

**dcps**

Duval County Public Schools

**2012**

# Flexible Benefits Plan

*COBRA Reference Guide*



**Plan Year - January 1, 2012 - December 31, 2012**

# Benefits Directory

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## EMPLOYER

### Duval County Public Schools

Employee Benefits Department  
Mon - Fri, 7:30 a.m. - 5:00 p.m. ET  
(904) 390-2351  
[www.duvalschools.org](http://www.duvalschools.org)

## PROVIDER COMPANIES

### Blue Cross Blue Shield (BCBS)

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

### Delta Dental

Group# 944-0003  
Customer Service  
(DeltaCare® USA Prepaid)  
Mon - Fri, 8 a.m. - 9 p.m. ET  
1-800-422-4234  
(Delta Dental PPO)  
Group# 944-0002  
Mon - Fri, 7:15 a.m. - 7:30 p.m. ET  
1-800-521-2651  
[www.deltadentalins.com](http://www.deltadentalins.com)

### Fringe Benefits Management Company, a Division of WageWorks

#### Customer Care Center

Mon - Fri, 7 a.m. - 10 p.m. ET  
1-800-342-8017  
Interactive Benefits  
24-hours a day  
1-800-865-3262  
Onsite Representatives:  
Nyck McCants, (904) 390-2349  
Taryn Thompson, (904) 390-2352

### Humana/CompBenefits Vision Care Plan

Group# 207020  
Customer Service  
Mon - Sat, 7:30 a.m. - 11 p.m.  
Sun, 11 a.m. - 8 p.m. ET  
1-800-865-3676  
[www.compbenefits.com/custom/Duval/](http://www.compbenefits.com/custom/Duval/)

### Medco Pharmacy

Customer Service  
24-hours a day  
1-866-544-6950  
[www.medco.com](http://www.medco.com)

This reference guide is designed to provide you important details about the 2012 Benefits Program. Every effort has been made to ensure that the information described in this guide is accurate. However, in the event of a discrepancy between program provisions described in this guide and the actual provisions of the official benefit plan documents, the plan documents will prevail. Your eligibility to enroll in benefits described in this guide is determined by the eligibility requirements of the plan. Additionally, receipt of this guide is for informational purposes only and should not be construed as a contract or offer of employment.

# Duval County Public Schools

## Important Dates to Remember

Open Enrollment dates are:  
**October 3, 2011, through November 4, 2011**

Your Period of Coverage dates are:  
**January 1, 2012, through December 31, 2012**

Welcome to the 2012 Benefits Open Enrollment. Open Enrollment is your annual opportunity to make changes to your benefit elections. You are encouraged to read this booklet 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 for benefits information.

DCPS is committed to providing security for you and your family by offering a comprehensive and affordable benefits program. It is your responsibility to read this Guide and any individual plan materials you receive before making your elections. Your benefits are valuable. Be sure you are making the most from them.

## Good News:

- No rate increases on any benefit plans for the 2012 Plan Year.
- All medical plans remain the same for the 2012 Plan Year.
- If you are satisfied with your current benefit elections, your current coverage will automatically be carried forward from the Quarter Plan Year (October - December 2011) for the 2012 Plan Year.
- Remember, the District has changed its Benefit Plan Year from October - September to January - December. This change will help align your annual deductibles with the insurance provider's calendar year deductibles.

## Important Enrollment Information

- Complete and mail an Enrollment Form to elect a new medical plan and to make changes to your optional benefits (ex: dental and vision plan) by November 4, 2011.
- Your 2012 Plan Year is January 1, 2012, through December 31, 2012.
- For more information regarding your COBRA medical, dental and vision coverage, contact Customer Care at 1-800-342-8017, Monday through Friday, 7 a.m. to 10 p.m. ET.

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# Eligibility Requirements

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## Who is Eligible?

Under certain qualifying events, covered employees may be eligible for continuation of group health plans coverage under the COBRA law. Please contact Fringe Benefits Management Company, a Division of WageWorks, Customer Care at 1-800-342-8017.

## COBRA Coverage

A Qualified Beneficiary's (QB) period of coverage is January 1, 2012, through December 31, 2012, unless a QB's scheduled COBRA expiration date is sooner. QBs who have elected to continue eligible group health plans under COBRA will be given the same opportunity to change their coverage options or add or drop eligible dependents at Open Enrollment as similarly situated active employees and beneficiaries.

A QB's Medical Expense FSA coverage will not be continued beyond the plan year in which the qualifying COBRA event occurs.

HIPAA's special enrollment rights may apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add dependents if such person acquires a new dependent, or if an eligible dependent declines coverage because of alternative coverage and later loses such coverage due to certain qualifying reasons. Spouse or dependents who are added under this law do not become Qualified Beneficiaries—and their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

If there's a loss of coverage for a group health plan, due to one of the triggering events below, then COBRA rights may have been created:

### **For Covered Employees upon:**

- termination of employment (other than for gross misconduct), including retirement, or
- a reduction in hours of employment

### **For Spouses or Dependent Child(ren) upon:**

- a covered employee's termination of employment (other than for gross misconduct), including retirement
- a covered employee's reduction in hours of employment
- a covered employee's death
- a divorce or legal separation (if recognized by state law) of a spouse from a covered employee
- a covered employee's entitlement to Medicare, or
- a child's loss of dependent status

## Method of Payment

A COBRA participant's initial payment including all back premiums is due within 45 days of COBRA continuation election. Subsequent monthly premium payments are due on the first of every month. COBRA law allows for a 30-day grace period after the due date for monthly payments. If a full premium payment is not received from a COBRA Participant by 30 days after the due date, COBRA coverage will be cancelled retroactive to the first day of the month for which the full premium payment is due. A cancellation notice will be sent to the COBRA Participant if his or her full premium payment is not received.

# Dependent Eligibility Requirements

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DCPS requires that all dependents newly enrolling 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.

## What does this mean for you?

If you are a DCPS COBRA participant and you are enrolling new dependents or re-enrolling previously-covered dependents, 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 that documentation when DCPS requests it, any unverified dependents will be removed from your coverage retroactive to the beginning of the current plan year.

## 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 former 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 individuals we cover 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 newly enroll or re-enroll an eligible dependent in your benefits coverage:

- During Open Enrollment
- Following a qualifying life event change

## 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.

# Dependent Eligibility Requirements

## Dependent Verification Chart

Dependent Relationship	Documentation Required
<b>Spouse Married prior to January 1, 2011</b> <i>2 Documents</i>	Copy or Original government issued Marriage Certificate; AND IRS 2010 1040 Tax Return
<b>Spouse Married on or after January 1, 2011</b> <i>1 Document</i>	Copy or Original government issued Marriage Certificate
<b>Birth Child</b> Maximum age end of the month of 26th birthday <i>1 Document</i>	Copy or Original government issued Birth Certificate that shows proof of relationship Newborn – Hospital Certificate of Birth (footprints) that shows proof of relationship
<b>Step Child</b> Maximum age end of the month of 26th birthday <i>2 Documents</i>	Copy or Original government issued Marriage Certificate; AND Copy or Original government issued Birth Certificate that shows proof of relationship
<b>Adopted Child</b> Maximum age end of the month of 26th birthday <i>1 or 2 Documents</i>	Legal Adoption Records naming employee (subscriber) as parent If spouse (not employee) is adoptive parent then bring: Copy or Original government issued Marriage Certificate.
<b>Birth outside of USA (not Adoption)</b> Maximum age end of the month of 26th birthday <i>1 Document</i>	Naturalization papers presented to Duval Employee Benefits Department that shows proof of relationship
<b>Legal Guardianship/Custody</b> Maximum age end of the month of 26th birthday <i>2 or 3 Documents</i>	Copy or Original Birth Certificate that shows proof of relationship; AND Court Documents naming employee (subscriber) as legal guardian / custodian If spouse (not employee) is guardian/custodian then bring: Copy or Original Government issued Marriage Certificate
<b>Grandchild</b> (Newborn to 18 months) <i>2 Documents</i>	Copy or Original government issued Birth Certificate of grandchild that shows proof of relationship; AND Copy or Original government issued Birth Certificate of covered dependent birth parent who is also enrolled in the plan Newborn – Hospital Certificate of Birth (footprints) that shows proof of relationship
<b>Disabled Adult Child</b> <i>2 Documents</i>	Copy or original government issued Birth Certificate that shows proof of relationship; AND Copy of Physician's Statement; AND/OR Copy or Original Social Security Papers

Official documents of birth, marriage and/or death certificates from anywhere in the United States may be obtained through [www.vitalchek.com](http://www.vitalchek.com) or by calling 1-800-255-2414 Option 3. Some fees apply.

# Medicaid and the Children’s Health Insurance Program (CHIP)

## Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your Duval County School Board, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Duval County School Board is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

**You may be eligible for assistance paying your employer health plan premiums. Florida and Georgia are eligible as of April 16, 2010. You should contact your State for further information on eligibility –**

Florida - Medicaid	Georgia - Medicaid
Website: <a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a> Phone: 1-866-762-2237	Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on Programs, then Medicaid Phone: 1-800-869-1150

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
 Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://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](http://www.cms.hhs.gov)  
 1-877-267-2323, Ext. 61565

# DCPS COBRA Q&A

## Important Continuation Coverage Information

### What is continuation coverage?

Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Medical Expense FSAs), give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “Qualified beneficiaries” can include the employee (or retired employee) covered under the group health plan, a covered employee’s spouse and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including open enrollment and special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be obtained from your employer.

### How long will continuation coverage last?

#### **For Group Health Plans (Except Medical Expense FSAs):**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation of coverage, under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

#### **For Medical Expense FSAs:**

If you fund your Medical Expense FSA entirely, you may continue your Medical Expense FSA (on a post-tax basis) only for 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 Medical Expense FSA for the year. For example, if you elected a Medical Expense FSA benefit of \$1,000 for the plan year and have received only \$200 in reimbursement, you may continue your Medical Expense FSA for the remainder of the plan year or until such time that you receive the maximum Medical Expense FSA benefit of \$1,000. If your employer funds all or any portion of your Medical Expense FSA, you may be eligible to continue your Medical Expense 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 Expense FSAs. If you have questions about your employer-funded Medical Expense FSA, you should call Fringe Benefits Management Company, a Division of WageWorks at 1-800-342-8017.

### 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 Fringe Benefits Management Company 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 under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To obtain this extended coverage, you must notify Fringe Benefits Management Company of the Social Security’s disability determination within 60 days of the determination and 18 months of the qualifying event. If elected, a disabled qualified beneficiary must pay 102% of the full cost of continuation coverage during the 11-month period of extended coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that 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. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such

# DCPS COBRA Q&A

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pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. 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, 102 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.

## 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 that 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 Fringe Benefits Management Company to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

### 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?

If you are retiring, you may have the right to elect alternative retiree group health coverage instead of the COBRA continuation coverage described in this Notice. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You should also note that if you enroll in the alternative group health coverage, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends. 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. You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

## 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 Fringe Benefits Management Company, a Division of WageWorks, Customer Care at 1-800-342-8017.

Private sector employees seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). State and local government employees should contact HHS-CMS at [www.cms.hhs.gov/COBRACContinuationofCov/](http://www.cms.hhs.gov/COBRACContinuationofCov/).

# COBRA Medical Plan Options

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## NON-CONTRIBUTORY/CONTRIBUTORY/HDHP

Blue Cross Blue Shield of Florida will continue providing Duval County Public School's medical administrative services for the New Plan Year (Jan 1 – Dec 31, 2012) The following medical options are available for you to choose from.

### DCPS Non-Contributory Plan

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 BCBS Network Blue providers found at [www.bcbsfl.com](http://www.bcbsfl.com).

**Plan highlights include:**

- Participants 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:
  - Inpatient Hospitalization
  - Physician Services Other than Office
  - All Out-of-Network Services
- Co-insurance and co-pays, other than Rx, will count towards the maximum out-of-pocket limit.

### DCPS Contributory Plan

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 BCBS Network Blue providers found at [www.bcbsfl.com](http://www.bcbsfl.com).

**Plan highlights include:**

- Participants have the freedom to choose an in or out of network service provider at the time of service.
- No in-network deductible.
- Co-insurance applies to all services that do not have set co-pays.
  - Inpatient and Outpatient Hospitalization
  - Ambulatory Surgical Center Facility
  - All Out-of-Network Services
- Co-insurance and co-pays, other than Rx, do count towards the maximum out-of-pocket limit.

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

# COBRA Medical Plan Options

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## DCPS High Deductible Health Plan

### Plan highlights include:

- Participants 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 except routine services.
- For coverage other than participant only, the family deductible must be met before co-insurance or co-payments are applicable.

Note: If you are ineligible to participate in an HSA, you may elect a High Deductible Health Plan and contribute to FSA.

- HSA accounts are set-up through Synovus Bank of Jacksonville.
- HSA Funds may be used based on what's available in the account.
- HSA Funds are NOT use it or lose it.
- Prior year participant-contributions through payroll deductions to the HSA will not roll-over and must be elected at your enrollment session.
- You may increase or decrease your pre-tax contributions to your HSA once per month.
- For Medicare Part D coverage, the prescription drug coverage offered by the High Deductible Health Plan is considered Non-Creditable.

## ID Cards

Blue Cross Blue Shield 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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All benefits are subject to the provisions and exclusions of the master contract.*

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

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**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 2012 contribution limit is \$3,100.00 for single and \$6,250.00 for family. 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.

### Catch-Up Contributions

HSA owners age 55 and older can make additional contributions to their HSA called "catch-up contributions". For 2012, the allowed catch-up contribution is \$1,000.

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# Health Savings Account FAQs

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## 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<sup>1</sup>, your contributions will be sent to the custodian, Synovus Bank of Jacksonville, a division of Synovus Bank<sup>2</sup>. 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 HSA Customer Support 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, Synovus Bank of Jacksonville will charge \$2 a month for account balances under \$2,500. 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).<sup>3</sup>

## 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. 2012 limits are \$3,100 for single and \$6,250 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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<sup>1</sup> A Bank Signature Card form MUST be completed to open a Health Savings Account.

<sup>2</sup> 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.

<sup>3</sup> 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 a High Deductible Health Plan with an HSA

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## 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

Go to the link <https://hsa.synovus.com/SNV.HSA/View/Form/Ext/hsaapp.aspx?TC=DUVALCOUNTY> and complete the online application. Print, sign, and mail the application with a copy of your photo ID to HSA Operations. Your account will be opened within two days of the receipt of your completed application and identification. Your VISA® debit card(s) will be mailed within 7-10 days.

## Contributing to Your HSA

The 2012 contribution limit is \$3,100.00 for single and \$6,250.00 for family.

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

- **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 Bank 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 Contribution 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 balance 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

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

# 2012 Monthly Contribution Rates

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DCPS Non-Contributory Plan Rates	
Coverage Tier Levels	Monthly plus 2% admin fee
Participants Only	\$574.88
Participants & Spouse	\$975.06
Participants & Child(ren)	\$871.95
Participants & Family	\$1,326.82

**Notification will be distributed if there are any modifications to these rates.**

DCPS Contributory Plan Rates	
Coverage Tier Levels	Monthly plus 2% admin fee
Participants Only	\$629.17
Participants & Spouse	\$1,067.12
Participants & Child(ren)	\$954.27
Participants & Family	\$1,452.09

**Notification will be distributed if there are any modifications to these rates.**

DCPS High Deductible Health Plan (HDHP) Rates	
Coverage Tier Levels	Monthly plus 2% admin fee
Participants Only	\$523.43
Participants & Spouse	\$887.79
Participants & Child(ren)	\$793.91
Participants & Family	\$1,208.07

**Notification will be distributed if there are any modifications to these rates.**

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# Medco

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## Medco Pharmacy Benefits

Medco Health Solutions (MHS) is the current Pharmacy Benefit Manager for Duval County Public Schools.

## Member Services

Visit Medco's website, [www.medco.com](http://www.medco.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 1-866-544-6950. For future reference, this number is listed on the back of your Medco 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.medco.com](http://www.medco.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 Medco 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. Medco provides a list of formulary brand name medications to help you and your doctor decide medications that are clinically appropriate and cost effective.

If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist. Using drugs on the formulary will keep your costs and client name's 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 Medco Pharmacy Network is a national network comprised of nearly 60,000 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. Use one of these pharmacies to fill prescriptions for short-term medications, such as antibiotics. To find a local pharmacy, visit [www.medco.com](http://www.medco.com) and click "Locate a pharmacy" or contact Member Services.

## Mail Order Pharmacy

### Medco by Mail Pharmacy Program

Medco by Mail 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 the Medco by Mail Pharmacy Program, mail your prescription, order form and payment in the envelope provided. You may also ask your doctor to fax your prescription by calling 1-888-327-9791 for further instruction. Your medication will usually be delivered within 8 days of Medco receiving your order.

To order refills, call the automated refill system at 1-800-REFILL (1-800-473-4355), or visit [www.medco.com](http://www.medco.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 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 the Medco by Mail Pharmacy.

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, Medco's pharmacists will contact either you or your doctor prior to dispensing the medication.

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# Medco

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## Retail Refill Allowance Program

Medco will implement the Retail Refill Allowance Program, effective October 1, 2011. This program allows members 3 fills at retail pharmacy for long-term maintenance medications. Contact Medco Customer Service at 1-866-544-6950 to verify whether your medication is on the long-term maintenance medication list.

Here is some key information about the Retail Refill Allowance Program:

- **After your third purchase of a long-term maintenance medication at retail, you'll pay more.** The first 3 times you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-payment. After the 3rd refill, you'll pay the ENTIRE COST if you continue to purchase it at retail.
- **To avoid paying more, use the Medco Pharmacy and pay your mail-order co-payment for up to a 90-day supply.** That means you'll pay less over time. Your medications will be delivered right to you, and standard shipping is free. Once you get started, you can request refills easily by mail, online, or over the phone.

### Two easy ways to start saving with the Medco Pharmacy:

1. By mail:
  - Ask your doctor for a new prescription for up to a 90 day supply, plus refills for up to 1 year (if appropriate).
  - Mail the new prescription with your mail order form to Medco. To obtain a mail order form, log on to [www.medco.com](http://www.medco.com) or contact Medco Customer Service at 1-866-544-6950.
2. By doctor fax:
  - Ask your doctor for a new prescription for up to a 90-day supply, plus refills.
  - Provide your doctor with your Medco member ID number (shown on your ID card) and ask him or her to call 1-888-327-9791 for instructions on how to use the fax service. You'll be billed later.

Your medication will usually arrive within 8 -14 days after Medco receives your order.

### Services to make refilling your prescriptions easier...

**Worry-free Fills** – With patient approval, the Medco Pharmacy sends refills automatically to patients at the appropriate time prior to their medication running out. Members can enroll into Worry-free Fills via customer service 1-866-544-6910, IVRU and [www.medco.com](http://www.medco.com). Members will get confirmation of enrollment when they sign up. Members are notified of upcoming shipments over 2 weeks prior to the shipment date so that they can cancel or modify the order if necessary.

**Refill Reminders** – Refill reminder are automatic for all Medco Pharmacy users for appropriate medications. Approximately two weeks prior to a member being due to run out of medication, Medco will reach out via email, phone or a letter to remind members to refill their prescriptions.

**Extended Payment Program** – The Extended Payment Program makes it easier to pay for 90-day supplies. Members have the option of paying their cost share in three equal, monthly installments. There are no additional fees for using the Extended Payment Program. Payments are charged automatically to the credit and/or debit card provided by the patient. An installment payment schedule is provided to the patient with their prescription order. Once selected, the Extended Payment Program is applied to all covered members of the household for all prescriptions. Members can enroll into the Extended Payment Program via customer service 1-866-544-6910, IVRU and [www.medco.com](http://www.medco.com).

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# Medco

## Medication Step Therapy

### What is Medication Step Therapy?

Medication Step Therapy (Step Therapy) is a program especially for people who take prescription drugs regularly — that is, for an ongoing condition like arthritis, asthma, stomach problems or high blood pressure. It provides the safe, effective and most appropriate treatment you need while keeping your costs as low as possible. The program moves you along a well-planned path, with your doctor approving your medications.

### How does Step Therapy work?

When you submit a prescription that is not for a first-step drug, you or your pharmacist should contact your doctor. Only your doctor can approve and change your prescription to a first-step drug. You can call Medco to get some examples of safe, effective first-step drugs to discuss with your doctor.

If you have already tried the first-step drugs provided by your program, or your doctor decides you need a different drug for medical reasons, then your doctor can call Medco to request a “prior authorization.” If a second-step drug can be covered, you will pay a higher copayment than for a first-step drug. If your “prior authorization” does not meet the established clinical criteria and is denied, you will have to pay the full price of the drug.

If you have documented prior clinical approval for the brand-name medication that is included in the step therapy program, you may continue taking the brand name medication. Prior authorization criteria shall be a part of the program. If you stop taking your medication for more than 60 days, you will be subject to Step Therapy when you refill your prescription.

**Generic drugs are usually in the first step.** Tested and approved by the U.S. Food & Drug Administration (FDA), the generics provided by your plan are effective for treating many medical conditions. This first step lets you begin or continue treatment with prescription drugs that have the lowest copayment.

**Brand-name drugs are usually in the second step.** If your medical condition requires different medications, then the program moves you along to this next step. Brand-name drugs have a higher copayment.

**Questions about Step-Therapy.** If you have questions about the Step Therapy program, please call a Medco representative at 1-866-544-6950.

## 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
Specialty Injectables	\$110	\$110	CYD + \$110 + 10% coins
Maximum Supply	90 days	90 days	90 days

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

# 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 [www.deltadentalins.com](http://www.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 [www.deltadentalins.com](http://www.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 [www.deltadentalins.com](http://www.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 Monthly Rates	
<b>DELTACARE® USA</b>	<b>Rate</b>
Participant	\$20.87
Participant & One	\$34.96
Participant & Family	\$51.43
<b>DELTA DENTAL PPO</b>	<b>Rate</b>
Participant	\$46.84
Participant & One	\$93.25
Participant & Family	\$121.54

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### Benefit Tip

Delta Dental provides an automated eligibility and benefit information line. You may also print ID cards from the Delta Dental web site.

#### Delta PPO:

7:15 a.m. - 7:30 p.m. ET  
Monday - Friday, at  
1-800-521-2651  
[www.deltadentalins.com](http://www.deltadentalins.com)

#### DeltaCare® USA:

8 a.m. - 9 p.m. ET  
Monday - Friday, at  
1-800-422-4234  
[www.deltadentalins.com](http://www.deltadentalins.com)

## Family Coverage

This plan covers:

- Your spouse.
- Your unmarried 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.

## Dental Providers

To locate a dental provider or facility, please visit [www.deltadentalins.com](http://www.deltadentalins.com) and click the "Find a Dentist" link on the homepage. You may also call the Delta Dental Customer Service Department at 1-800-422-4234 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.

# DeltaCare® USA – Prepaid Plan

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

- DeltaCare® USA 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 1-800-422-4234.

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

## 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 copayments 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.

## 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 (one per 6 months)
- Specialty care is covered by referral from your primary dentist at the same defined co-pays as general dentists

## 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 (Calendar Year is Jan. 1 - Dec. 31)	none
Calendar Year Maximum	none
Claim Forms	none
<b>Diagnostic Procedures</b>	<b>You Pay</b>
Office visit	\$0 - \$20
Routine exams	no cost
Prophylaxis (cleaning) - basic	no cost (one per 6 months)
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)
<b>Basic/restorative procedures</b>	
Simple extractions	\$6
Amalgam fillings - 1 surface perm	no cost
Resin based fillings - posteriors	\$15 - \$35
Root canal - anterior***	\$75
Root canal - molar***	\$180
<b>Major procedures</b>	
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)
<b>Periodontics</b>	
Scaling and root planing	\$45 per quadrant
<b>Orthodontics</b>	
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

**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.**

# Delta Dental PPO – Indemnity

## Delta Dental PPO Option

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

<b>Benefit</b>	<b>Delta Dental Indemnity (PPO Option)**</b>
Use dentist of choice	
Deductible* (Calendar Year is 1/1 - 12/31)	\$75 per year, individual \$150 per year, per family
Calendar Year Maximum	\$2,000 per person
Claim Forms	None if using Delta Dental dentists
<b>Procedures</b>	<b>Delta Dental reimbursement according to PPO In/UCR Out fee schedule</b>
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)
<b>Basic/restorative procedures</b>	
Oral surgery (extractions)	80%
Amalgam fillings	80%
Root canal	80%
<b>Major procedures</b>	
Crowns	50%
Dentures	50%
Bridges	50%
<b>Periodontics</b>	50%
<b>Orthodontics</b>	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 Benefits	50% up to \$1,000 lifetime maximum (effective October 2006)

## PPO Dentist Benefits

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

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

\*\* DeltaPPO 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 UCR (Usual, Customary, and Reasonable) fee.

Non-Delta Dental Dentists may balance bill for amounts over Delta Dental's UCR (Usual, Customary and Reasonable) fee.

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# Delta Dental PPO – Indemnity

## 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](http://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 unmarried 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 and Premier Providers

Visit [www.deltadentalins.com](http://www.deltadentalins.com) for a complete and up-to-date listing of Delta Dental Premier® Dentists in your area.

### 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.

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# VisionCare Plan

Humana /CompBenefits Vision Care Plan (VCP) options have you covered and make eye care affordable.

## Vision health impacts overall health

Good visual health plays an extremely important role in contributing to overall health. Periodic eye examinations are an important part of routine preventive healthcare. Because many eye and vision conditions have no obvious symptoms, you may be unaware of problems. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss.<sup>1</sup> Vision care is essential to maintaining a healthy lifestyle. Eye exams can detect symptoms of diseases such as diabetes, hypertension, multiple sclerosis, brain tumors, osteoporosis and rheumatoid arthritis.<sup>2</sup>

<sup>1</sup> American Optometric Association  
<sup>2</sup> Thompson Media Inc.

## National network provides real savings

You have access to one of the largest vision networks in the United States, with more than 35,000 provider locations with independent optometrists and ophthalmologists and national retail locations – and every one accepts new patients. You will be able to use your benefits at some of the top names in eye care, including LensCrafters®, Pearle Vision®, Sears® Optical, Target® Optical, and JCPenney® Optical in addition to the many independent optometrists and ophthalmologists. Plus, you save on frames. You pay the wholesale price, avoiding high retail markups. And the cost of frames is the same at any provider location.

### How the Vision Care Plan works

1. After signing up for the Vision Care Plan, you'll receive an ID card in the mail.

### Humana/CompBenefits VisionCare Plan Providers

Please check with the doctor of your choice or call our Customer Care department at 1-800-865-3676 when making your appointment to make certain he or she is currently a participating doctor. You may also visit our website at [www.compbenefits.com/custom/duval/](http://www.compbenefits.com/custom/duval/) for a nationwide listing of providers.

You must receive services from one of our participating providers in order to receive full benefits (as outlined in your vision care booklet). If you receive service from a provider who does not participate in the plan, you will receive reimbursement according to the non-panel reimbursement schedule established by your group.

2. Prior to scheduling your appointment, select a network provider through the Customer Care center, automated information line, or [www.compbenefits.com/custom/duval](http://www.compbenefits.com/custom/duval/)
3. Schedule an appointment, providing your name, patient's name and group
4. Sign your provider's Vision Care Plan form after your exam. You'll pay any copays and/or costs of any upgrades at that time.

## Family Coverage

This plan covers:

- Your spouse.
- Your unmarried 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.

Vision care services	See a participating provider	See a nonparticipating provider
<b>Exam with dilation</b> as necessary	100% after \$10 copay	\$35 allowance
<b>Lenses<sup>1</sup></b>		
• Single	100% after \$15 copay	\$25 allowance
• Bifocal	100% after \$15 copay	\$40 allowance
• Trifocal	100% after \$15 copay	\$60 allowance
<b>Frames<sup>1</sup></b>	\$50 wholesale frame allowance	\$50 retail allowance
<b>Contact lenses<sup>2</sup></b>		
• Elective (conventional and disposable) <sup>3</sup>	\$150 Contact lens allowance	\$150 Contact lens allowance
• Medically necessary	100%	\$210 allowance
<b>Frequency</b> (based on date of service)		
• Examination	Once every 12 months	
• Lenses or contact lenses	Once every 12 months	
• Frame	Once every 24 months	
<b>Exam/material copay</b>	\$10/\$15	
<b>Wholesale frame allowance</b>	\$100-\$150 approximate retail value	

<sup>1</sup> Material copay is required for a complete pair of eyeglasses, lenses or frames.

<sup>2</sup> If a member prefers contact lenses, the plan provides an allowance for contacts in lieu of lenses.

<sup>3</sup> The contact lens allowance applies to professional services (evaluation and fitting fee) and materials. Members receive a 15% discount on professional services. The discount for professional services is available for 12 months after the covered eye exam.

# VisionCare Plan

## Lasik and PRK procedures

Members receive substantial reductions when procedures are done by network providers.

Members can expect to pay no more than \$1,800 per eye for conventional Lasik procedures and \$2,300 per eye for custom Lasik, or they can use designated TLC Laser Centers (TLC Vision) that have the following fixed prices:

- Conventional Lasik \$895 per eye
- Custom Lasik \$1,295 per eye
- Custom Lasik with IntraLase \$1,895 per eye

NOTE: you must call the TLC Vision Advantage Program at 1-888-358-3937 to initiate services.

## Additional plan discounts

- Members receive additional fixed copayments on lens options including anti-reflective and scratch-resistant coatings.
- Members also receive a 20% retail discount on a second pair of eyeglasses. This discount is available for 12 months after the covered eye exam, and is available through the VCP network provider who sold the initial pair of eyeglasses.

## Limitations and Exclusions

The Vision Care Plan provides a complete analysis of the eyes and related structures to determine vision problems or other abnormalities once every 12 months. The plan covers any lenses needed for the patient's visual welfare as determined by the network doctor. Certain lenses such as those described in the "Limitations" are cosmetic in nature and are not necessary for the visual welfare of the patient. The extra cost of these must be borne by the patient. The plan offers a wide selection of frames every 24 months. The plan covers contact lenses every 12 months. The contact lens allowance replaces the lens and frame benefits, and plan copayments do not apply for the contact lens allowance.

### Limitations

In no event will coverage exceed the lesser of:

1. The actual costs of covered services or materials;
2. The limits of the policy, shown in the Schedule of Benefits; or
3. The allowance as shown in the Schedule of Benefits.

### Example of how the wholesale frame allowance works

Benefits include a wholesale frame allowance. If the wholesale cost exceeds the frame allowance, members pay twice the wholesale difference. They never pay full retail.

Retail price*	Wholesale price	Wholesale allowance	Member pays	Savings
\$100 – \$150	\$50	\$50	\$0	\$100 – \$150
\$140 – \$210	\$70	\$50	\$40 (\$70-\$50=\$20x2=\$40)	\$100 – \$170

\* Retail costs may differ and are based on two to three times the wholesale costs. Actual savings may vary.

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### Your Monthly Rates

Participant	\$6.67
Participant + Family	\$18.24

Materials covered by the policy that are lost or broken will only be replaced at normal intervals as provided for in the Schedule of Benefits.

The plan will pay only for the basic cost for lenses and frames covered by the policy. The insured is responsible for extras selected, including but not limited to:

1. Blended lenses;
2. Progressive multifocal lenses;
3. Photochromatic lenses, tinted lenses, sunglasses, prescription and plano;
4. Coating of lens or lenses;
5. Laminating of lens or lenses;
6. Groove, drill or notch, and roll and polish; unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

### Exclusions

The plan will not cover:

1. Orthopic or vision training and any associated supplemental testing;
2. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
3. Medical or surgical treatment of the eyes;
4. Any services and/or materials required by an employer as a condition of employment;
5. Any injury or illness covered under any Worker's Compensation or similar law;
6. Sub-normal vision aids, aniseikonic lenses or non-prescription lenses;
7. Charges incurred after: (a) the policy ends; or (b) the insured's coverage under the policy ends, except as stated in the policy;
8. Experimental or non-conventional treatment or device;
9. Contact lenses; except as specifically covered by the policy;
10. Hi index, aspheric or non-aspheric styles;
11. Oversized 61 and above lens or lenses;
12. Cosmetic items, unless otherwise specifically listed as a covered benefit in the Schedule of Benefits.

# Beyond Your Benefits

## 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 FBMC Customer Care Center at 1-800-342-8017 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

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. 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 Care Center and fulfill legal and regulatory requirements. The sources and types of information collected generally varies 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.

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

Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA). You may receive a Privacy Notice from your employer or from the providers of various health plans in which you enroll. You should read these statements carefully to assure you understand your rights under HIPAA

## 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. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. 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.

## Appeal Process

Approved appeals must comply with IRS regulations and the guidelines within your employer's plan(s). If you have an FSA reimbursement claim, a request for a mid-plan year election change, or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request for review to your employer's designee, Fringe Benefits Management Company, a Division of WageWorks, P.O. Box 1878, Tallahassee, FL 32302-1878 – Customer Care 1-800-342-8017, within 30 days of your receipt of the denial. Appeals will be reviewed on a uniform and consistent basis, including the facts and circumstances of each timely submitted and processable appeal request.

Your appeal must state:

- why you think your claim or request should not have been denied
- the name of your employer
- the date of the services for which your claim or request was denied
- a copy of the denied request
- the written denial you received
- any additional documents, information or comments you think may have a bearing on your appeal.

Call Customer Care at 1-800-342-8017 to discuss your appeal. Within 30 days of receipt of your processable appeal, it will be reviewed and you will be notified of the results of its review. In unusual cases, as when review of your appeal requires additional documentation, the review may take longer. If your appeal is approved, additional processing time is required to modify your benefit elections

# Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

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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 1-800-664-5295 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.

# Creditable Coverage Notice

## FOR DCPS NON-CONTRIBUTORY PLAN AND DCPS 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
<b>Retail</b>		
Generic - Formulary	\$7	\$7
Brand - Formulary	\$25	\$25
Non-Formulary	\$40	\$40
Specialty Injectables	\$55	\$55
Maximum Supply	One month	One month
<b>Mail Order</b>		
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.

# Creditable Coverage Notice

## FOR DCPS NON-CONTRIBUTORY PLAN AND DCPS CONTRIBUTORY PLAN

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 (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) 390-2353 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](http://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](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

CMS Form 10182-CC Updated April 1, 2011 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, 2011
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

# Non-Creditable Coverage Notice

## FOR 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 Medco Health Solutions 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 Medco Health Solutions 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 Medco Health Solutions. 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.

# Non-Creditable Coverage Notice

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## FOR DCPS HIGH DEDUCTIBLE HEALTH PLAN

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://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](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	October 1, 2011
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, 2011 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.**



# **FBMC**

**BENEFITS MANAGEMENT**

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FBMC Benefits Management, Inc.  
P.O. Box 1878 • Tallahassee, Florida 32302-1878  
Customer Care Center 1-800-342-8017 • 1-800-955-8771 (TDD)  
[www.myFBMC.com](http://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.