

Featuring Some of the
Lowest Rates Available In
Florida's Pre-tax Program



Hospital Income Plan

A pre-tax insurance plan for employees with the State of Florida

HOSPITAL INCOME

HOME HEALTH CARE

CONVALESCENT CARE

EXTENDED CARE



Hospital Income Plan

This is a hospital income plan. The plan is also an ideal supplement plan for State of Florida Employees who choose an HMO. It is also beneficial for employees using both preferred and non-preferred providers to help offset the out-of-pocket expenses when confined to a hospital.

EXPANDED COVERAGE RIDER

For a modest premium, you will receive \$100.00 or \$200.00 for each night of room and board charges made by the hospital. Additionally, if you enroll in the \$100.00 per day benefit with the Expanded Coverage Rider (ECR), you will receive an additional \$200.00 per night of room and board charges for the 4th through the 10th night of your inpatient hospital stay. There is a maximum \$1,400.00 benefit per illness or injury, unless 90 days separate hospital stays for same or related cause.

After one or more days of hospital confinement, other benefits include:

HOME HEALTH CARE

50% of the daily benefit **for up to 30 days** per illness or injury, provided confinement in a convalescent care facility is not required.

CONVALESCENT CARE FACILITY OR HOSPICE CARE

60% of the daily benefit **for up to 30 days** per illness or injury, or **for up to 45 days if enrolled in the \$100.00 per day plan with ECR!**

EXTENDED CARE FACILITY

90% of the daily benefit **for up to 30 days** per illness or injury, or **for up to 45 days if enrolled in the \$100.00 per day plan with ECR**, provided a surgical procedure caused the need for such extended care!

AMBULATORY SURGICAL PROCEDURE

If an insured is not confined in a hospital but sickness or injury requires surgery in an ambulatory surgical center and the use of a recovery room after surgery, **\$100.00 per visit will be paid!**

THERE ARE NO CALENDAR YEAR MAXIMUMS EXCEPT ON THE DAILY BENEFIT WHICH IS 365 DAYS PER ILLNESS OR INJURY!

Hospital confinements that are more than 90 days apart are considered to be the result of a new injury or illness and subject to a new maximum benefit period.

Benefits are paid directly to the Employee; benefits are not paid to the HMO or hospital unless the employee chooses otherwise.

Premiums for the Hospital Income Plan

Plan	\$100 Per Day (#8160)	\$100 Per Day w/ECR (#8180)	\$200.00 Per Day (#8170)
Employee Only	\$9.58 Monthly \$4.79 Biweekly	\$12.92 Monthly \$6.46 Biweekly	\$20.36 Monthly \$10.18 Biweekly
Employee/One Dependent	\$19.20 Monthly \$9.60 Biweekly	\$25.86 Monthly \$12.93 Biweekly	\$40.60 Monthly \$20.30 Biweekly
Employee/Two or More Dependents	\$25.18 Monthly \$12.59 Biweekly	\$32.72 Monthly \$16.36 Biweekly	\$53.52 Monthly \$26.76 Biweekly

Important Notice: This brochure provides general information about the policy described. It is not a contract. Only the actual policy provisions issued by New Era Life Insurance Company will control.

FREQUENTLY ASKED QUESTIONS

1. Why choose the New Era Life Insurance Company (NELIC) hospital income plan?

The New Era Life Insurance Company (NELIC) hospital income plan offers a low cost option in the state pre-tax supplemental program. Additionally, the rates for the NELIC plan have not increased in the last 6 consecutive years.

2. Who is eligible to enroll in the NELIC Plan?

All permanent employees of the State of Florida under age 66 as of the effective date of coverage, together with their eligible dependents. Eligible dependents include your spouse under age 66 as of the effective date of coverage and all unmarried dependent children up to age 26. If you are currently enrolled and you and/or your spouse are over age 65, you may not increase your coverage.

3. Until what age can I continue this coverage for myself and my dependent spouse?

You may continue coverage for yourself and your spouse for as long as you continue to be employed by the State of Florida. However, if you terminate your employment prior to age 70, you may convert this policy by notifying the Company within 31 days of your termination date. The conversion policy will have similar benefits and the premiums will be the rates charged by the Company for individual policies. The Expanded Coverage Rider (ECR) does not apply to converted policies. All converted policies will terminate at age 70.

4. Why should I buy the NELIC Plan?

Because it is a simple, easy to understand, generous plan at an affordable cost. For a modest premium, you receive \$100.00 or \$200.00 for each night of room and board charges made by the hospital, while you or an insured family member are hospitalized, to use to help pay the medical and hospital costs that may not be covered by the State Employees' PPO Plan, your HMO, or other insurance plan. It also provides benefits for treatment in an ambulatory surgical center when a recovery room is required, convalescent care confinement, extended care confinement and home health care (in lieu of convalescent care confinement only.) Please refer to the terms of policy for further details.

5. What is the Expanded Coverage Rider?

The Expanded Coverage Rider (ECR) adds an additional \$200.00 per day beginning with the 4th night of hospitalization and continuing through the 10th night of

hospitalization. This gives you additional funds in more serious cases. It also expands the Hospice Care, Convalescent Care Facility, and Extended Care Facility Coverage to 45 days. However, a maximum of 7 days ECR benefit (\$1,400) will be paid for each illness or injury. Hospital confinements, which are more than 90 consecutive days apart, are considered to be the result of a new injury or illness and subject to a new maximum benefit period.

6. What if I use the maximum number of days in the hospital, convalescent care facility or hospice, home health care or extended care? Does that mean that I have no more benefits in the policy?

You still have benefits! Hospital confinements which are more than 90 consecutive days apart are considered the result of a new injury or illness and are subject to a new maximum benefit period.

7. I am a single parent with one child. Must I pay the full family rate?

No. If you are a two-person family, whether two adults or an adult with one child, you just pay a two-person rate. The full family rate is payable only if there are three or more insured in the family.

8. Can I add or delete a spouse or child from my coverage?

Participants can only add or delete a dependent during the open enrollment or when they experience a qualifying status change (QSC) event. QSC events include marriage or divorce, death of a spouse or dependent, birth, adoption or legal guardianship, or change in a dependent's eligibility. Participants who experience a QSC event and wish to change their coverage (not the daily benefit), must do so through the People First Service Center within 60 days of the event, and provide the required documentation.

9. Are there any exclusions in the plan?

Yes. Not covered are mental or nervous disorders beyond 30 days of coverage for any one illness (but hospitalizations separated by 90 consecutive days or more are considered new illnesses); confinements in a V.A. or government hospital unless, in the absence of insurance, there is a legal obligation for you to pay for the confinement; certain types of cosmetic surgery; or hospitalization for a condition for which the covered person received medical treatment or consultation, had medical care or services including diagnostic measures or prescribed drugs or medications within the 90 days prior to the start date of this insurance until after a period of 90 days following the effective

date; and Workers' Compensation or Occupational Disease cases (because these normally would be at no cost to you).

10. I have an illness for which I see my physician on a regular basis and for which I take prescription medication. If I require hospitalization as a result of this illness, will I be covered and when will my coverage begin?

If you have received medical treatment or consultation, had medical care or services including diagnostic measures, or prescribed drugs or medications within 90 days prior to the start of this insurance, you will not be covered for that illness until 90 days after the insurance effective date.

11. Do I have to wait for my State Health Insurance, HMO or other coverage to pay before I file my claim for the NELIC Plan?

No. After your hospital stay you can contact the hospital billing department to request a UB92 or UB04. This along with your Statement of Employment Form will help to process your claim. Payment is usually made within 7 working days from the time that we receive this information.

12. I already have this insurance. Can I increase the daily benefit or add the Expanded Coverage Rider?

Yes, during open enrollment. You must complete a new company application and also submit an enrollment form to the People First Service Center or <https://peoplefirst.myflorida.com/peoplefirst> for any changes that you make to your existing plan (i.e. adding/deleting dependents, adding/deleting ECR, changing daily benefit, etc.) The ECR is available only on the \$100.00 per day plan. The pre-existing condition provision will only apply to the addition of coverage or dependents. You cannot add benefits or increase your coverage if you or your spouse reach age 66 by the January 1st effective date following open enrollment.

13. How do I get a claim form?

Call our toll free number (800) 277-2300 and ask for the Hospital Income Benefits Department.

14. How long do I have to file my claim? You have a 15 month period from date of service to file claims. All claims must be filed promptly.