2 DIRECTORY

EMPLOYER

Duval County Public Schools (DCPS)
Employee Benefits Department
Mon - Fri, 7:30 a.m. - 4:30 p.m. ET
(904) 390-2351
www.duvalschools.org

PROVIDER COMPANIES

American Family Life Assurance Company of Columbus (AFLAC)
(Personal Cancer Expense*)
(Hospital Intensive Care*)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-992-3522
www.aflac.com
* AFLAC policies are no longer sold. If you are a current AFLAC customer, you may continue the policy currently in force.

Allstate Benefits,
AHL American Heritage Life Insurance Co.
Group# 63103
Group Voluntary Hospital Indemnity Insurance
(Hospital Indemnity Insurance)
(Critical Illness Insurance)
Claims (AWD)
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-348-4489
www.allstatebenefits.com
* Allstate individual SHOP policies are no longer sold. If you are a current Allstate individual SHOP customer, you may continue the policy currently in force.

Corporate Care Works
(Employee Assistance Program)
24-Hour Careline: 1-800-327-9757
Mon - Fri, 8 a.m. - 5 p.m. ET
(904) 296-9436
www.corporatecareworks.com

Davis Vision (Client Code# 3651)
Customer Service
Mon - Fri, 8 a.m. - 11 p.m. ET
1-877-923-2847
www.davisvision.com

Delta Dental Deltacare
Group# 70944-00002 & 00003
Customer Service
Mon - Fri, 8 a.m. - 9 p.m. ET
1-800-422-4234

Delta Dental PPO (Group# 01441-00001)
Customer Service
Mon - Fri, 8:00 a.m. - 8:00 p.m. ET
1-800-521-2651
www.deltadentalins.com

FBMC Benefits Management, Inc.
(Contract Administrator)
Service Center
Mon - Fri, 7 a.m. - 8 p.m. ET
1-855-5MY-DCPS (1-855-569-3277)
Onsite Representative:
Wiley Gray (904) 390-2349
Earnesteen Townsend (904) 390-2354
www.myFBMC.com

Florida Blue
(Medical Plan)
Group# 78155
Customer Service
M-Thu, 8 a.m. - 9 p.m. ET, Fri 9 a.m.- 9 p.m. ET
1-800-664-5295
Onsite Representative:
Pat Lewis (904) 390-2323
www.floridablue.com

Florida Retirement System (FRS)
Bureau of Retirement Calculations
1-888-738-2252
Enrollment Section
1-877-377-3675
www.myfrs.com

PayFlex Systems USA, Inc.
COBRA
Customer Care
1-855-5MY-DCPS (1-855-569-3277)
Mon - Fri, 8 a.m. - 8 p.m. ET
www.payflex.com

Prime Therapeutics
(Pharmacy)
Customer Service 24-Hours
1-888-849-7865
www.myprime.com

Standard Insurance Company
(Group Term Life)
Group #158390
M-F, 9:00 a.m. to 8:00 p.m. EST
1-800-348-3226
www.standard.com

Trustmark Insurance Co.
(Life)
(Accident Insurance)
(Critical Illness)
(Universal Life)
(Universal LifeEvents®)
Customer Service
Mon - Thurs, 8 a.m. - 8 p.m. ET
Fri 8 a.m. - 7 p.m. EST
1-800-918-8877
www.trustmarksolutions.com

Unum Short & Long Term Disability
1-800-633-7479
Short Term Disability Claim
(Group# 23310021)
1-888-857-0157
Long-Term Care*
(Group# 23310011)
1-800-227-4165
* Unum LTC policies are no longer sold. If you are a current Unum LTC customer, you may continue the policy currently in force.

Whole Life Insurance (Group# 40033)
Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-800-635-5597
www.unum.com

WageWorks
(FBMC Benefits Management, Inc.'s Outsource Partner)
(Flexible Spending Accounts)
Customer Service
Mon-Fri, 8 a.m. - 8 p.m. ET
1-855-5MY-DCPS (855-569-3277)
Automated Services
24 hours a day
1-800-865-FBMC (3262)
Toll-Free Claims Fax
1-855-291-0625
US Mail: CLAIMS ADMINISTRATOR-FBWW,
P.O. Box 14326
Lexington, KY, 40512
www.wageworks.com

WageWorks Health Care Card
(Lost or Stolen Card)
1-888-462-1909
(Dispute Line)
1-855-428-0446
www.wageworks.com

Zurich North America
(Voluntary Accidental Death and Dismemberment)
Group# GTU 5091403
Customer Service
1-866-841-4771 or 1-800-887-9111
www.zurichna.com

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Availability of Summary Health Information

Choosing a health care coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the DCPS Employee Benefits website at: www.duvalschools.org/benefits. A paper copy is also available, free of charge, by calling (904) 390-2351.

Certificate of Coverage

The materials contained in this guide do not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusions of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance and posted on the DCPS Employee Benefits website at www.duvalschools.org/benefits.

The School Board of Duval County, Florida reserves the right to amend or to terminate the plans described in this guide at any time, subject to the specific restrictions, if any, in the collective bargaining agreement. In the event of any such amendment or termination, your coverage may be modified or discontinued and the School Board assumes no obligation to continue the benefits or coverages described in this guide.

2015 Open Enrollment
October 6 – November 7, 2014

Welcome to the 2015 Benefits Open Enrollment. This open enrollment is for benefits effective January 1, 2015 through December 31, 2015. Open Enrollment is your annual opportunity to switch, add, adjust or cancel insurance and/or add or remove a spouse or dependent(s) from insurance(s). You are encouraged to read your Online Employee Benefits Guide which provides the information necessary to help you decide the benefits that are right for you. It is also a good tool to refer to throughout the year.

DCPS is committed to providing security for you and your family by offering a comprehensive and affordable benefits program. The diligent efforts of the Superintendent of Schools, School Board Members, employee unions and associations continue to demonstrate the result of an excellent partnership. Your benefits are a valuable part of your employment with DCPS. Be sure you are making the most of them. **Remember: It is your responsibility to read the benefit plan information before making your elections.**

All benefit-eligible employees actively at work will have the opportunity to review current benefits, initiate changes and enroll online at www.myFBMC.com or schedule an appointment with an enrollment counselor at your worksite location. Visit www.myenrollmentschedule.com/schedules/967 to view the date and time enrollment counselors will be at your locations. Evening and Saturday appointments will also be available.

Good news!

- Medical Rates ***Unchanged!*** – No medical plan rate increases for the 2015 plan year; rates will remain the same.
- Dental Rates ***Decreased!*** – We are pleased to announce that premium rates for the Delta Dental Plans are decreasing by 4%.
- Vision Rates ***Decreased!*** – Vision rates are decreasing by 23% for the single tier and 20% for the family tier.
- Group Life Insurance Rates ***Decreased!*** – Life insurance rates for the Basic Life/Accidental Death & Dismemberment are decreasing by 41% and the Supplemental Life/Accidental Death & Dismemberment rates are decreasing by 8%.

DUVAL COUNTY
PUBLIC SCHOOLS

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What's new for 2015?

- **Declination of Medical Coverage Opt-out Program** ***New!*** – Benefit-eligible employees may elect to opt-out of medical insurance coverage during the annual open enrollment period – ***you must meet with an enrollment counselor to opt-out:*** If you do not provide the completed Declination of Medical Coverage Affidavit and proof of other group employer or government funded medical coverage (i.e., Medicaid, Medicare, TRICARE) at the time of your enrollment session, your medical coverage will automatically be carried forward from the 2014 plan year.
  Note: If you choose to opt-out of medical, you are still eligible for dental and/or vision coverage, and all other voluntary benefits.
- **Employer-sponsored Life Insurance Carrier** ***New!*** – DCPS is pleased to introduce Standard Insurance Company as the new carrier for its board-paid $10,000 Group Term Basic Life/Accidental Death & Dismemberment (AD&D), and Additional Supplemental Life Insurance, effective January 1, 2015.

  Guaranteed Issue – For the 2015 Open Enrollment Period, all benefit-eligible employees of DCPS are able to elect up to three times their annual salary or a flat $50,000 in life insurance coverage without medical underwriting approval, not to exceed $310,000.

  Note: All employees must update their beneficiary information.
- **Vision Care Carrier** ***New!*** – The DCPS vision plan is changing to Davis Vision. If you're currently enrolled in the vision plan and don't want to make changes, your current elections will continue with the new carrier for the 2015 plan year.
- **Dental DPO Benefit Maximum Increased** – 2015 calendar year benefit maximum for the Delta Dental DPO plan has increased from $2,000 to $5,000.
- **$250 Flex Benefit** – Leftover dollars from the $250 board-paid flex benefit will no longer be placed on an MFSA Card/DFSA account or placed in an HSA account. Any leftover flex dollars will now be added into the employee's payroll check.
- **High Deductible Health Plan** – Per IRS regulations, the 2015 calendar year deductibles for the HDHP changed to – In-network Single - $1,300 / Family - $2600; Out-of-Network Single - $2,600 / Family - $5,200.00. 2015 HSA limits: Single – $3,350.00 Family - $6,650.00 which includes employee and employer contributions.

Who should participate?

Mandatory Beneficiary Update - All employees must update their beneficiary information. There will be an enrollment option for those who wish to only update beneficiary information and not make changes to current benefit elections.

Employees who wish to make changes and/or hear about new benefits can meet with an enrollment counselor to review current benefit elections and choose benefits for the new plan year effective January 1, 2015. New enrollments are required when making changes to benefits or adding/dropping dependents.

You *MUST* complete an enrollment if you contribute your own dollars to the Medical Flexible Spending Account (MFSA), Dependent Flexible Spending Account (DFSA) or Health Savings Account (HSA). Please note the following:

- Employee-contributions to MFSA or DFSA
  - Prior year contributions **WILL NOT** automatically roll-over.
  - Employee-contributions through payroll deductions to the MFSA/DFSA must be elected at your enrollment session.
  - Employees **WILL** lose any unused flex spending account funds from the prior plan year.

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- Employee-contributions to a HSA
    - Employee-contributions through payroll deductions to the HSA must be elected at your enrollment session.
    - Employees **WILL NOT** lose any unused HSA funds from the prior plan year.

If you **DO NOT** wish to make any changes to your current benefit elections **AND** you **DO NOT** make employee contributions to a MFSA, DFSA, or HSA, your current coverage will automatically be carried forward from the 2014 plan year.

Is dependent verification required this year?

All **newly** added dependents will be required to provide dependent verification. Employees may bring the documentation to an enrollment counselor to verify their relationship to dependent(s) that were not covered during the 2014 plan year. Documents will be reviewed and returned at the time of the enrollment session. See the Dependent Eligibility section of the online enrollment guide for a list of the required documents.

Things to know:

- Employees who elect the DCPS Contributory Medical Plan will have employer contributions to the Medical Flexible Spending Account (MFSA) for the 2015 plan year ($450 –Single coverage / $750-Dependent coverage)
- Employees who elect the DCPS Non-Contributory Plan will not have employer contributions to the MFSA.
- The MFSA maximum contribution for 2015 is $2,500, which includes employee and employer contributions.
- Both DCPS Contributory and Non-Contributory Medical Plans allow for employee contributions to the MFSA.
- Employees who elect the DCPS High Deductible Health Plan will have employer contributions to the Health Savings Account (HSA) for the 2015 plan year ($678.52). Employees can also contribute to the HSA.
- All employees will receive the $250 Flex dollars to help reduce any pretax deductions, excluding Group Life Insurance.
- Newly hired employees who do not meet with an enrollment counselor or enroll online will automatically be optioned with the following plans: Board-paid DCPS Non-Contributory "Employee Only" medical plan, $10,000 basic life and $250 Flex dollars.
- If you and your spouse both work for DCPS and cover a dependent(s) under the DCPS medical plan, one of you has the option to give your Flex Dollars to your spouse which could significantly reduce your family medical premiums. If you think you are eligible for Flex to Spouse enrollment, please contact Employee Benefits Department at 904-390-2351 for more information.

2015 Guaranteed Issue Voluntary Benefits

The following voluntary benefits are being offered Guarantee Issue* for the 2015 Plan Year:

- Allstate Benefits Group Critical Illness
- Allstate Benefits Group Hospital Indemnity
- Trustmark Accident (Off the Job Coverage)
- Trustmark Universal Life*
- Trustmark Universal LifeEvents®*
- UNUM Whole Life

**Modified or Simplified Guarantee Issue is available for existing policy holders. See an enrollment counselor for details.*

Pre-Enrollment Checklist:

Bring the following information to your appointment when you see an enrollment counselor:

- Beneficiary information
- Dependent verification if adding new dependents (i.e., birth certificate, marriage certificate, 2013 IRS 1040, etc.)
- Social Security numbers for all dependents
- Dates of Birth for all dependents and beneficiaries
- Addresses for all dependents and beneficiaries
- Proof of other medical coverage if opting out of the medical plan.

Saturday and Evening Appointments - Available For your Convenience at the Administration Building (3001)

Evening Dates	Hours	Saturday Dates	Hours
Mon. – Thurs. 10/27/14 – 10/30/14	5 p.m. – 7 p.m.	Saturday – 10/11/14	8 a.m. – 3 p.m.
Mon. – Thurs. 11/03/14 – 11/06/14	5 p.m. – 7 p.m.	Saturday – 10/18/14	8 a.m. – 3 p.m.
		Saturday – 10/25/14	8 a.m. – 3 p.m.

Important

To ensure deductions are correct on the December 12th paycheck, your enrollment must be completed by **November 7, 2014.** You should pay close attention and confirm that you are enrolled in the correct plans and that the correct dependents, if applicable, are attached to those benefits.

Enrollment Changes after Enrollment has Ended - All enrollment changes must be completed during the Open Enrollment Period (October 6 – November 7, 2014). After open enrollment has ended, you **will no longer** have a supersede period to make changes; however, you can submit an enrollment appeal to DCPS Employee Benefits Department for consideration.

Enrollment appeals will only be granted under **very narrow circumstances** as provided by IRS guidance and consistent with district and insurer practices. **All appeals must be submitted to DCPS Employee Benefits Department by Friday, November 21, 2014.**

Examples of errors that **will not** be considered as an appeal:

- Failure to complete an enrollment during the open enrollment Period
- Failure to provide dependent verification during enrollment
- Accidentally electing or dropping a plan
- Deleting a dependent in error

See the Appeals section of the 2015 Employee Benefits Reference Guide for more information.

DCPS Employee Benefits 1701 Prudential Drive – 2nd Floor Jacksonville, FL 32207
Phone: 904-390-2351 Fax: 904-390-2370
Office Hours: 7:30 a.m. – 4:30 p.m.

To schedule an evening or Saturday appointment, go to: www.myenrollmentschedule.com/duval or call 1-866-998-2915.

Go Green! In a continued effort to "Go Green", we no longer distribute printed benefits reference guides to employees. However, you will have the ability to print a PDF copy if needed. Each worksite will be provided 3 PDF copies for employees to review. The PDF copies **must remain** at each worksite location for future employee reference.

Employees may access benefits information online at: http://www.duvalschools.org/benefits

What if I don't have a computer at home? There are kiosks available at all worksites, in the Employee Benefits Department, and available at all public libraries. Employees may also access with their smart phones, PDA devices, or electronic devices.

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8 EMPLOYEE RESPONSIBILITIES

Employee Responsibilities

Open Enrollment is the time of year employees are allowed to make changes to current benefits.

- You are responsible for participating in and completing the online web enrollment process. You may do this on your own or with an Enrollment Counselor.
- You are responsible for entering your enrollment data, including your beneficiaries, dependents, and dependents' dates of birth and Social Security information within the established enrollment time frames.
- You are responsible for providing required documentation to satisfy the eligibility criteria for all enrolled dependents. Otherwise, dependent coverage will be canceled.
- You are responsible for carefully reviewing your data to make sure that the information in the system is what you have elected. The benefits you elect will remain in effect until the end of the plan year.
- You are responsible for maintaining your personal information such as your address and telephone number. It is your responsibility to make sure your employer has your current information on file.
- You are responsible for reviewing your paycheck stub to ensure your elected benefits are being deducted correctly.
- You are responsible for notifying Employee Benefits immediately (within 30 calendar days of the effective date of your benefits) if payroll deductions are taken for elections you have not made or if required contributions are not deducted from your pay.
- You are responsible for notifying Employee Benefits immediately (no later than 60 calendar days) when a covered dependent no longer meets the eligibility requirements as defined in the Eligibility and Coverage section.
- Benefit elections are irrevocable during the plan year, unless you experience a valid Change in Status and provide written documentation of the event. Approved pre-tax deductions will be made prospectively on the first day of the month after the benefits change form and supporting documentation showing that your request is consistent with, and on account of, the event.
- Waiving medical coverage requires that an election be made. Otherwise, default enrollment in the Non-Contributory single coverage medical plan, basic term life and $250 Flex will be processed.
- Waiving medical coverage is only an option for those who have medical coverage provided by another employer plan or government funded plan (i.e. Medicaid, Medicare, TRICARE).
- Enrollment appeals are granted under very limited circumstances and generally are not permitted in the case of accidentally enrolling a plan or adding/deleting a dependent in error. It is important that you confirm your elections and entries prior to the end of your enrollment period.

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Participation in the District Benefit Program

Be aware that when you participate in the District Benefit Program, you are automatically making the following affirmations:

1. You authorize the District to deduct premiums for the benefits rolled over or elected for the plan year.
2. You certify that the information you supplied on the online enrollment website is true and complete to the best of your knowledge.
3. You understand that health, dental, vision, and Flexible Spending Account(s) contributions will be pre-taxed to the extent possible and that your income subject to federal income tax and Social Security withholding (FICA) will be reduced, and that this may slightly affect your Social Security benefits in the future.
4. You acknowledge that you cannot stop or change benefits paid for on a pre-tax basis during the plan year unless you experience a relevant qualifying event.
5. All benefits are subject to change. All benefits are subject to the provisions and exclusions of the master contract.
6. You understand that a Section 125 Flexible Spending Account (Medical Expense and Dependent Care) can be used only to reimburse payment of eligible expenses incurred during the plan year while participating in the plan and that any amount remaining in either spending account, that is not used during the plan year, will be forfeited. Funds in one spending account cannot be used to reimburse expenses covered by another account. Expenses for which you are reimbursed cannot be claimed.
7. You understand and agree that the District and the Third Party Administrator (TPA) will not incur any liability resulting from failure to read all rules pertaining to benefit enrollment; to enroll online accurately or to submit elections; or in the administration of your flexible spending accounts. You also understand that elections for benefits on a pre-tax basis are irrevocable and cannot be changed after the established deadline date. Subsequent changes can only be made upon experiencing a relevant qualifying event.
8. You agree for yourself and covered members of your family under District insurance plans to be bound by the benefits, deductibles, co-payments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements and plan documents for the plans in which you enroll.
9. Chapter 207-251 Laws of Florida requires agencies to notify individuals of the purpose(s) that required the collection of Social Security numbers. Duval County Public Schools collects Social Security numbers (SSNs) of employee and dependents for enrollment in health insurance, life insurance, and other miscellaneous insurances. The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
10. Your contributions to the Flexible Benefits Plan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS. Any salary directed to your Flexible Benefit Plan is included in the compensation reported to the FRS.
11. Social Security consists of two components: FICA and Medicare. A separate maximum wage to which the tax is assessed applies to both tax components. The maximum taxable annual wage for FICA varies from year to year. There is no maximum taxable annual wage for Medicare. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

Important Reminders...

- Open Enrollment ends **November 7, 2014**.
- It is YOUR responsibility to verify that the benefit selections made **during** Open Enrollment are correct. You can verify this information during a scheduled enrollment session or by logging onto **www.myFBMC.com** to view your benefits prior to the close of enrollment on **November 7, 2014**.

How to Find Information About Your Benefits

There are three ways to receive benefit information:

1. You may contact the individual providers' customer service department about the specific plan for which you are inquiring (refer to the Benefits Directory).
2. Visit www.myFBMC.com to view a listing of your current benefits and to submit questions via e-mail to Customer Care.
3. For personal assistance call the Service Center 1-855-5MY-DCPS (855-569-3277), Monday-Friday, 7 a.m. - 8 p.m. EST.

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Overview - January 1 - December 31, 2015 Plan Year

For the 2015 Plan Year, Duval County Public Schools will provide the following free benefits to all benefit-eligible employees:

- DCPS Board paid medical insurance depending on which medical plan you choose (see medical insurance section).
  Note: Employees who can demonstrate and attest to having other employer-sponsored group health insurance or government-funded health insurance (i.e. Medicaid, Medicare, TRICARE) may elect to opt out of DCPS's Medical Plan Options.
- $10,000 Group Term Basic Life insurance
- $250 Flex Basic Dollars to defray the cost of voluntary pretax benefits, excluding life insurance. ($12.50 per pay for 20 deduct employees and $10.42 per pay for 24 deduct employees)
  Note: Flex dollars not used to offset pre-tax benefits will be added to the employee's payroll check.
- DCPS contributes to the Medical Flexible Spending Account (MFSA) for employees who elect the DCPS Contributory medical plan. Contributions to the MFSA will be $450 (employee only coverage) and additional $300 (dependent/family coverage). This contribution is designed to be used towards the annual deductible and any other medically necessary, out-of-pocket expenses not covered by your insurance.

DCPS recognizes that your needs change from year to year. Consequently, we are providing one-to-one benefits sessions. Your enrollment counselor will provide you with guidance on the following valuable benefits:

Florida Blue— provides comprehensive medical and pharmacy benefits.

Delta Dental Care — provides valuable dental benefits with both a Managed Care and PPO plan.

Davis Vision Care — offers paid-in-full eye examinations, eyeglasses and contacts and one-year eyeglass breakage warranty included on the plan eyewear at no addtional cost!

Standard Insurance Company Group Term Life — In addition to the $10,000 Group Term Basic Life, offerings of up to three times annual salary or a flat $50,000 are available.

Allstate Benefits Group Voluntary Hospital Indemnity Insurance — provides daily benefits for continuous hospital confinement, up to 365 days per period.

Allstate Benefits Group Critical Illness Insurance — pays a lump sum benefit upon diagnosis of a covered critical illness.

UNUM Whole Life Insurance — features affordable fixed premiums, guaranteed for life. Accumulates cash value. You own the policy and it has living benefit options.

UNUM Disability Income Protection (STD/LTD) — can provide you with an adequate income if you become disabled and are unable to work. You do not have to exhaust your sick leave before taking advantage of this benefit.

UNUM Long-Term Care (current UNUM Long-Term Care participants only) — provides benefits for nursing homes, assisted living facilities and home healthcare for you and your parents.

Medical Expense Flexible Spending Accounts — can help you save tax dollars on qualified medical expenses and certain Over-the-Counter drugs and medicines.

Dependent Care Flexible Spending Accounts — can help you save tax dollars on care for your dependents while you are working or actively looking for work.

Trustmark Accident Insurance — helps cover unexpected expenses that result from all kinds of accidents, even sports related and household ones. It provides cash benefits to cover deductibles, co-payments, transportation and lodging cost and everyday bills.

Trustmark Universal Life Insurance —is the traditional life insurance product, which offers a flexible premium, builds cash value and features level death benefits throughout the life of the product.

Trustmark Universal LifeEvents—is a cost effective alternative to the traditional life insurance product, which offers a flexible premium, builds cash value and for the same premium pays a higher death benefit during working years that reduces at age 70 (or your 15th policy year, if later).

Trustmark Critical Illness and Cancer (current Trustmark participants only)—designed to pay you a lump-sum cash benefit ($5,000 -$100,000) upon first diagnosis of a covered critical illness or condition.

Zurich Accidental Death and Dismemberment Insurance — offered to newly hired employees only - provides protection against financial hardship when death is result of an accident or help during recovery and rehabilitation if you suffer an accidental dismemberment.

The following voluntary benefits are being offered Guarantee Issue* for the 2015 Plan Year:

Allstate Benefits Group Critical Illness
Allstate Benefits Group Hospital Indemnity
Trustmark Accident (Off the Job Coverage)
Trustmark Universal Life*
Trustmark Universal LifeEvents®*
UNUM Whole Life

*** Modified or Simplified Guarantee Issue is available for existing policy holders. See an enrollment counselor for details.**

Advantage of Pre-tax versus Post-tax deductions

Electing your benefit deductions as pretax gives you a break in your taxes paid. Pretax means your benefits are deducted before taxes are calculated in your check. Post-tax means your benefit deductions are included in the amount your check is taxed which means you are paying taxes on your benefit deductions. If you want to take advantage of the pretax benefit and pay less taxes, make sure you select those qualifying benefits pretax during your enrollment session.

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Introduction

Duval County Public Schools offers a wide range of benefits to our benefit eligible employees. This booklet will describe those programs, which include medical, dental, vision, life, disability, flexible spending accounts and voluntary benefits. During open enrollment, all benefit eligible employees can make changes to their current elections or add new coverages. If you chose to meet with an enrollment counselor, please review the benefit materials prior to your appointment so you are prepared to make critical decisions.

Please note that there are certain situations in which you MUST take action. If you wish to enroll, modify or cancel AB Group Hospital Indemnity, AB Hospital Indemnity, AHL Critical Illness, AHL Group Critical Illness, AFLAC Intensive Care, AFLAC Cancer, UNUM Whole Life, UNUM Long Term Care, Trustmark Universal Life, Trustmark Universal LifeEvents®, Trustmark Critical Illness and Trustmark Accident Insurance, you must meet with an enrollment counselor. Several plans require the company to be notified to cancel the policy.

You Must complete an enrollment if any of these apply:

- Opt-out of Medical Insurance Coverage
  - Employee must meet with an Enrollment Counselor to complete a Declination of Medical Coverage Affidavit
  - Employee must provide proof of other group employer or government funded medical coverage (i.e. Medicaid, Medicare, TRICARE) at the time of your enrollment session.
- Employee contributions to a Medical Flexible Spending Account (MFSA) or Dependent Care Flexible Spending Account (DFSA).
  - Prior year employee contributions **will not** automatically roll-over.
  - Employee-contributions through payroll deductions to the Medical FSA must be made at your enrollment session.
  - Employees **will** lose any unspent flex spending account funds from the prior plan year.
- Employee-contributions to a Health Savings Account (HSA)
  - Employee-contributions through payroll deductions to the HSA must be made at your enrollment session.
  - Employees **will not** lose any unspent HSA funds from the prior plan year
- Due to a new life insurance carrier, all employees are required to update their beneficiary information.

If you **do not** wish to make any changes **and** you **do not** make employee contributions to a MFSA, DFSA, or HSA, your current coverage will automatically be carried forward from the 2014 plan year.

All employees with newly added dependent coverage will be required to show documentation of their dependent's eligibility to an enrollment counselor.

Important Dates to Remember

Your Annual Enrollment dates are:

October 6, 2014, through November 7, 2014.

Your Period of Coverage Dates are:

January 1, 2015, through December 31, 2015.

Online Enrollment

Benefit eligible employees have the ability to make benefit elections and changes online during open enrollment for the 2015 Plan Year. The website is accessible 24 hours a day during the open enrollment period.

Accessing the Online Enrollment website:

- Log in to **www.myFBMC.com**
- Follow the instructions to set up your own user name and password.
- Click the "Web Enrollment" link.
- Verify your demographic information.
- Add or update any beneficiary information.
- Begin the enrollment process.
- For each benefit, choose your coverage level or election amounts and then go to the next benefit.
- Continue until enrollment is complete.
- Print out your confirmation statement containing all your benefit elections for you and your family.

Note: You may save your enrollment session progress and return later to complete the enrollment at any point once you've started the benefit selections.

Whether you choose to individually enroll online or meet with an enrollment counselor, it is your responsibility to carefully review your confirmation statement. All enrollment changes must be completed during the open enrollment period (October 6 – November 7, 2014). After open enrollment has ended, you **will no longer** have a **"Supersede Period"** to make changes; however, you can submit an enrollment appeal to DCPS Employee Benefits Office for consideration.

Enrollment Appeals will only be granted under very narrow circumstances as provided by IRS guidance and consistent with district and insurer practices. **All appeals must be submitted to DCPS Employee Benefits Dept. by Friday, November 21, 2014.**

Examples of errors that will not be considered as an appeal:

- Failure to complete an enrollment during the open enrollment period
- Failure to provide dependent verification during enrollment
- Accidentally electing or dropping a plan
- Deleting a dependent in error

See the Appeal section for more information.

How To Enroll

Option 1	Option 2
Enroll On Your Own Via the Internet at www.myFBMC.com: By exercising this option, you are not required to meet with an Enrollment Counselor to complete the enrollment process unless you are opting out of medical coverage or enrolling a new dependent in the medical, dental and/or vision plan (see Dependent Eligibility Requirements section for more information).	**By Enrollment Appointment with an Enrollment Counselor:** If you prefer to meet one-on-one with an Enrollment Counselor, you must make an appointment for an Open Enrollment session at any of the designated locations. The Enrollment Counselor will review your current benefits selections and assist with any changes that you wish to make.

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Accessing Your Benefits

FBMC Benefits Management, Inc., is a benefits manager specializing in payroll deduction benefit services. FBMC conducts the enrollment and offers a variety of management services for Duval County Public Schools. The Service Center offers a variety of resources for inquiring about your benefits and Flexible Spending Accounts (FSAs). This includes the FBMC website, Wageworks website and Customer Care.

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On the Web

Type "**www.myFBMC.com**" into your Internet browser to access FBMC's home page. Use the navigational tabs along the top of the web page to get answers to many of your benefits questions.

If you previously registered on the website with an e-mail address and password, continue using this information. If you are not registered, log into the site as a first time user. Follow the link on the login page and register through FBMC's Premier Login.

Benefits

You can check your benefit status, read benefit descriptions, use our tax calculator and much more.

WageWorks Health Care Card

Log on to www.wageworks.com to submit and check the status of your claim, download forms, get more information about mailing and faxing your claim or see transactions that need documentation. You can also download a card fact sheet and read detailed instructions on proper use and review our IIAS Store List to maximize card convenience. You may also contact Wageworks at 1-877-924-3967.

Accounts

View your account balance and contributions or review monthly statements and your transaction history.

Profile

Change the e-mail address we have on file, complete your online registration or select a new PIN.

Resources

Browse through our extensive resource library, including: benefit materials, eligible expenses, required documentation, Over-the-Counter drug listings and benefit tips.

Note: Keep this reference guide in a safe and convenient place for easy access to benefit information.

The District's group insurance plan year is January 1st through December 31st. For new hires eligible to participate in the District's group insurance plans, coverage will be effective the first of the month following the first scheduled payroll deduction.

Carefully review your enrollment materials and make selections which best meet your insurance needs. Keep in mind that you will be making choices that will remain in effect until the end of the plan year. Elections are considered to be irrevocable and are subject to Internal Revenue Code (IRC) Section 125.

Default Plan Enrollment

Newly eligible employees who fail to make enrollment choices will be automatically processed as being enrolled with employee-only coverage in the Non-Contributory Medical plan, basic term life insurance, and $250 flex dollars.

Eligible Employees

- All full-time salaried employees of Duval County Public Schools
- Retiring employees – please contact the Employee Benefits Department prior to retirement to discuss your benefit options.

Flex to Spouse Employees

If both you and your spouse are employed by DCPS and have benefit-eligible dependents on your medical plan, you are defined by DCPS as "Flex to Spouse" and enrollment for your insurance benefits is different from the standard procedure. All "Flex to Spouse" employees are encouraged to meet with an Enrollment Counselor or enroll online at the same time. Please contact the Employee Benefits Department at (904) 390-2351 for more information.

Note: If both of you are employees of DCPS but are NOT insuring dependent children, you are not considered as "Flex to Spouse" employees. Each of you must enroll separately and select your own plan(s). If your "Flex to Spouse" status changes at any time during the year, you must notify the Employee Benefits Department immediately.

Terminating Employees

Provided you've made the necessary contributions, your group health plans and flexible benefits will continue until the last day of the month in which termination occurs, unless you separate on the last work day of the month, then your benefits will continue to the end of the following month. If you have completed your contract year, your benefits will continue until August 31st.

You will receive a COBRA notice allowing you the opportunity to continue your group health and life insurance benefit coverage after the end of the month of your termination.

Exception: You qualify for the Family and Medical Leave Act (FMLA). In that case, coverage will end the last day of the month in which eligibility for FMLA ends, as long as required employee contributions are made.

Terminations Due to Change in Status

Requests to terminate coverage for you and/or your dependent(s) based upon an approved Change in Status (CIS) event will be made effective the last day of the month after receipt of a completed CIS form and supporting documents. The CIS form and supporting documentation must be submitted within 60 calendar days of the qualifying event and the change must be consistent with the type of event.

Note: If you have dependent coverage, and request to terminate coverage for yourself, your dependent's coverage will terminate on the date you, the employee, lose coverage.

Retirement

Your benefits as an active employee end on the last day of the month in which you retire. However, for all employees who retire at the end of a school year and work through their contract period, coverage will end on August 31st of that year. As a retiree of the School District of Duval County, you are eligible to continue your health, dental, vision, basic life, and some voluntary benefits if you pay the monthly premium in full. The Florida Blue medical plans are not available options to retirees age 65+ and Medicare eligible. Retirees age 65+ and Medicare eligible are given the option to enroll in one of the Medicare Supplement or Medicare Advantage Plans and/or one of the Medicare Part D Pharmacy Plans.

Note: Your retirement date must be in a month in which you are covered under the district's benefits plan in order to continue benefits as a retiree.

COBRA Coverage

Under certain qualifying events, covered employees may be eligible for continuation of group health plans covered under the COBRA law (see COBRA Section for more details).

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14 BENEFITS WHILE ON LEAVE OF ABSENCE

When Should You Apply for a Leave of Absence?

To protect your benefits you should apply for a leave of absence (LOA) whenever you will be in an unpaid status. While you are using sick and/or annual leave, you do not need to apply for a leave of absence since you are still receiving pay from the district. However, if you miss work as a result of a work-related injury/illness, you should apply for a leave of absence even if you receive workers' compensation. Keep in mind that your benefits eligibility requires that you work the majority of the duty days. Therefore, anytime you are in an unpaid status, applying for a leave preserves your access to benefits. It's important for you to notify and keep your supervisor informed of all absences.

Types of leave

- Family and Medical Leave Act (FMLA)
- Personal Health Leave
- OJI (On the job injury)
- FMLA/Military Exigency
- FMLA/Military Caregiver
- Military Leave
- Personal Leave – Not available currently
- Professional/Educational Leave – Not available currently

The following actions are required by the employee prior to the start of your unpaid LOA:

- Contact your immediate principal/administrator/supervisor of your intent to go on unpaid LOA.
- Apply for LOA by contacting Human Resource department at 904-390-2065. LOA paperwork is also available at www.duvalschools.org under Departments/HR/Current Employees/Sick Leave Pool/Leave of Absence.
- Contact the Employee Benefits department at (904) 390-2887 for information about your benefits and how to continue insurance premiums/coverage while you are on LOA.
- Contact the Payroll Department at (904) 390-2022 to advise the Payroll Technician assigned to your work location of your intent to go on LOA.

When will your active coverage end?

Employer Paid Health coverage:

A. For FMLA leaves, the end of the month after your 84th day of leave (3 months).
B. For Non-FMLA leaves, the end of the month following the 30th day of leave.

Employer Paid Group Life Insurance:

A. For FMLA leaves, the end of the month following the 30th day of leave.
B. For Non-FMLA leaves, the end of the month following the 30th day of leave.

Continuing Benefits While on Leave Of Absence

We encourage employees going on leave of absence to contact the Employee Benefits department at 390-2351 if you have any questions about paying for benefits and how to cancel benefits while on LOA. Based on the type of leave an employee is on dictates how long a benefit may be paid by the employer; can be continued by the employee; and can be reinstated if cancelled due to non-payment.

Approved medical leave (FMLA) – You may continue your benefits while in an approved FMLA status. The district will make medical plan "Employee Only" contributions on your behalf while on approved FMLA up to 3 months. You will be responsible for the employee cost for the medical plan if you have dependents covered or have employee only Contributory plan coverage. You will also be responsible for all of your other current benefit contributions. FBMC Management Inc. will mail all LOA employees payment coupons. All billing is on a bi-monthly basis and payments are mailed to them. Coverage will be terminated due to non-payment if premium payments are not received by the end of the month the payment is due.

Non FMLA leave – You may continue your benefits while in an approved non-FMLA status.

The district will make medical plan "Employee Only" contributions and group life insurance on your behalf up to the end of the month following your 30th day on LOA. You will be responsible for the employee cost for the medical plan if you have dependents covered or have employee only Contributory plan coverage. You will also be responsible for all of your current benefit contributions. FBMC Management Inc. will mail all LOA employees payment coupons. All billing is on a bi-monthly basis and payments are mailed to them. Coverage will be terminated due to non-payment if premium payments are not received by the end of the month the payment is due.

Benefit Changes While on LOA

Employees on LOA are allowed to make changes (qualifying event) to their current benefits elections when they go on LOA and return from LOA. Employees may cancel some or all of their benefits they wish not to continue while on LOA. Certain voluntary benefits that are cancelled or termed due to non-payment while on LOA cannot be restarted when you return for leave.

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Short Term/Long Term Disability Income Protection for personal illness

Employees who are enrolled in short-term and/or long term disability plans and are on a leave of absence due to their own personal illness (FMLA or Personal Health Leave) will be billed for those plans from the first day of the leave through the date that the disability benefits are expected to begin. When premium waiver is applied, employees will not be required to make premium payments. Note: if you have both short and long term disability plans and are waiver of premium for one of them you are still required to pay premiums on the other benefit.

Employees on leave of absence other than for their own illness are not eligible to continue the short-term or long-term disability plans while on LOA. The coverage will end the end of the following month once your LOA begins. Premiums for these plans should not appear on any billing statements.

Employees whose short and long term disability benefit is termed due to the type of leave taken or due to non-payment while on LOA must complete and enrollment on their return to work in order for the plans to be added back. These plans will not be automatically restarted on your return to work.

Flexible Spending Accounts (FSA) while on leave

Reimbursement for FSA's are only considered if expenses are incurred during the period you have made contributions. No reimbursement will be made for expenses during an unpaid leave if you fail to continue to make contributions. You should continue your monthly contribution if you wish to request reimbursement for the period that you are on leave.

Dependent FSA – contributions cannot be made while on an unpaid leave of absence.

Important Reminders...

If you do not pay FBMC Benefits Management, Inc. for your benefits while on LOA your benefits will be termed. When you return to work from your LOA, you must contact the Employee Benefits department to complete a new enrollment form to restart those benefits that were termed. Any individual voluntary benefit plans for UNUM, Trustmark or AHL may not be restarted if they were termed due to non-payment. You must contact the provider and pay them directly.

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16 CHANGING YOUR COVERAGE

DCPS requires that all newly added dependents be verified as eligible for benefits coverage (this also applies if you remove dependents from your coverage and then re-enroll them at a future date). This requirement is part of an important initiative to ensure legal compliance and good governance, and is intended to aid in the District's continuing efforts to control healthcare costs.

Dependent Relationship	Documentation Required
Spouse (Married Prior to Current Calendar Year)	• Copy or Original government issued marriage certificate; **AND** • Copy or Original IRS 1040 Tax Return from the prior year; **AND** • Social Security Number
Spouse (Married on or After January 1st of Current Calendar Year)	• Copy or Original government issued marriage certificate; **AND** • Social Security Number
Natural Children: Ages 0-26 years of age	• Copy or Original government issued birth certificate (Hospital Certificate of Birth is acceptable for Newborns) that shows proof of relationship; **AND** • Social Security Number
Step-Children: Ages 0-26 years of age	• Copy or Original government issued marriage certificate; **AND** • Copy or Original government issued birth certificate(s) that shows proof of relationship; **AND** • Social Security Number Note: If the last name of the child is different from the employee's current last name, the employee must also provide proof of the name change (i.e. marriage certificate or legal name change documentation)
Child(ren) under Legal Guardianship, Adopted, Custody or Foster Care: Ages 0-26 years of age	• Copy or Original government issued birth certificate (Hospital Certificate of Birth is acceptable for Newborns) that shows proof of relationship; **AND** • Copy or Original legal guardianship/adopted/custody document from Courts naming employee as legal guardian/ adoptive parent/custodian/; **OR** • Copy or Original foster care documentation from Courts naming employee as foster parent; **AND** • Social Security Number If spouse (not employee is legal guardian/adoptive parent/ custodian/foster parent: Copy or Original government issued marriage certificate.
Gr**and**child(ren) 0-18 months	• Copy or Original government issued birth certificate of child(ren) stating child was born to an insured dependent child of the District employee; **AND** • Copy or Original government issued birth certificate of insured dependent birth parent who is also enrolled in the plan; **AND** • Social Security Number
Incapacitated or Handicapped Dependents (Over age 26)	• Copy or Original government issued birth certificate(s) that shows proof of relationship; **AND** • Social Security Number; **AND** • Statement from the dependent's physician certifying that the dependent is incapable of self-sustaining employment by reason of retardation or physical handicap, **AND** is chiefly dependent upon the employee or retiree for support **AND** maintenance; **OR** • Copy or Original Social Security Papers
Birth outside of USA (not Adoption): Ages 0-26 years of age	• Naturalization papers presented to DCPS Employee Benefits Department

NOTE: It is your responsibility to respond to insurance companies and DCPS periodic inquiries about dependent eligibility. Failure to provide timely dependent verification information will result in loss of dependent coverage.
Official documents of birth, marriage and/or death certificates from anywhere in the United States may be obtained through www.vitalchek.com or by calling 1-800-255-2414 Option 3. Some fees apply.

What does this mean for you?

If you are a DCPS employee and you are enrolling dependents that were not covered in the prior plan year, you'll need to provide documentation verifying their eligibility under DCPS's plan rules. It's important to understand that if you can't produce the required documentation at your enrollment session, the dependent will not be added to your coverage.

Why is DCPS requiring this verification?

Dependent eligibility verification is a growing trend nationwide. This type of verification helps us to ensure that DCPS's benefits plans are there for the people who need them—our employees and their dependents. The District also has certain fiduciary duties under federal law, as well as under our own Principles of Responsible Conduct. Dependent eligibility verification is one of the best ways for us to meet these responsibilities. Finally, dependent eligibility verification can also help DCPS in our continuing quest to control healthcare costs. Keeping healthcare affordable for all employees is critically important, and ineligible dependents drive up the cost of benefits for everyone.

How does dependent verification work?

There are several situations in which you may enroll or re-enroll an eligible dependent in your benefits coverage:

- During your new employee enrollment;
- During Open Enrollment;
- Following a qualifying life event change; or
- Following a change in your work status

How do I know if my dependents are eligible?

Eligible dependents include but are not limited to your spouse, children up to the end of the month the child(ren) reaches age 26, and disabled children.

Where do I go if I still have questions?

If you have questions about verifying your dependents' eligibility, please call DCPS Employee Benefits at (904) 390-2351.

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Qualifying Events for Changing Your Coverage

Under certain circumstances, you may be allowed to make changes to your benefit elections during the plan year, such as adding or dropping dependents, depending on whether or not you experience an "eligible" qualifying event as determined by the Internal Revenue Service (IRS) Code, Section 125. Change in status will be made effective on a prospective basis only. Making a change on a prospective basis means that the district will process all approved mid-year changes on the first day of the month after you have completed a benefits change form and have submitted all required documentation supporting your request.

Within **60 days** of a qualifying event, you must submit a Change in Status/ Enrollment Form along with supporting documentation to the Employee Benefits Department. Upon the approval of your election change request, your existing elections may be stopped or modified (as appropriate). However, if your election change request is denied, you will have **30 days** from the date you receive the denial to file an appeal with DCPS Employee Benefits. For more information, refer to the **"Appeal Process"** section of this Benefits Reference Guide. Visit **www.myFBMC.com** for information on rules governing periods of coverage and IRS Special Consistency Rules.

How do I make a change?

Partial lists of permitted and not permitted qualifying events under the district's plans(s) appear on the following pages. Election changes must be consistent with and on account of the event. The district will, in its sole discretion, review on a uniform and consistent basis the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To make a change: Within **60 calendar days** of an event that is consistent with one of the events on the following pages, you must complete and submit a benefit change form to Employee Benefits. Documentation supporting your election change request is required.

Once your request has been reviewed, approved and processed, your existing elections and contribution amount will change (as appropriate). Approved changes will become effective on the first of the month following receipt of the benefits change form and all required documentation. If your FSA election change is denied, you will have **60** calendar days from the date you receive the denial to file a written appeal with FBMC. For more information, refer to the **"Appeals Process"** section.

What is my period of coverage?

Your period of coverage for incurring expenses is your full plan year (Jan 1 - Dec. 31), unless you make a permitted plan year election change. For a Health Care FSA, a mid-plan year election change will result in split periods of coverage, creating more than one period of coverage in a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change.

However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Health Care FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within your employer's Health Care FSA plan and the IRS regulations governing the plan.

Note: Split periods of coverage do not apply to the Dependent Care FSA.

What are the IRS Special Consistency Rules governing changes in status?

1. **Loss of Dependent Eligibility** – If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to your divorce, annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances. In most cases a change in plans is not allowed (e.g., Contributory to Non-Contributory).
2. **Gain of Coverage Eligibility Under Another Employer's Plan** – If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses** – You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRC §129.
4. **Group-Term Life Insurance** – For any valid CIS event, you may elect either to increase or decrease these types of coverage, as long as the request is consistent with the qualifying event.

Is enrolling into or terminating out of an individual plan (i.e. individual plans offered through the Health Care Exchange) a valid change in status events?

Enrolling into or terminating out of a private individual health insurance plan is not a valid change in status event.

Is enrolling into or terminating out of Florida KidCare a valid change in status events?

Enrolling into or terminating out of Florida KidCare is a valid change in status event. Your child may be eligible for health insurance through Florida KidCare, even if one or both parents are working. The Florida KidCare program provides children with comprehensive health coverage from birth through age 18.

How do I apply for Florida KidCare?

Visit www.floridakidcare.org and click **"Apply Online Now"** or request an application by calling 1-888-540-5437.

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ALL CHANGES MUST BE MADE WITHIN 60 DAYS OF THE QUALIFYING EVENT

Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
I. CHANGE IN STATUS						
A. Change in Employee's Legal Marital Status						
1. Gain Spouse (Marriage)	• Marriage Certificate; and • Recent IRS Tax Return required (if married prior to current calendar year)	Employee may enroll or increase election for newly eligible spouse and dependent children as well as pre-existing dependents; employee may also revoke or decrease own or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan. HIPAA special enrollment rights may also apply.		Employee may enroll or increase election for newly eligible spouse and dependents; employee may also decrease election if employee or dependents become eligible under new spouse's health plan.	Employee may enroll or increase election for newly eligible spouse and dependents; employee may also decrease election if employee or dependents become eligible under new spouse's Dependent Care FSA plan; or, employee may cease coverage if new spouse is not employed or makes a Dependent Care FSA coverage election under spouse's plan.	Employee may enroll in coverage when eligibility is affected.
2. Lose Spouse (Divorce, legal separation, annulment, or death of spouse)	• Divorce Decree • Court documentation stating legally separated or marriage annulled • Death certificate	Employee may revoke election only for spouse; employee may also elect coverage for self or dependents that lose eligibility under spouse's plan if such individual loses eligibility; employee may also enroll new and pre-existing dependents so long as at least one dependent has lost coverage under the spouse's plan. HIPAA special enrollment rights may also apply.		Employee may decrease election to reflect loss of spouse's eligibility; employee may also enroll or increase election where coverage is lost under spouse's health plan.	Employee may enroll or increase election to accommodate newly eligible dependents (e.g., due to death of spouse); employee may also cease coverage if eligibility is lost (e.g., because dependent now resides with ex-spouse).	Employee may cease coverage when eligibility is affected.
B. Change in the Number of Employee's Dependents						
1. Gain Dependent (Birth, adoption, legal custody)	• Birth Certificate or Hospital Certificate with Foot Prints • Adoptions papers or placement for adoption papers • Legal custody papers • Marriage certificate - if spouse (not employee) is legal guardian / adoptive parent/ custodian / foster parent	Employee may enroll or increase election for newly eligible dependents and/or enroll any pre-existing dependents; employee may also revoke or decrease own or dependent's coverage if employee or dependent become eligible under spouse's plan. HIPAA special enrollment rights may also apply.			Employee may enroll or increase election to accommodate newly eligible dependents and any other non-covered dependents.	Employee may increase coverage when eligibility is affected.
2. Lose Dependent (Death, dependent no longer meets eligibility requirements)	• Death Certificate • Birth Certificate	Employee may drop coverage only for the dependent who loses eligibility.			Employee may decrease election for dependent who lost eligibility.	Employee may decrease or cease coverage even when eligibility is not affected.

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Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
C. Change in Employment Status of Employee, Spouse, or Dependent that Affects Eligibility						
1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) that Triggers Eligibility						
a. Commencement of employment by employee or other change in employment status (e.g., PT to FT) triggering eligibility under component plan.	Letter from employer verifying employment status change.	Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents.				No change permitted.
b. Commencement of employment by spouse or dependent or other employment event triggering eligibility under their employer's plan.	Letter from employer verifying employment event triggering eligibility under the employer's plan.	Employee may revoke or decrease election under employee's, spouse's, or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's coverage.		Employee may decrease or cease election if he or she gains eligibility for health coverage under spouse's or dependent's plan.	Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work); employee may also revoke election for dependent's coverage if dependent is added to spouse's plan.	No change permitted.
2. Termination of Employment by Employee, Spouse or Dependent (or Other Change in Employment Status) That Causes Loss of Eligibility						
a. Termination of employee's employment or other change in employment status (e.g., unpaid leave, FT to PT) resulting in loss of eligibility.	Letter from employer verifying employment termination or employment status change.	Employee may revoke or decrease election for employee, spouse or dependent that loses eligibility under the plan.		Employee may revoke election to reflect loss of eligibility (note that under most health FSAs, employee loses coverage automatically).	Employee may revoke or decrease election to reflect loss of eligibility.	Employee may revoke or decrease election to reflect loss of eligibility.
i. Termination of rehire within 30 days.	Letter from employer verifying employment termination.	Prior elections at termination are reinstated unless another event has occurred that allows a change.				
ii. Termination and rehire after 30 days.	Letter from employer verifying employment termination and rehire.	Employee may make new elections.				
b. Termination of spouse's or dependent's employment (or other change in employment status resulting in a loss of eligibility under their employer's plan).	Letter from employer verifying employment termination.	Employee may enroll or increase election for employee, spouse or dependent that loses eligibility under spouse's or dependent's employer's plan; employee may also enroll previously eligible dependents. HIPAA special enrollment rights may also apply.		Employee may enroll or increase election to reflect loss of eligibility for health coverage.	Employee may enroll or increase election if spouse or dependent loses eligibility for Dependent Care FSA; employee may also decrease or cease election to reflect loss of eligibility for coverage (e.g., if spouse stops working).	No change permitted.
D. Event Causing Employee's Dependent to Satisfy Eligibility Requirements						
1. Event by which dependent ceases to satisfy eligibility requirements under another employer's plan (attaining a specified age, getting married, ceasing to be a student, etc.)	Letter from employer indicating dependent no longer meets eligibility requirements.	Employee may enroll or increase election for affected dependent, employee may also add previously eligible but not enrolled dependents.		Employee may increase election or enroll only if dependent gains eligibility under health FSA.	Employee may increase election or enroll to take into account expenses of affected dependent.	No change permitted.

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Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
E. Change in Place of Residence of Employee, Spouse, or Dependent						
1. Move triggers eligibility	Documentation of the move.	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.			N/A – Dependent Care FSA eligibility is not generally affected by place of resident	No change permitted.
2. Move causes loss of eligibility (e.g. employee or dependent moves outside HMO service area)	Documentation of the move.	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.			N/A – Dependent Care FSA eligibility is not generally affected by place of resident	No change permitted.
F. Change in Coverage Under Other Employer Cafeteria Plan or Qualified Benefits Plan						
1. Other employer plan increases coverage	Letter from employer verifying coverage increase.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under another employer plan.		No change permitted.		
2. Other employer's plan decreases or ceases coverage	Letter from employer verifying decrease or cease of coverage.	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer plan. Other previously eligible dependents may be enrolled		No change permitted.		
3. Open Enrollment under other employer plan/different year	Letter from employer verifying open enrollment.	Corresponding changes can be made under employer's plan permitted		No change permitted		
4. Loss of group health coverage sponsored by Governmental or Educational Institution.	• Letter from Governmental or Educational Institution verifying loss of group health coverage. • Certificate of Creditable Coverage	Employee may enroll or increase election for employee, spouse, or dependent if employee, spouse, or dependent loses group health coverage sponsored by governmental or educational institution.		No change permitted		
G. Florida Kidcare, Medicaid, Medicare or TRICARE						
1. Employee, spouse, or dependent enrolled in employer's health plan become entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines)	• Letter from Florida Kidcare, Medicaid, Medicare or TRICARE verifying enrollment • Florida Kidcare, Medicaid, Medicare or TRICARE ID card reflecting effective date of coverage.	Employee may cancel or reduce coverage for employee, spouse, or dependent as applicable.	Employee may cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Employee may decrease or revoke election under employer plan.	No change permitted	

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Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
2. Employee, spouse, or dependent loses eligibility for Medicare or Medicaid (other than coverage solely for pediatric vaccines.	Letter from Florida Kidcare, Medicaid, Medicare or TRICARE verifying loss of eligibility.	Employee may elect to commence or increase coverage for employee, spouse, or dependent, as applicable and add previously eligible (but not yet enrolled) dependents.	Employee may cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Employee may commence or increase election under employer plan.	No change permitted.	
H. FMLA Leaves of Absence						
Employee's commencement of FMLA leave.	Documentation verifying employee is on LOA.	Employee can make same election changes as employee on non-FMLA leave. Employer must allow employee on unpaid FMLA leave either to revoke coverage or to continue coverage, but allow employee to discontinue payment of his or her share of the contribution during the leave. The employer may recover the employee's share of contributions when the employee returns to work.		Same as previous column. Upon return, employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) .	Employee may make a new election if coverage terminated while on FMLA leave. Employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from non-FLA leave are required to be reinstated in their elections.	

Travel Alerts!

To Make Changes: Within 60 days of an event that's consistent with one of the events on the Changing Your Coverage pages, you must complete a Change In Status/ Online Enrollment and submit it to the Employee Benefits Department in a timely manner.

Contact Employee Benefits at (904) 390-2351 for further instructions. Documentation supporting your election change request is required.

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CCW
A HealthAdvocate™ Company

CCW Health Advocate EAP Has Great Information ONLINE!

Our Online Solution Center offers resources that are tailored to specific life needs, providing you with the right tools to help you through some of life's toughest challenges.

You can…

- ✓ Watch a video about Celiac Disease
- ✓ Take a quiz about Workplace Stress Management
- ✓ Use our Mortgage Loan calculator
- ✓ Access forms to Create a Living Will
- ✓ Read an article on Getting Starting with Exercise

EAP - Solutions for Daily Living: Wills, Relationships, Exercise and more!

HOW TO ACCESS

Step 1. In the address bar of your internet browser, enter: www.corporatecareworks.com

Step 2. On the Welcome Member page, type in Duval County Public Schools.

Step 3. Select Submit.

***Note*: You will be prompted to either "Register" or "Sign In" with a username and password when taking an Online Course, Training or Assessment.**

For EAP counseling assistance, call 1-800-327-9757

Corporate Care Works, Inc.
8649 Baypine Road, Suite 101 | Jacksonville, FL 32256 | **Phone** 800.327.9757 | **Fax** 904.296.1511 | CorporateCareWorks.com

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District Wellness
For You. For Us. For Life.

Our mission is to provide high quality comprehensive programs, initiatives and educational opportunities that positively impact individual health and fosters a culture of wellness throughout DCPS and the community.

Staff Programs and Services include:

- Employee Assistance Program Referrals
- Diabetes Management Program
- Educational Lunch n Learns
- Intramural Sports Program
- On-site Flu Shot Clinics
- On-site Health Screenings
- Personal Health Assessments
- Smoking Cessation Resources
- Weight Loss Resources

Announcing…
District Wellness provides support for programs and services for all members of our school communities – staff, students and their families!

For more information on DCPS Employee Wellness please visit our website:

www.duvalschools.org/wellness

DCPS Wellness Office is located in the Main District Administration Building,
1701 Prudential Drive, Jacksonville, Florida 32207
5th floor, Room 514

Office Number: (904) 390-2499

Group Term Life Insurance

Group Term Life Insurance

DCPS is pleased to introduce The Standard Insurance Company as the new carrier for its board-paid $10,000 Group Term Life and Accidental Death & Dismemberment (AD&D) insurance for all full-time benefit-eligible employees.

Guaranteed Life Insurance Coverage

For the 2015 Open Enrollment Period, all benefit-eligible employees of DCPS are able to elect up to three times their annual salary in life insurance coverage without medical underwriting approval, not to exceed $310,000. This includes your board-paid $10,000 of basic life insurance. Instead of a multiple of annual salary, you may purchase a flat $50,000 of coverage. This is in addition to your basic board-paid coverage. Equal amounts of accidental death and dismemberment insurance is also provided.

Additional enhancements under the Group Term Life policy include: When you are diagnosed with a terminal illness with 12 or fewer months to live, the employee may elect to receive up to 75% of in force Basic and Additional Life insurance amount (not to exceed $500,000). AD&D benefits are not part of the amounts payable under the Accelerated Benefit.

The AD&D coverage also pays an additional $10,000 if you die as a result of an automobile accident for which an AD&D insurance benefit is payable for loss of your life and you were wearing and properly utilizing a seat belt system at the time of the accident. If the seat belt benefit is payable, an additional $5,000 may be payable if the automobile is equipped with an air bag system.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

New Hires

All newly-hired employees of Duval County Public Schools are able to elect up to three times their annual salary in life insurance coverage without medial underwriting approval, not to exceed $310,000.

Premium Waiver

If you become totally disabled while insured under this plan and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium payment, subject to the terms of the group policy. Waiver of Premium does not apply to AD&D insurance. Please contact Employee Benefits at (904) 390-2351 for the required paper work.

Insurance Amounts in Excess of $50,000

Premiums for life insurance may not be paid with your $250 Flex Money. In accordance with IRS regulations, any premiums for amounts exceeding $50,000 (which includes your school board-provided $10,000) must be paid with after-tax dollars.

Federal Income Taxes: Under Section 79 of the IRS Code, employees are liable to pay federal income taxes on Group Term Life Insurance amounts in excess of $50,000 to the extent that the costs for amounts in excess of $50,000, less any employer contributions for the entire coverage amount, is included in the employee's gross income. This additional amount will be listed as imputed income on your W-2.

Terminating Employment

If you terminate your employment from Duval County Public Schools, you may elect to continue coverage one of two ways:

- Port* a minimum of $10,000 (combined) Term Life and Accidental Death and Dismemberment (AD&D) coverage up to the same amount of coverage you had as an active employee (not to exceed $750,000 Group Life & AD&D plans combined). Employee must be under age 65 to be eligible to port. Group portability rates in force at time of port will apply; or

- Convert your Group Term Life coverage to an individual Whole Life contract up to the same amount of coverage you had as an active employee at rates effective at such time.

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All current employees who retire with Duval County Public Schools may retain their Basic Life amount under the Retiree group insurance plan. A retiree may also elect to convert any portion of optional coverage to an individual Whole Life contract. Regardless of the elected option upon retirement, you will pay the premium.

* You are not eligible to apply for portable coverage if you have an injury or sickness, under the terms of this plan, which has a material effect on life expectancy.

Plan Provider

Standard Insurance Company insures this plan. The Standard is a nationally recognized provider of group life insurance. We provide insurance to more than 24,800 groups, covering over 8 million employees nationwide*

* As of June 30, 2013, based on internal data developed by Standard Insurance Company.

Beneficiary

It is important that you review your policy every couple of years and update your beneficiary designations (insurance policies, retirement accounts, pensions, payable-on-death accounts, etc.) whenever there's a big life event: you get married, you divorce, or a child or grandchild joins the family.

Don't Try to Use Your Will to Change a Beneficiary

If you want to name or change a life insurance beneficiary, fill out the required documents with the life insurance company. You can't change a beneficiary in your will - the terms of your will have no effect on your agreement with the life insurance company.

Designating a minor as beneficiary

While you may name your minor children as your designated beneficiary, the life insurance carrier will be unable to pay the life insurance proceeds to your children until the earlier of:

- The date that your children reach the age of majority (usually age 18 or 21, depending on applicable state law).
- The date that a legal guardian of the minors' estate has been appointed by a court. This appointment process can be costly, and state laws may limit who may be named a guardian of an estate. Generally, a guardian of the minors' estate will hold the money for their' benefit until they reach the age of majority, usually age 18 or 21, depending on state law.

If you want your minor children to receive your life insurance proceeds, you should consult your legal advisor to determine the best way to accomplish this under the laws of your State.

Designating an Ex-Spouse as beneficiary:

Effective July 1, 2012, the Florida Legislature passed Florida Statue Sec. 732.703, which will invalidate the designation of an ex-spouse as a beneficiary on life insurance policies and other elements within an employee benefits plan if those designations were made prior to the divorce.

After July 1, 2012, if an employee wants their ex-spouse to be a beneficiary on a life insurance policy or another employee benefit plan product, they will have to make that designation after the dissolution of the marriage. Any employees who currently have an ex-spouse as a beneficiary and want to keep this designation will have to re-submit a beneficiary form designating the ex-spouse dated after July 1, 2012.

If coverage becomes effective, and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. Neither the information presented in this summary nor the certificate modifies the group policy or the insurance coverage in any way.

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26 FLEX BASIC DOLLARS

Duval County Public Schools strives to provide competitive benefits to all benefit-eligible employees. As a part of this effort, employees receive $250 per year in "Flex Basic Dollars" to help pay for their benefits. This is funded bi-weekly in accordance with the payroll deduction schedule.

Using Your Flex Basic Dollars

1. If you add dependents to your medical plan, your $250 "Flex Basic Dollars" are automatically used to reduce your premium cost each pay period by $12.50 (20 pay periods) or $10.42 (24 pay periods).
2. If you do not add dependents to your medical plan, the Flex Basic Dollars will be used for other pre-tax benefits, including the Employee portion for the DCPS Contributory medical plan, but excluding life insurance.
3. If you do not enroll during open enrollment and your previous year's elections rollover for new plan year, the flex dollars will not follow the same rules.
4. If you choose pre-tax benefits that total less than $250 per year, the flex basic dollars balance will be added to your payroll check. If you select benefits that total more than $250, then deductions for the remaining difference will be payroll deducted on a pre-tax basis.
5. If you and your spouse are employed by Duval County Public Schools and cover a dependent(s) under the DCPS medical plan, one of you may give your Flex Basic Dollars to the other to help reduce the amount of dependent medical premium. (See Flex to Spouse Section)
6. If you decide to pay for your benefits from your post-tax pay, you may not use your $250 Flex Basic Dollars to pay for post-tax benefits.

Important Reminder...

Any left over Flex Dollars not used to offset pre-tax benefits will no longer be placed on a WageWorks MFSA Card, but will be added to your payroll check.

How your Flex Basic Dollars work for you

Duval County Public Schools provides each benefit-eligible employee with Flex Basic Dollars every pay period. The Flex Basic Dollars are used to reduce the out of pocket expense to the employee. Please see the following example:

DeltaCare Dental Employee and Family	$ 29.04
Vision Employee and Family	$ 8.57
Total before Flex Money	$ 37.61
Less Flex Basic Dollars	- 12.50
Total Payroll Deduction	$ 25.11

Travel Tips!

If you and your spouse work for DCPS and cover a dependent on the medical plan you may be eligible for the Flex to Spouse option. Ask the enrollment counselor or Employee Benefits Department to see if you qualify.

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DUVAL COUNTY PUBLIC SCHOOLS

Healthcare Reform & You

No more pre-existing condition limits on any health insurance participants.

Your insurance coverage for healthcare cannot be canceled by the insurance company for health reasons.

You can keep covering your dependents until they reach age 26.*

Your health insurance coverage no longer has a lifetime or annual benefit limit.

Many kinds of preventive care no longer have co-pays or deductibles to encourage you to use these preventive health care benefits.

You must get a prescription in order to claim over-the-counter items for reimbursement from a Medical Flexible Spending Account (FSA). (Diabetic supplies are an exception.)

Employers begin reporting cost of employer-sponsored group health plan coverage on your W-2 (for IRS informational purposes only).

Summary of Benefits Coverage (SBC) provided by insurance carriers make your benefit easier to understand.

Women's preventive care has been expanded to include:
- Well Woman visits, mammograms and pap smears
- Counseling and screenings for: all FDA-approved contraception methods, domestic violence and HIV and other sexually transmitted infections
- Breastfeeding support, supplies, and counseling

The Medical Expense FSA contribution limit ia lowered to $2,500 per year.

In order to claim medical deductions on your tax return, your total expenses must now exceed 10% of your adjusted gross income. This is an increase from 7.5% in prior years.

You will receive a notice annually from DCPS, explaining the health care exchanges.

Healthcare exchanges are operating, giving small business and individuals a marketplace to purchase health insurance.

Financial assistance is available through the Marketplace for low-income households.

Effective in 2015 employers with at least 50 full-time employees or more must provide health insurance or pay a penalty.

Required to provide coverage that meets minimal essential guidelines and cannot exceed 9.56% of an employees income for single coverage.

Beginning in 2014, a "shared responsibility penalty" went into effect. The shared responsibility rules provide that a person who does not carry health insurance will be assessed a tax penalty. When you elect health coverage for yourself and your family through the School Board-sponsored healthcare plan, no penalty will be assessed.

Tax credits are available to those that qualify.

Beginning in 2018 tax will apply to high-cost plans, known as "Cadillac" plans and not to plans offering rich benefits.

* Ages 26-30 must meet certain criteria.

Disclaimer: The information provided is intended only to assist employees in understanding federal healthcare reform regulations. Visit www.healthcare.gov for updates.

For more information, visit http://www.whitehouse.gov/healthreform and www.healthcare.gov.

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Healthcare Cost Savings Tips

Primary Care Physicians (PCP) –
Be sure to make an appointment for an annual physical with your PCP.

Locate PCP and Specialists -
within the network to reduce your out-of-pocket expense.

Florida Blue, Blue Options (Network Blue) Providers –
You save money when going to a Florida Blue, Blue Options (Network Blue) provider. A complete list of participating providers can be found at **www.floridablue.com**.
Click on the "Find A Doctor" link.

Preventive Care is Covered 100% -
Checkups, immunizations, and screenings can help you detect or prevent serious diseases.

Your PCP can help you coordinate what screenings and shots are right for you, based on your age, gender and family history.

Urgent Care Centers -
For conditions that are not life threatening urgent care centers are staffed with nurses and doctors, and they're always open on evening and weekends. The cost is lower than an emergency room visit. No appointment needed and wait time varies.

- Price and Compare Online - Log in at **www.floridablue.com** Make the drug pricing and medical services cost estimator tools work for you.

- Talk with a Care Consultant - Florida Blue Care Consultants are experts when it comes to explaining quality care and treatment options, that can help save you money. Call 1.888.476.2227 or visit **www.floridablue.com** for locations.

Know Before You Go -
Quality and cost are important factors when making health care decisions. As a member, you can compare quality and cost—before you receive medical care or buy prescriptions. Get cost estimates based on your plan benefits, and see treatment options that may save you money. Costs vary depending on where you go for treatment. And prescription prices vary based on the brand you buy—and where you buy them.

Emergency Room (ER) -
For the immediate treatment of critical injuries or illness. They are open 24/7 and waiting time varies.

Health Dialog – Health Dialog empowers you to better manage your health and make informed, confident health decisions in partnership with your physician that reflect your personal values and preferences. Health Dialog health coaches are available 24 hours a day, 7 days a week. Simply call toll free, 1.877.789.2583 to speak to a health coach or to access the Healthwise® Audio Library. For the Dialog Center log on to our website at **www.floridablue.com**. Have your Florida Blue ID card handy in order to log on to the website and set up your account.

Prescription Mail Order Program -
Right from your home, PrimeMail makes your health a top priority. With PrimeMail, ordering and receiving your long-term medications is easier than ever. PrimeMail provides safe, fast and cost-effective pharmacy services that can save you time and money without sacrificing quality or care. PrimeMail will deliver a 90-day supply to your home with a co-pay of two times the tier cost. Find PrimeMail forms at **www.MyPrimeMail.com** OR call PrimeMail at 1-866-260-0487.

Over the Counter alternative (OTC) –
Ask your physician if there is an OTC alternative available that's right for you.

Generic Medications
Will save you money, so talk to your doctor about prescribing an equivalent generic prescription versus a brand name.

Note: Only you and your doctor can determine if generic is your best choice.

Medical Expense Flexible Spending Accounts (FSA)
Allows you to set aside an amount of money each year to be deducted on a pre-tax basis from your paycheck per pay period. The funds can be used to pay for eligible, medical expenses not covered by your health insurance.

MFSA Debit Card
Gives you easy access to your MFSA funds, saving you time and eliminates your out-of-pocket expenses for certain eligible healthcare expenses.

Employee Wellness Program -
The mission of DCPS Employee Wellness is to provide high quality programs, events and educational opportunities that meet the unique needs of and are inclusive of ALL employees in order to foster a culture of wellness throughout DCPS.

Employee Wellness Initiatives and Events Include:
DCPS Well Workplace Recognition Program, Diabetes Management Program, Educational Lunch and Learns, Fitness Center Discounts, Flu Shot Clinics, Health Screenings, Personal Health Assessments, Weight Management Programs and more!

Become Informed and Get Involved –
Apart from maintaining a healthy lifestyle, your main role is to become informed about your healthcare options and get involved in your own care.

DUVAL COUNTY
PUBLIC SCHOOLS

For additional information, contact:
Florida Blue: 1-800-664-5295, Mon – Thurs. 8 a.m. – 8 p.m., Fri. 9 a.m. – 8 p.m., Sat. 10 a.m. – 8 p.m. ET, www.floridablue.com
FBMC: 1.855-5MYDCPS (855-569-3277), Mon - Fri, 7a.m. - 8 p.m. ET, www.fbmc.com
DCPS: 904.390.2351, Mon - Fri, 7:30 a.m. - 4:30 p.m. ET, www.duvalschools.org/benefits

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Medical Plan Options

NON-CONTRIBUTORY/CONTRIBUTORY

Florida Blue will continue providing Duval County Public School's medical administrative services for the New Plan Year (Jan – Dec, 2015). The following medical options are available for you to choose from based upon your Bargaining Union or Non-Bargaining Group representation.

DCPS Non-Contributory Plan

Available to employees represented by the following Bargaining Unions and Non-Bargaining Groups:

Administrative, AFSCME, Exempt, FOPD, IBEW, JSA, LIUNA, Paraprofessionals, Teachers, UOPD

This is an open access plan that does not require you to choose a primary care physician. You may choose the physician of your choice. However, to receive your maximum benefit, you should select an in-network doctor from participating Florida Blue, Blue Options (Network Blue) providers found at **www.floridablue.com.**

Plan highlights include:

- Your School District continues to provide employee medical coverage at no premium cost to you.
- Your School District continues to offset a portion of the dependent coverage cost.
- Employees have the freedom to choose an in or out of network service provider at the time of service.
- Deductible and co-insurance applies to all services that do not have set co-pays; for example:
  - Inpatient Hospitalization
  - Physician Services Other than Office
  - All Out-of-Network Services.
- Deductible, co-insurance and co-pays (including Rx), count towards the maximum out-of-pocket limit.
- Medical Flexible Spending Account available (Employee Contributions Only)
- Medical Swipe Card accounts will not roll over the amount elected in the prior plan year.

  Note: If you wish to contribute to the Medical FSA, you must make that election at your enrollment session. Again, prior year contributions are not going to automatically roll-over.

DCPS Contributory Plan

Available to employees represented by the following Bargaining Unions and Non-Bargaining Groups:

Administrative, AFSCME, Exempt, FOPD, IBEW, JSA, LIUNA, Paraprofessionals, Teachers, UOPD

This is an open access plan that does not require you to choose a primary care physician. You may choose the physician of your choice. However, to receive your maximum benefit, you should select an in-network doctor from participating Florida Blue, Blue Options (Network Blue) providers found at **www.floridablue.com**.

Plan highlights include:

- There is a cost for Employee-Only coverage.
- Your School District continues to offset a portion of the dependent coverage cost.
- Employees have the freedom to choose an in or out of network service provider at the time of service.
- Does not have an in-network deductible.
- Co-insurance applies to all services that do not have set co-pays; for example:
  - Inpatient and Outpatient Hospitalization
  - Ambulatory Surgical Center Facility
  - All Out-of-Network Services.
- Co-insurance and copays (including Rx) count towards the maximum out-of-pocket limit.
- Medical Flexible Spending Account established (Employer and Employee Contributions permitted)
- Medical Swipe Card accounts will not roll over the amount elected in the prior plan year.

  Note: If you wish to contribute to the Medical FSA, you must make that election at your enrollment session. Again, prior year contributions are not going to automatically roll-over.

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High Deductible Health Plan (HDHP)

DCPS High Deductible Health Plan

Available to employees represented by the following Bargaining Unions and Non-Bargaining Groups:
Administrative, Exempt, FOPD, IBEW, JSA, and LIUNA.

This is an open access plan that does not require you to choose a primary care physician. You may choose the physician of your choice. However, to receive your maximum benefit, you should select an in-network doctor from participating Florida Blue, Blue Options (Network Blue) providers found at **www.floridablue.com.**

Plan highlights include:

- Your School District continues to provide employee only medical coverage at no premium cost to you.
- Your School District continues to offset a portion of the dependent coverage cost.
- Employees have the freedom to choose an in or out of network service provider at the time of service.
- For coverage other than employee only, the family deductible must be met before co-insurance or co-payments are applicable.
- Your School District contributes $678.52 to your Health Savings Account
  Note: If you are ineligible to participate in an HSA, you may elect a High Deductible Health Plan and contribute to FSA.
- HSA Funds may be used based on what's available in the account.
- HSA Funds are not use it or lose it. **Employees who contribute their own money to the HSA must make that election again at the enrollment session.**
- Changes to your HSA may be made once per month.
- For Medicare Part D coverage, the prescription drug coverage offered by the High Deductible Health Plan is considered Non-Creditable.

Travel Tips!

ID Cards

Florida Blue ID Cards will be issued to new employees only. If you are a current employee, you will continue to use the same ID card.

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High Deductible Health Plan (HDHP) and Health Savings Account (HSA)

What is a High Deductible Health Plan (HDHP)? The HDHP is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. It gives you greater control over how you spend your health care dollars. This plan blends the best features of a preferred provider organization (PPO) with a tax-advantaged Health Savings Account (HSA) that you can use to pay eligible medical expenses.

Plan Benefits

The HDHP allows you to use in-network **and** out-of-network providers. It is always more cost effective to use in-network doctors, facilities, and other providers.

Here is how the plan works in-network:

- You are not required to select a primary care provider (PCP) or get referrals for in-network specialists.
- You pay 100% of the negotiated, discounted fee for all in-network services and prescription drugs until you reach the annual deductible.
- Once you meet the deductible, the plan pays:
  - 75% of the negotiated, discounted fees for covered in-network in-patient services
  - 80% of the negotiated, discounted fees for all other covered in-network services except for prescription drugs (see below).
- Your deductible and coinsurance, including prescription drugs, applies to your out-of-pocket maximum.
- After you reach your out-of-pocket maximum, all covered services, including prescriptions, are paid at 100% by the health plan.

Here is how the plan works out-of-network:

- You pay 100% of the eligible fees for all out-of-network services. **Note: You will be responsible for all ineligible charges. Ineligible charges do not count towards the deductible and they do not count towards the out-of-pocket maximum.**
- Once you meet the out-of-network deductible, the plan pays 50% of the allowed amount for covered out-of-network services.
- Your deductible and coinsurance, including prescription drugs, applies to your out-of-pocket maximum.
- After you reach your out-of-pocket maximum, all covered services are paid at 100% by the health plan.

Health Savings Account

A Health Savings Account (HSA) is an interest-bearing spending and savings account that you use to pay for eligible health care expenses using tax-free dollars. You must be enrolled in the High Deductible Health Plan (HDHP) to contribute to the HSA.

Qualifying for an HSA

In order to open an HSA, you must be "HSA Eligible." IRS guidelines say that an HSA Eligible Individual is anyone who:

- Is covered by an HSA-qualified High Deductible Health Plan (HDHP).
- Cannot be claimed as a dependent by another person .
- Isn't covered by some sort of additional, non-HDHP insurance program.
- Is under age 65 and not entitled to Medicare.

Annual HSA Contributions

The IRS sets limits for how much you can contribute to an HSA in each calendar year. These limits, established by the federal government and subject to change, are tied to the rate of inflation. Over-contributing to your HSA leads to a tax penalty on excessive funds.

2015 contribution limit is $3,350.00 for single and $6,650.00 for family.

Catch-Up Contributions

HSA owners age 55 and older can make additional contributions to their HSA called "catch-up contributions". For 2015, the allowed catch-up contribution is $1,000.

Important facts about High Deductible Health Plans (HDHP) with HSA

The law stipulates that in order to have a Health Savings Account (HSA) you must participate in a qualified High Deductible Health Plan (HDHP). However, if any of the following situations pertain to you, you can participate in the HDHP but NOT the HSA.

- If you enrolled in Medicare or Medicaid, you cannot open an HSA.
- If you have Tricare, you cannot have a HSA because Tricare does not offer a HDHP.
- If you have received any Veterans Administration health benefits in the last 3 months, you cannot have an HSA.
- You cannot be covered by any other health insurance that reimburses you for health expenses you incur unless it is another HDHP with an HSA. If two family members each have a HDHP, the maximum annual HSA contribution remains the same. In other words, it is not doubled. 2015 limits are $3,350 for single and $6,650 for family coverage.
- Flexible Spending Accounts (FSA) which cover all medically necessary expenses make you ineligible for an HSA.
- Employees may not contribute to an HSA until either their FSA account is empty or until their 2.5 month grace period has ended.
- If a spouse participates in a private healthcare plan, Medicare, Medicaid, or Tricare, this will make you ineligible for a HSA if you are also covered.
- If you no longer have an HSA qualified HDHP, you cannot contribute to your HSA, but you can maintain and spend the already deposited funds as stipulated by law.

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Health Savings Account FAQs

How are funds placed into my HSA?

Step 1: Employee enrolls in HDHP and HSA

Step 2: Employee Opens HSA with Bank

Step 3: Employee Contributions taken via Pre-tax Payroll Deduction

Step 4: Employer Contributes to Employee's HSA

Step 5: FBMC Deposits Employee and Employer Contributions via ACH Direct Deposit to Synovus Bank

Step 6: Employee uses HSA debit card or check to pay for medical expenses.

How may I change my HSA contribution?

You may change the amount you contribute to your HSA once a month. To change your HSA contribution, contact your benefits administrator.

How do I get funds out of my HSA?

After enrolling in the HSA and completing the required Bank Signature Card form,[1] your contributions will be sent to the custodian, Synovus Bank of Jacksonville, a division of Synovus Bank.[2] Synovus Bank of Jacksonville will establish an individual account for you and mail up to two VISA® Check Cards to your home address at no charge. You may order additional cards or a starter supply of checks by contacting Synovus Bank of Jacksonville at 1-877-367-4HSA (4472). You may use the Check Cards or checks to get funds out of your HSA. If you choose to use your Check Card, you will need to sign for the transaction like a credit card transaction. Remember, as long as you are taking funds out for qualified medical expenses, you pay no taxes on the funds. However, if you withdraw funds for ineligible expenses, you may have to pay taxes and penalties on those funds, unless you reimburse your HSA for the ineligible amount.

Will I be charged any banking or custodian fees?

Yes, there is $2 monthly fee. Synovus Bank of Jacksonville will charge $2 a month to your HSA. This fee includes the VISA® debit card, all transaction fees associated with the card, a supply of checks, monthly statements and other banking services. There is a $0.50 charge to process each check you write to get funds from your HSA. Synovus Bank of Jacksonville will deduct these fees automatically from your HSA. Other fees may apply, including fees for insufficient funds. Refer to your HSA Disclosure Statement for more information.

How are my HSA funds invested?

Your funds will initially be held in an interest-bearing checking account at Synovus Bank of Jacksonville. The bank can provide you with current interest rates for HSAs since these rates are subject to change. As your account balance grows, you may be eligible to place your funds into the HSA Investment Option. Once your balance reaches $3,500 or more, Synovus Bank of Jacksonville will communicate the investment opportunities available to you through their broker, Synovus Securities, Inc. (SSI).[3]

1 A Bank Signature Card form MUST be completed to open a Health Savings Account.

2 Synovus Bank of Jacksonville is a division of Synovus Bank. Synovus Bank, Member FDIC, is chartered in the state of Georgia and operates under multiple trade names across the Southeast. Divisions of Synovus Bank are not separately FDIC-insured banks. The FDIC coverage extended to deposit customers is that of one insured bank.

3 The registered broker-dealer offering brokerage products for Synovus is Synovus Securities, Inc., Member FINRA/SIPC. Investment products and services are not FDIC insured, are not deposits of or obligations of any Synovus Financial Corp. (SFC) bank, are not guaranteed by any SFC bank and involve investment risk, including possible loss of principal amount invested. Your bank and Synovus Securities, Inc. are members of the Synovus family of companies. Are there any special tax forms or tax reporting that I must complete when filing my income taxes?

Using an HDHP with an HSA

A Health Savings Account is just a bank account with special features. Your HSA belongs entirely to you, and you and your employer may deposit money into your Health Savings Account for future medical expenses.

Use It or Save It

Your HSA is your personal account, and you can choose how you want to use it. You can choose to use the funds as you need them for medical care, or pay for medical expenses with other non-HSA funds.

Opening a Health Savings Account

Enrolling in an HDHP will not automatically open your HSA. To open an HSA, you can either visit one of the Synovus branch offices or use the form on the website: **https://synovusbankjax.synovus.com/?id=28**

Contributing to Your HSA

The 2015 contribution limit is $3,350.00 for single and $6,650.00 for family. This is the maximum including the amount contributed by Duval County Public Schools.

There are a number of ways to make deposits into your HSA:

- Payroll Pre-tax Deductions: One of the most common ways people deposit funds into their HSA is by using scheduled deductions. Talk to your Benefits Department to set up or change deductions to your HSA. Changes will be allowed once per month.
- Regular Recurring Electronic Deposits Post-tax
- Mail-In Deposits: Fill out an HSA Contribution Form to make a deposit through the mail. Mailing instructions are on the form. These deposits would be post-tax
- Branch Deposits: For account holders living in the Jacksonville area deposits can be made at any of the 5 Synovus branch offices or branch ATMs. These deposits would be post-tax.

Withdrawing from Your HSA

You can access funds in your HSA for qualified medical purposes in the following ways.

- **Debit Card:** Use your HSA debit card for purchases or to make payments for qualified medical expenses.
- **Personalized Checks:** Order checks to pay for qualified medical expenses or to reimburse yourself for medical expenses you paid for out of pocket.
- **Request for Check Reimbursement:** Fill out an HSA Distribution Form to instruct Synovus Bank to issue a check from your account on your behalf. Mailing instructions are on the form.

Banking or Custodian Fees

The $2.00 fee is deducted each month from account balances under $2,500. There is not a bank fee once your account exceeds $2,500.

Paying for Services with Your HSA

With an HSA-based plan, you'll still have an Insurance ID Card, and you'll need to make sure that you present this card anytime you go to the doctor or pharmacy. This will ensure that:

(1) You always get any network discounts available to you,
(2) Your medical provider will file a claim with the insurance company, and
(3) The amount you pay will be applied to your deductible.

HSA Paperwork: How to Handle It

Since an HSA is a tax exempt benefit when used according to the IRS Rules, you'll need to be able to prove that money you spend from your HSA is for eligible medical expenses, if you're ever audited. The employee is responsible for all record keeping of money spent from their HSA.

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Summary of Health Plan Options

Benefit Category	DCPS Contributory Plan (No In-network Deductible)	DCPS Non-Contributory Plan (Low Deductible)	DCPS HDHP (High Deductible Health Plan)
HOSPITAL			
Inpatient			
In-Network (Network Blue)	80% Coins	CYD + 75% Coins	CYD + 75% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Out-of-State			
In-Network	80% Coins	CYD + 75% Coins	CYD + 75% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Outpatient Hospital Facility			
In-Network	80% Coins	$250 Co-pay	CYD + 75% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Emergency Room			
In-Network	$250 Co-pay	$300 Co-pay	CYD + 75% Coins
Out-of-Network	$250 Co-pay	$300 Co-pay	CYD + 75% Coins
ANCILLARY			
Urgent Care Center			
In-Network	$35 Co-pay	$60 Co-pay	CYD + 80% Coins
Out-of-Network	$35 Co-pay	$60 Co-pay	CYD + 80% Coins
Ambulatory Surgical Center Facility			
In-Network	80% Coins	$150 Co-pay	CYD + 80% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Independent Diagnostic Testing Facility (X-Ray / Imaging)			
In-Network	$35 Co-pay	$80 Co-pay	CYD + 80% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Independent Clinical Lab			
In-Network	$0	$0 Co-pay	CYD + 80% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Mammograms	$0	$0	$0
PHYSICIAN			
Office Services			
In-Network Family Physician	$15 Co-pay	$25 Co-pay	CYD + 80% Coins
In-Network Specialist	$35 Co-pay	$45 Co-pay	CYD + 80% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Routine Physicals			
In-Network	$0	$0	$0
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Physician Services Other than Office			
In-Network Family Physician	$15 Co-pay	CYD + 80% Coins	CYD + 80% Coins
In-Network Specialist	$35 Co-pay	CYD + 80% Coins	CYD + 80% Coins
Out-of-Network Physician/Specialist	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
PRESCRIPTION DRUGS			
Retail			
Generic Drugs	$7 Co-pay	$7 Co-pay	CYD + $7 Co-pay
Preferred Brand Drugs	$25 Co-pay	$25 Co-pay	CYD + $25 Co-pay + 10% Coins
Non-Preferred Brand Drugs	$40 Co-pay	$40 Co-pay	CYD+ $40 Co-pay + 10% Coins
Specialty Injectables	$55 Co-pay	$55 Co-pay	CYD + $55 Co-pay + 10% Coins
Mail Order	2 x Retail	2 x Retail	2 x Retail
DED / COINS / OOP			
Calendar Year Deductible (CYD)	Single/Family	Single/Family	Single/Family
In-Network (INN)	$0/$0	$500/$1,000	$1,300/$2,600
Out-of-Network (OON)	$500/$1000	$1,000/$2,000	$2,600/$5,200
Coinsurance (Coins)		75% Inpatient/	75% Inpatient/
In-Network	80% Coins	80% All others	80% All others
Out-of-Network	50% Coins	50% Coins	50% Coins
Out-of-Pocket Maximum (OOP) (Includes CYD, Copays, Coins)	Single/Family	Single/Family	Single/Family
In-Network (Network Blue)	$2,500/$5,000	$4,000/$8,000	$5,000/$10,000
Out-of-Network	$3,250/$6,500	$6,000/$12,000	$10,000/$20,000

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2015 Bi-Weekly Contribution Rates

DCPS Contributory Plan Rates

DCPS Contributory Rates apply to employees represented by the following Bargaining Unit and Non-Bargaining Group:
Administrative, AFSCME, Exempt, FOPD, IBEW, JSA, LIUNA, Paraprofessionals, Teachers, UOPD

Coverage Tier Levels	Employee 20-Deductions	Employee 24-Pay
Employee Only	$58.30	$48.58
Employee & Spouse	$337.49	$281.24
Employee & Child(ren)	$263.07	$219.23
Employee & Family	$591.34	$492.79
Medical FSA/myFBMC Card®	Employer Contributions to Medical FSA $450-Individual or $750-Dep/Family	

DCPS Non-Contributory Plan Rates

DCPS Non-Contributory Plan Rates apply to employees represented by the following Bargaining Units and Non-Bargaining Group:
Administrative, AFSCME, Exempt, FOPD, IBEW, JSA, LIUNA, Paraprofessionals, Teachers, UOPD

Coverage Tier Levels	Employee 20-Pay	Employee 24-Pay
Employee Only	$0.00	$0.00
Employee & Spouse	$239.28	$199.40
Employee & Child(ren)	$171.29	$142.74
Employee & Family	$471.23	$392.70
Medical FSA/myFBMC Card®	Employee Contributions Only	

DCPS HDHP Plan Rates

DCPS HDHP Rates apply to employees represented by the following Bargaining Units and Non-Bargaining Group:
Administrative, Exempt, FOPD, IBEW, JSA, LIUNA

Coverage Tier Levels	Employee 20-Pay	Employee 24-Pay
Employee Only	$0.00	$0.00
Employee & Spouse	$215.66	$179.72
Employee & Child(ren)	$153.75	$128.13
Employee & Family	$426.86	$355.71
Medical FSA/myFBMC Card®	Not Available	
Health Savings Account	Employer Contribution: $678.52	

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Florida Blue

In the pursuit of health®

The health and wellness of our employees and their family members is very important to the Duval County School Board. The goal of the District's health and wellness programs is to motivate our members with chronic conditions to take an active part developing their treatment plans to increase their quality of life. The District, in partnership with Florida Blue, provides our members' access to various resources to assist members with every aspect of their health care needs.

Questions	Resources	How to Access
Why pay more?	**Know Before You Go** Use our online Medical Cost Comparison Tool to shop around for health care services. You can save money and still get the quality care you deserve.	Go to **www.floridablue.com** and log into your Member Account - select Tools - select Medical Care Comparison
Questions about your treatment options?	**Care Consultants** Our team of Care Consultants is standing by to answer questions about your benefits, treatment choices and cost saving options.	Toll Free at **1-888-476-2227** Monday through Friday 8 AM to 9 PM
Want help face-to-face?	**Florida Blue Center** Visit or call the Florida Blue Center Retail Store nearest you with two Jacksonville locations, providing great customer service, in person. No appointment needed.	**River City Marketplace** 13141 City Station Drive #106 **St. Johns Town Center** 4855 Town Center Parkway Open 10 AM – 8 PM (Monday – Saturday) Toll Free at **1-877-3582-5830**
ER or doctor's office?	**Health Dialog 24-hour Nurse Line** Questions about health can come up at any time, including times when doctors' offices are closed. Our 24-hour nurse line can help you make informed health care choices.	Toll Free at **1-877-789-2583**
Plan benefits or claim question?	**On-Site Customer Service** The Florida Blue on-site Customer Service Representative is available to assist members with Benefit Issues including plan design questions and claim inquiries.	Pat Lewis Located on the 5th floor – DCPS Admin. Bldg. 904-390-2323 pat.lewis@bcbsfl.com
Need help with a claim or have other questions?	**Customer Service** Ask your customer service representative how to: Find out what's covered and how much you'll pay. Shop for the best value on upcoming medical procedures. Maximize your health plan benefits to save money. Access online tools and resources to help you better manage your health. Receive support for a health condition (like diabetes or asthma).	Toll Free at **1-800-664-5295** Monday – Thursday 8 AM – 6 PM Friday 9 AM – 6 PM
Prefer online help?	**Register your online Member Account to**: · Review your plan benefits · See your deductible · Find a participating doctor or hospital · View claim activity, status and history · Use your personalized WebMD site · Understand your upfront medical costs · Find tools to improve your health · Access our exclusive discount program	Go to **www.floridablue.com** and register. All you need to register is a valid email address, your SSN and your Member Number (located on your Florida Blue Member ID card).

All enrollment & eligibility questions should be directed to DCPS Employee Benefits Department at 904-390-2351.

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Pharmacy Benefits

Prime Therapeutics is the current Pharmacy Benefit Manager for Duval County Public Schools.

Member Services

Visit Prime Therapeutics' website, www.myprime.com, to view your plan design and co-payment information, search for details on prescription medications, locate a participating pharmacy near you, and manage your home delivery prescriptions. For additional plan inquiries, you may call Member Services directly at 1 800-664-5295. For future reference, this number is listed on the back of your Florida Blue ID card.

Benefit ID Cards

Present your ID card when filling a prescription at the pharmacy. Should you need additional or replacement ID cards, please contact Member Services or visit www.floridablue.com to either request a new card or print a temporary card.

Covered Expenses

- Federal legend prescription drugs, unless otherwise indicated;
- Drugs requiring a prescription under the applicable state law;
- Insulin, insulin needs and syringes on prescription; or
- Compound medications, of which at least one ingredient is a federal legend drug.

Medications

Generic Medications

Generic medications contain the same active ingredients as brand-name medications, are just as safe and effective, and meet the same U.S. Food and Drug Administration standards for quality, strength and purity. However, generic drugs normally cost substantially less than their brand name counterparts. Therefore, generic drugs offer a simple and safe alternative to help reduce your medication costs. Ask your doctor to see if a generic drug could treat your condition.

Formulary and Non-Formulary Medications

The Prime Therapeutics Formulary List is a guide for you and your doctor to refer to when filling out your prescriptions. If there is no generic medication available for your condition, there may be more than one brand name for you and your doctor to consider. Prime Therapeutics provides a list of formulary brand name medications to help you and your doctor decide on medications that are clinically appropriate and cost effective.

If a drug you are taking is not on the formulary list, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary list will keep your costs lower. A current drug list is available online or upon request by calling Member Services. To avoid paying higher co-payments associated with non-preferred drugs, please take this list with you when you visit your doctor so he or she can refer to it when prescribing medications for you and your eligible family participants.

Retail Pharmacies

Network Retail Pharmacies

The Prime Therapeutics Pharmacy Network is a national network comprised of thousands of retail pharmacies. The network includes most major chains, discount, grocery and independent pharmacies, so there is a good chance that your local pharmacy is a participating member of the network. To find a local pharmacy, visit www.myprime.com and click "Find a Pharmacy" or contact Member Services.

Mail Order Pharmacy

PrimeMail Pharmacy Program is designed for plan participants taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions. The program provides up to a 90-day supply of medication, delivered directly to your home or other requested location, postage paid.

In order to fill your prescription through PrimeMail Pharmacy Program, mail your prescription, order form and payment to PrimeMail. You may also ask your doctor to fax your prescription by calling 1-800-664-5295 for further instruction. Your medication will usually be delivered within 5-7 days of PrimeMail receiving your order.

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To order refills, call Member Services at 1-800-664-5295, or visit www.myprimemail.com Refills are normally delivered within 3 to 5 days. If you are a first-time visitor to the site, please take a moment to register and have your member ID and a prescription number available.

To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact Member Services.

If a new medication has been prescribed for you to take immediately, please ask your doctor to issue two prescriptions; one prescription should be written and filled at your local pharmacy and the second should be written for up to a 90-day supply and mailed to PrimeMail.

As you manage your prescriptions, please be aware that each and every prescription is filled and checked by highly qualified registered pharmacists to ensure that quantity, quality and strength are accurate. A patient profile is maintained on file to ensure that there are no adverse reactions with other prescriptions you are receiving from retail and/or mail order pharmacies. If any questions arise regarding potential drug interactions or other adverse reactions, Prime's pharmacists will contact either you or your doctor prior to dispensing the medication.

Medication Step Therapy

Step Therapy requires the previous use of one or more drugs before coverage of a different drug is provided. If your health plan's formulary guide reflects that Step Therapy is used for a specific drug, your physician must submit a prior authorization request form to the health plan for approval. If the request is not approved, please remember that you always have the option to purchase the medication at your own expense.

Prior Authorization

Prior authorization is required on some medications before your drug will be covered. If your health plan's formulary guide indicates that you need a prior authorization for a specific drug, your physician must submit a prior authorization request form to the health plan for approval. If the request is not approved, please remember that you always have the option to purchase the medication at your own expense.

Quantity Limits

Quantity limits applied to certain drugs based on the approved dosing limits established during the FDA approval process. Quantity limits are applied to the number of units dispensed for each prescription. If your health plan's formulary guide reflects that there is a quantity limit for a specific drug, your physician must submit a prior authorization request form to the health plan for approval. If the request is not approved, please remember that you always have the option to purchase the medication at your own expense.

Formulary Exception

Formulary Exceptions are necessary for certain drugs that are eligible for coverage under your health plan's drug benefit. Your physician must submit a formulary exception form to your health plan for approval. If the request is not approved by the health plan you may still purchase the medication at your own expense. The general form can be used if the drug you are requesting coverage for is not on the formulary list.

Rx Copay Summary

	DCPS Contributory Plan	DCPS Non-Contributory Plan	DCPS * HDHP w/HSA
Retail			Calendar Year Deductible MUST be met then:
Generic - Formulary	$7	$7	CYD + $7
Brand - Formulary	$25	$25	CYD + $25 + 10% Coins
Non-Formulary	$40	$40	CYD + $40 + 10% Coins
Specialty Injectables	$55	$55	CYD + $55 + 10% coins
Maximum Supply	One month	One month	One Month
Mail Order			Calendar Year Deductible MUST be met then:
Generic - Formulary	$14	$14	CYD + $14
Brand - Formulary	$50	$50	CYD + $50 + 10% Coins
Non-Formulary	$80	$80	CYD + $80 + 10% Coins
Maximum Supply	90 days	90 days	90 days

*HDHP W/HSA: Rx costs go to deductible. Once deductible is met, then employee pays co-pay for generic and co-pay+10% for all other Rx.

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Declination of Medical Coverage Opt-out Program

All benefit-eligible employees may elect to opt-out of medical insurance coverage during the annual Open Enrollment period – you must meet with an Enrollment Counselor to opt-out and provide the following:

- Completed Declination of Medical Coverage Affidavit; and
- Proof of other group employer coverage; or
- Proof of government-funded coverage (i.e. Medicaid, Medicare, TRICARE)

If you do not provide the affidavit and proof of other group employer or government-funded coverage, your medical coverage will automatically carry forward from the 2014 plan year:

Note: If you choose to opt-out of medical, you are still eligible for dental and/or vision coverage, and all other voluntary benefits.

Special Enrollment Period

An employee may re-enroll into the DCPS health plan only during an annual open enrollment period as determined by the School Board of Duval County, FL or during a "special enrollment period" (Change in Status). A "special enrollment period" is a period of time during which you may be able to elect to enroll yourself and/or dependents after one of the following events occur*:

- Loss of other medical insurance coverage – You may be able to enroll yourself and/or your dependent(s) provided that you request enrollment within sixty (60) days after such other coverage ends. In the case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for failure to timely pay the required premiums.

  Internal Revenue Service (IRS) guidelines state that the loss of coverage through an individual health plan does not constitute a valid Change in Status event.

- Acquiring a new dependent – If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption you may be able to enroll yourself and/or your dependents provided that you request enrollment within sixty (60) days after the date of marriage, birth, adoption or placement for adoption*.

**Note: In order to enroll a dependent, the employee must also be enrolled.*

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DUVAL COUNTY
PUBLIC SCHOOLS

Declination of Healthcare Coverage Affidavit

I hereby certify that:

1. I have been given an opportunity to fully participate in the group medical plans provided by Duval County Public Schools.
2. The benefits of the plans have been thoroughly explained to me and I decline to participate.
3. I understand that I will not be enrolled in a Board-paid medical plan. I will receive $10,000 Group Term Basic Life Insurance and $250 Flex Basic Dollars to defray the cost of voluntary pretax benefits (excluding life insurance).
4. I understand that I must provide proof of other group employer or government funded medical coverage (i.e. Medicaid, Medicare, TRICARE).

Reason for Declining Coverage:

☐ Covered by another employer's health plan

Carrier name_____

ID Number _____

Name(s) _____

☐ Covered under government-funded medical coverage (i.e. Medicaid, Medicare, TRICARE)
Specify plan name _____

ID Number _____

Name(s) _____

Special Enrollment Period
I understand that I may re-enroll into the DCPS health plan only during an annual open enrollment period as determined by the School Board of Duval County, FL or during a "special enrollment period" (Change in Status). A "special enrollment period" is a period of time during which you may be able to elect to enroll yourself and/or dependents after one of the following events occurs:

- **Loss of other medical insurance coverage** – You may be able to enroll yourself and/or your dependent(s) provided that you request enrollment within **sixty (60) days** after such other coverage ends. In the case of COBRA continuation coverage, you may be eligible for a special enrollment period if the COBRA coverage is exhausted. A special enrollment period is not available if coverage under your prior plan or COBRA coverage was terminated for failure to timely pay the required premiums.

  Internal Revenue Service (IRS) guidelines state that the loss of coverage through an *individual health plan* does not constitute a valid Change in Status event.

- **Acquiring a new dependent** – If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption you may be able to enroll yourself and/or your dependents provided that you request enrollment within **sixty (60) days** after the date of marriage, birth, adoption or placement for adoption.

I have read, understand and agree to comply with the requirements stated above. **Mid-year**: changes are effective the first day of the month following receipt of this completed form. **Open Enrollment:** changes are effective January 1.

Employee Name (Print): _____ Personnel #:_____

Employee Signature: _____ Date: _____

Return form to:
Duval County Public Schools - Benefits Department
1701 Prudential Dr., Ste. 209 Jacksonville, FL 32207
Phone: 904-390-2351 Fax: 904-390-2370

This Affidavit must be submitted with proof of other group or government funded healthcare coverage, even if previously submitted.

Dental Care

Dental Care Benefit Options

Delta Dental Insurance Company offers two choices for dental coverage:

- DeltaCare®USA Option (Prepaid) and
- Delta Dental PPO℠ Option (Indemnity).

The DeltaCare USA Option plan features no deductible and low out-of-pocket costs for your basic dental care, however, you must select a dentist from the provider listing at **deltadentalins.com**. The PPO Plan allows you the flexibility of choosing an in-network or out-of-network dentist at the time of service.

Selecting a Dentist

DeltaCare USA Option – Under this option, each family member can select a dentist, up to three dentists per family, from the DeltaCare USA Provider List located at **deltadentalins.com**.

Delta Dental PPO Option – Under this option, you can receive services from a PPO Dentist or the dentist of your choice.

To obtain a list of PPO dentists visit **deltadentalins.com**. You may be required to pay up-front costs and file a claim form if you use a non-Delta Dental dentist.

PPO Dentists will file claims on your behalf and have agreed to charge no more than the predetermined PPO fee schedule.

All benefits are subject to limitations and exclusions and governing administrative policies of the plan. The dental health plan contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment.

Your Tax-free Rates*

DELTACARE USA	20 Pay	24 Pay
Employee	$11.78	$9.82
Employee + one	$19.74	$16.45
Employee + family	$29.04	$24.20

DELTA DENTAL PPO	20 Pay	24 Pay
Employee	$26.45	$22.04
Employee + one	$52.66	$43.88
Employee + family	$68.63	$57.20

*Premiums may be deducted pre-tax or post-tax.

Family Coverage

This plan covers:

- Your spouse
- Your dependent children to the end of the month they reach age 26.
- Disabled dependent children are covered as long as disability remains total. A physician's statement will be required.

DeltaCare USA Benefits

- No maximum benefit, except for accidental injury
- No claim forms to complete
- Budgetable and predictable
- Co-pay for orthodontics - No waiting periods
- No co-pays for basic cleanings (2 per calendar year)
- Specialty care is covered by referral from your primary dentist at the same defined co-pays as general dentists

For the 2015 Plan Year (January 1, 2015 through December 31, 2015, all rates are shown for 20 or 24 payroll deduction cycles.

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Delta Dental provides an automated eligibility and benefit information line. You can print ID cards from the Delta Dental website.

Delta Dental PPO:
Monday - Friday,
8:00 a.m. - 8:00 p.m. ET at
800-521-2651
deltadentalins.com

DeltaCare®USA:
Monday - Friday,
8:00 a.m. - 9:00 p.m. ET at
800-422-4234
deltadentalins.com

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DeltaCare USA - Accident Injury Benefit

An accidental oral injury is damage to the hard and soft tissue of the mouth caused directly and independently of all other causes by external forces. Damage to the hard and soft tissue of the mouth from normal chewing function is covered under your Plan FLM08 Description of Benefits and Co-payments.

Plan Features

- Delta Dental will pay up to 100 percent of the Contract Dentist's "filed fees*," for expenses an enrollee incurs for an accident injury, less any applicable co-payments, up to a maximum of $1,600 in any 12-month period.
- Accident injury benefits include tooth re-implantation and/or stabilization of accidentally evulsed (lost) or displaced tooth and/or alveolus (bone). This includes splinting and/or stabilization. (CODE D7270)

Limitations

Accident injury benefits are limited to services provided as a result of an accident which occurred:

- while the enrollee was covered under the DeltaCare USA program or
- while the enrollee was covered under another DeltaCare USA program, and if the benefits for the expenses incurred would have been paid if the enrollee had remained covered under that program.

Exclusions

In addition to limitations #13, #15, #20, #21 and #24, and exclusions #1 - 9, #11 - 15 and #18 - 20 in Schedule B of your Plan FLM08 Description of Benefits and Co-payments, the following exclusions apply:

- Prophylaxis
- Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue)
- Replacement of existing restorations due to decay
- Orthodontic services (treatment of malalignment of teeth and/or jaws)
- Replacement of existing restorations, crowns, bridges, dentures and other dental or orthodontic appliances damaged by accident injury.

What if I have questions about this benefit?

After you enroll, you can get answers by calling Delta Dental's Customer Service department at 800-422-4234.

* "Filed fees" are the contract dentist's fees on file with Delta Dental.

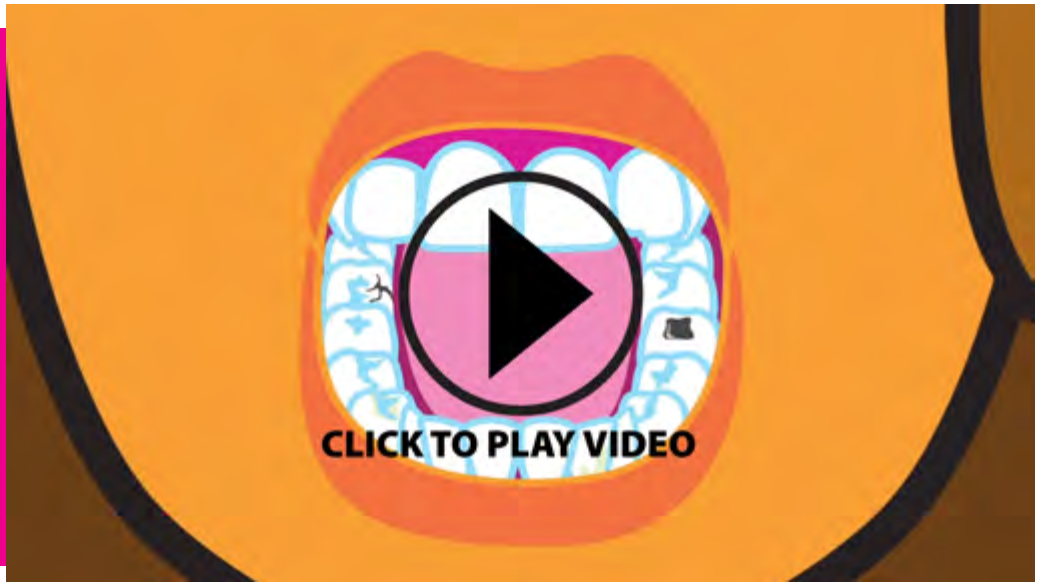
DeltaCare USA

The health plan contract must be consulted to determine the exact terms and conditions of coverage.

Benefit	DeltaCare USA Plan FLM08
Choose a panel dentist	
Deductible	none
(Calendar Year is Jan. 1 - Dec. 31)	
Calendar Year Maximum	none
Claim Forms	none
Diagnostic Procedures	**You Pay**
Office visit	$0 - $20
Routine exams	no cost
Prophylaxis (cleaning) - basic	no cost (2 per calendar yr.)
Emergency treatment	$10 (regular office hours)
X-ray and complete series including bitewings**	no cost
Fluoride application	no charge to age 19 (one per 6 months)
Basic/restorative procedures	
Simple extractions	$6
Amalgam fillings - 1 surface perm	no cost
Resin based fillings - posteriors	$15 - $35
Root canal - anterior***	$75
Root canal - molar***	$180
Major procedures	
Crowns - porcelain, base metal	$195
Crowns - porcelain, high noble metal	$295
Dentures - upper/lower	$225
Bridges - porcelain, base metal	$195 (per unit)
Bridges - resin, high noble metal	$295 (per unit)
Periodontics	
Scaling and root planing	$45 per quadrant
Orthodontics	
Start up fee	$350
Routine 24 month fully banded case	
Adult	$2,000
Child	$1,800

** Under the DeltaCare USA plan, bitewing X-rays (code D0274) are limited to not more than one series of four films in any six-month period.

*** Excluding final restoration



Temporomandibular Joint (TMJ) Dysfunctions

Delta Dental will pay 100 percent of the Dentist's usual fees or of the fees actually charged for covered TMJ procedures, as noted herein, up to a lifetime benefit maximum of $400.00, per enrollee, less any applicable co-payments for covered procedures. TMJ benefits are intended only for the treatment of the temporomandibular (jaw) joint and are limited to the procedures noted below when provided by a licensed dentist as necessary according to the standards of generally accepted dental practice and only when provided for the treatment of the TMJ:

D7880	Occlusal orthotic device;
D7899	Temporary repositioning appliance;
D9310	Consultation;
D9940	Occlusal guard;
D9951	Occlusal adjustment – limited;
D9952	Occlusal adjustment – complete

TMJ benefits are subject to plan limitations and exclusions of benefits.

To locate a dental provider or facility

Please visit **deltadentalins.com** and click the "Find a Dentist" link on the homepage. You may also call the Delta Dental Customer Service department at 800-422-4234 for updated provider information. If any office is closed to further enrollment, Delta Dental reserves the right to assign you another dental office as close to your home as possible.

In Florida, DeltaCare USA is underwritten and administered by Delta Dental Insurance Company.

Note: Contact the provider before making your choice if you have scheduling problems or small children.

Sample Claim Payment

(Assuming deductible and contract provisions are met)

	PPO Dentist	Premier Dentist	Non-Delta Dental Dentist
Dentist Submitted Amount	$130.00	$130.00	$130.00
Delta Dental Approved Amount	$71.00	$115.00	$130.00
Delta Dental Allowed Amount	$71.00	$115.00	$96.00
Delta Dental Payment	$56.80	$92.00	$76.80
Patient Payment	$14.20*	$23.00*	$53.20*

*The difference between the Approved Amount and the Delta Dental Payment.

Delta Dental PPO and Premier Providers

Visit **deltadentalins.com** for a complete and up-to-date listing of Delta Dental Premier® Dentists in your area.

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PPO Dentist Benefits

No hassle administration: Claim forms are completed and submitted by the PPO dental office - not the patient.

How the PPO Program Option Plan Works

The Delta Dental PPO Option Plan allows each person covered under the plan to have the freedom to visit any dentist. There may be a savings advantage to receiving care from a PPO Dentist because your out-of-pocket costs tend to be lower than visiting a non-Delta Dental dentist.

When you visit a PPO Dentist, payment is based on the PPO fee schedule. The PPO Dentist has agreed to accept this fee as the Approved Amount. Although you are responsible for deductibles, co-insurances and any expenses above the maximum, a PPO Dentist cannot bill you for any covered charges above the approved amount.

In addition to PPO Dentists, Delta Dental has Participating Delta Dental Premier® Dentists. You can search for a Delta Dental Dentist (Premier and PPO) by visiting our website at **www.deltadentalins.com**.

Although you are responsible for deductibles, co-insurances and any expenses above the maximum, Premier dentists have an agreement with Delta Dental not to charge you more than the Approved Amount.

Family Coverage

This plan covers:

- Your spouse
- Your dependent children to the end of the month they reach age 26.
- Disabled dependent children are covered as long as disability remains total.

The Delta Dental PPO Plan is underwritten and administered by Delta Dental Insurance Company.

Delta Dental PPO Option

The health plan contract must be consulted to determine the exact terms and conditions of coverage.

BENEFIT	DELTA DENTAL INDEMNITY (PPO OPTION)**
Use dentist of choice	
Deductible* (Calendar Year is Jan. 1 - Dec. 31)	$75 per year, individual $150 per year, per family
Calendar Year Maximum	$5,000 per person
Claim Forms	None if using Delta Dental dentists
Procedures	**Delta Dental reimbursement according to PPO In/MPA Out fee schedule**
Office visit	100%
Routine exams	100%
Prophylaxis (cleaning) - basic	100% (limit 2 in 12 months)
Emergency treatment	80%
X-ray and complete series including bitewings	100% (1 per 36 months- full)
Under 18	(2 per 12 months - bitewing)
Over 18	(1 per 12 months - bitewing)
Fluoride application	100% (2 per 12 months, children under 19 only)
Basic/restorative procedures	
Oral surgery (extractions)	80%
Amalgam fillings	80%
Root canal	80%
Major procedures	
Crowns	50%
Dentures	50%
Bridges	50%
Periodontics	50%
Orthodontics	50% up to $1,000 lifetime maximum after 1 year waiting period (dependent children under age 19 only)
Waiting Period	Applies to new participants (orthodontics only)
TMJ benefit	50% up to $1,000 lifetime maximum (effective October 2006)

* Note the deductible does not apply to diagnostic & preventative services, orthodontics

** PPO Dentists are limited to the PPO fee.
Delta Dental Premier® Dentists are limited to the least of: the dentist's filed fee, submitted fee, or Delta Dental's MPA (Maximum Plan Allowance) fee.
Non-Delta Dental Dentists may balance bill for amounts over Delta Dental's MPA-TJM Benefits (Maximum Plan Allowance) fee.

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Vision Care

Your Rates*

	20 Pay	24 Pay
Employee	$3.01	$2.51
Employee + Family	$8.57	$7.15

* Premiums may be paid either "before" or "after" taxes are deducted from your salary.

For the 2015 Plan Year (January 1, 2015 through December 31, 2015), all rates are shown for 20 or 24 payroll deduction cycles.

Davis Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

- Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]
- Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]
- One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks®

For more details about the plan, just log on to the Open Enrollment section of our Member site at davisvision.com or call **1.877.923.2847** and enter Client Code **3651**

Value for Davis Vision Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Replacement contacts through Davis Vision contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

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In-Network Benefits

Eye Examination	Every January 1, Covered in full after $10 co-payment
Eyeglasses	
Spectacle Lenses	Every January 1, Covered in full For standard single-vision, lined bifocal, or trifocal lenses after $15 co-payment
Frames	$130[6] retail allowance toward any frame from provider, plus 20% off balance[2] OR Every other January 1, Covered in full Any Fashion or Designer frame from Davis Vision's Collection[1] (value up to $175)
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every January 1, Collection Contacts: Covered in full OR Non Collection Contacts: Standard Contacts: 15% discount[2] Specialty Contacts[3]: 15% discount[2]
Contact Lenses (in lieu of eyeglasses)	$150 retail allowance toward provider supplied contact lenses, plus 15% off balance[2] OR Every January 1, Covered in full Any contact lenses from Davis Vision's Contact Lens Collection[1]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS

MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	**Without Davis Vision**	**With Davis Vision**
Scratch-Resistant Coating	$40	$0
Polycarbonate Lenses	$64	$0[4] - $30
Standard Anti-Reflective (AR) Coating	$62	$35
Standard Progressives (no-line bifocal)	$154	$50
Plastic Photosensitive (Transitions®[5])	$123	$65

1. The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.
2. Additional discounts not applicable at Walmart, Sam's Club or Costco locations.
3. Including, but not limited to toric, multifocal and gas permeable contact lenses.
4. For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
5. Transitions® is a registered trademark of Transitions Optical Inc.
6. Enhanced frame allowance of $180 only available at Visionworks locations nationwide.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

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Service	Without Davis Vision	With Davis Vision
Eye Examination	$100	$10
Lenses		
Bifocals	$80	$15
Scratch-Resistant Coating	$40	$0
Transitions®[5]	$123	$65
Frame	$150	$0
Total	**$493**	**$90**

Additional Options	Without Davis Vision	With Davis Vision
Frames		
Fashion Frame (from the Davis Vision Collection)	$125	$0
Designer Frame (from the Davis Vision Collection)	$175	$0
Premier Frame (from the Davis Vision Collection)	$225	$25
Lenses		
All Ranges of Prescriptions and Sizes	**$90**	**$0**
Plastic Lenses	**$33**	**$0**
Oversized Lenses	**$20**	**$0**
Tinting of Plastic Lenses	**$20**	**$0**
Scratch-Resistant Coating	**$40**	**$0**
Polycarbonate Lenses	$64	$0[1] or $30
Ultraviolet Coating	$28	$12
Standard Anti-Reflective (AR) Coating	$62	$35
Premium AR Coating	$80	$48
Ultra AR Coating	$113	$60
Standard Progressive Addition Lenses	$154	$50
Premium Progressives (Varilux® [2], etc.)	$248	$90
Ultra[3] Progressive Addition Lenses	$430	$140
High-Index Lenses	$120	$55
Polarized Lenses	$103	$75
Plastic Photosensitive Lenses	$123	$65
Scratch Protection Plan (Single vision | Multifocal lenses)		$20|$40

1. Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.
2. Varilux® is a registered trademark of Societe Essilor International
3. Category includes digital free-form progressive lenses.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE	
Eye Examination	up to $35
Frame	up to $50
Spectacle Lenses (per pair) up to:	
Single Vision	$25
Bifocal/progressive	$40
Trifocal	$60
Lenticular	$100
Elective Contacts	up to $150
Medically Necessary Contacts	up to $210

Contact Info

For more details about the plan, just log on to the Open Enrollment section of our Member site at davisvision.com or call 1.877.923.2847 and enter Client Code 3651.

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Flexible Spending Accounts

Medical FSA

A Medical FSA is used to pay for eligible medical expenses which aren't covered by your insurance or other plan. These expenses can be incurred by you, your spouse, a qualifying child or relative. Your full annual contribution amount is available at the beginning of the plan year, so you don't have to wait for the money to accumulate.

An individual is an adult child if they do not attain age 27 during the taxable year.

An individual is a qualifying child if they do not attain age 19 or age 24 if a full-time student, during the taxable year and:

- are a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- have a specified family-type relationship to you
- live in your household for more than half of the taxable year, and
- provides no more than 50% of his/her own support for the calendar year.

Note: There is no age requirement for a qualifying child if they are physically and/or mentally incapable of self-care.

An individual is a qualifying relative if they are a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- have a specified family-type relationship to you, are not someone else's qualifying child and receive over one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive over one-half of their support from you during the taxable year.

Dependent Care FSA

The Dependent Care FSA is a great way to pay for eligible dependent care expenses such as after school care, baby-sitting fees, elder care services, nursery and preschool. Eligible dependents include your qualifying child, spouse and/or relative.

You can request reimbursement from your Dependent Care FSA as often as you like. However, your approved expense will not be reimbursed until the last date of service for which you are requesting reimbursement has passed. Also, remember that for timely processing of your reimbursement, your payroll contributions must be current.

Annual Contribution Limits

For Medical Expense FSA:

Minimum Annual Deposit: None
Maximum Annual Deposit: $2,500

For Dependent Care FSA:

Minimum Annual Deposit: $250
The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual deposit is $2,500.
- If you are single and head of household, your maximum annual deposit is $5,000.
- If you are married and filing jointly, your maximum annual deposit is $5,000.
- If either you or your spouse earn less than $5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is $3,000 a year for one dependent and $5,000 a year for two or more dependents.

Typical FSA-Eligible Expenses

Use your FSA to save on hundreds of products and services for you and your family. Eligible expenses are defined by the IRS and your employer. For details and more eligible expenses, visit: **www.myfbmc.com.**

Eligible medical expenses
Typically, your Medical FSA covers:

Acupuncture
Ambulance service
Birth control pills and devices
Breast pumps
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Over-the-counter items (some require prescription)
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/ treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

Eligible dependent care expenses
Your Dependent Care FSA typically covers expenses, such as:

After school care
Baby-sitting fees
Day care services
In-home care/au pair services
Nursery and preschool
Summer day camps

Typical Ineligible Expenses

For Medical FSA:

- insurance premiums
- vision warranties and service contracts
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition and
- over-the-counter items requiring a prescription.

For Dependent Care FSA:

- books and supplies
- child support payments or child care if you are a non-custodial parent
- health care or educational tuition costs and
- services provided by your dependent, your spouse's dependent or your child who is under age 19.

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FSA Savings Example

	(With FSA)	(Without FSA)
Annual Gross Income	$31,000.00	$31,000.00
FSA Deposit for Eligible Expenses	- 2,500.00	- 0.00
Taxable Gross Income	$28,500.00	$31,000.00
Federal, Social Security Taxes	- 6,455.25	- 7,021.50
Annual Net Income	$22,044.75	$23,978.50
Cost of Eligible Expenses	- 0.00	- 2,500.00
Spendable Income	$22,044.75	$21,478.50

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of **$566.25!**

Using Your FSA Dollars

When you pay for an eligible health care or dependent care expense, you want to put your account to work right away. WageWorks gives you several convenient reimbursement options.

Filing a claim

You can file a claim online to request reimbursement for your eligible expenses. To submit a paper claim by fax or mail, log into your account, download a Pay Me Back claim form and follow the instructions for submission. You may also contact Customer Service at 1-855-5MY-DCPS (855-569-3277) to obtain a claim form.

- Go to www.myfbmc.com, log into your account and click the Health Care or Dependent Care tab.
- Select the online claim form.
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
  - ✓ Date of service or purchase
  - ✓ Detailed description
  - ✓ Provider or merchant name
  - ✓ Patient name
  - ✓ Patient portion (or amount owed)

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter.

- If you use your Card at an eye doctor's or dentist's office, you will most likely be asked to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do so will result in your Card being suspended.
- If you lose your Card, please call WageWorks immediately and order a new one. You will be responsible for any charges until you report the lost Card.

Examples of how to use your FSA

Medical FSA Example:

Paying an office visit

After paying for your care at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with a claim form to WageWorks. Within five business days, WageWorks will process your request and mail your reimbursement check to you or direct deposit your funds into the account of your choice. Or, you may have the ability to use your WageWorks Health Care Card, and have instant access to your medical reimbursement funds.

Dependent Care FSA Example:

Paying for dependent care services

Once you have paid for (and received) dependent care service, send a completed claim form to WageWorks, along with documentation showing the following:

- Provider Name – Facility name or person who provided the service.
- Dates of Service – Start and end dates for services provided.
- Service Description – Detailed description for services provided.
- Amount – The amount incurred for the services.
- Dependent Name – Person who received the service.

Your request will be processed within five business days and either mailed to you or deposited into the account you have chosen.

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Appeals

To Appeal a Denied Medical FSA or Dependent Care FSA Claim

If you feel your claim was denied in error, you have the right to file an appeal by writing a letter that explains why you believe the claim should be approved.

Your appeal may be submitted in writing and mailed to:

WageWorks Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

Otherwise, your appeal may be submitted in writing and faxed to:

Fax Number: 1-877-220-3248

- Your appeal must be received within 180 days of the date you receive notice that your claim was denied.
- You will be notified of the decision regarding your appeal in writing by WageWorks within 30 days of receipt of your written appeal.
- You can request copies of all documents and information related to your denied claim. These will be provided at no charge.
- For Medical FSAs: You are welcome to submit additional information related to your claim along with your appeal, such as: written comments, documents, records, a letter from your health practitioner indicating medical necessity of the denied product or service, and any other information you feel will support your claim.

Important Considerations

It is important to be conservative in making elections because any unused funds left in your FSA at the close of the Plan Year are not refundable to you. You are urged to take precautionary steps, such as tracking account balances on the WageWorks website and/or using the Interactive Voice Response System, to avoid having funds remaining in your account at year-end.

Changing Elections During the Plan Year:

You may change your FSA elections during the Plan Year only if you experience a change in status such as:

- a marriage or divorce
- birth or adoption of a child; or
- a change in employment status

Refer to the Change In Status section for a list of valid events for changing elections mid year.

Appeal Review Process for FSA Claims

- Your appeal will be reviewed by a person who was not involved with the initial claim denial and who is not a subordinate of any person who was.
- The review will be a fresh look at your claim and appeal without reference to the initial denial and will take into account all information submitted with your claim and/or appeal.
- You will be notified of the decision regarding your appeal in writing by WageWorks within 30 days of receipt of your written appeal.
- The appeal decision on review is the Third Party Administrator's (WageWorks) final decision. If you choose to appeal this claim again, your employer has the final coverage decision.

Important FSA Notes:

- You have a **91-day run-out period** (ending March 31, 2016) after your plan year ends to submit reimbursement requests for all eligible FSA expenses (for both Medical Expense or Dependent Care FSAs) incurred DURING your plan year.

Send all FSA Pay Me Back forms to:

Fax Toll-Free : 1-855-291-0625
Mail to: Claims Administrator
P.O. Box 14326
Lexington, KY 40512

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About Your Card

While your WageWorks Health Care Card and account offer a great deal of convenience, both are regulated by IRS rules that all participants are required to follow. In most instances, you will be able to use your Card with little or no inconvenience. There are, however, situations where the Card will be declined or you will be required to submit receipts and/or other documentation to verify that the item or service purchased was eligible.

How To...

Use your Card

You can use your Card in these ways:

1) For eligible goods and services at health care providers and select pharmacies
2) For eligible over-the-counter (OTC) non-drug items at general merchandise stores (including most drugstores) that have an industry standard (IIAS) inventory and checkout system
3) For prescribed OTC drugs at the pharmacy counter, as long as the drug is dispensed as a valid prescription. In most instances, your Card transaction will be verified at checkout, which means you will not have to submit a receipt to WageWorks after the transaction. You are, however, required to keep each receipt for tax purposes, and in the event it is needed for verification.

Before shopping for prescriptions and over-the-counter items, always visit www.sigis.com for a list of merchants that have an IIAS system in place.

Use your Card at the doctor or other health care provider

If you use the Card at a health care provider or at a pharmacy that does not have an IIAS system, WageWorks will likely require that you submit a receipt or your health insurance explanation of benefits (EOB) to verify that the transaction was for an eligible health care expense or service.

Verify a Card transaction after the purchase

If WageWorks is unable to determine that your Card was used to pay for eligible health care products and services, you will need to take the following action to verify the transaction:

- Log into your account at **www.myfbmc.com**
- Click on the "Submit Receipts or Claim" link on the right-hand side of the Welcome page
- Select the unverified transaction
- Scan and upload the corresponding receipt and/or documentation

If you have lost or misplaced the receipt, you can submit a substitute receipt of equivalent value or repay your account.

- To mail or fax your documentation:
  Fax Toll-Free: 1-855-291-0625
  Mail to: **Claims Administrator**
  P.O. Box 14326
  Lexington, KY 40512

Make sure your receipts meet the requirements for verification

In order for the receipt (or any documentation) to be valid, it must include the five specific pieces of information required by the IRS:

- The patient name
- Provider name
- Date of service
- Type of service
- The amount you were charged or your cost (e.g. your deductible or co-pay amount or the portion not covered by your insurance)
- For OTC prescriptions drugs, the receipt must also include the prescription number. If not included, a copy of the prescription must accompany the receipt.

Know when a Card transaction needs to be verified

WageWorks will notify you of any Card transactions that require attention by email and when you log into your account.

Using your Smartphone or Mobile Device

With the EZ Receipts mobile app from WageWorks, you can file and manage your reimbursement claims and Card usage paperwork on the spot, with a click of your smartphone or mobile device camera, from anywhere.

Quick Tips

Log into your account at **www.myfbmc.com** regularly to see if you have any Card transactions in need of verification.

If you have a Card transaction that requires verification, you will be notified immediately on the Welcome page upon login and via email. Remember to also monitor the Statement of Activity page for pending transactions, as it can take up to three weeks to verify a purchase. If a pending transaction cannot be verified, the Status will update to "Receipt Needed."

Avoid problems: Act quickly to resolve all unverified transactions.

You have 90 days from the date of the transaction to take care of any outstanding unverified purchases. If you do not take action within 90 days your Card will be suspended.

If your Card is suspended, it will be reactivated within 24 – 48 hours after receipts or repayment have been processed for all unverified Card transactions.

Use EZ Receipts:

- Download the app from www.wageworks.com.
- Log into your account.
- Choose the type of receipt from the simple menu.
- Enter some basic information about the claim or Card transaction.
- Use your smartphone camera or device to capture the documentation.
- Submit the image and details to WageWorks.

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FSA Worksheets

Use the worksheets below to determine how much to deposit in your FSA. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount (including the administrative fees) cannot exceed established IRS and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any monies remaining in your accounts cannot be returned to you or carried forward to the next plan year. Be sure to include the DCPS Contributory Plan contribution for the Employee-only medical and Dependent medical when calculating your total on the Medical FSA worksheet.

Medical FSA Worksheet

Estimate your eligible, uninsured out-of-pocket medical expenses for the plan year.

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Coinsurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses	$ _____
TOTAL (cannot exceed $2,500)	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.	$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Dependent Care FSA Worksheet

Estimate your eligible dependent care expenses for the plan year. Remember that your calculated amount cannot exceed the calendar year limits established by the IRS.

CHILD CARE EXPENSES

Day care services	$ _____
In-home care/au pair services	$ _____
Nursery and preschool	$ _____
After school care	$ _____
Summer day camps	$ _____

ELDER CARE SERVICES

Day care center	$ _____
In-home care	$ _____
TOTAL Remember, your total contribution cannot exceed IRS limits.	$ _____
DIVIDE by the number of paychecks you will receive during the plan year.*	÷ _____
This is your pay period contribution.	$ _____

* If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Direct Deposit delivers your money to you faster, and unlike with a check, the funds are in your account automatically – no waiting in bank or ATM lines, no waiting for it to clear.
You will have the opportunity to elect Direct Deposit reimbursements when setting up your profile.

Please note the bank information entered will be sent to the bank to confirm the account number. Any reimbursements issued during this pre-note process will be issued as a check until this process has been completed. If you do not want your reimbursements sent via direct deposit, you may have your reimbursements sent via a check to your home address.

Allstate Benefits Group Voluntary Hospital Indemnity Insurance

Policy GVSP1FL

- Guaranteed Issue
- All benefits are paid direct to insured, unless assigned
- Benefits increase 5% each year for the first 6 years the policy remains in force at no corresponding increase in premium
- Rates are age banded; unisex
- 4 Tier Coverage options include: Employee Only, Employee + Spouse, Employee + Children and Employee + Family
- Eligible to full time employees; excludes part-time, temporary and seasonal employees
- This plan is not HSA compatible

Group Voluntary Hospital Indemnity Insurance (GVSP1(FL)) Policy Benefits

Policy GVSP1 pays the following benefits for services and treatments administered to or received by a covered person. Such treatment or service must be (a) incurred by a covered person while coverage under the policy and certificate is in force on that person; (b) necessary for the care and treatment of sickness or injury of a covered person; and (c) recommended by a physician. Any loss not stated is not covered. Treatment must be received in the United States or its territories. Benefits increase each coverage year up to year 6.

Terms of Coverage

Family Plan coverage may include employee/member, spouse and dependent children as defined in the policy. Individual and Spouse coverage includes employee/member and spouse. Individual and Children coverage includes employee/member and eligible children as defined in the policy.

Effective Date

The effective date of coverage will be the policy date assigned by the Home Office and shown on the certificate specification page, not the application date.

Pre-Existing Condition Limitation

Allstate Benefits does not pay for any loss due to a pre-existing condition as defined during the 12-month period beginning on the date that person became a covered person. A Pre-Existing Condition is a disease or physical condition for which: symptoms existed within the 12 month period prior to the effective date of coverage; or medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage. A pre-existing condition can exist even though a diagnosis has not yet been made.

Policy Limitations and Exclusions

Allstate Benefits does not pay benefits caused by or resulting from:

- injury or sickness incurred prior to the covered person's effective date of coverage subject to the Pre-Existing Condition Limitation and Incontestability provisions; or
- any act of war whether or not declared, participation in a riot, insurrection or rebellion; or
- suicide, or any attempt at suicide, whether sane or insane; or
- any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician; or
- participation in any form of aeronautics (including parachuting, parasailing and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or

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- injury incurred while engaging in an illegal occupation or committing or attempting to commit an assault or felony; or
- dental or plastic surgery for cosmetic purposes except when such surgery is required to: (a) treat an injury; or (b) correct a disorder of normal bodily function; or
- alcoholism, drug addiction, or dependence upon any controlled substance; or
- mental or nervous disorders; or
- intentionally self-inflicted injuries; or
- a newborn child's routine nursing or routine well baby care during the initial hospital confinement; or
- childbirth occurring within the first 10 months of the covered person's effective date of coverage (complications of pregnancy are covered to the same extent as a sickness); or
- hospitalization that begins before the covered person's effective date of coverage; or
- the reversal of a tubal ligation and vasectomy; or
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law; or
- routine eye examinations or fitting of eye glasses; or
- hearing aids or fitting of hearing aids; or
- dental examinations or dental care other than expenses resulting from an accident; or
- driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.

Termination of Coverage

The insured employee's/member's coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which any required premium payments were made; or the last day the insured employee/member is in active employment, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision in the policy; or the date the insured employee/member is no longer in an eligible class; or the date the insured employee's/member's class is no longer eligible. If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. Coverage for your child will end on the issue day of the month that follows when the child reaches age 26 or otherwise does not meet the requirements of an eligible dependent.

Portability Privilege

If your coverage terminates for reasons other than non-payment of premium, or if coverage of a spouse terminates due to divorce or your death, or if coverage of a child terminates due to the dependent child reaching age 26, the covered person will be eligible for portability coverage. This means the covered person may continue the same benefits you had under the group policy, subject to the conditions defined in the policy, as long as premiums are paid directly to American Heritage Life Insurance Company."

Coverage Subject to Policy

Coverage under the certificate is subject in every way to the terms of the policy that is issued to the policyholder. The group policy may at any time be amended or discontinued by agreement between AllState Benefits and the policyholder. The certificate holder's consent is not required for this. Nor is Allstate Benefits required to give the certificate holder prior notice. This illustration highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy and sets fourth, in detail, the rights and obligations of both the insured and the insurance company.

The policy Limited Benefit Insurance which supplemental benefits as defined in the policy. The policy are not a Medicare Supplement Policy. If eligible for Medicare, review the Medicare Supplement Buyer's Guide, available from Allstate Benefits.

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Initial Hospitalization Confinement Benefit	Year	Low Plan	Medium Plan
Allstate Benefits pays the benefit amount shown for the first confinement to a hospital during a coverage year, provided a benefit is paid under the Daily Hospital Confinement Benefit. The benefit is payable only once per covered person per continuous hospital confinement and per coverage year. The benefit is not paid for normal pregnancy or complications of pregnancy, or for a newborn child's initial hospitalization after birth.	1	$415.00	$1,245.00
	2	$435.75	$1,307.25
	3	$456.50	$1,369.50
	4	$477.25	$1,431.75
	5	$498.00	$1,494.00
	6+	$518.75	$1,556.25

Daily Hospital Confinement Benefit	Year	Low Plan	Medium Plan
Allstate Benefits pays the benefit amount shown for each day a covered person is admitted to and confined as an inpatient in a hospital as a result of an injury or sickness. Maximum of 180 days for each period of continuous hospital confinement. The benefit is not payable for a newborn child's routine nursing or routine well baby care during the initial hospital confinement.	1	$165.00/day	$495.00
	2	$173.25/day	$519.75
	3	$181.50/day	$544.50
	4	$189.75/day	$569.25
	5	$198.00/day	$594.00
	6+	$206.25/day	$618.75

Hospital Intensive Care Benefit	Year	Low Plan	Medium Plan
Allstate Benefits pays the amount shown for each day a covered person is confined to a hospital intensive care unit, provided a benefit is also paid under the Daily Hospital Confinement Benefit. The covered person must provide proof for each day that a hospital intensive care room and board charge is incurred. Paid in addition to the Daily Hospital Confinement Benefit. Maximum of 60 days for each period of continuous hospital confinement.	1	$165.00/day	$495.00
	2	$173.25/day	$519.75
	3	$181.50/day	$544.50
	4	$189.75/day	$569.25
	5	$198.00/day	$594.00
	6+	$206.25/day	$618.75

Surgery Benefit	Year	Plan
Allstate Benefits pays a benefit up to the amount shown, depending on the surgery, for a surgical operation performed in a hospital or an ambulatory surgical center. Two or more procedures performed at the same time through one incision are considered one operation; Allstate Benefits pays the amount shown in the Schedule of Operations for the operation with the largest benefit. If any operation other than those listed is performed, Allstate Benefits pays an amount based upon the amount stated in the Schedule of Operations for the most comparable procedure.	1	$33.00 to $825.00
	2	$34.65 to $866.25
	3	$36.30 to $907.50
	4	$37.95 to $948.75
	5	$39.60 to $990.00
	6+	$41.25 to $1,031.25

Anesthesia Benefit	Benefit Amount – All Plans
Pays 25% of surgical benefit for anesthesia received by a covered person during the course of a covered surgical operation.	25% of Surgery Benefit

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Inpatient Physician's Treatment Benefit	Year	All Plans
Allstate Benefits pays the amount shown for each day a covered person requires and receives the services of a physician (other than a surgeon) during a covered hospital confinement. The benefit is payable for the number of days the Daily Hospital Confinement Benefit is payable.	1	$41.00/day
	2	$43.05/day
	3	$45.10/day
	4	$47.15/day
	5	$49.20/day
	6+	$51.25/day

Outpatient Emergency Accident Benefit	Year	All Plans
Allstate Benefits pays the amount shown for each day a covered person, as a result of an injury, requires medical or surgical treatment in an emergency treatment center. Limited to 2 days per covered person per coverage year.	1	$415.00/day
	2	$435.75/day
	3	$456.50/day
	4	$477.25/day
	5	$498.00/day
	6+	$518.75/day

Outpatient Physician's Treatment Benefit	Year	All Plans
Allstate Benefits pays the amount shown if a covered person is treated by a physician for any cause outside of a hospital. Limited to 5 days per covered person per coverage year; and a maximum of 10 days per coverage year for Individual and Spouse coverage or Individual and Children coverage; or a maximum of 15 days per coverage year if Family Coverage.	1	$41.00/day
	2	$43.05/day
	3	$45.10/day
	4	$47.15/day
	5	$49.20/day
	6+	$51.25/day

At Home Nursing Benefit	Year	All Plans
Allstate Benefits pays the amount shown for each day a covered person requires at home nursing care during the 60 days following a hospital confinement covered under the policy. At home nursing services must be required and authorized by the attending physician. The benefit is limited to a total of 30 days within the 60 days following a covered hospital confinement.	1	$83.00/day
	2	$87.15/day
	3	$91.30/day
	4	$95.45/day
	5	$99.60/day
	6+	$103.75/day

Ambulance Benefit	Year	All Plans
Allstate Benefits pays the amount shown for transfer by a licensed ambulance service or hospital owned ambulance to a hospital or emergency treatment center (for air ambulance, the benefit pays 2 times the amount stated). Limited to a maximum of 3 days per covered person, per coverage year.	1	$249.00/day
	2	$261.45/day
	3	$273.90/day
	4	$286.35/day
	5	$298.80/day
	6+	$311.25/day

Non-Local Transportation Benefit		
Allstate Benefits pays the amount shown when a covered person requires hospital confinement for treatment prescribed by the local attending physician that cannot be obtained locally. Non-local treatment must be received beyond a 100-mile radius from the home of the covered person. Limited to 3 round trips per covered person per coverage year.	1	$249.00/day
	2	$261.45/day
	3	$273.90/day
	4	$286.35/day
	5	$298.80/day

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Group Voluntary Hospital Indemnity (GVSP1(FL)) Policy Rates

20 Pay

Low Plan Option

Issue Age	18-35	36-49	50-59	60-64	65+
Employee Only	$12.80	$14.90	$18.25	$23.87	$31.43
Employee + Spouse	$24.52	$28.62	$35.91	$47.74	$62.86
Employee + Children	$21.52	$24.70	$28.34	$34.24	$42.77
Employee + Family	$32.57	$37.72	$45.23	$57.20	$73.13

Medium Plan Option

Issue Age	18-35	36-49	50-59	60-64	65+
Employee Only	$25.54	$30.02	$37.69	$50.87	$68.69
Employee + Spouse	$47.84	$56.48	$73.60	$101.74	$137.38
Employee + Children	$40.42	$46.84	$53.61	$64.69	$81.65
Employee + Family	$62.05	$72.60	$88.75	$114.65	$149.27

24 Pay

Low Plan Option

Issue Age	18-35	36-49	50-59	60-64	65+
Employee Only	$10.67	$12.42	$15.21	$19.89	$26.19
Employee + Spouse	$20.43	$23.85	$29.93	$39.78	$52.38
Employee + Children	$17.94	$20.59	$23.62	$28.53	$35.64
Employee + Family	$27.14	$31.43	$37.69	$47.67	$60.94

Medium Plan Option

Issue Age	18-35	36-49	50-59	60-64	65+
Employee Only	$21.29	$25.02	$31.41	$42.39	$57.24
Employee + Spouse	$39.87	$47.07	$61.34	$84.78	$114.48
Employee + Children	$33.69	$39.04	$44.68	$53.91	$68.04
Employee + Family	$51.71	$60.50	$73.96	$95.55	$124.39

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Allstate Benefits Hospital Indemnity Insurance

Policy CHCFL with SAR1FL and IHR1 Riders

For Current Participants Only

The Hospital Indemnity Insurance policy supplements your medical insurance by providing additional insurance every day that you or your covered dependents are in the hospital for a covered accident or illness, from the first day of hospitalization (subject to the pre-existing condition limitation) up to 365 days of each period of continuous hospital confinement.

You may choose between two daily coverage amounts ($90 or $180) up to 365 days of continuous hospital confinement to supplement any other coverage you have. Your benefit amounts double if you are confined in a hospital intensive care unit. This benefit is payable for up to 60 days of continuous intensive care confinement. If there are any outstanding bills, the benefit will be paid to the employee, not to the care provider, unless assigned.

In cases when a covered person has an outpatient surgical procedure performed in an ambulatory surgical center as defined in the policy, the Ambulatory Surgical Benefit will pay $180 per occurrence, per unit of coverage.

Why Do I Need This Benefit?

Duval County Public Schools' medical plan pays 75-80 percent of in-patient hospitalization. This benefit can be used to supplement the remaining 20-25 percent that is not covered.

Waiver of Premium

After the insured has been confined for 30 consecutive days, the premiums that become due on the policy and riders are waived during a primary insured's continued hospital confinement. Once the hospital confinement ends, premium payments must begin again.

What's Not Covered

The policy and riders do not pay benefits for conditions caused by or resulting from:

- any act of war, whether or not declared, participation in a riot, insurrection or rebellion
- intoxication or being under the influence of drugs not prescribed or recommended by a physician
- an attempted suicide or an intentional self-inflicted injury
- nervous or mental disorders
- alcoholism or drug addiction
- dental or plastic surgery for cosmetic purposes. This exclusion does not apply to such surgery required by (a) an injury, or (b) correction of disorders of normal bodily functions.
- a newborn child's routine nursing or routine well baby care
- childbirth occurring during the first 10 months of the policy date (complications of pregnancy are covered to the same extent as a sickness)
- hospitalization that begins before the policy date.

Benefits are not paid under the hospital intensive care unit benefit for confinement in any care unit that does not qualify as defined or which has been excluded. The exclusions and other limitations provisions of the policy also apply to the riders.

Surgery and Anesthesia Benefit Rider

If you undergo surgery in a hospital or an ambulatory surgical center, your surgical benefit pays you $18-$450, depending on the surgery.

Two or more procedures done at the same time through one incision are considered one operation. The rider will pay the amount shown in the Schedule of Operations for the operation with the largest benefit. If any operation other than those listed is performed, the rider pays an amount based on the amount stated in the Schedule of Operations for the most comparable procedure.

If you require anesthesia during the course of a covered operation, your anesthesia benefit pays you an additional 30 percent of the surgical benefit.

Optional Initial Hospitalization Rider

One or two units of this rider are available. The Initial Hospitalization Benefit pays $450 (one unit) or $900 (two units) on the first continuous confinement to a hospital during a calendar year, provided a benefit is paid under the Hospital Confinement Benefit in the policy. This benefit is payable only once for each covered person for each continuous hospital confinement and for each calendar year.

Family Coverage

If family coverage is selected, the policy covers your spouse if he or she is under age 65. It also covers your children until they reach age 26.

Renewability

Issue ages are 18-64. Guaranteed renewable to age 65 subject to change in premiums by class. A notice will be mailed in advance of any change.

Taxable Benefits and the IRS

Please refer to Beyond Your Benefits section for further details.

Pre-existing Conditions

If a covered person has a pre-existing condition as defined, benefits are not paid for such condition during the 12-month period beginning on the date that person became a covered person. A pre-existing condition is a condition not revealed in the application for which symptoms existed within a 1 year period before the effective date of coverage; or medical advice, diagnosis, care, or treatment was recommended by or received from a physician within the 1 year period before the application date.

Policy Provider

Allstate Benefits is the marketing name for American Heritage Life Insurance Company (Home Office: Jacksonville, FL), a subsidiary of The Allstate Corporation. American Heritage Life Insurance Company underwrites the policy and riders. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates American Heritage Life "A+" Superior. Benefits are provided by Policy CHCFL and riders IHR1 and SAR1FL. The policy and riders are not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide, available from Allstate Benefits.

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Disability Income Protection Insurance Plans

A disability can put a lot of things in your life on hold. One out of three Americans can expect to have a sickness or disability lasting at least 90 days at some time during his or her career.*

* Applies to disabilities occurring before age 65. Source: Commissioner's Individual Disability Table A, Society of Actuaries, 1985. The society's 1985 statistics are the current standard for income protection risk evaluation and policy pricing throughout the insurance industry.

Length of Benefit

Age at the time of disability	Long Term Disability Benefits payable for the following maximum*
Under 60	To Age 65, but not less than 5 years
60	60 Months
61	48 Months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and Over	12 Months

*The maximum benefit period is the period in which the benefit will be paid to you.

The following Disability Income Protection Insurance plans provide you with weekly short term disability income replacement if you become disabled, as defined in the policy. Choose short term or long term disability income protection insurance, or both.

What are Deductible Sources of Income?

Deductible Sources of Income (payments received other sources of income) will reduce the amount of the benefit paid. Refer to your Long Term and Short Term Disability certificates for these sources. Some examples of these Deductible Sources of Income include:

- workers compensation (LTD only)
- retirement plans (FRS)
- Social Security awards
- other group insurance.

The Short-Term Disability Insurance plan can provide:

Injury and Sickness Benefits

The Short Term Disability monthly benefit of the level selected (refer to the rates at the end of this section) may be payable during each period of total disability. Short Term Disability benefits begin to accrue after you meet the definition of disability and satisfy a 14-consecutive-day waiting period. Short term disability benefit payments are issued in arrears on a weekly basis, and benefits can continue for each period of disability, but not beyond the maximum benefit period of 24 weeks. The Short-Term Disability minimum weekly benefit is 25 percent of your gross disability payment. Under no circumstance will a benefit be payable which exceeds 66 2/3% of your weekly earnings.

The Long-Term Disability Insurance provides:

Injury and Sickness Benefits

The Long Term Disability monthly benefit may be payable during each period of disability. Long Term Disability benefits begin after you meet the definition of disability as defined in the policy and satisfy a benefit waiting (elimination) period of 180 days. You can satisfy your elimination

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period if you are working, as long as you meet the definition of disability. Your disability will be treated as continuous as long as you do not exceed 30 return-to-work days during the elimination period.

After 24 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience. Benefits can continue for each period of disability according to the schedule below.

In addition, the long-term disability minimum monthly benefit is 25 percent of your gross disability payment. Under no circumstance will a benefit be payable which exceeds 66 2/3% of your monthly earnings.

Mental Illness and Self-reported Systems Limitation

Disabilities, due to sickness or injury which are primarily based upon self-reported symptoms, and disabilities due to mental illness have a limited pay period up to 24 months. However, if at any time you are confined in a hospital for at least 14 consecutive days due to this disability, the monthly LTD benefit can be payable for the period of hospital confinement for up to 90 days following your discharge, provided you remain disabled. Unum will not pay beyond the limited pay period, or the maximum period of payment, whichever occurs first.

What's Not Covered

Benefits will not be paid for disabilities resulting from:

- Intentionally self-inflicted injuries
- War, declared or undeclared, or any act of war or active participation in a riot
- Incarceration
- The commission of a crime for which you have been convicted under state or federal law
- Occupational sickness or injury (STD only)
- Workers Compensation (STD only)
- Pre-existing condition
- The loss of a professional license or certification

In addition, benefits will not be paid for a disability if you are not receiving regular in-person medical treatment from a legally qualified physician during the period of disability or if the disability is not certified by a legally qualified physician.

DEFINITIONS

Injury means a bodily injury that is the direct result of an accident and not related to any other cause. Disability must begin while you are covered under the plan.

Sickness means an illness or disease. Disability must begin while you are covered under the plan.

Deductible Sources of Income means payments received from other income sources as defined in the contract.

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Self-Reported Symptoms (LTD) means the manifestations of your condition which you tell your physician, that are not verifiable using tests, procedures or clinical examinations standardly accepted in the practice of medicine. Examples of self reported symptoms include, but are not limited to headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Period of Disability means a continuous length of time during which you are disabled due to any one accidental injury or sickness. Under both the STD and LTD plans, successive periods of disability will be considered as one period of disability unless they are due to separate and unrelated causes or if you return to work by a period of more than 14 days for STD and more than six months for LTD.

Travel Tips!

To determine your need for short-term or long-term disability protection, consider how you would pay monthly expenses if you had no income due to an accident or illness.

Long-Term & Short-Term
Income Protection Insurance Plans

What is a Pre-Existing Condition?
A pre-existing condition is a sickness or accidental injury for which medical treatment is received or prescription drugs taken during the six-month period prior to your coverage effective date.

All new employees and employees who have bypassed or cancelled disability coverage must satisfy the following pre-existing condition provision:

- Benefits will not be paid if you are disabled due to a pre-existing condition during the first 12 months of coverage.

In addition, if you increase your benefit level and become disabled due to a pre-existing condition within 12 months, the amount of the increase will not be paid at any time during that disability.

Waiver of Premium
After benefit payments begin, premium payments for the period of certified disability will be waived.

Short-Term Disability: You are disabled when Unum determines that due to sickness or injury:

- you are unable to perform the material and substantial duties of your regular occupation, and
- you are not working in any occupation.

Long-Term Disability: You are disabled when Unum determines that:

- you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and
- you have a 20 percent or more loss in your indexed monthly earnings due to the same sickness or injury.

Coverage Levels
You may participate in the plans under any one of the benefit levels outlined below. There may not be an election that accommodates your current salary; therefore, you should elect the coverage level that doesn't exceed your current salary.

Policy Provider
Unum Life Insurance Company of America underwrites these plans. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Unum Life Insurance Company of America "A" Excellent (rating effective as of January, 2014).

Submitting a claim for Short-Term Disability
A telephonic claims intake service is available on the Short-Term Disability (STD) plan. This service eliminates the need to submit a paper claim. Initiate your claim by calling Unum's toll-free telephonic claim intake number, 1-888-857-0157, and report your claim. Call within 14 days after the date your disability begins or as soon as possible. A Unum intake specialist will take your information by phone. However, it will be your responsibility to provide an authorization form to your physician to be signed/dated and faxed or mailed to Unum. This allows Unum to access your medical records in order to process your claim.

Submitting a claim for Long-Term Disability
Contact our Service Center at 1-855-569-3277 or DCPS Employee Benefits at (904) 390-2351 to request a claim form. The claim form includes everything you will need to submit a claim, including sections for your doctor to complete and an authorization form that enables Unum to gather additional information as it becomes necessary. Your claim should be submitted within 30 days after the date your disability begins or as soon as possible. However, Unum must receive written proof of your claim no later than 90 days after your elimination period. If this is not possible, proof must be given no later than one year after the time proof is required except in the absence of legal capacity. If you are covered under both the STD and LTD plans it is not necessary to complete a paper LTD Claim form if you are collecting STD benefits and your disability continues into LTD. Unum will transition your claim into LTD, however additional medical documentation may be required.

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Long-Term & Short-Term
Income Protection Insurance Plans

Your Rates and Disability Benefit Amount

Rate Per 20 Pay Periods		Benefit Amount		Rate Per 24 Pay Periods	
Short-Term (14th day)	Long-Term (180th day)	If your gross annual is at least:	You're eligible for a monthly accident & sickness disability benefit of:	Short-Term (14th day)	Long-Term (180th day)
$4.48	$5.26	$7,200	$400	$3.74	$4.38
$6.72	$7.92	$10,800	$600	$5.60	$6.60
$8.95	$10.54	$14,400	$800	$7.46	$8.78
$11.19	$13.19	$18,000	$1,000	$9.33	$11.00
$13.43	$15.86	$21,600	$1,200	$11.19	$13.22
$16.79	$19.81	$27,000	$1,500	$14.00	$16.51
$20.14	$23.77	$32,400	$1,800	$16.79	$19.81
$26.87	$31.69	$43,200	$2,400	$22.40	$26.41
$32.90	$38.84	$50,400	$2,800	$27.42	$32.37
$41.11	$48.58	$63,000	$3,500	$34.26	$40.48
$46.97	$55.53	$72,000	$4,000	$39.14	$46.28

All benefits in this booklet are subject to change. This is an Employer Benefits Highlights Summary and not a contract. All benefits are subject to the provisions and exclusions of the master contract.

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Trustmark Non-Occupational Accident Insurance

Trustmark's Accident insurance helps pay for unexpected healthcare expenses due to non-occupational accidents that occur every day – from the soccer field to the beach and the highway in-between. Accident insurance provides benefits due to covered accidents for initial care, injuries and follow-up care. Benefits are paid directly to the employee, in addition to any other coverage they have.

Who is Eligible?

Who is Eligible?

- Employees – Ages 18 to 80, actively working full-time
- Spouses – Ages 18 to 80, who are not disabled
- Children – Birth to age 26, who are unmarried and dependent

Plan Features

- Coverage for non-occupational injuries
- Guaranteed issue – No medical questions
- Level premiums – Rates do not increase with age
- No limitations for pre-existing conditions
- Guaranteed renewable – Coverage remains in force for life, as long as premiums are paid
- Portable coverage – Employees can continue coverage if they leave or retire

Wellness Benefit

Promotes good health among employees and their families by providing them a $100 benefit to offset the cost of going to the doctor for routine physicals, immunizations and health screening tests, regardless of other coverage. The benefit provides a maximum of two visits per person, annually. Eligible tests include:

- Low-dose mammography
- Pap smear for women over age 18
- Flexible sigmoidoscopy
- Hemocult stool specimen
- Colonoscopy
- Prostate-specific antigen (PSA) test for prostate cancer
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Bone marrow testing
- Serum cholesterol test to determine HDL and LDL levels
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Serum protein electrophoresis (blood test for myeloma)
- Immunizations
- Themograph

Accidental Death Benefit

- Provides a lump-sum benefit for an accidental death that occurs within 90 days of a covered accident:
  - Pays $100,000 for the insured, $50,000 for the spouse and $25,000 for a child.
  - The benefit doubles if the accidental death is due to a common carrier.

Catastrophic Accident Benefit

- Helps families during the transitional period following a catastrophic loss:
  - Provides a lump-sum benefit for catastrophic loss after fulfilling a 90-day elimination period.
  - Pays $150,000 for the insured, $75,000 for the spouse and $75,000 for a child.
  - A catastrophic loss is the loss of use of sight, hearing, speech, arms or legs.

Definitions

Covered Accident

An accident causing injury, which:

- Occurs after the effective date;
- Occurs while the certificate is in force; and
- Is not excluded by name or specific description in the certificate.

Elimination Period

The period of time after the date of a covered accident for which catastrophic accident benefits are not payable.

Injury or Injuries

An accidental bodily injury that resulted from a covered accident. It does not include sickness, disease or bodily infirmity. Overuses syndromes, typically due to repetitive or recurrent activities, such as osteoarthritis, carpal tunnel syndrome or tendonitis, are considered to be a sickness and not an injury.

Maximum Benefit Period

The longest period of time for which hospital benefits will be paid.

Non-occupational Injury

An injury that did not result from a person's work or occupation; applicable to non-occupational coverage only.

Waiting Period

There is a 60 day period of time following the effective date of the certificate during which wellness benefits are not payable.

Accident Insurance Rates

Level	20 Deduction	24 Deduction
Employee Only	$10.09	$8.41
Employee & Spouse	$15.42	$12.85
Employee & Children	$24.83	$20.69
Employee & Family	$30.16	$25.13

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Accident/Injury	Benefit Amount Florida
Accident Follow-Up Treatment	$200
Accidental Death Benefit Rider	Employee $100,000 Spouse $50,000 Children $25,000
Accidental Death Benefit Rider Common Carrier	Employee $200,000 Spouse $100,000 Children $50,000
Ambulance (Ground)	$600
Air	$2,500
Appliance	$250
Blood, Plasma and Platelets	$600
Burns – Flat Amount for:	
Third-degree 35 or more sq. in	$25,000
Third-degree 9 to 34 sq. in.	$4,000
Second-degree for 36% or more of body	$2,000
Catastrophic Accident Benefit	Employee $150,000 Spouse $75,000 Children $75,000
Concussion	$200
Dislocations	
Open reduction	Up to $12,000
Closed reduction	Up to $6,000
Initial Doctor's Office Visit	$200
Emergency Dental Benefit	
Extraction	$150
Crown	$450
Emergency Room Treatment	$150
Eye Injury (requires surgery or removal of foreign body)	$400
Fractures	
Open reduction	Up to $15,000
Closed reduction	Up to $7,500
Chips	25% of closed amount
Herniated Disc	$1,000
Hospital Admission (per admission)	$3,200
Hospital Confinement (per day up to 365 days)	$500
Hospital ICU (per day up to 15 days)	$1,000
Laceration	$50 - $1,000
Lodging (per accident)	$200 per night up to 30 days

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Trustmark Non-Occupational Accident Insurance

Accident/Injury	Benefit Amount Florida
Loss of finger, toe, hand, foot or sight of an eye	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	$30,000
Loss of one hand, foot or sight of one eye	$15,000
Loss of two or more fingers, toes or any combination of two or more losses	$3,000
Loss of one finger or one toe	$1,500
Physical Therapy (per accident)	$100 per visit, up to six visits
Prosthetic Device or Artificial Limb	
More than one	$2,000
One	$1,000
Skin Grafts	25% of burn benefit
Surgery	
Open, abdominal, thoracic	$2,000
Exploratory	$200
Tendon/Ligament/Rotator Cuff	
Repair of more than one	$1,500
Repair of one	$1,000
Exploratory without repair	$200
Torn Knee Cartilage	$1,250
Exploratory	$200
Transportation	$600 (100+ miles up to three trips)
Wellness Benefit Two per person annual routine physicals, immunizations and health screening tests. 60-day waiting period applies.	$100

Exclusions.

No benefits will be payable for an Injury as the result of a Covered Accident that occurs:

- During any involvement in any period of any type of armed conflict;
- While riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- While operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft, including those which are not motor-driven. This does not include flying as a fare paying passenger in a scheduled or chartered flight operated by a commercial airline;
- While engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, or parakiting;
- While participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received;
- While participating or attempting to participate in an illegal activity, whether or not You are charged with a crime;
- While committing or attempting to commit suicide or injuring Yourself intentionally, whether You are sane or not;

No benefits will be payable for:

- Sickness or infection including physical or mental condition which is not caused solely by or as a direct result of a Covered Accident;
- A work related Injury or accident.

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Allstate Benefits Group Voluntary Critical Illness Insurance

OFFERED DURING OPEN ENROLLMENT ONLY.

With the advancements in medical technology and treatment, people are living longer and once-deadly diseases are being controlled and cured. One way you can help protect yourself, your family and your finances is to purchase a critical illness policy, which pays a lump sum benefit when you are diagnosed with a critical illness.

The basic benefit amounts available are $10,000 - $25,000 (in $5,000 increments) on a Guaranteed Issue basis. Amounts in excess of $25,000 up to $100,000 are available but subject to underwriting guidelines (see an enrollment counselor for details). Up to 100 percent is payable for covered illnesses from each of Category 1, Category 2, and Category 3 as illustrated below. You choose the amount that best fits you and your family's needs.

Subject to the conditions in the policy and the Pre-existing Condition Limitation, Allstate Benefits pays this benefit if you are diagnosed for the first time ever with one of the illnesses shown below if:

- the date of the diagnosis is after the policy date and
- the date of diagnosis is while the policy is in force and
- that illness is not excluded by name or specific description in the policy; or
- it is determined, as the result of an autopsy, that the insured died as the result of one of the specified critical illnesses listed below.

The amount payable for each illness is the percentage multiplied by the basic benefit amount selected. The percentage of the basic benefit amount payable for each illness is shown beside the illness. The maximum total percentage of the basic benefit amount payable per category of the illnesses is shown in the last column of the chart on below. The policy remains in force after a benefit is paid for an illness. However, after 100 percent of the basic benefit amount has been paid within a category (Category 1, 2, or 3), no more benefits are paid for illnesses associated within that category for a covered person. If you receive a percentage of the basic benefit amount for one illness within a category, and then become eligible for benefits for another illness within the same category, the percentage of the basic benefit amount you receive for the subsequent illness is the lesser of:

- the percentage of the basic benefit amount shown on the chart at left for that illness or
- 100 percent minus the percentage of the basic benefit amount you received for the previous illness(es) in that category.
- Covered Spouse and children basic benefit amount is 50% of benefit.shown and 100% of the Wellness Benefit.

Policy GVCIP1

Benefit Category 1 - Group Critical Illness Coverage

Illness	Percentage of the Basic Benefit Amount	Maximum Total Percentage of Basic Benefit Amount for Category
Heart Attack	100%	100%
Heart Transplant	100%	100%
Stroke	100%	100%
Coronary Artery By-Pass Surgery	25%	25%

Benefit Category 2 - Group Critical Illness Coverage

Illness	Percentage of the Basic Benefit Amount	Maximum Total Percentage of Basic Benefit Amount for Category
Major Organ Transplant (other than heart)	100%	100%
End Stage Renal Failure	100%	100%
Paralysis (not as a result of a stroke)	100%	100%
Alzheimer's Disease	25%	25%

Benefit Category 3 - Cancer Coverage

Illness	Percentage of the Basic Benefit Amount	Maximum Total Percentage of Basic Benefit Amount for Category
Invasive Cancer	100%	100%
Carcinoma in Situ	25%	25%

Wellness Benefit (Cancer Screenings or Heart Screenings)

Allstate Benefits pays $100 for each calendar year per insured, for one of the following cancer screening tests or heart screening tests performed while not hospital confined:

Bone Marrow Testing; CA15-3 (blood test for breast cancer); CA125 (blood test for ovarian cancer); CEA (blood test for colon cancer); chest X-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; mammography, including breast ultrasound; Pap Smear, including ThinPrep Pap Test; PSA (blood test for prostate cancer); Serum Protein Electrophoresis (test for myeloma); biopsy for skin cancer; stress test on bike or treadmill; electrocardiogram (EKG); carotid doppler; echocardiogram; lipid panel (total cholesterol count); and blood test for triglycerides. There is no limit to the number of years a covered person can receive cancer screening tests. This benefit is paid regardless of the result of the test(s) and is limited to one test per calendar year per insured.

Recurrence Benefit

Allstate Benefits pays this benefit if an insured is diagnosed more than once with the same specified critical illness listed in category 1 or 2 for which a benefit was previously paid if: there is more than 18 months between each diagnosis; and treatment was not received during that 18 month period (for purposes of the preceding statement, treatment does not include medications and follow-up visits to the insured's physician); and the subsequent date of diagnosis is while coverage is in force; and the specified critical illness is not excluded by name or specific description in the policy and certificate.

We will pay an amount equal to 25% of the specified critical illness basic benefit amount previously paid for that specified critical illness. We will pay no more than one recurrence benefit per previously paid specified critical illness under category 1 and 2.

True Guaranteed Issue

The employee must complete the Group Enrollment Form (AWD5017 or AWD5018), and answer the tobacco use question.

Benefit amounts are available on a Guaranteed Issue basis for employees from $10,000 - $25,000.

For benefit amounts over the limits listed above, Evidence of Insurability (AWD4504FL) will be requested.

It is a requirement that the name and address of the proposed insured's personal physician be included in the Required Health History section for all applications.

Current AHL Critical Illness Participants

If you are currently enrolled in Allstate Benefits Critical Illness, you may continue your coverage. You are also eligible to enroll in the Group Voluntary Critical Illness (GVCI). The GVCI is available during this initial enrollment period on a Guarantee Issue basis up to $25,000. See your Enrollment Specialist for more information and details on how to enroll.

Portability Privilege

Allstate Benefits will provide Group Voluntary Critical Illness insurance portability coverage, subject to the policy provisions.

Pre-Existing Condition Limitation

Allstate Benefits does not pay for any loss due to a pre-existing condition, as defined, during the 12 month period beginning on the date the employee or member became insured. A pre-existing condition is a disease or physical condition for which symptoms existed within the 12 month period prior to the effective date of coverage; or medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage. The exception to the above would be for follow-up care for breast cancer. Routine follow-up care for a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care or treatment unless evidence of breast cancer is found during, or as a result of, the follow-up care. A pre-existing condition can exist even though a diagnosis has not yet been made.

Exclusions and Limitations

Allstate Benefits does not pay benefits for an illness due to, or resulting from, (directly or indirectly): any act of war, whether or not declared, participation in a riot, insurrection or rebellion; or intentionally self-inflicted injuries; or injury incurred while engaging in an illegal occupation or committing or attempting to commit a felony; or attempted suicide, while sane or insane; or any injury sustained while under the influence of alcohol, narcotics or any other controlled substance or drug unless administered upon the advice of a physician; or participation in any form of aeronautics except as a fare paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or alcohol abuse or alcoholism, drug addiction or dependence upon any controlled substance.

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Claims for benefits under the policy not satisfying all the criteria for diagnosis are subject to review by our medical director or his or her designee.

The policy provides benefits only for the illnesses shown. The policy does not cover any other disease, sickness or incapacity. All covered conditions must be diagnosed by a medical doctor. Emergency situations that occur while the covered person is outside the United States will be reviewed and considered for approval by a United States medical doctor on foreign soil or when the covered person returns to the United States.

Stroke: Transient ischemic attacks (TIAs) are excluded.

By-Pass Surgery: The following procedures are not covered under the by-pass surgery benefit: balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

Critical Illness Cancer Benefit: We do not pay a benefit under the rider for any disease other than cancer as defined in the policy.

Eligibility: Your employer determines the criteria for eligibility (such as length of service and hours worked each week). Issue ages are 18 and over if actively at work for the number of hours determined by your employer.

Dependent Coverage: Family members who are eligible for coverage are: your legal spouse; your children including newborn children, adopted children, children during pendency of adoption procedures, foster children, stepchildren, or legal ward who are under 26 years of age. Children born to you or your spouse while individual and children coverage or family coverage is in force will be eligible for coverage. Coverage begins at the moment of birth.

Termination of Coverage: Coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which any required premium payments were made; or the last day you are in active employment, except as provided under the "Temporary Layoff, Leave of Absence, or Family and Medical Leave of Absence" provision; or the date you are no longer in an eligible class; or the date your class is no longer eligible; or the date you have received the maximum total percentage of the basic benefit amount for each critical illness category, including the Optional Recurrence Benefit, if applicable.

Policy Provider

The coverage is provided by limited benefit supplemental insurance. This material is valid as long as information remains current, but in no event later than February 1, 2016. Group Critical Illness benefits provided by policy form GVCIP1, or state variations thereof, which provides stated benefits for specified illnesses. The policy does not provide benefits for any other sickness or condition. The policy is not a Medicare Supplement Policy. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, including premiums, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

Allstate Benefits is the marketing name for American Heritage Life Insurance Company (Home Office: Jacksonville, FL), a subsidiary of The Allstate Corporation. American Heritage Life Insurance Company underwrites the policy and riders. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates American Heritage Life "A+" Superior. Benefits are provided by Policy GVCIP1FL. The policy is not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide, available from Allstate Benefits.

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Whole Life Insurance

How would your family get by if something happened to you suddenly and they could no longer rely on your paycheck? With Unum's whole life insurance, you can help give your family the added financial protection they may need in the event something unexpected happens.

Plan Features

- Voluntary, individual coverage is available for employees, with multiple family coverage options available.
- No physical exams are required to apply for coverage. Policy issue may depend upon answers to health questions contained in the application when applying for coverage amounts in excess of the guarantee issue limits.
- Premiums are guaranteed level based on your age at the time of policy issue and do not increase due to age.
- Cash value is based on a tabular rate of 4.5%
- The policy contains a reduced paid-up provision, which allows you to use your accumulated cash value to purchase a smaller, paid-up policy with no further premiums due.
- Coverage may be continued as long as sufficient premiums are paid.
- A Living Benefit Option rider is automatically included at no extra premium on all policies. This feature allows the policy owner to request up to 100% of the death benefit (to a maximum of $150,000) if the insured is diagnosed with a medical condition that limits life expectancy to 12 months or less. Any payout reduces the death benefit.
- The policy is individually owned, which means you can take the policy with you should you retire or leave the school board.

Eligibility

Employee

- Issue ages: 15 – 80
- Must be actively at work at time of application
- Must work at least 20 hours per week

Being "actively at work" means that on any day the employee applies for coverage, he/she is working at one of their company's business locations, or is working at a location where he/she is required to represent the company. If he/she is applying for coverage on a day that is not a scheduled workday, then he/she will be considered actively at work if he/she meets this definition as of the last scheduled workday. Employees are not considered actively at work if their normal duties are limited or altered due to their health, or if they are on a leave of absence.

Spouse

- Issue ages: 15 – 80

Child – Standalone Policy

- Issue ages: 14 days – 26 years
- Available to children, grandchildren, stepchildren, and legally adopted children of the employee between the ages of 14 days and 26 years
- Children must reside in the United States

Underwriting Levels

Guaranteed Issue (GI)

- Current and newly eligible employees
- Participants with existing coverage who wish to increase to GI limit
- Must meet the "actively at work" definition
- No health questions

Conditional Guaranteed Issue (CGI)

One qualifying health question must be answered. The question states: "During the last 12 months, has the spouse been hospitalized or treated, including medication, for an injury or sickness, excluding pregnancy, colds, flu and back problems?" If qualifying health question is answered "yes", Simplified Issue underwriting will be required.

Re-enrollment Underwriting Guidelines:

Have your Enrollment Counselor complete the Unum Whole Life Insurance application.

All employees have the opportunity to enroll on a guaranteed issue basis during this enrollment period. This includes applications which were previously declined, not taken, cancelled or lapsed.

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UNUM Whole Life Insurance

Employee Weekly Premium Limits

Guaranteed Issue*	Simplified Issue
$3 - $30	$31 - $40

Spouse Weekly Premium Limits

Conditional Guaranteed Issue*	Simplified Issue
$3 - $5	$6 - $1-10

* Applies to newly eligible employees, spouses and participants with existing coverage who wish to increase coverage up to the GI limit.

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Current and newly eligible employees

Guaranteed Issue (GI) for Employees and Dependent Children; Conditional Guaranteed Issue (CGI) for Spouses.

- Employees: Amount purchased by $30.00 per week to a maximum of $300,000 (GI).
- Spouses (CGI): Amount purchased by $5.00 per week to a maximum of $75,000 (CGI).
- Children: Available for $3.00 (GI) or $4.00 or $5.00 (SI) per week.

Participants with existing coverage

- **Participants with active Unum VWL coverage may increase under GI underwriting** up to the original GI amount of $30.00 per week to a total benefit cap of $300,000.
- Spouses may increase coverage under CGI underwriting up to the original CGI amount of $5.00 per week to a maximum of $75,000.
- Children: Available for $3.00 (GI) or $4.00 or $5.00 (SI) per week.

Benefits in excess of the amount purchased by the above stated premium levels will be underwritten on a Simplified Issue basis.

Coverage Levels

- The overall maximum face amount for employees is $300,000.
- The overall maximum face amount for spouses is $75,000.
- Minimum premium of $3 per week and minimum face amount of $2,000 is required for employee and/or spouse coverage.
- Simplified Issue underwriting maximums include the Guaranteed Issue premium. The amount above the Guaranteed Issue weekly maximum is the Simplified Issue underwritten amount.

Family Coverage Options

Spouse Coverage

- The policy can build cash value that earns interest. Interest earned on the policy is tax deferred under current laws.
- The employee does not have to apply for coverage to purchase spouse coverage.
- Minimum is $2,000 face amount and $3 weekly premium.
- Premiums are based on the issue age of the spouse.
- The policy is individually owned, so coverage can be continued if the employee retires or leaves the school board.

Children's Coverage

Adult insureds have the option of choosing a standalone policy for each child or adding the Children's Term Rider to the base policy. Children may be covered under a policy or a rider.

Children's Voluntary Whole Life Insurance

- The employee does not have to apply for coverage to purchase coverage for children.
- Available for $1 to $3 (guaranteed issue) or $4 to $5 (simplified issue) per week.
- Premiums are based on the issue age of the child.
- The policy can build cash value that earns interest. Interest earned on the policy is tax deferred under current laws.
- Individually owned policy, so coverage can be continued if the employee retires or leaves the school board.

Children's Term Rider

- Available to children, stepchildren, and legally adopted children of the primary insured between the ages of 14 days and 25 years who are unmarried, reside with and are dependent on the employee for at least half of their support.
- The rider may be added to the employee or spouse policy, but not both. Employee or spouse must be age 64 or younger.
- Guaranteed level premium rider coverage with available benefit amounts of $1,000 - $10,000 in $1,000 increments. Premium is $6.00 per $1,000 annually.
- This rider must be added during an enrollment period when the first child is at least 14 days old in order for that child and all future children to have coverage.
- All future children are automatically covered after 14 days of age with no increase in premium.
- Death of the primary insured results in paid-up term coverage for each child until that child reaches age 25.
- As each child reaches age 25, he or she may purchase level premium coverage, other than term life, at current rates, up to five times the amount of coverage in force, up to a maximum of $50,000, subject to minimum policy requirements that apply to that contract. The insured is responsible for notifying Unum in writing at least 31 days prior to the child's 25th birthday if this change is desired.

UNUM Whole Life Insurance

Additional Coverage Options

Accidental Death Benefit Rider

The Accidental Death Benefit Rider provides an additional death benefit equal to the base policy face amount if the insured dies before age 70 as a result of an accident as defined in the policy.

- Available to employees and spouses between the ages of 15 – 65 and only at initial enrollment
- Maximum available benefit is $150,000

Waiver of Premium

Waives the policy's monthly premium during disability if the insured employee becomes disabled prior to age 65 and remains disabled for at least six months.

- Available to employees between the ages of 15 – 55, and only at initial enrollment.
- Premiums paid during the six-month waiting period can be refunded and will be waived as long as the disability continues, as defined in the policy.

Exclusions

If the insured commits suicide within two years from the policy date, Unum's liability will be the refund of premiums paid, without interest, less the sum of any debt, any partial surrender and the cost of any supplementary benefit riders.

Terminations

All coverage under this policy will terminate when any of the following occurs:

- the insured's request to terminate the policy
- the insured dies
- the policy matures, or
- the grace period ends.

Plan Provider

Provident Life and Accident Insurance Company, a subsidiary of Unum Corporation, underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates Unum "A" Excellent (rating effective as of January, 2014).

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Trustmark Voluntary Universal Life Insurance Plan

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Wouldn't you like to know that your loved ones will be taken care of should something happen to you? The Voluntary Universal Life Plan features progressive coverage for your peace of mind.

Wouldn't you like to have life insurance you can take with you if you leave the school system? A plan that features portable coverage and cash values that can increase during your lifetime?

Who is eligible?

- Full-time or regular part-time employees who work an average of 20 hours per week
- Employees between the ages of 18 and 80

What does the plan offer?

Voluntary Universal Life Insurance offers you and your family the following flexible benefits:

- **Death Benefit**
- **LTC Living Benefits***
- **Interest-earning Cash Value**
- **EZ Value Plan Option****
- **Death Benefit Restoration Rider**
- **Guaranteed issue is available to employees ages 18 – 80 who are not currently enrolled**
- **Modified Guarantee Issue is available for existing policy holders *(See an enrollment counselor for details)***

How do I apply?

Have your Enrollment Counselor, who is a Florida-licensed agent, complete the Universal Life Insurance plan application.

Can I continue my Universal Life coverage if I terminate employment or retire?

Yes. This plan is portable after the first payroll deduction. You can continue with the full amount of insurance coverage and arrange for premiums to be billed directly to you. Your coverage and premiums stay the same.

* This benefit is subtracted from the final death benefit.

** Existing EZ Value participants may extend to the 10-year options (with restrictions) if they choose to do so.

What about the group term life policy I already have with the school system?

This Universal Life Insurance plan complements any group term life insurance you may have and enables you to vary your premiums, coverage and cash value accumulation as your needs change. You can adjust the death benefit and premium upward and downward throughout your lifetime, subject to certificate limits.

What payroll deduction premiums will I pay?

You select the coverage and premium that best fit your budget and family needs. As a Duval County Public Schools employee, you may receive a substantial insurance value at an affordable cost.

How do I make changes to my election?

You may elect to change your policy after it goes into effect by calling the Trustmark Service Center at 1-800-918-8877. Changes are forwarded to your employer and should be reflected in your paycheck within two to four weeks.

Plan Provider

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" Excellent. This information is being provided to employees by Duval County Public Schools in advance of more complete information from the insurer.

Universal Life Insurance is available on a post-tax basis, and a separate application is required. To apply have your Enrollment Counselor, who is a Florida-licensed agent, fill out the Universal Life Insurance Plan application.

Note: If you need to make any changes throughout the year or would like answers about your certificate, you must contact Trustmark Customer Service at 1-800-918-8877.

Policy Form UL-205

Rider Forms HH/LTC.205FL, BRR.205FL

Trustmark Universal LifeEvents® Insurance

How does LifeEvents work?

LifeEvents combines two important benefits into one affordable product. With LifeEvents, your benefits may be paid as a Death Benefit under the Long-Term Care Insurance Rider, or as a combination of both. Let's take a closer look.

Death Benefit

Most people buy life insurance for the financial security of the death benefit. And it's easy to see why. A death benefit puts money in your family's hands quickly when they need it most. It's money they may use any way they want to help cover short- and long-term expenses, such as funeral costs, rent or mortgage, debt, tuition, and more.

Long-Term Care Insurance Rider

This benefit makes it easy to accelerate the death benefit to help pay for home healthcare, assisted living, nursing care and adult day care services when you are chronically ill, should you or your covered spouse ever need them.

The LifeEvents Advantage

LifeEvents is unique. It's designed to match your needs throughout your lifetime, so you have the benefits you need, when you need them most. See for yourself:

Working years — LifeEvents pays a higher death benefit during working years when expenses are high and your family needs maximum protection. Then at age 70, when expenses typically reduce, LifeEvents reduces the death benefit amount to better fit your needs; however, your benefits for the Long-Term Care Insurance Rider never reduce.[1]

Throughout retirement — LifeEvents pays a consistent level of benefits during retirement, which is when you may be susceptible to becoming chronically ill and may need long-term care services.

Features you'll appreciate

- Lifelong protection
- Family coverage
- Accelerated Death Benefit Insurance Rider for Terminal Illness
- Guaranteed renewable — Guaranteed coverage, as long as your premiums are paid. Your premium may change if the premium for all certificates in your class changes.

Separately priced benefits:

Children's term life insurance rider — Covers newborns to age 23.

EZ Value — Automatically raises your benefits to keep pace with your increasing needs, without additional underwriting.

How Living Benefits Add Up

Example: $100,000 Death Benefit	Maximum Benefit Amount
Long-Term Care Insurance Rider (LTC)[3] Pays a monthly benefit equal to 4 percent of your death benefit for up to 25 months. The Long-Term Care Insurance Rider accelerates the death benefit and proportionately reduces it.	**$100,000**
Benefit Restoration Insurance Rider Restores the death benefit[2] that is reduced by the Long-Term Care Insurance Rider, so your family receives the full death benefit amount when they need it most.	**$100,000**
Total Maximum Benefit Living Benefits may double the value of your life insurance.	**$200,000**

1 Death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary. Issue age is 64 and under.

3 The Long-Term Care (LTC) Insurance Accelerated Death Benefit Rider is an acceleration of the death benefit and is not Long-Term Care Insurance. It begins to pay after 90 days of confinement or services, and to qualify for benefits you must be chronically ill. Pre-existing condition limitation may apply. Please consult your certificate for complete details.

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Trustmark Critical Illness Insurance

For Current Participants Only

The Trustmark Critical Illness Plan can provide a benefit ranging from $5,000 - $100,000. This plan gives you the flexibility of using the money at your own discretion.

The plan provides an immediate pre-selected lump sum cash benefit upon first diagnosis[1] of a covered critical illness or cancer after the plan's effective date. Your benefit is paid in full regardless of whether you have started treatment and allows you to decide how to use your benefit money.

Who is eligible?

- Employees who have previously purchased cancer and/or critical illness coverage through Trustmark may apply for an increase up to a total of $100,000 of coverage. The $100,000 is a combination of current critical illness and cancer and/or critical illness coverage (including the EZ Value Plan) and new critical illness coverage.
- Employees with existing cancer coverage through Trustmark may continue their current plans. No new policies will be issued to replace current plans.

Plan Features

- The Critical Illness Plan includes cancer coverage. However, the plan can be separated for "cancer-only" or "critical illness-only" coverage. See your enrollment counselor for further details.
- Waiver of Premium Rider available.
- You may add the EZ Value Plan Option to this plan, which automatically increases your coverage annually on each of the first five policy anniversaries. The increase is equal to the amount of protection an additional $1 per week of deduction would purchase.*

* Maximum issue age is 60.

Optional Health Screening Benefit

Pays the cost of one screening test per calendar year (up to $50 or $100 benefit maximum). Eligible tests include:

- Low Dose Mammography
- Pap Smear (women over age 18)
- Hemocult Stool Specimen
- Prostate Specific Antigen
- Colonoscopy
- Flexible Sigmoidoscopy
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test to determine levels of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography

1As defined by policy/group certificate. Most states define eligibility as first diagnosis. First diagnosis means the first time a physician identifies a covered condition from its signs or symptoms. If you've been diagnosed with a covered condition prior to having coverage, you may not be eligible for a benefit.

Issue Ages

- Employees (18 through 70)
- Spouse (18 through 70)
- Children (15 days through 26)

What payroll deduction premiums will I pay for this plan?

You select the coverage and premium that best fits your budget and family needs. Premiums are based on age, coverage selected and tobacco use. As a Duval County Public Schools employee, you may receive a high insurance value at an affordable cost. Speak with your Enrollment Counselor for more information.

Can I continue my coverage if I terminate employment or retire?

Yes. This plan is portable after the first payroll deduction. You can continue with the full amount of insurance coverage and arrange for premiums to be billed directly to you.

How do I make changes to my election?

You may elect to change your policy after it goes into effect by calling the Trustmark Service Center at 1-800-918-8877. Changes are forwarded to your employer and should be reflected in your paycheck within two to four weeks.

What if I have questions about my certificate?

After you enroll, you can get answers about your certificate by calling Trustmark Customer Service at 1-800-918-8877.

Plan Provider

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" Excellent. This information is being provided to employees by Duval County Public Schools in advance of more complete information from the insurer.

Policy Form CACI-82001

For current Trustmark Cancer Protector Participants

If you currently enrolled in Trustmark Cancer Protector, you may:

- continue coverage
- make changes to your coverage
- add riders
- apply for an increase up to a total of $50,000
- add the EZ Value plan to current Cancer Protector plans.

If you have not previously purchased Trustmark Cancer insurance coverage, you are not eligible to purchase it during the 2015 Open Enrollment.

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UNUM Long-Term Care Protection

Available to Current Participants Only

Long-Term Care (LTC) should be a part of everyone's retirement planning.

Are you saving for retirement? If you do not have Long-Term Care protection, you could be risking the following assets:

- 403(b) / 457 plans
- equity in your home
- savings accounts.

People who require LTC services and have no insurance must pay out-of-pocket.

Eligibility Requirements

Long-Term Care is available to:

- Employees with existing LTC coverage through Unum may continue their current plans. No new policies will be issued to replace current plans.
- active employees and/or their spouses
- parents
- natural, adoptive or step-parents
- grandparents of an active employee or spouse.

Plan Description

You may choose one of the following plans based on your needs:

- Base Plan - Includes each of the following coverages:
  a) Facility Care - provides a monthly benefit which will be paid if you receive care in a nursing facility, or 60 percent of the nursing facility benefit for care in an assisted living facility.
  b) Professional Home Care - this pays you a 50 percent monthly benefit of the nursing facility benefit if you receive care at home from a licensed professional (through a Home Health Care Agency).

Optional Benefits

- Total Home Care - This pays you a flat 50 percent (per month) of the nursing facility benefit you selected for the Base Plan when you receive care at home. Care does not have to be provided by a licensed health care worker. Subject to the lifetime maximum, benefits may be payable up to six years.
- Inflation Protection - This option helps protect your Long-Term Care benefit from the impact of inflation. Your Monthly Benefit Amount will automatically increase each year on January 1 by 5 percent of the original Monthly Benefit, regardless of your health and whether or not you are disabled. Your remaining Lifetime Maximum Benefit Amount will also increase. Your premium will not increase as a result of these automatic increases to your Monthly Benefit. In no event will the total Monthly Benefit Amount be more than 200 percent of your original Monthly Benefit Amount.

Ask your Enrollment Counselor for details on how to purchase these options.

Your Coverage Levels

- Base Plan - Select either $1,000 or $3,000 monthly facility benefit with either a three year or six year benefit duration. The Base Plan provides the monthly benefit you select when you are in a nursing facility, or 60 percent of the facility benefit when you are in an assisted living facility. For Professional Home Care you receive up to 50 percent of the facility benefit you selected (1/30th of that amount for each day of care).

Plan Features

- You may receive benefits after 60 consecutive days of continuous loss of functional capacity.
- This benefit is portable — If you leave the School Board, you may take it with you at the same group rate.
- You are not required to pay premiums while receiving Long-Term Care benefits.

Note: You must complete a separate enrollment application to enroll in this benefit.

What's Not Covered

This plan will not pay benefits for:

- a chronic illness caused by any act of declared or undeclared war
- a chronic illness caused by self-destruction or attempted suicide (while sane or insane)
- a chronic illness caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law
- chronic illnesses or confinements during which you are outside the United States, its territories or possessions for longer than 30 days
- a chronic illness caused by alcoholism and alcohol abuse
- a chronic illness caused by voluntary use of any controlled substance (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments)
- any days over fifteen days in each calendar year during which you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention)
- a chronic illness caused by psychological, psychiatric or mental conditions, which include depression, generalized anxiety disorders, personality disorders, schizophrenia, manic depressive disorders whether treated by drugs, counseling or other forms of therapy. However, Unum will make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infarct dementia, or Parkinson's disease.
- a chronic illness caused by pre-existing conditions.

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UNUM Long-Term Care Protection

Available to Current Participants Only

Pre-existing Conditions

Pre-existing conditions are those for which an employee received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines during the six months before coverage began.

Where a pre-existing condition exists and chronic illness due to that condition begins before the employee has been insured for six months, such chronic illness will NOT be covered.

Note: Even though you may not have to complete an Evidence of Insurability form for Long-Term Care Insurance, a pre-existing condition exclusion may apply to you.

Loss of Functional Capacity Defined

After the effective date of this coverage, benefits are payable upon loss of two or more Activities of Daily Living (ADLs) or if you suffer a Cognitive Impairment (i.e. Alzheimer's). The six ADLs are: bathing, dressing, transferring, toileting, continence, and eating.

Rates

Rates are based on your age at the time of purchase and do not increase with age. Ask your Enrollment Counselor for specific rate information.

Plan Provider

Unum Life Insurance Company of America underwrites this plan. A.M. Best's Reports, which compares and rates the financial strength and performance of insurance companies, rates Unum "A" Excellent.

For use with Policy series TQB.LTC

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Your Long-Term Care (LTC) insurance plan is listed below.

Elimination Period: 60 days

Guarantee Issue: The LTC plan is being offered on a Guaranteed Issue basis if you apply or increase your coverage during this enrollment. You only need to complete the Benefit Election Form, unless you have been previously declined for LTC coverage by Unum. In this case, you must also complete Unum's Long Term Care Application (medical questionnaire/proof of good health). Spouses, parents, parents-in-law, grandparents and grandparents-in-law always require proof of good health.

Lifetime Maximum: The Lifetime Maximum is the maximum benefit dollar amount Unum will pay over the life of your coverage. This dollar amount is based on the Facility Benefit Amount and Benefit Duration.

Insurance Age: Insurance Age is used to determine the cost of your coverage. Insurance Age is your age on the effective date if you enroll for coverage prior to the plan effective date. If you enroll for coverage after the plan effective date, Insurance Age is your age on the date you sign the application for coverage.

Facility Benefit Amount	$1,000	$3,000
Benefit Duration Choice	3 years or 6 years	3 years or 6 years
Assisted Living Facility Percent	60%	60%
Lifetime Maximum	$36,000 (3 year plan) or $72,000 (6 year plan)	$108,000 (3 year plan) or $216,000 (6 year plan)
Professional Home Care	50%	50%
Total Home Care - optional	50%	50%
Inflation Protection - optional	simple capped	simple capped

COBRA Q&A

Important Continuation Coverage Information

COBRA Administrator

FBMC Benefits Management Inc., benefits manager for DCPS, has contracted with PayFlex Systems USA, Inc. to administer COBRA services as required by law.

What is continuation coverage?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. This right extends to your plan's Medical and Health FSA.

How long will continuation coverage last?

COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

For Medical & Health FSAs, continuation coverage is generally limited to the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the account for the year. For example, if you elected a Medical & Health FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical & Health FSA for the remainder of the plan year or until such time that you receive the maximum Medical & Health FSA benefit of $1,000.

If your employer funds all or any portion of your Medical & Health FSA, you may be eligible to continue your Medical & Health FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Medical & Health FSAs.

If you have questions about your employer-funded Medical or Health FSA, call FBMC Benefits Management (FBMC) at 1-855-5MY-DCPS or 1-855-569-3277 between the hours of 7:00 a.m. and 8:00 p.m..

How can you extend the length of continuation coverage?

For Group Health Plans (Except Medical Expense FSAs):

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify PayFlex Systems USA, Inc. of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify PayFlex of that fact within 60 days of the later of 1) the SSA's determination of disability (the date of the SSA award letter); 2) the date of your qualifying event; 3) the date of your loss of coverage; or 4) the date you were notified of the requirement (the date of your qualifying event letter). The notification must also be provided before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify PayFlex of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan and FBMC within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. For Medical Expense FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

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COBRA Q&A

Important Continuation Coverage Information

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact PayFlex to confirm the correct amount of your first payment.

Premium Payments should be mailed to:
PayFlex Systems USA, Inc.
Benefits Billing Department
P.O. BOX 2239

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace Periods for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You must contact your employer if you wish to elect alternative coverage. If your group health plan offers conversion privileges, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum COBRA continuation coverage available to you.

How do I continue coverage on voluntary benefits?

Contact Trustmark at 1-800-918-8877 if you would like to continue your Trustmark Accident, Cancer Protector, Critical Illness or Universal Life policy. Contact DCPS Employee Benefits Department at 904-390-2351 if you would like to continue your Unum Long Term Care policy or Standard Group Term Life coverage.

For More Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact FBMC Service Center toll free at 1-855-5MY-DCPS or 1-855-569-3277 between the hours of 7:00 a.m. and 8:00 p.m. ET.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the COBRA Administrator.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

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Retiree Q&A

What should I do when I am ready to retire?

During the 60 days prior to your anticipated retirement date, contact the Employee Benefits Department at 904-390-2351 to schedule your appointment. At this appointment you will complete all required retirement paperwork and enrollment of health/life plans and voluntary flexible benefits you wish to continue.

When I retire, to whom do I send payments?

Retirees continuing their eligible group health and/or term life insurance should elect to pay their full premium payments through monthly deductions from their Florida Retirement System (FRS) check. Deductions for health and/or term life insurance must be paid from your FRS retirement check – provided the retirement benefit would support the deduction.

FBMC Benefits Management, Inc. administers all retiree billing for all retirees who continue benefits. If your retirement benefit will not support your deductions, you will receive payment coupons from FBMC Benefits Management, Inc. to provide direct payment. When you retire, a representative from the Employee Benefits Department will meet with you. During this appointment, you will decide how you will be paying for your group benefits.

**Check your policy to compare benefits.
If you have any questions,
call FBMC Service Center at
1-855-5MY-DCPS (855-569-3277).**

TRAVEL ALERT!

If you are scheduled to retire during the 2015 Plan Year, please plan and select your benefits accordingly.

Continue Basic Life Insurance

All current employees who retire with DCPS may retain their Basic Life amount under the Retiree group insurance plan. A retiree may also elect to port their optional Term Life and AD&D or convert any portion of optional coverage to a Whole Life contract.

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Taxable Benefits and the IRS

Certain benefits may be taxed if you become disabled, depending on how the premiums were paid during the year of the disabling event. Payments, such as disability, from coverages purchased with pre-tax premiums and/or nontaxable employer credits, will be subject to federal income and employment (FICA) tax. If premiums were paid with a combination of pre-tax and after-tax dollars, then any payments received under the plan will be taxed on a pro-rata basis. If premiums were paid on a post-tax basis, you will not be taxed on the money you receive from the plan. You can elect to have federal income tax withheld by the provider just as it is withheld from your wages. Consult your personal tax adviser for additional information.

In addition, FICA and Medicare taxes will be withheld from any disability payments paid through six calendar months following the last calendar month in which you worked prior to becoming disabled. Thereafter no FICA or Medicare tax will be withheld.

You will be required by the IRS to pay FICA, Medicare, and federal income taxes on certain other benefit payments, such as those from Hospital Indemnity Insurance, Personal Cancer Expense Insurance and Hospital Intensive Care Insurance, that exceed the actual Healthcares you incur, if these premiums were paid with pre-tax dollars and/or nontaxable employer credits. If you have questions, consult your personal tax adviser.

According to IRS regulations, you can pay life insurance premiums tax free on your first $50,000 of life insurance. You must pay tax on premiums for coverage exceeding $50,000.

Life Insurance Premiums and the IRS

According to IRS regulations, you can pay premiums on a pre-tax basis, for the first $50,000 of life insurance. However, you must pay tax on any coverage exceeding $50,000 (which includes your School Board-provided $10,000) with after-tax money.

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

However, the tax savings realized through the Flexible Benefits Plan generally outweigh the Social Security reduction. Call Customer Care Center at 1-855-5MY-DCPS (1-855-569-3277) for an approximation.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided not by your Employer's Flexible Benefits Plan, but by the Health Insurance Plan(s). The types and amounts of health insurance benefits available under the Health Insurance Plan(s), the requirements for participating in the Health Insurance Plan(s) and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s). All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) and the rules, regulations, policies and procedures from time to time adopted.

FBMC Privacy Notice

This statement applies to products administered by FBMC Benefits Management, Inc. FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal-and sometimes, sensitive-information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended. FBMC's privacy statement is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services.

FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally vary depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under Federal Law you have certain rights with respect to your protected health information.

You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information.

We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.

IV. We limit how, and with whom, we share customer information.

We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Notice of Administrator's Capacity

This notice advises insured persons of the identity and relationship among the contract administrator, the policyholder and the insurer:

1. Contract Administrator. FBMC Benefits Management (FBMC) has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.

2. Policyholder. This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. Insurer. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly. In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

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Notices

Available Notices are on the following pages for your convenience:

- Creditable Coverage Notice
- Non-Creditable Coverage Notice
- Medicaid and the Children's Health Insurance Program (CHIP)
- HIPAA Notice
- Social Security Number Disclosure Notice
- Special Enrollment Rights Notice
- Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice
- Health Care Exchange Notice

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Creditable Coverage Notice

DCPS Contributory Plan
DCPS Non-Contributory Plan

Important Notice from DUVAL COUNTY PUBLIC SCHOOLS about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Duval County Public Schools (DCPS) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Duval County Public Schools has determined that the prescription drug coverage offered by the DCPS Contributory Plan and Non-Contributory Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

   When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. *In addition, if you lose or decide to leave employer sponsored coverage; you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.*

	DCPS Contributory Plan	DCPS Non-Contributory Plan
Retail		
Generic - Formulary	$7	$7
Brand - Formulary	$25	$25
Non-Formulary	$40	$40
Specialty Injectables	$55	$55
Maximum Supply	One month	One month
Mail Order		
Generic - Formulary	$14	$14
Brand - Formulary	$50	$50
Non-Formulary	$80	$80
Specialty Injectables	$110	$110
Maximum Supply	90 days	90 days

See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Participants who are retired may retain the DCPS Group Medical coverage and choose not to enroll in Medicare Part D plan; or you can enroll in a Medicare Part D drug plan, your DCPS prescription coverage will coordinate with Medicare Part D coverage. However, your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your dependents will still be eligible to receive all of your current health benefits.

If you decide to join a Medicare drug plan, and drop your DCPS Medical Plan prescription drug coverage, be aware that you and your dependents cannot get this coverage back.

You should also know that if you drop or lose your current coverage with DCPS Medical Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. Your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, you premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium

Creditable Coverage Notice

(a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Duval County Employee Benefits at (904) 390-2351 for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through DCPS Group Medical Plan changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

CMS Form 10182-CC Updated April 1, 2014 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2014
Name of Entity/Sender:	Duval County Public Schools
Contact--Position/Office:	Employee Benefits Department
Address:	1701 Prudential Drive, Jacksonville Florida 32207
Phone Number:	904-390-2351

This is an Employer Benefits Highlights Summary and not a contract.
All benefits are subject to the provisions and exclusions of the master contract.

Non-Creditable Coverage Notice

DCPS HIGH DEDUCTIBLE HEALTH PLAN

Important Notice from DUVAL COUNTY PUBLIC SCHOOLS About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prime Therapeutic prescription drug coverage with Duval County Public Schools (DCPS) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Duval County Public Schools has determined that the Prime Therapeutics Prescription Drug coverage offered by the DCPS High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage**. **This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from Prime Therapeutics. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

   You can keep your current coverage from Duval County Public Schools. However, because the DCPS High Deductible Health Plan is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage.

Since the coverage under DCPS High Deductible Health Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't' join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Participants who are retired may retain the DCPS Group Medical coverage and choose not to enroll in Medicare Part D plan or enroll in a Medicare Part D drug plan; DCPS prescription coverage will coordinate with Medicare Part D coverage. However, the current coverage pays for other health expenses in addition to prescription drug. If the participant enrolls in a Medicare prescription drug plan, the participant and dependents will still be eligible to receive all current health benefits.

If you decide to join a Medicare drug plan, and drop your DCPS Medical Plan prescription drug coverage, be aware that you and your dependents cannot get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact our office at (904) 390-2351 for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through DCPS Group Medical Plan changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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Non-Creditable Coverage Notice

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	October 1, 2014
Name of Entity/Sender:	Duval County Public Schools
Contact--Position/Office:	Employee Benefits Department
Address:	1701 Prudential Drive, Jacksonville Florida 32207
Phone Number:	(904) 390-2351

CMS Form 10182-NC Updated April 1, 2014 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Medicaid and the Children's Health Insurance Program (CHIP)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

FLORIDA – Medicaid	**GEORGIA** – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Employee Benefit Plan and Cafeteria Plan Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

This Notice describes the legal duties privacy practices of the group health plans sponsored by Duval County Public Schools as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). It specifically describes how the Duval County Public Schools Employee Benefit Plan and the Duval County Public Schools Cafeteria Plan (the "Plans") may use or disclose your protected health information to carry out treatment, payment, or health care operations, or for any other purposes permitted or required by law. You are receiving this Notice because you participate in either one or both of the Plans as an employee of Duval County School Board (the "School Board"). This Notice refers the School Board as the "Plan Sponsor."

HIPAA protects only certain medical information known as "protected health information." Generally, protected health information is information collected by a health care provider, health care clearinghouse or group health plan that identifies you and relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past present or future payment for health care furnished to you.

It's important to note that HIPAA's privacy rules apply to the Plans listed above, not the Plan Sponsors as employers—that is the way HIPAA works. The terms "we" and "our" in this Notice refer to the Plans.

If you have any questions about this Notice or the Plans' privacy practices, please contact DCPS Employee Benefits Department at (904) 390-2351.

Our Responsibilities

The Plans are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- give you a copy of this Notice; and
- follow the terms of the Notice that is currently in effect.

This Notice and the Plans' privacy practices may change, as allowed or required by law. If this Notice changes significantly, the Plans will provide you with a copy of the revised Notice of Privacy Practices by posting a copy of the current notice on the Plan Sponsors' websites, www.duvalschools.org.

How the Plans are Operated

The Plans themselves do not have employees. Therefore either DCPS and/or a third party administrator administer the Plans. Currently, for example, Florida Blue administers our major medical plan. Third party administrators administer the Plans in a way similar to the way a commercial health insurance company would administer an insured health plan. We have provisions in our contracts with the third party administrators requiring them to keep your protected health information confidential. When DCPS employees conduct plan administration functions on behalf of the Plans, they are acting as an administrator of the Plans. These Plan administrators keep your protected health information separate and do not share it with other departments of the Plan Sponsors except in very limited cases described in this Notice.

Because the Plans are all sponsored by the Plan Sponsors, they are part of an organized health care arrangement. This means the Plans may share your protected health information with each other as needed for the purposes of treatment, payment and health care operations, as described below.

How We May Use and Disclose Your Protected Medical Health Information

The law allows the Plans to use or disclose your protected health information in some cases without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category is listed. However, all of the ways we are allowed to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose protected health information to assist health care providers, such as a hospital or physician, in treating you. We do not plan to make disclosures "for treatment" purposes. However, if necessary, the Plans may make such disclosures without your authorization.

For Payment. Our third party administrators (like Florida Blue) will use your protected health information to pay claims from providers for any treatment and services provided to you that are covered by the Plans or to process payments from your health care reimbursement benefit. Payment also includes using or disclosing information to make determinations on disputed claims, to determine eligibility for benefits, and to coordinate benefits.

- For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plans will cover the treatment.

Payment also includes making decisions regarding cost sharing and responsibility for paying a claim or obtaining reimbursement, examining medical necessity, obtaining payment under stop loss insurance, and conducting utilization review.

- For example, you may have a question regarding payment of a claim. We may need to access your claim information to assist in answering questions necessary to ensure the payment of the claim.

The "we" we are talking about is our third party administrators or selected employees in the DCPS Employee Benefits Department.

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For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plans. For example, we may use protected health information in connection with quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. We may hire third parties such as third party administrators, auditors, attorneys, and consultants to help administer the Plans. These third parties are known as Business Associates. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to Florida Blue, as a third party administrator, to administer claims or to provide support services, such as utilization management.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To the Plan Sponsors. We may disclose protected health information to certain employees of the Plan Sponsors for purposes of administering the Plans. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. For example, we may disclose to certain School Board employees that you are enrolled in, or disenrolled from, one of the Plans. Your protected health information cannot be used for employment purposes without your specific permission.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a
- disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;

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- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity,
- description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for treatment, payment or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;

(2) treating such person as your personal representative could endanger you; or

(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee.

This includes mail relating to the employee's spouse and other family members who are covered under the Plans, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plans has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plans.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

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We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plans;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a time period of not longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You may also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request in most cases. We will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. If we agree or must comply with your request, we will honor the restriction until you revoke it or we notify you.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our websites, www.duvalschools.org.

To obtain a paper copy of this notice contact:
Duval County Public Schools, Employee Benefits Department, 1701 Prudential Drive, Jacksonville, Florida 32207, (904) 390-2351.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plans or with the Office for Civil Rights of the United States Department of Health and Human Services. You will not be penalized, or in any other way retaliated against, for filing a complaint. All complaints made to us must be in writing and sent to Duval County Public Schools, Employee Benefits Department, 1701 Prudential Drive, Jacksonville, Florida 32207, (904) 390-2351.

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Notice of Social Security Number Disclosure

Chapter 2007-251 Laws of Florida, requires agencies to notify individuals of the purpose(s) that require the collection of Social Security numbers. Duval County Public Schools collects Social Security numbers (SSNs) for the following purposes:

- **The Internal Revenue Service and Social Security Administration require a Social Security number on a Form W-4, that is used to determine how much federal withholding tax is to be collected and Federal Insurance Contribution Act (FICA) tax on wages paid and later reported in a W-2 Wage and Tax Statement.**
- **The Internal Revenue Service requires a Taxpayer Identification Number on Form W-9 which could be a Social Security or an Employer Identification number that could be used to generate a 1099 Miscellaneous Income Statement based on expenditures processed through accounts payable. Vendors with Social Security numbers are captured in the Vendor Application process.**
- **The SAP Human Resources/Finance software program requires use of Social Security numbers as the primary personal identification of employees for wages, leaves, payroll deductions, etc.**
- **Social Security numbers are also used as identifiers for processing fingerprints with the Federal Bureau of Investigation and the Florida Department of Law Enforcement.**
- **Social Security numbers are required by the Florida Agency for Workforce Innovation to report wages on a quarterly basis to determine unemployment taxes due to the state by Duval County Public Schools.**
- **Social Security numbers are requested by the National School Lunch Act from parents on the free or reduced price meal application and household verification process as part of determining a family's eligibility for their child(ren) for free or reduced price meals.**
- **Social Security numbers for employees, retirees and dependents are required for enrollment in health insurance, life insurance, and other miscellaneous insurances**
- **Social Security numbers are used by the Florida Department of Education as a standardized identification number for the required reporting of yearly certification and training information.**
- **Social Security numbers are required by the Florida Division of Retirement to report earnings used to document creditable years of service in the Florida Retirement System.**
- **Social Security numbers are used by the Florida Department of Education as a standardized identification number to track students from year to year and when they move from one school or county to another. Social Security numbers are used for students in grades 10 through 12 as identifiers for colleges and scholarship programs such as Bright Futures. For students in grades Pre-Kindergarten through 12, Social Security numbers are used as identifiers for enrollment and attendance, funding reports (such as FTE), tracking of achievement gains, and standardized testing such as FCAT. Student Social Security numbers are included in all Florida Department of Education required reporting.**
- **For adult students and approved GED Exit Option students taking the GED exam for graduation purposes, Social Security numbers are used by the Florida Department of Education as a standardized identification number to track students.**
- **Social Security numbers are used in the Magnet Web application.**
- **Student Social Security numbers are also used to report to the State Department of Licenses that students have passed the written test and completed the Drinking and Driving course requirement for their Restricted Driver's License.**

The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator, Blue Cross Blue Shield of Florida, at 1-800-810-2583 for more information.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:
48 hours following a vaginal delivery OR 96 hours following a cesarean section.

Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery:
  The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the **last delivery**.
- For a delivery outside the hospital (i.e. birthing center):
  The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

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Special Enrollment Notice

Notice of Special Enrollment Rights
This Notice is being provided to ensure you understand your right to apply for the Duval County Public School District Group Health Care Plan. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage
If you are declining for yourself and/or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. If you notify us within 60 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. During the year, you get married. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 60 days from the date of your marriage.

If you are losing coverage under Medicaid or CHIP, this is also a special enrollment right, and you must request enrollment under the DCPS Group Health Care Plan within 60 days of the date you and/or your dependents lose Medicaid or CHIP coverage.

For More Information or Assistance
To request special enrollment or obtain more information, please contact: DCPS Employee Benefits Department at (904) 390-2351.

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New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Duval County Public Schools Employee Benefits Department, (904) 390-2351.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Duval County Public Schools		4. Employer Identification Number (EIN) 59-6000589
5. Employer address 1701 Prudential Drive		6. Employer phone number (904) 390-2000
7. City Jacksonville	8. State Florida	9. ZIP code 32207
10. Who can we contact about employee health coverage at this job? Crystal Wright		
11. Phone number (if different from above) (904) 390-2351	12. Email address whitec3@duvalschools.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are:

    A full time employee person who is employed for a regular work week for the number of hours each day as established by the Board for that position or job, but not less than 30 hours a week, except for employees approved for job-sharing and food service employees who work ten (10) months/four(4) hours.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Eligible dependents include a spouse, child(ren) up to the end of the month the child(ren) reaches age 26, and disabled children who have exceeded age 26.
  - ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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Appeals Process Information and Deadlines

Open Enrollment Appeals

It is our goal to process your elections correctly. We need your help to make sure we do so. That is why we ask that you pay careful attention to plan details and dependent information as you enroll.

You have until the close of business on November 7, 2014, to review and confirm your benefit elections whether you enroll with an enroller or complete the enrollment yourself and make any adjustments that may be needed. You should pay close attention and confirm that you are enrolled in the correct plans and that the correct dependents, if applicable, are attached to those benefits.

After Open Enrollment has ended, Enrollment Appeals are granted under very narrow circumstances as provided by IRS guidance and consistent with district and insurer practices. It is important to note that failure to provide dependent verification information during enrollment, or accidentally electing or dropping a plan, adding or deleting a dependent in error are not errors that will be considered as an appeal and if submitted will be returned to you unprocessed.

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If you experience one of the following types of enrollment errors FBMC/Employee Benefits staff will review and consider your request:

- Enrolling in a Dependent Flexible Spending Account and you do not have dependents who attend daycare/eldercare.
- Any extenuating circumstances related to the enrollment process that would otherwise be deemed outside of your control by the plan and the IRS.
- To assure your appeal is handled promptly and with due consideration:
- Include your name, address, phone number (cell and home), email address and employee personnel number.
- Provide a detailed description of the reason for the appeal.
- Include any additional supporting documents, information or comments you think may have a bearing on your appeal.

Generally, within 30 business days, FBMC will notify you if additional information is needed and will provide the final determination.
All enrollment appeal decisions are final.

ALL APPEALS MUST BE SUBMITTED BY FRIDAY, NOVEMBER 21, 2014

Direct Enrollment Appeals to:

Duval County Public Schools
Attn: Employee Benefits Dept. 2nd Floor
Jacksonville, FL 32207
Fax: 904-390-2370

FSA Appeals

To Appeal a Denied Medical FSA or Dependent Care FSA Claim

If you feel your claim was denied in error, you have the right to file an appeal by writing a letter that explains why you believe the claim should be approved. Your appeal may be submitted in writing and mailed to:

WageWorks Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0991
Fax Number: 1-877-220-3248

Your appeal must be received within 180 days of the date you receive notice that your claim was denied.
Note: If you had a MFSA or DFSA the prior benefits year and failed to complete an enrollment to make your election to contribute to those accounts for the 2015 benefits plan year, your appeal will not be approved.

Mid-year Plan Change Appeals

If you have an enrollment change request for a mid-plan year election change, you have the right to appeal the decision by sending a written request for a review within 30 days of the initial denial.

Your appeal must include:

- The name of your employer
- Your contact information, including an email address so that you may be contacted easily and timely
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal

Submit your appeal as follows:

Appeals involving mid-year changes must be submitted in writing and mailed to:

FBMC
Attn: Enrollment Appeals, Mail Slot 79
PO Box 1878
Tallahassee, FL 32302-1878

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FBMC
BENEFITS MANAGEMENT

Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Service Center 1-855-5MY-DCPS (1-855-569-3277)
711 National Telecommunication Relay Service (TDD)
www.myFBMC.com

Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.

 FBMC/DCPS/0914