JUSTICE ADMINISTRATIVE COMMISSION

Benefits

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May 16 , 2017

JUSTICE ADMINISTRATIVE COMMISSION

Objectives

- Provide contact information where employees can get more information regarding benefits
- Provide overview on the benefits available to State of Florida employees
- Explain the conditions and limitations of OPS employment benefit eligibility
- Give useful tips for enrolling in benefits & FSAs/HSAs
- Provide overview of SMS/SES Disability Benefits
- Provide explanation and examples of Under/Overpayment Benefits Report

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Stay Informed - People First

- **My Benefits Website**
- **Benefits Guide**
- **Learn about changes**
- **Read about plans**
- **Use Cost Estimators**
- **Insurance Company Contact Info**
- **http://mybenefits.myflorida.com/**

- **How employees will receive information**
- **Employees MUST verify mailing and home address in People First**
- **Benefits Summary will be mailed and available online**
- **Confirmations will be mailed and available online**
- **New hire letter**

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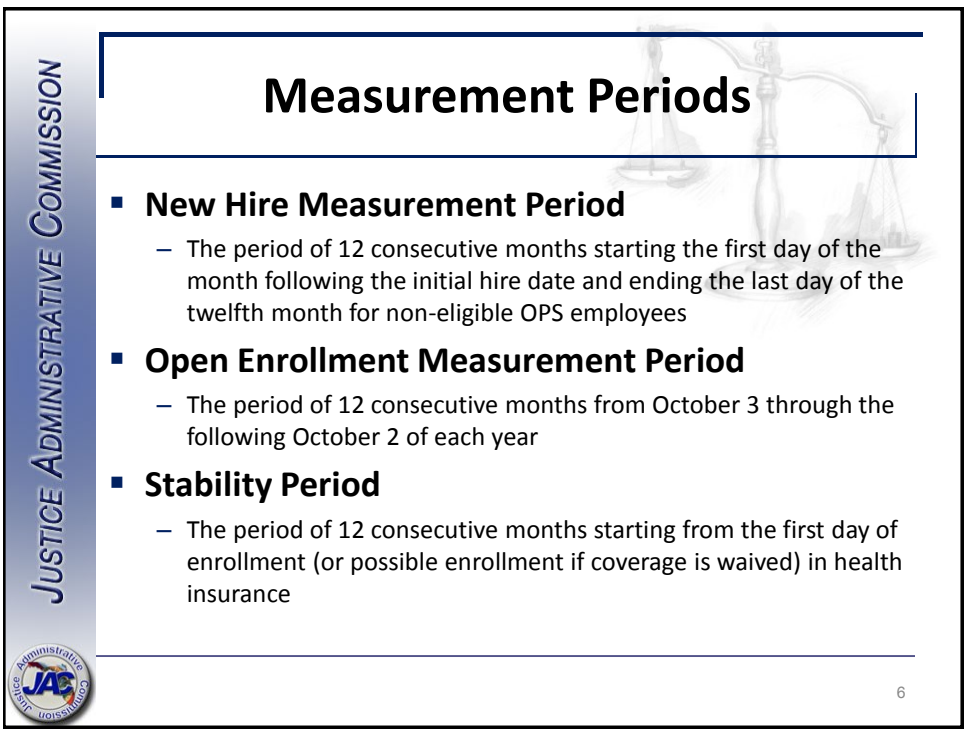
Home
Services
Court Appointed/IFC
Due Process (CAC/IFC)
Contacts
Search
MY JAC LOGIN
JAC Home / Human Resources / Benefits
Benefits
Benefits | Post Tax Benefits | Miscellaneous Benefits
State Group Insurance Information | Open Enrollment
2017 Plan Year Information
People First is the Benefits Administrator for the State of Florida pre-tax insurance plan and is responsible for new hire enroll
administration and dependent eligibility among many others. If you experience issues with your pre-tax insurance or have qu
Benefits Coordinator at benefits@justiceadmin.org or the People First Service Center at 1-866-663-4735 (TTY users: 1-866-221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Measurement Periods
New Hire Measurement Period
The period of 12 consecutive months starting the first day of the month following the initial hire date and ending the last day of the twelfth month for non-eligible OPS employees
Open Enrollment Measurement Period
The period of 12 consecutive months from October 3 through the following October 2 of each year
Stability Period
The period of 12 consecutive months starting from the first day of enrollment (or possible enrollment if coverage is waived) in health insurance
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Eligible Variable Hour (OPS) Employees

- Any state employee working an average of 30 hours or more per week will be eligible for:
  - Health Insurance: same premiums as Career Service; eligible for spouse program and HSA contribution
  - Basic life: employee must enroll and pay $3.58 monthly premium
  - Spouse life and child life (as long as they are enrolled in the basic life plan)
  - Dental, vision and other supplemental plans
  - Health Savings Account- Enrolled in HIHP Health Plan
  - Dependent Care FSA
- ***Not*** eligible for optional life, Health Care FSA (formerly known as MRA) or Limited Purpose FSA

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Eligible Variable Hour (OPS) Employees

- Qualifying Events
  - Eligible employees are subject to the rules of the program
  - OPS **eligible** moving to FTE is no longer a QSC event
- OPS Payroll vs. Benefits Month
  - OPS Payroll processed mid-month to mid-month
  - OPS Benefits are calendar month

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Life Insurance

- Securian
- Employer paid premium $3.58/ $25,000 basic life insurance:
  - $25,000 Basic Life for Full-Time Employees at no cost to employee
  - $25,000 Basic Life for Part-Time Employee at a pro-rated premium
  - OPS employees are eligible; must pay entire premium
  - Over $500,000 requires medical underwriting
  - Maximum Coverage $1,000,000
  - Spouse and Dependant children are eligible for life insurance coverage
  - **Spouse-** $4.50/ $15,000 or $6.00/ $20,000
    - Medical Underwriting
  - **Dependent** $.85-$10,000 in coverage
  - Employee is the beneficiary on all spouse and dependent policies

Tips

- Encourage employees to visit the myBenefits website when they have questions about their benefits
- Remind employees to review their current Benefits Statement
- Employees may contact the People First Service Center regarding benefits
- Contact JAC if the employee has any problems with their enrollment

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Emergency Reinstatements

- Only health insurance
- Must be a true emergency
  - Employee, or their dependent, needs **immediate/ urgent** medical treatment or required medicines
- Must follow emergency reinstatement rules
  - Employee provides payment for underpayment
  - A copy of the payment is sent to JAC via email
  - You place payment in the mail for employee

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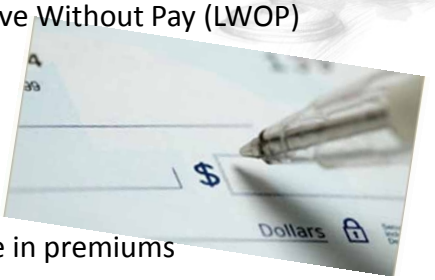
When to Send Payment to People First

- Initial enrollment after payroll cutoff
  - Health insurance only
- While employee is on Leave Without Pay (LWOP)
  - FMLA
  - Personal
  - Suspension
  - Military
- When there is an increase in premiums
  - Optional Life
  - Going from individual to higher coverage level



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Danger Zones

- Please remember People First and JAC can not accept paper enrollment forms.
- Employees must complete their own enrollments online; however, you can assist them or they can contact the People First Service Center if needed.
- If the employee is having trouble enrolling online, they should call the People First Service Center for assistance.
- Please do not use an employee's People First number to enroll as the employee.
- Remind employees to print confirmation(s) for their records.
- **Dependent Social Security numbers and information must be accurate; an IRS penalty can result.**

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Questions?

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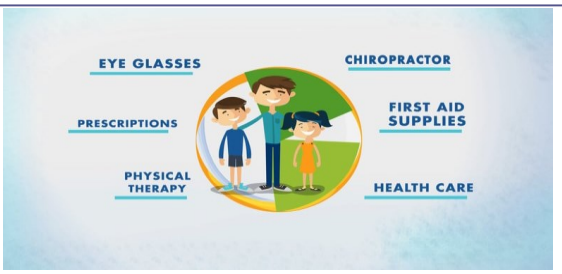
Flexible Spending Accounts



Flexible Spending and Tax Favored Accounts

- Health Care FSA (formerly known as MRA)
  - Standard HMO and PPO Members
  - Maximum Annual Contribution
    - $2,600 per year or $216.66 per month
- Health Savings Account (HSA)
  - Health Investor HMO and PPO – Only with HIHP Plan
  - Maximum Annual Contribution (includes State Contribution)
    - Individual = $3,400
    - Family = $6,750
- Limited Purpose FSA (formerly known as LPMRS)
  - Only for Employees Enrolled in the Health Investor HMO and PPO
  - Maximum Annual Contribution
    - $2,600 per year or $216.66 per month
  - Can only be used for preventative care expenses not covered by health plan, dental, and vision
- Dependent Care FSA (formerly known as DCRA)
  - Maximum Annual Contribution
    - $5,000 per year or $416.00 per month
  - **Dependent Care Only**

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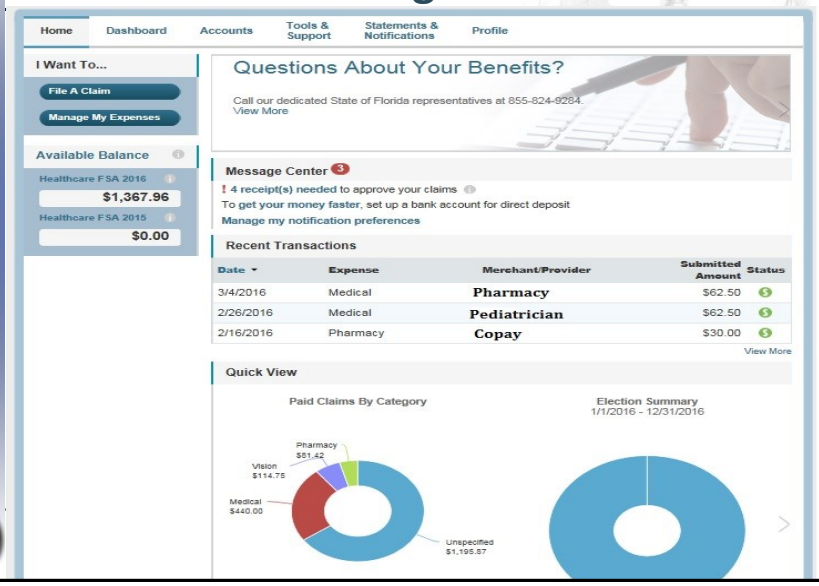
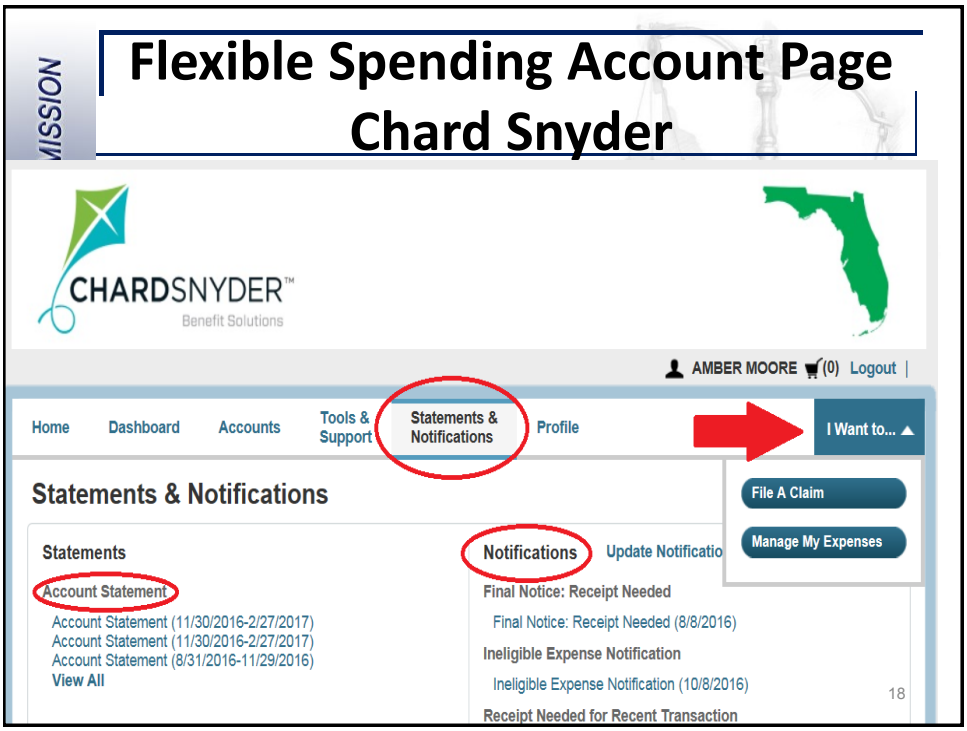
Chard Snyder Tax Favored Account Login



Flexible Spending Account Page Chard Snyder



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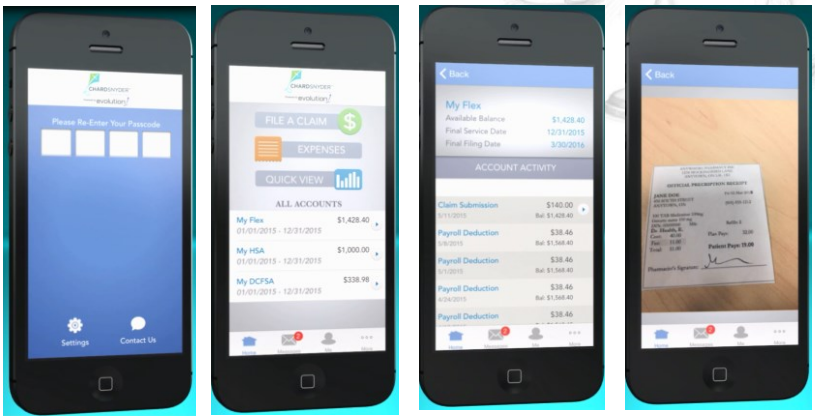
Chard Snyder Mobile App



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Benny Card

The easiest way to access the funds in your FSA accounts is to use your Benny *MasterCard* debit card. When you pay with the card, your purchase amount is deducted from the appropriate balance in your Flexible Spending Account. Certain payments will require further verification, **so please hold on to your itemized bills and receipts**. Custom Design Benefits will request documentation only when it is needed.

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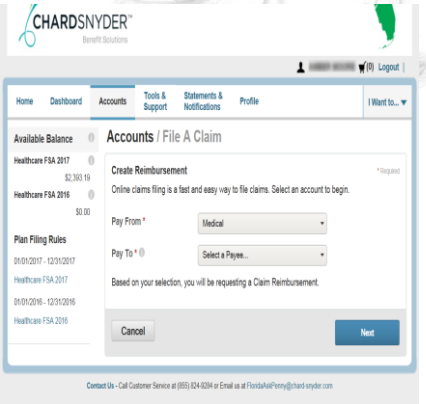
How Do I Get My Money If I Didn't Use My Benny Card?

- **Complete a CLAIM FORM only if your Benny card was not used.**
  - **Medical-** Complete required information on claim form. The claim can be submitted online through People First/ FSA & HSA Information.
  - Vision and Dental
  - **Dependent Care-** Complete required information on the claim form and upload or attach receipt for expenses from Dependent Care Provider.



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FSA/HSA Claim Forms

- Online Claim Submission
- Claim forms can be downloaded from the Chard Snyder website.
  http://www.chard-snyder.com/
  - Enter website
  - Go to forms at the top of the page
  - Select the appropriate claim form

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Account Options When Employment Ends

- Flexible Spending Account Options When Employment Ends Form
- Current Status of Medical Reimbursement Account
- Participation Options
- Payment Options

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Questions?

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State Group Disability Coverage SMS/SES Employees

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SMS/SES Disability

- Definitions
- Eligibility and Enrollment
- Exclusions
- Effective Date of Coverage
- Cost
- Benefits
- Filing a Claim
- Termination of Benefits
- Required Documentation

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Definitions

- Basic Daily Earnings
- Employee
- Physician
- Sickness/ Injury
- Total Disability

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State Group Disability Income Plan Benefit

State Group Disability Income Plan Certificate

II. Calculation of Benefits

The following worksheet may be used to estimate the Plan benefit.

Step 1: Annualize Salary[1]

a. Employees paid biweekly multiply their gross biweekly pay amount times 26.1.

$_____ (biweekly pay) x 26.1 = $_____ (annual salary)

b. Employees paid monthly multiply their gross monthly pay times 12.

$_____ (monthly pay) x 12 = $_____ (annual salary)

Step 2: Determine Basic Daily Earnings

Divide annual salary by 364 benefit days to determine Basic Daily Earnings.

$_____ (annual salary) ÷ 364 = $_____ (Basic Daily Earnings)

Step 3: Estimate Daily Benefit

Multiply the Basic Daily Earnings by 65% to estimate the daily benefit.

$_____ (Basic Daily Earnings) x .65 = $_____ (daily benefit)

Reminder: the benefit will be reduced if you are receiving other disability benefits as described in section G above.

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Cost of Disability Coverage

- Employer Paid Premium
- Voucher Processing
- Underpaid Premium

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Eligibility and Earnings

- The “first benefit day”
- Leave Status
- Reduction of Benefit
- Suspension of Benefit

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Filing a Claim

- Employee Coverage
- State Group Disability Income Plan Claim Form
- Resubmission of Forms and Documents
- Physician's Statement

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Employee & Employer

SGI-09
11/15

III. State Group Disability Income Plan Claim Form
A. Employee and Agency

People First
STATE OF FLORIDA HR

Employee Information - All Fields Required:

People First ID: 0 0
First Name:
Last Name:
Complete Mailing Address:
Birth Date: ___/___/___ Male: ___ Female: ___
Work Phone: (___) Home Phone: (___)

1. I have been unable to work because of this disability since: ___/___/___
   a. I returned to work on a part-time basis on: ___/___/___
   b. I returned to work on a full-time basis on: ___/___/___
2. Date of your accident or the date you first noticed symptoms of your illness: ___/___/___
   a. Is your accident or illness related to your occupation? Yes ___ No ___
   b. If Yes, explain:
3. Describe how and where the accident occurred or describe the first symptoms of your illness.
4. Date you were first treated for your illness or injury: ___/___/___
   Treated by: Hospital's Name/Address:
   Doctor's Name/Address:
5. Have you ever had the same or similar condition in the past? Yes ___ No ___
   Treated by: Hospital's Name/Address:
   Doctor's Name/Address:
6. Are you receiving, or are you eligible to receive, income from any of the following sources?

Yes	No	Benefits	Weekly Income	Date Income Began/Begins	Date Ended/Ends
		a. Worker's Compensation Benefits			
		b. Retirement or Disability Benefits under the State of Florida Retirement System			
		c. Primary and/or Family Benefits under the Social Security Act			

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or their person who has attended me or examined me, or any company or government agency to furnish People First, or thei representative, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits an copies of all applicable records. A photostatic copy of this form will be as valid as the original. I also understand that I must immediately contact People First or their representative, upon approval for or receipt of payment of any of the above benefits

Employee's Signature: Date:

Employer Information - To be Completed by Agency Human Resource Office - All Fields Required:

Date of Hire	Effective Date of Insurance	Last Day Worked	Reason for Stopping Work	Date Returned to Work	Occupation at Time of Disability

1. Is the employee entitled to benefits by virtue of employment? Yes ___ No ___ 2. Biweekly earnings at time of disability: $ ___
3. Employee is eligible for accumulated accident/sick leave time as of date of disability for ___ weeks and ___ days, ending on ___
4. State Regular or Disability Retirement Benefit $ ___ per week. 5. Worker's Compensation Benefits $ ___ per wee

Name & Address of Employer:

Title: Phone Number: (___) Date:
Print Name: Signature:

A person who knowingly files a statement of claim containing any false, incomplete or misleading information maybe guilty of a crime and subject to criminal prosecution.

Send Parts A and B of this form to People First Service Center • PO Box 6830 • Tallahassee, FL 32314 or fax to (800) 422-3128
You must resubmit the completed form to People First every 60 days of your Total Disability.

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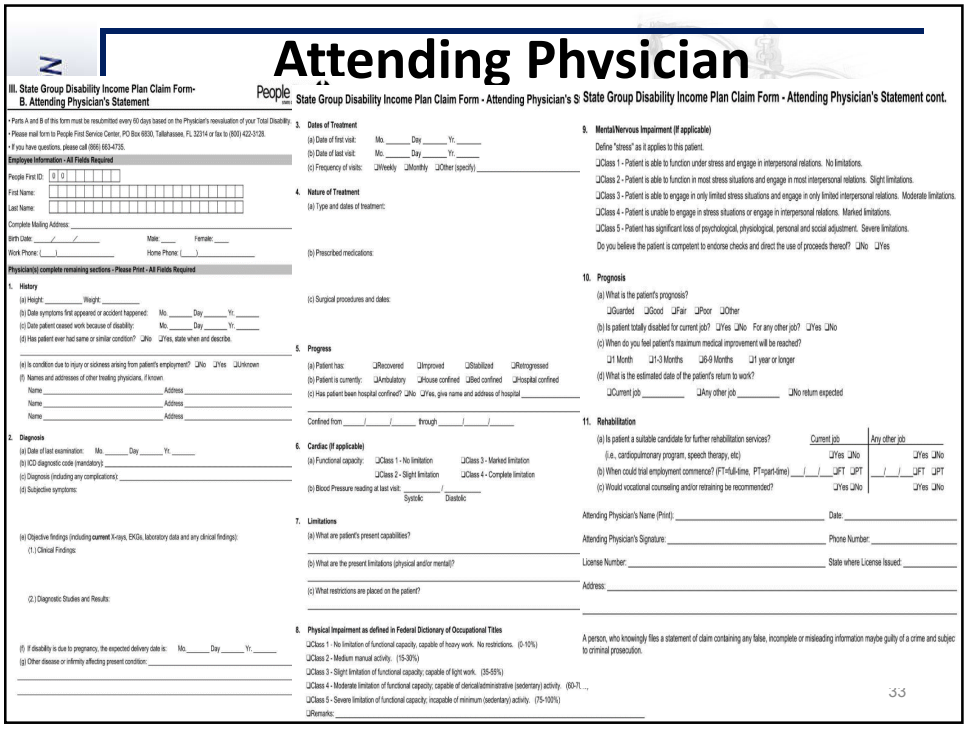
Attending Physician



III. State Group Disability Income Plan Claim Form-
B. Attending Physician's Statement

People First

State Group Disability Income Plan Claim Form - Attending Physician's S

State Group Disability Income Plan Claim Form - Attending Physician's Statement cont.

• Parts A and B of this form must be resubmitted every 60 days based on the Physician's reevaluation of your Total Disability.
• Please mail form to People First Service Center, PO Box 6830, Tallahassee, FL 32314 or fax to (800) 422-3128.
• If you have questions, please call (866) 663-4735.

Employee Information - All Fields Required

People First ID: 0 0
First Name:
Last Name:
Complete Mailing Address:
Birth Date: ___/___/___ Male: ___ Female: ___
Work Phone: (___)_____ Home Phone: (___)_____

Physician(s) complete remaining sections - Please Print - All Fields Required

1. **History**
(a) Height: _____ Weight: _____
(b) Date symptoms first appeared or accident happened: Mo. _____ Day _____ Yr. _____
(c) Date patient ceased work because of disability: Mo. _____ Day _____ Yr. _____
(d) Has patient ever had same or similar condition? ☐No ☐Yes, state when and describe.
(e) Is condition due to injury or sickness arising from patient's employment? ☐No ☐Yes ☐Unknown
(f) Names and addresses of other treating physicians, if known
Name _____ Address _____
Name _____ Address _____
Name _____ Address _____

2. **Diagnosis**
(a) Date of last examination: Mo. _____ Day _____ Yr. _____
(b) ICD diagnostic code (mandatory): _____
(c) Diagnosis (including any complications): _____
(d) Subjective symptoms:
(e) Objective findings (including **current** X-rays, EKGs, laboratory data and any clinical findings):
(1.) Clinical Findings:
(2.) Diagnostic Studies and Results:
(f) If disability is due to pregnancy, the expected delivery date is: Mo. _____ Day _____ Yr. _____
(g) Other disease or infirmity affecting present condition: _____

3. **Dates of Treatment**
(a) Date of first visit: Mo. _____ Day _____ Yr. _____
(b) Date of last visit: Mo. _____ Day _____ Yr. _____
(c) Frequency of visits: ☐Weekly ☐Monthly ☐Other (specify) _____

4. **Nature of Treatment**
(a) Type and dates of treatment:
(b) Prescribed medications:
(c) Surgical procedures and dates:

5. **Progress**
(a) Patient has: ☐Recovered ☐Improved ☐Stabilized ☐Retrogressed
(b) Patient is currently: ☐Ambulatory ☐House confined ☐Bed confined ☐Hospital confined
(c) Has patient been hospital confined? ☐No ☐Yes, give name and address of hospital _____
Confined from ___/___/___ through ___/___/___

6. **Cardiac (If applicable)**
(a) Functional capacity: ☐Class 1 - No limitation ☐Class 3 - Marked limitation
☐Class 2 - Slight limitation ☐Class 4 - Complete limitation
(b) Blood Pressure reading at last visit: ___/___ Systolic Diastolic

7. **Limitations**
(a) What are patient's present capabilities?
(b) What are the present limitations (physical and/or mental)?
(c) What restrictions are placed on the patient?

8. **Physical Impairment as defined in Federal Dictionary of Occupational Titles**
☐Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions. (0-10%)
☐Class 2 - Medium manual activity. (15-30%)
☐Class 3 - Slight limitation of functional capacity; capable of light work. (35-55%)
☐Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60-7[illegible]...
☐Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75-100%)
☐Remarks: _____

9. **Mental/Nervous Impairment (If applicable)**
Define "stress" as it applies to this patient.
☐Class 1 - Patient is able to function under stress and engage in interpersonal relations. No limitations.
☐Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations. Slight limitations.
☐Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. Moderate limitations.
☐Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. Marked limitations.
☐Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment. Severe limitations.
Do you believe the patient is competent to endorse checks and direct the use of proceeds thereof? ☐No ☐Yes

10. **Prognosis**
(a) What is the patient's prognosis?
☐Guarded ☐Good ☐Fair ☐Poor ☐Other
(b) Is patient totally disabled for current job? ☐Yes ☐No For any other job? ☐Yes ☐No
(c) When do you feel patient's maximum medical improvement will be reached?
☐1 Month ☐1-3 Months ☐6-9 Months ☐1 year or longer
(d) What is the estimated date of the patient's return to work?
☐Current job _____ ☐Any other job _____ ☐No return expected

11. **Rehabilitation**

	Current job	Any other job
(a) Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc)	☐Yes ☐No	☐Yes ☐No
(b) When could trial employment commence? (FT=full-time, PT=part-time)	___/___/___ ☐FT ☐PT	___/___/___ ☐FT ☐PT
(c) Would vocational counseling and/or retraining be recommended?	☐Yes ☐No	☐Yes ☐No

Attending Physician's Name (Print): _____ Date: _____
Attending Physician's Signature: _____ Phone Number: _____
License Number: _____ State where License Issued: _____
Address: _____

A person, who knowingly files a statement of claim containing any false, incomplete or misleading information maybe guilty of a crime and subject to criminal prosecution.

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Questions?

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Under/Overpayment Benefits Report

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Under/Overpayment Benefits Report

- Overview of Under/Overpayment Report
- How to read the Under/Overpayment Report
- What Causes Under/Overpayments in Benefits Premiums
- State Premium Amount Underpaid
- Employee and Employer Refunds and Move Money Requests
- Employee Underpayment in Premiums

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What is the Under/Overpayment Benefits Report?

- The report identifies employees and employers whose benefits are either underpaid or overpaid for the requested coverage period.

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What Does the Under/Overpayment Report Show?

- Employee Underpayment
- Employer Underpayment
- Employee and Employer Overpayment
- Move Money Request

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Under/Overpayment Fields

- **Employee Due:** Employee contribution due for the insurance plan for the coverage month.
- **Employee Paid:** Employee contribution paid for the insurance plan for the coverage month.
- **Employee Variance:** Employee underpayment or overpayment amount for the insurance and coverage month.
- **Employer Due:** Employer contribution due for the insurance plan for the coverage month
- **Employer Paid:** Employer contribution paid for the insurance plan for the coverage month
- **Employer Variance:** Employer underpayment or overpayment amount for the insurance plan and coverage month

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Circuit Role and JAC Role

- Circuit:
  - Review Under/Overpayment Report
  - Inform Employee's of Underpayments
- JAC:
  - Request all overpayment refunds from People First for both employee and employer
  - Create JT Back-up Documentation for Voucher
  - Voucher Underpaid Portion
  - Submit Move Money Request to People First

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How to Read Under/Overpayment Report

USER ID	NAME	PLAN TYPE DESC	COVERAGE PERIOD	EMPLOYEE DUE	EMPLOYEE PAID	EMPLOYEE VARIANCE	EMPLOYER DUE	EMPLOYER PAID	EMPLOYER VARIANCE	ACTION
123456	SPONGE BOB	HEALTH	01/01/2017 - 01/31/2017	30	180	150	1529.6	1529.6	0	EE Due Refund
123456	SPONGE BOB	HEALTH	02/01/2017 - 02/28/2017	30	180	150	1529.6	1529.6	0	EE Due Refund
123456	SPONGE BOB	HEALTH	03/01/2017 - 03/31/2017	30	30	0	1529.6	1229.6	-300	Voucher Needed for State Underpayment
954874	HARRY POTTER	OPTIONAL LIFE	03/01/2017 - 03/31/2017	14.79	14.46	-.33	0	0	0	EE Owes Premium
650648	NORMA JEAN BAKER	HEALTH	03/01/2017 - 03/31/2017	15.78	0	-15.78	0	0	0	EE Owes Premium
620456	BURT RENYOLDS	OPTIONAL LIFE	02/01/2016 - 02/29/2016	2.62	2.43	-.19	0	0	0	EE Owes Premium
115789	CORNELIUS CHASE	HEALTH	03/01/2017 - 03/31/2017	180	0	-180	1529.6	1529.6	0	EE Owes Premium
8963458	JUDY GARLAND	DENTAL	02/01/2016 - 02/29/2016	78.25	60.15	-18.10	0	0	0	EE Owes Premium
5874698	BOB BARKER	HEALTH	03/01/2017 - 03/31/2017	30	30	0	1529.6	3059.2	1529.6	Move Money Request
5874698	BOB BARKER	HEALTH	04/01/2017-04/30/2017	30	30	0	1529.6	0	-1529.6	Move Money Request

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What Causes Under/Overpayments?

- Pay Increase
- Position Changes
- QSC Events
- New Hire/Payroll Cutoff
- LWOP
- Termination
- People First
- Warrant Cancellation/On-demand
- Supplemental Payroll
- Personal Payment- Employee
- Voucher
- Age/Date of Birth

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Questions?

"Nurse, get on the internet, go to SURGERY.COM, scroll down and click on the 'Are you totally lost?' icon."

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Contact Information

- JAC Contacts
  - State Attorney Offices
    - Call Amber Moore at 850-488-2415 or email at benefits@justiceadmin.org
  - Public Defender Offices, Guardian Ad Litem Offices, Capital Collateral Regional Offices and Criminal Conflict and Civil Regional Offices
    - Call Amy Maros at 850-488-2415 or email at benefits@justiceadmin.org
- People First
  - Call at 866-663-4735
  - Fax at 800-422-3128
  - https://peoplefirst.myflorida.com/peoplefirst(bD1IbiZjPTIzMA==)/logon.htm

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