependents authorize you to see their claim records, gather the claim history for the entire family and use it to consider what your 2008 expenses may be.

► Understand your medical plan options

Most retirees have four types of health plans to choose from:

- A standard Preferred Provider Organization with statewide coverage.
- A Health Investor Preferred Provider Organization that's also available statewide.
- A standard Health Maintenance Organization Plan, depending on where you live.
- A Health Investor Health Maintenance Organization Plan, again depending on where you live.

Use the myBenefits Web site to learn more about how the plans work and what they cover.

► Compare your options

The state offers a Medical Plan Cost Comparison Tool to help you compare what your total costs are likely to be under each of the medical plan options, including what you pay for care and what you pay to purchase coverage. The tool is available on the myBenefits Web site.

Resources to Help You Choose

- Benefits Guide
- The new myBenefits Web site at www.MyFlorida.com/myBenefits with convenient links to all our benefit vendors
- People First – the way to enroll online for most state benefits. Make sure you know your password or reset it by calling (866) 663-4735 or TTY (866) 221-0268.

► **Check out the doctors, hospitals and other medical professionals participating in each plan.**

The standard and Health Investor PPO plans both use the same network of BCBSF medical professionals. The provider networks available under the HMO plans will vary by plan. Remember: With the PPOs, you receive a higher level of benefits when you use network providers. With the HMOs, there are no benefits for care outside the network (except in emergency situations). There are links to the BCBSF Web site and all the HMO Web sites from myBenefits Web site.

► **If you decide to participate, enroll in the plan that is best for you.**

See Step 3 for more information on how to switch.

Step 2: Review Your Life Insurance Options

Learn more about your options. Retirees are eligible for basic term life insurance with Accidental Death and Dismemberment in one of two benefit amounts:

- \$2,500 or
- \$10,000.

► **Think about your family needs in the event of your death.** What expenses would they have on an ongoing basis such as daily living expenses, college education, and what financial resources would they have to draw on?

► **Select your coverage amount and enroll. See Step 3 for more information on how to make changes.**

Step 3: Make Your Selections

Make your 2008 benefit changes online or by telephone through People First, or by completing and returning an enrollment form. For open enrollment, you must enroll by 5:30 p.m. EDT on October 26, 2007. If you are making changes because of a qualifying change in status, you have 31 or 60 days, depending on the event, from the qualifying status change to make related benefit changes.



Basic Definitions for myBenefits

Annual Maximum – Total dollar amount a medical plan will pay during a calendar year toward the covered expenses of each person enrolled.

Co-insurance – Co-insurance is a percentage you are required to pay for certain services you receive after meeting the calendar year deductible.

Co-payment – Set dollar amount you pay for network doctor office visits and specified in-network preventive care. No other fees or deductibles apply.

Deductible – Total dollar amount you must pay for covered medical care each calendar year before the State Employees' PPO Plan or the Health Investor PPO plan pays benefits for most services. Deductible does not apply to network preventive care and any services where you pay a co-payment rather than co insurance.

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

- Lower cost to buy coverage than the State Employees' Standard PPO or the Standard HMO.
- The opportunity to have a Health Savings Account that can be used to pay eligible health care expenses.

Health Maintenance Organization (HMO) – A prepaid medical plan in which you agree to use a specific, more limited network of providers.

Health Savings Account (HSA) – An account associated with the Health Investor HMO and PPO that allows you to pay your share of the cost for eligible medical and, if continued via COBRA, dental or vision care services that aren't otherwise covered.

- You must be in a Health Investor medical option to contribute post-tax to an HSA.
- Any unused HSA funds at the end of a year carry forward to the next year.
- You must open a personal HSA bank account at your favorite bank or credit union.

Lifetime Maximum – Combined total dollar amount the State of Florida medical plans pay toward the covered expenses of each person enrolled in the PPO plan while covered as an employee or an employee's dependent.

Out-of-Pocket Maximum (medical plan) – Annual dollar limit an individual or family pays in medical co-insurance in a calendar year. The PPO plan pays 100% of eligible expenses when you reach the out-of-pocket maximum. This feature provides financial protection for you by limiting your out-of-pocket expenses in a given calendar year.

Preferred Provider Organization (PPO) – A plan offering discounted rates on services if you use providers in the network. If you use services outside of the network, you are reimbursed a smaller portion of the charges.

Primary Care Physician – The health care professional who monitors your needs and coordinates your medical care, including referrals for tests or specialists.

Provider Network – A group of health care providers, including physicians, hospitals and other health care providers, who agree to accept pre-determined rates when serving members.

Qualifying Status Change – A specific event or change meeting federal guidelines that allows you to make changes to your benefit elections outside of the annual Open Enrollment period. A QSC is a loss of insurance coverage and certain personal status changes (e.g., marriage or acquiring other new dependents).

Enrollment and Eligibility for myBenefits

General Enrollment Information

Retired state of Florida employees and officers may elect to continue state group health and life insurance at the time of their retirement. Retirees pay the full premium amount and such coverage may be maintained for life. Once you or your spouse becomes eligible for Medicare - generally age 65 or older – Medicare becomes the primary plan for health insurance purposes. Retirees may also continue vision and dental coverage under COBRA provisions. **If you cancel coverage under the State Group Insurance Program or otherwise fail to pay the full premium each month, you will not be permitted to re-enroll in our benefits plan unless directed by the Florida Legislature.**

During the annual Open Enrollment period, you can make changes to your existing group health and/or life insurance coverage.

Outside of the annual Open Enrollment period, state and federal regulations prohibit additions, changes or cancellations in our plans unless you experience a Qualifying Status Change (QSC) event. (See the Definition section for more information on QSCs.)

Enrollment Opportunities

As a retiree, there are two opportunities to make benefit changes:

- 1) when you have a QSC event or
- 2) during Open Enrollment

Option 1 – QSC Event

If you have a QSC, you typically have 31 days from the date of the QSC to make any changes to your benefits, such as increasing coverage or changing family status. You have 60 days from the date you make changes to your benefits to submit any required documentation. Currently, the following are some, but not all, valid QSC events:

- Marriage or divorce
- Death of a spouse or dependent, a birth or adoption (60 days for notice rather than 31 days)
- Legal guardianship
- Change in dependent eligibility

If you have a QSC and want to change your benefits selections, complete the following steps:

1. Within 31 days of the QSC event, using your 6-digit user identification number provided by People First and the password you created, log on to www.PeopleFirst.MyFlorida.com and select the “Health and Insurance” tab. Select the “Process Benefits Elections” icon and then select the New Event button to choose the pertinent event to make the change online.
2. Complete all required forms authorizing the change. The People First Service Center must receive the required enrollment forms within 31 days of the QSC event. If the forms are received after 31 days, your change(s) will be denied and you will not be able to make changes until the next Open Enrollment.
3. Provide the supporting documentation (e.g. marriage certificate, birth certificate, divorce decree, etc.).

To ensure appropriate coverage, you must provide documentation for the dependent(s) you have added to your plans. This documentation can be mailed to:

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

You can also fax the information to (904) 828-6092. You must write your People First ID Number on the top right corner of each page of your fax.

(Note: To make an enrollment change based on a QSC, federal law requires that the event result in a gain or loss of eligibility for coverage, and general consistency rules must be met. For example, if you have family health insurance coverage and you get a divorce and no longer have dependents, you may change from family to individual coverage. However, you cannot cancel enrollment in health insurance because the QSC event only changes the level of coverage eligibility. Cancellation would not be consistent with the nature of the QSC event.)

Option 2 - Open Enrollment

We have Open Enrollment each year to give you an opportunity to review benefit plan options and make changes for the following plan year. It is usually held in the fall. All benefits chosen during this time take effect on January 1 of the following calendar year. The benefit plan year is January 1 through December 31. Before Open Enrollment begins, we mail and/or e-mail notices announcing Open Enrollment dates so you can confirm your address, update your password and be ready to make your selections.

We encourage you to take full advantage of this once-a-year opportunity to review your benefit plans and select the options that best meet the needs of you and your family.

General Eligibility Information

When you retire, you may continue benefits for yourself and your eligible dependents. In addition, if you don't already have state health insurance, prior to your retirement, you may enroll as an active employee provided that you do so within 31 days before you terminate employment. Once enrolled with active employee coverage for one month, you may then continue your health insurance coverage as a retiree. **You must complete the "New Retiree Insurance Election Form" within 31 days of your termination date. If you do not enroll or continue coverage within this time, you will not be allowed to re-enroll at a later date as a retiree.**

Dependents eligible for coverage:

- Your legal spouse
- Your natural children, legally-adopted children, and children placed in the home for the purpose of adoption in accordance with Chapter 63, Florida Statutes
- Stepchildren
- Foster children
- Children for whom you have established legal guardianship (Chapter 744, Florida Statutes) or court-ordered temporary custody

Generally, children must be under the age of 19 and dependent on you for support. Eligibility for dependent children usually ceases at the end of the month the child turns 19 years old, but over-age dependent children and children with disabilities may be covered beyond the age of 19.

- Over-age dependent children: From age 19 through the end of the calendar year when the child turns 25, children must meet both of the following criteria to remain eligible dependents:
- Must be dependent on you for financial support, and
- Must either live with you or be a full-time or part-time student

Children with disabilities: Children who have mental or physical disabilities are eligible to continue coverage after they attain these age limits when you enroll or while your family coverage is in effect, provided that they are incapable of self-sustaining employment because of mental or physical disability and are chiefly dependent on you for financial support and maintenance.

To ensure appropriate coverage, you must provide documentation for the dependent(s) you have added to your plans. This documentation can be mailed to:

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

You can also fax the information to (904) 828-6092. You must write your People First ID Number on the top right corner of each page of your fax.

myBenefits = myHealth

One of the most important benefits available to you from the state is health insurance. There are a number of things to consider before selecting a health plan. Keep in mind that one plan is not better than another; each plan simply offers different benefits. Carefully consider the health care needs of you and your family and review the comparisons and other materials available before making your selection.

You may choose between four types of health plans:

- the State Employees' Standard Preferred Provider Organization (PPO) plan,
- a Health Investor PPO plan,
- a Standard Health Maintenance Organization (HMO) plan*, or
- a Health Investor HMO plan.*

*HMO coverage is only available if you live in the HMO's service area.

These are managed-care plans, which means they have specific provider networks you are expected to use. If you use a provider outside of the plan's network, you may have higher out-of-pocket costs. To get the maximum benefits from your plan, you may need to follow specific procedures before receiving care.

There are differences in premium among the four health options, and retirees pay the full premium amount for their selected plan. Premiums for Medicare participants who are enrolled in an HMO plan are listed on the People First Web site and vary by HMO and by county. Visit the People First Web site to learn how much your premiums will be each year.

Things to Consider When Choosing Health Insurance

- While the core benefits between the PPO Plan and the HMO plans are similar, there are differences. PPO coverage has broader provider access.
- Both plans contract with networks of providers to deliver services. HMO plans require you to use an exclusive network of providers for services with very few options for using non-network providers. In the State Employees' Standard PPO Plan, you have the option of using out-of-network providers, but this may result in additional costs.
- PPO plans allow you to self-refer or visit specialists without approval from a primary care physician. Some HMO plans require you to first obtain a referral from your primary care physician to have your treatment by a specialist covered under the plan.
- All Standard HMO plans charge co-payments for visits. A co-payment is a fee you pay to visit a provider. The Standard PPO Plan has deductibles, co-insurance and co-payments. Health Investor PPO and Health Investor HMO plans have higher deductibles and co-insurance. Co-insurance is a percentage you are required to pay for certain services you receive after meeting the calendar year deductible.
- HMO plans typically provide care through regionally-based networks of providers; these plans cover out-of-network care only in emergencies. To enroll in an HMO, you must therefore live or work in its service area. If you choose an HMO, make sure coverage is available. The State Employees' Standard PPO Plan uses a statewide network and offers out-of-state coverage through the BlueCross BlueShield BlueCard™ Program. If you spend a lot of time traveling or do not live in Florida, the State Employees' Standard PPO Plan may be more suitable to your needs.
- We recommend that you select a plan with providers you would feel comfortable using in the event that your current provider's relationship with a plan ends.

Carefully consider all of these factors. You should call the plans to learn more. The People First Web site provides links and contact phone numbers for all of the plans outlined in this guide. To further help you, the Agency for Health Care Administration has a Florida Health Plans Consumer Information Web site that evaluates all the health plans in Florida, with their findings posted at: <http://healthplans.floridahealthstat.com>.

Preferred Provider Organization (PPO)

The State Employees' Standard PPO Plan is a self-insured health plan administered by BlueCross BlueShield of Florida, Inc. (BCBSF). As the administrator, BCBSF processes health claims, supplies the preferred provider care network and provides customer service. To learn more about BCBSF, contact them at (800) 825-2583 or visit www.bcbsfl.com.

Pharmaceutical services are administered by Caremark. Caremark can be contacted by calling (800) 378-4408 or visiting www.caremark.com.

Charges for the State Employees' Standard PPO plan and Health Investor PPO plan include:

- Pre-negotiated fees: the plan negotiated in advance with a network provider are usually lower than the provider's actual charge.
- Annual Deductible: a yearly amount you are required to pay first for certain services before the plan starts paying. The deductible varies based on the network status of the provider you choose, either a network or non-network provider and the type of plan, either individual or family. Once your deductible is met, you will typically only pay your co-insurance or co-payment.
- Co-insurance: a percentage of the medical costs you are required to pay for certain services after your annual deductible is met.
- Co-payment: a per visit fee for select services.

The State Employees' Standard PPO plan and Health Investor PPO plan rely on a network of providers contracted with BCBSF. When you need to see a provider, you have the freedom of choice to visit a network provider or a non-network provider. You should contact BCBSF Customer Service to find out if using a non-network provider will cost you more.

Network providers include physicians, hospitals and other providers who will charge you no more than a pre-negotiated fee for covered services. This fee is generally lower than the provider's actual charge and you do not pay more than this pre-negotiated fee. Choosing a network provider saves you money.

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Greater Choices From the Name You Know and Trust

Blue Cross and Blue Shield of Florida, Inc. has a strong tradition of helping to keep Florida families healthy and happy. For more than 25 years, we have been proud to be the servicing agent for the State Employees' PPO plan.

The State Employees' PPO plan covers most medical expenses and gives you access to an extensive network of providers as well as a number of special benefits, services and additional programs. These include our Healthy AdditionSM prenatal education program, 24/7 access to health-related resources and information, and out-of-state health care coverage with the BlueCard[®] Program.

Freedom to Visit Any Doctor or Hospital You Choose

The PPO plan has an extensive network spanning across Florida's 67 counties where you have access to almost all hospitals and more than 32,000 physicians and specialists. PPO plan participants are protected from balance billing and enjoy the same network benefits nationwide through our BlueCard program.

On-line Resources Just for You

We've created a section of our Web site specifically for members of the State Employees' PPO plan. Just visit www.bcbsfl.com and click on: **Members > Products, Plans & Services > State Employees' PPO Plan**

Below are just a few of the resources available to you 24 hours a day, seven days a week:

- Health Dialog[®], a comprehensive resource for health information with access to live Health Coaches to discuss different treatment options;
- MyBlueServiceSM, our online member service center where you can check claim status, request a replacement ID card, print forms, and make general inquiries; and
- Online tools to evaluate and compare hospitals, physician attributes, medical conditions and treatment options, provided through SubminoTM.

Value-Added Programs and Services

As part of our ongoing commitment to provide greater value for health plan members, Blue Cross and Blue Shield of Florida, Inc. offers a program of discounted products and value-added services called Blue ComplementsSM. Some of the services currently offered include discounts on vision care, laser vision correction, weight management programs, hearing exams and hearing aids, fitness center membership fees, and a contact lens mail order service.

We're Here to Help You

To contact a dedicated State Employees' PPO plan customer service representative, call 800-825-2583.

Non-network providers do not participate in the preferred provider network. **Hospital-based physicians such as radiologists, pathologists, anesthesiologists and emergency room physicians may be non-network providers.**

When you receive covered services from a non-network provider, you will have to pay higher non-network deductibles, co-payments and co-insurance costs. For these services, you will be billed directly by the provider for the difference between the amount BCBSF allows for a covered service and the non-network provider's actual charge for that service. When care is provided by a non-network provider, the plan will pay the provider a formula-determined amount based on the type of service provided. The non-network provider's actual charges often exceed these amounts. If that occurs, the enrollee will experience higher out-of-pocket costs than those associated with services from a network provider.

You are responsible for checking to see if your provider is part of the BCBSF network before you receive service. Otherwise, you may have to pay more than you expected. You can find this out by searching the provider networks of the BCBS plans across the country through the BlueCard® Program. Even if you travel outside of Florida you receive the same coverage you would receive in Florida when a provider or hospital is part of the network.

If you have questions about the BlueCard® Program, contact (800)-825-BLUE (2583). You can learn more about out-of-state participating PPO providers by calling (800)-810-BLUE (2583) or visiting www.bluecares.com.

Vision Care Coverage

Discounted coverage for exams, glasses and some corrective surgeries is available to PPO members through BCBSF's Enhanced Vision Care program. You pay \$40 for eyeglass exams and save up to 40 percent off retail prices for frames and lenses. You can also take advantage of the discounts offered through the TruVision contact lens mail order service. Use your ID card to receive discounts at participating providers including optometrists, ophthalmologists, opticians or optical retailers. You can find more details and participating providers by going to the "BlueComplements" information sheet on the Members site at www.bcbsfl.com or by calling (800) 825-2583.

Maximum Lifetime Benefit

The State Employees' Standard PPO Plan and Health Investor PPO plans pay a maximum of \$2 million during your lifetime.

Maximum Annual Out-of-Pocket Expenditures

The State Employees' Standard PPO Plan has a \$2,500 (individual) or \$5,000 (family) annual out-of-pocket maximum limit. Your co-insurance amounts count toward this limit. Once you reach this maximum dollar amount in a calendar year, the plan will pay 100 percent of your co-insurance or allowed amount for covered expenses for the rest of the calendar year.

The Health Investor PPO plan requires you to pay up to \$3,000 (individual) for network providers and \$7,500 (individual) for non-network providers each year. For family coverage, you pay up to \$6,000 for network providers and \$15,000 for non-network providers each year. Once you've reached this maximum dollar amount in a calendar year, the plan pays 100 percent of the allowed amount for covered services for the rest of the calendar year.

For the State Employees' Standard and Health Investor PPO plans, deductibles, office visit and emergency room (ER) co-payments, non-covered services and/or supplies, per admission fees and provider charges exceeding the plan's allowed amounts do not count toward the annual out-of-pocket maximum limit.

Pre-existing Condition Limitation

The State Employees' Standard PPO plan and Health Investor PPO plan have a "6 month/12 month" pre-existing condition limitation for new members. A pre-existing condition may be diabetes, asthma or some other condition that you or your dependent(s) have been diagnosed with or treated for during the 6 months before your coverage began. If you or your dependents have a pre-existing condition, the State Employees' Standard PPO plan and Health Investor PPO plan will not cover services for this condition for 12 months after your coverage begins.

However, if you and your dependent(s) had prior health insurance coverage, and it has been less than 63 days since that coverage ended, you may be eligible to have all or part of the pre-existing condition limitation waived.

If you would like to be excluded from pre-existing condition limitation, submit a "waiver of the pre-existing limitation" to the People First Service Center. You will need a Certificate of Creditable Health Insurance Coverage or Portability from your previous insurer which provides your covered family members' beginning and ending dates of coverage. People First will review your information and contact you about your eligibility for a waiver.

Standard PPO Benefits-at-a-Glance

State Employees' PPO		
Covers care received in or out of network		
You meet annual deductible <ul style="list-style-type: none"> Individual Family 	Network \$250 \$500	Non-Network \$750 \$1,500
What you pay for care received <ul style="list-style-type: none"> Doctor office visits Hospital stay 	\$15/visit for PCP; \$25/visit for specialists \$250/admission then 20% of network allowed amount	40% of non-network allowed amount plus amount between charge and allowed amount \$500/admission then 40% of non-network allowed amount plus amount between charge and allowed amount
<ul style="list-style-type: none"> Prescription drug (provided by Caremark) <ul style="list-style-type: none"> generic preferred brand non-preferred brand 	Up to 30-day retail or 90-day mail order prescription <div> <div>\$10/retail; \$20/mail order</div> <div>Pay in full and file a claim</div> </div> <div> <div>\$25/retail; \$50/mail order</div> <div>Pay in full and file a claim</div> </div> <div> <div>\$40/retail; \$80/mail order</div> <div>Pay in full and file a claim</div> </div>	
Preventive care; some routine physical exams, health screenings and immunizations	100% of allowed amount; see preventive care .	40% of non-network allowed amount plus amount between charge and allowed amount; see preventive care .
Annual out-of-pocket co-insurance maximum (not including deductible, co-payments, cost of care not covered by plan)		
<ul style="list-style-type: none"> Individual coverage Family coverage 	\$ 2,500 network & non-network combined \$5,000 network & non-network combined after your out-of-pocket co-insurance costs reach these maximums, for the rest of the calendar year, the plan pays 100% for covered co-insurance in most cases, up to the allowed amount	

In addition:

- Network co-payments make doctor visit and prescription drug costs more predictable.
- Plan pays 100% of allowed amounts for some preventive care services received from network providers.
- You meet an annual deductible and pay a co-insurance percentage of most other costs.

For more information, see the [BCBSF-PPO Brochure](#) that summarizes the State Employees' PPO Plan on the People First Web site.

Health Investor Preferred Provider Organization

Like the current State Employees' PPO Plan, the Health Investor PPO gives you flexibility to see network or non-network providers, with a lower cost to you when you use network providers. If you are Medicare-eligible, the Health Investor PPO provides secondary coverage - paying benefits after Medicare pays its benefits.

Prescription Drug Benefit

Prescription drug benefits for the State Employees' Standard PPO plan and Health Investor PPO plan are administered by Caremark, L.L.C. Caremark is a pharmacy benefit management company providing your comprehensive prescription benefit management services. To learn more, call (800) 378-4408 or visit www.caremark.com.

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it all starts with care

How can I order all of my family's prescription refills at once? It's easy... on Caremark.com

You can manage your family's prescription benefits in one convenient location when you register on Caremark.com. Dependents under 18 are automatically listed in your online account, and adults can give you access to their accounts when they register. Then log in once to order prescription refills for everyone on your plan.

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Health Maintenance Organization (HMO)

Each HMO is a self-administered, pre-paid health plan providing health services for people who live or work within the HMO's service area. There is limited or no coverage for services outside their service areas except in limited circumstances. Carefully consider the HMO's policy, especially if you have dependents who do not live in the service area. Do not choose your HMO plan only because a particular physician, physician group, hospital or other provider participates in a plan. At any point providers can leave the HMO. If this happens, you will have to choose a new provider from the network. If you continue to use the provider who is not part of the network, you will have to pay for services. You will not be able to change health plans simply because your doctor leaves the health plan, except during the annual Open Enrollment period.

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

HMO coverage is not available in all Florida counties. To find out if your county offers HMO coverage, visit the People First Web site or call the People First Service Center.

For some HMOs, you must choose a primary care physician within the HMO provider network. A primary care physician is the provider you visit for most of your health care needs. If you need to see a specialist for a specific concern, the primary care physician must make a referral for you. (Please note: You do not need a referral to see dermatologists, gynecologists, chiropractors, podiatrists or for emergency care.) If you decide to change your primary care physician, you must contact the HMO and complete the necessary paperwork. Some participating HMOs do not require referrals from your primary care physician, but you will need to use specialists in the HMO network. Primary care physicians and other providers vary among HMOs and the list can change at any time. You should contact the HMO and review the network providers. There is a list of the HMOs and their contact information on the People First and myBenefits Web sites.

The Agency for Health Care Administration publishes an HMO Report Card that evaluates the services provided by HMOs in Florida. Please visit www.floridahealthstat.com and select "Health Plans," then "HMO Report." It can also be obtained by mail from the State Center for Health Statistics by calling their toll-free number at (888) 419-3456.

Charges for HMO plans include:

- Co-payment: a payment for office visits, rehabilitation therapy, emergency room visits and hospital admissions fees.

Charges for the Health Investor HMO include:

- Co-insurance: a percentage of the medical and pharmacy costs you are required to pay after your annual deductible is met.
- Annual Deductible for the Health Investor HMO: Aside from some preventive services, this is a yearly amount you are required to pay for services. The annual deductible is \$1,250 individual and \$2,500 family. Once your total annual deductible is met, you pay the co-insurance amount.

Vision Care Coverage

Routine eye exams are covered as part of your preventive benefit package when you enroll in an HMO. HMO plans may also offer significant discounts on glasses, contact lenses and some corrective surgeries. Contact the HMOs available in your area to get details on the vision care discounts they offer.

Health Investor Health Maintenance Organization Plan

While the Health Investor HMOs cover all the same services and supplies as their traditional HMO counterparts, there are some key differences. Under the Health Investor HMO:

- If you contribute toward the cost of your coverage, your monthly insurance premiums are lower.
- If you or your covered dependents do not have other medical coverage, you may open a Health Savings Account and make pre-tax contributions to it. You can use the HSA to pay out-of-pocket expenses like your deductible and coinsurance - now or in the future.
- For specific preventive care services, there's no deductible.

Standard HMO Benefits-at-a-Glance

Standard HMOs	
Covers care received in network only	
No annual deductible	
• Individual coverage	\$0
• Family Coverage	\$0
What you pay for care received	
• Doctor office visits	\$ 15/visit for PCP; \$25/visit for specialists
• Hospital stay	\$250/admission
• Prescription drug	
• generic	\$10/retail; \$20/mail order
• preferred brand	\$25/retail; \$50/mail order
• non-preferred brand	\$40/retail; \$80/mail order
Annual out-of-pocket maximum	
• Individual coverage	\$1,500
• Family coverage	\$3,000
Preventive care: routine physical exams, health screenings and immunizations at specified intervals	See the HMO's certificate of Insurance for specifics for the HMO you are considering

View a [list of the standard HMOs](#) offered in 2008 and the areas where each is available. The 2008 Benefit Statement you receive in late September 2007 will show the specific HMO options available to you.

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FHCP has been honored as an outstanding Health Plan by receiving the following recognition:

- Voted "Best HMO" for 17 consecutive years by News-Journal readers.
Source: News-Journal 2007 Readers Choice Poll
- FHCP has the lowest disenrollment rate of any Medicare Advantage HMO in Volusia and Flagler counties.
- FHCP was rated higher in member satisfaction by its members than any other Medicare Advantage HMO in Volusia and Flagler counties.

FHCP provides health care services to over 60,000 members in our service area, and 1300 State employees have chosen FHCP as their health plan for over thirty years.

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Prescription Drug Benefits

All your health insurance options include comprehensive prescription drug coverage with two components: a network-based retail program and a mail order pharmacy program.

For the State Employees' Standard PPO and the Standard HMO plans, retail co-payments, for up to a 30-day supply are \$10 for generic, \$25 for preferred brand name and \$40 for non-preferred brand name drugs. Co-payments for the mail order program for up to a 90 day supply are \$20 for generic, \$50 for preferred brand and \$80.00 for non-preferred brand drugs. You will need to have your doctor write your prescription for up to a 90-day supply to take advantage of the savings offered by the mail order program.

Preferred brand drugs are medications on the preferred drug lists supplied by Caremark, the pharmacy benefits administrator for the State Employees' Standard PPO plan and Health Investor PPO plan, and by each of the various HMOs. Non-preferred brand drugs are brand name medications that do not appear on any of the preferred drug lists.

For the Health Investor PPO and Health Investor HMO, you must first satisfy the appropriate individual or family annual deductible. After paying this deductible, your co-insurance for retail and mail order drugs is 30 percent for generic and preferred brand drugs and 50 percent for non-preferred brand drugs.

In all of the plans described above, if you request a brand name drug when a generic is available, you must pay the difference between the generic and brand name drug, plus the appropriate co-payment or co-insurance. If your physician writes on the prescription that the brand name drug is medically necessary, you will only pay the appropriate co-payment or co-insurance.

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Minnesota Life is proud to partner with the State of Florida to provide group life insurance benefits to members. As one of the country's strongest group life insurance carriers¹, we are dedicated to helping you get more out of your life with affordable coverage and excellent service.

Your Minnesota Life plan features these important benefits:

- Significant amounts of coverage — up to \$500,000 — available at affordable group rates.
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Will preparation services are provided by and are the sole responsibility of Ceridian LifeWorks. The services are not affiliated with Minnesota Life or its policyholders and may be discontinued at any time.

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

¹Minnesota Life is highly rated by the major agencies that analyze the financial soundness and claims-paying ability of insurance companies. View our ratings at www.lifebenefits.com.

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Life Insurance

Upon retirement, you may continue your term life insurance, including an accidental death and dismemberment benefit, underwritten by Minnesota Life. Minnesota Life is a new provider for 2008 and replaces Prudential Life. Because of this change, you must submit a new beneficiary form. Forms are available on the People First Web site and also at www.minnesotalife.com.

Coverage & Premiums

You pay the entire life insurance premium, which is \$7.41 for a benefit of \$2,500 or \$29.65 for \$10,000. You should complete your beneficiary form as soon as possible. Please note: Even if you previously submitted a beneficiary form to Prudential Life, you will need to submit a new form to the new carrier, Minnesota Life. If a beneficiary is not designated in writing, the proceeds will be paid according to the default beneficiary provisions of the policy in this order: your spouse, children, parents or the personal representative of your estate. Payments made to an estate, however, may result in a reduction in total benefits due to taxes and probate costs. Be sure to complete your Beneficiary Form.

Accidental Death and Dismemberment

Basic life insurance coverage includes accidental death and dismemberment coverage. Significant benefits may be available in the event of accidental death or injury. Payment amounts vary from 25 to 100 percent of your coverage. You may be eligible to receive benefits for the loss of use of limbs, in instances where no amputation is required.

Accelerated Death Benefit

The Accelerated Death Benefit, or “living benefit option,” provides you with an advance benefit if you are diagnosed with a terminal illness that will result in death within one year. You may be eligible for up to 100 percent of your life insurance benefits, with a maximum of \$1 million. Upon death, the balance of the life insurance benefit, if any, will be paid to the named beneficiaries.

Conversion Privileges

You can convert your life insurance to an individual contract. Regardless of your age or health, you can purchase a whole life insurance policy, provided the conversion request and premium payment are made to Minnesota Life within 31 days of group plan termination. You should contact Minnesota Life directly for the conversion forms and applicable premium information.

To learn more about Minnesota Life call (888) 826-2756 or visit www.minnesotalife.com.



myPrivacy

State of Florida Employees' Group Health Insurance Program Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by plans — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices for the State of Florida's Flexible Spending Account, and discusses administrative activities performed by the State for the State of Florida Employees' Group Health Self-Insurance Plan (the self-insured plan) and for insurance companies and HMOs in the State Group Insurance Program (the insured plans).

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

The Plans' duties with respect to health information about you

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

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

How the plans may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care Treatment, Payment activities, and Health Care Operations. Here are some examples of what that might entail:

Treatment includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the plans may share health information about you with physicians who are treating you.

Payment includes activities by these plans, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the

plans may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

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

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

How the plans may share your health information with the State

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

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

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

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

Other allowable uses or disclosures of your health information

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

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

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

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

Your individual rights

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

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

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

The plans are not required to agree to a requested restriction. And if the plans do agree, a restriction may later be terminated by your written request, by agreement between you and the plans (including

an oral agreement), or unilaterally by the plans for health information created or received after you're notified that the plans have removed the restrictions. The plans may also disclose health information about you if you need emergency treatment, even if the plans had agreed to a restriction.

Right to receive confidential communications of your health information

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

Right to inspect and copy your health information

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

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the plans use to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the plans may deny your right to access, although in certain circumstances you may request a review of the denial.

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

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

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

Right to amend your health information that is inaccurate or incomplete

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

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

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

Right to receive an accounting of disclosures of your health information

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

You may receive information on disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules are effective). You do not have a right to receive an accounting of any disclosures made:

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

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

If you want to exercise this right, your request must be in writing. Within 60 days of the request, the plans will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the plans expect to address your request. You may make one (1) request in any 12-month period at no cost to you, but the plans may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

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

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

Changes to the information in this notice

The plans must abide by the terms of the Privacy Notice currently in

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

Complaints

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

Contact

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



Special Notice About the Medicare Part D Drug Program

Please, read this notice carefully.

It explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll

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

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

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

If you do decide to enroll in a Medicare prescription drug plan and drop your State Health Program coverage, be aware that you and your dependents will be dropping your hospital, medical and prescription drug coverage. **If you choose to drop your State Health Program coverage, you will NOT be able to enroll back in the State Health Program unless a special Open Enrollment period for non-enrolled State of Florida retirees is mandated by the Florida Legislature.**

If you enroll in a Medicare prescription drug plan and you DO NOT drop your State Health Program coverage, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

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

Additional information about Medicare prescription drug plans is available from:

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

For people with limited income and resources, payment assistance for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you may call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage, contact the People First Service Center at 1-866-663-4735.

Keep this notice. If you enroll in one of the plans approved by Medicare which offers prescription drug coverage you may need to give a copy of this notice when you join to avoid paying a higher premium amount (a penalty).

Notes

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