

## 2008-2009 Open Enrollment FAQs

- Q. Who should participate in Open Enrollment?  
A. **This is a complete enrollment. All employees should meet with an Enrollment Counselor to review benefit selections and discuss new benefits information.**
- Q. What will happen to my current benefits if I do not meet with an Enrollment Counselor during Open Enrollment?  
A. **Your benefits and tier levels will remain the same with the exception of medical coverage. Your medical coverage will default to the plan you're eligible for.**
- Q. Why should I see an Enrollment Counselor?  
A. **All employees are encouraged to meet with an Enrollment Counselor who can help you decide which benefit selections could best meet your needs.**
- **Enrollment Counselors can answer questions that are specific to you and your benefit needs.**
  - **Employees, who enroll "Online" and wish to select a new voluntary benefit or make a change to their current voluntary benefit, will be required to schedule an appointment with an Enrollment Counselor for the voluntary benefits portion due to the application requirement. These Voluntary Benefits include Long Term Care, Hospital Indemnity, AHL Group Critical Illness, UNUM Whole Life, Trustmark Universal Life and Premier Select Critical Illness (current Trustmark participants only).**
- Q. What do I need to bring to my enrollment appointment?  
A. **Employees should bring the following to an enrollment appointment:**
- **Birthdates**
  - **Social Security Numbers**
  - **Addresses for dependents and beneficiaries**
  - **Insurance information if any dependent is covered under another plan.**
  - **For employees wishing to add a dependent to the plan, appropriate documentation showing proof of dependency (birth certificate, adoption decree, marriage certificate, etc.) will be required.**
- Q. Are there any changes being made to the medical benefit plans this year?  
A. **Yes. The new medical plan you're eligible for is based on the Non-Bargaining or Collective Bargaining Unit you're represented by:**
- DCPS Blue A – Administrators, Exempt, and Employees represented by School Maintenance Employee Association (School Maintenance Employee Association represents all maintenance employees even if you aren't a dues paying member of that Collective Bargaining Union.)**
- DCPS Blue C – Employees represented by DTU (Teachers, Paraprofessionals, UOPD), AFSME, LIUNA, and JSA (even if you aren't a dues paying member of that Collective Bargaining Union.)**
- There are changes in the Office Visit Co-pays, Emergency Room Co-pay, In-Network Deductibles, Out-of-Pocket Maximums, and RX Co-pays:**
- DCPS Blue A**
- **In-Network Office Visit Co-pay - \$10**
  - **In-Network Deductible: Individual - \$300 / Family - \$600**
  - **In-Network Out-of-Pocket Max: Individual - \$2,500 / Family - \$5,000**
  - **Out-of-Network Out-of-Pocket Max: Individual – Individual - \$3,250 / Family - \$6,500**
  - **Emergency Room Co-pay: \$250**
  - **Rx Coverage: Generics - \$7 / Preferred Brand - \$30 / Non-Preferred - \$55 / Specialty - \$55**  
**Mail Order: Generics - \$14 / Preferred Brand - \$60 / Non-Preferred - \$110**
  - **Routine Eye Exams, Infertility Treatments, and Massage Therapy are no longer covered under the medical plan**
- DCPS Blue C**
- **In-Network Office Visit Co-pay - \$15**
  - **In-Network Deductible - Individual - \$0.00 / Family - \$0.00**
  - **In-Network Out-of-Pocket Max – Individual - \$2,500 / Family - \$5,000**
  - **Out-of-Network Out-of-Pocket Max: Individual – Individual - \$3,250 / Family - \$6,500**
  - **Emergency Room Co-pay: \$250**
  - **Rx Coverage: Generics - \$25 / Preferred Brand - \$25 / Non-Preferred - \$40 / Specialty - \$55**  
**Mail Order: Generics - \$14 / Preferred Brand - \$50 / Non-Preferred - \$80**
  - **Routine Eye Exams, Infertility Treatments, and Massage Therapy are no longer covered under the medical plan**
- Q. What if I'm currently receiving infertility treatment?  
A. **If you are currently receiving infertility treatments, you may be able to complete the current cycle of treatment. Please contact BCBS Customer Service to verify coverage.**

Q. When will the new medical plan changes become effective?

A. **The new medical plan changes are effective 10/1/08**

Q. When does my benefit coverage end?

A. **Group health plans and flexible benefits will continue until the last day of the month in which termination occurs, unless the terms of your contract have been completed. If the terms of the contract have been completed, benefits will continue until the end of the plan year (September 30, 2009), provided that all necessary contributions have been made.**

Q. Can I make a change to my benefits once I have completed my enrollment?

A. **Yes, an employee has 14 days (Supersede Period) to make changes after their enrollment.**

Q. What if I have a family status change that requires me to add a family member or drop a family member from my benefit coverage after Open Enrollment ends, can I make a change?

A. **Yes, a change can be made if it meets the qualifying events listed on page 9 and 10 of your Reference Guide. All qualifying family status changes outside of the Open Enrollment period must be completed within 30 days of the qualifying event.**

Q. Are there any changes to the Medical Expense Flexible Spending Account (MFSA)?

A. **Yes. The employer contribution amount you receive is based on the Non-Bargaining or Collective Bargaining Unit you're represented by. The funds contributed into your MFSA are designed to be utilized towards the annual deductible and any other medically necessary, out-of-pocket expenses not covered by your insurance plans.**

**DCPS Blue A – The employer contributions to your Medical Expense Flexible Spending Account will total \$500 (employee-only coverage) and an additional \$300 (dependent/family unit coverage)**

**DCPS Blue C – The employer contributions to your Medical Expense Flexible Spending Account will total \$450 (employee-only coverage) and an additional \$300 (dependent/family unit coverage)**

Q. Will I receive new ID cards?

A. **You will receive new ID cards if any of the following applies to you:**

- **You are a newly hired employee**
- **You were previously enrolled in the Select Plus or Premier Plans and you're now in the DCPS Blue C**
- **You were previously enrolled in the Select Plan and you're now enrolled in DCPS Blue A**

Q. What if I need to see a medical provider before I receive my new medical insurance ID card?

A. **If you need to see a medical physician before you receive your new ID cards and after the start of the new plan year (10/1/08), you may use your current ID card or you may contact BCBS Customer Service for assistance.**

Q. What is the main number for BCBS Customer Service?

A. **The dedicated Customer Service telephone number for DCPS employees is 1-800-664-5295.**

Q. What are the BCBS Customer Service hours?

A. **8 am – 9 pm Mon – Thurs, 9 am – 9 pm Friday (Extended hours are subject to change after Open Enrollment)**

Q. Will I need to select a Primary Care Physician (PCP) if I have Blue Cross Blue Shield of Florida?

A. **No. You will not be assigned a PCP from the BCBS Provider network.**

Q. Will I need a referral to see specialists?

A. **No. DCPS Blue A and DCPS Blue C are both Open Access Plans. Referrals are not required.**

Q. Is there a change in the network of providers I am allowed to see at the In-Network benefit level?

A. **Yes, only medical providers that are participating in BlueOptions NetworkBlue are In-Network. Medical providers who are in the Traditional Network are Out-of-Network under the new medical plan.**

Q. Is Mayo Clinic In-Network or Out-of-Network?

A. **Mayo Clinic and Mayo Hospital are Out-of-Network for the new medical plan. If you continue to see physicians at the Mayo Clinic and/or Mayo Hospital, your claims will be processed at the Out-of-Network benefit level.**

Q. What is the best method for me to validate a provider's network status?

A. **The best method to validate a provider's network status is to go online: [www.bcbsfl.com](http://www.bcbsfl.com) and click on Find a doctor or hospital.**

Q. What is the difference between the calendar year and plan year?

A. **The calendar year is January 1- December 31. The plan year is October 1 – September 30.**

Q. What is a deductible?

A. **A deductible is a set amount of money that a member must pay for covered medical services each calendar year before covered services are paid by the plan.**

- Q. What expenses are subject to the deductible?  
A. **All medical expenses, other than co-payments, including hospital charges (both inpatient and outpatient), surgery charges (both inpatient and outpatient), skilled nursing care, hospice care, X-ray and lab fees that are done at the facility.**
- Q. If I met my deductible earlier this calendar year, will I have to meet it again once the new plan year starts on October 1, 2008?  
A. **No. If you met the calendar year deductible prior to October 1, 2008, you will not have to meet a new deductible during this calendar year.**
- Q. What medical expenses are applied to the out-of-pocket maximum?  
A. **Deductibles, co-insurance and medical co-payments are applied to the out-of-pocket maximum. Prescription drug co-payments are not applied toward the out-of-pocket maximum.**
- Q. If I met the Out-of-Pocket Maximum earlier this calendar year, will I have to meet it again once the new plan year starts on October 1, 2008?  
A. **No. If you met the Out-of-Pocket Maximum prior to October 1, 2008, you will not have to meet a new Out-of-Pocket Maximum this calendar year.**
- Q. Is there a carryover of the deductible and/or out-of-pocket maximum?  
A. **Yes. Any deductible met in October through December 2008 will carry over to the 2009 calendar year. Out-of-Pocket Maximums met in October through December 2008 will not carry over to the 2009.**
- Q. Is the Deductible and Out-of-Pocket Maximum based on a calendar year or plan year?  
A. **The Deductible and Out-of-Pocket Maximum are both based on a calendar year.**
- Q. What is the Usual, Customary, and Reasonable (UCR) charge and how does it affect me?  
A. **The UCR is established by Blue Cross Blue Shield of Florida using the average medical fees charged within a given zip code area. If you are using in-network services, all eligible charges will be covered. However, if you elect to access medical services out of the network, all charges that exceed the UCR rates are your responsibility and you will be balance billed by the medical provider. This will significantly increase your out-of-pocket costs.**
- Q. Will Prime Therapeutics continue to be the Rx Mail Order Provider?  
A. **Yes**
- Q. What is the contact information for Prime Therapeutics?  
A. **PrimeMail  
PO Box 660319  
Dallas, TX 75266-0319  
1-888-849-7865  
[www.mvrhealth.com](http://www.mvrhealth.com)**
- Q. Where can I go to receive a colonoscopy at the lowest out of pocket expense?  
A. **If you go to a participating ambulatory surgical center to receive a colonoscopy, you will pay a total of \$70 (\$35 co-pay for the facility + \$35 co-pay for the physician services).**

**Participating Ambulatory Surgical Centers:**

**Jacksonville Beach Surgery Ctr.  
3316 3<sup>rd</sup> St. S.  
Jacksonville Beach, FL  
(904) 247-8181**

**Jacksonville Ctr. for Endoscopy  
4800 Belfort Rd.  
Jacksonville, FL  
(904) 265-4801 / (904) 387-6750**

**Jacksonville Surgery Ctr.  
7021 AC Skinner Pkwy  
Jacksonville, FL  
(904) 281-0021**

**Medical Partners Surgery Ctr.  
4545 Emerson St.  
Jacksonville, FL  
(904) 399-2600**

**Parkside Surgery Ctr.  
2731 Park St.  
Jacksonville, FL  
(904) 389-1077**

**Plaza Surgery Center, LTD  
6138 Kennerly Rd. Ste. 101  
Jacksonville, FL  
(904) 208-4120**