



Live Well, Choose Health

2018 BENEFITS REFERENCE GUIDE



Flexible Benefits Plan Reference Guide
Plan Year January 1, 2018 through December 31, 2018

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Certificate of Coverage

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

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

EMPLOYER

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

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

PROVIDER COMPANIES

Health & Welfare Benefits

Florida Blue
(Medical Plan)
Group# 78155
Customer Service
Mon. - Thurs., 8 a.m. - 9 p.m. ET,
Fri. 9 a.m. - 9 p.m. ET
1-800-664-5295
Onsite Representative:
Resa Askew 904-390-2323
DCPS Personal Health Advocate
Nancy Byers, RN 904-905-0901
www.floridablue.com

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

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

Delta Dental PPO
(Group# 01441-00001)
Customer Service
Mon. - Fri., 7:15 a.m. - 7:30 p.m. ET
1-800-521-2651
www.deltadentalins.com

Davis Vision (Client Code# 3651)
Customer Service
Mon. - Fri., 8 a.m. - 11 p.m. ET
1-800-999-5431
www.davisvision.com

DCPS Welfare

Health Advocate
(Employee Assistance Program)
24-Hour Careline: 1-877-240-6863
www.healthadvocate.com/members

Tax Favored Accounts

PayFlex Systems USA, Inc.
(Flexible Spending Accounts &
Health Savings Accounts)
Customer Service
Lost or Stolen Card
Mon. - Fri., 7 a.m. - 7 p.m. CT
Sat., 9 a.m. - 2 p.m. CT
1-844-PAYFLEX (1-844-729-3539)
Toll-Free Claims Fax
1-888-238-3539
www.payflex.com

Life Insurance

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

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

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

Trustmark Insurance Co.
(Universal Life)
(Universal LifeEvents®)
Customer Service
Mon. - Thurs., 8 a.m. - 8 p.m. ET
Fri. 8 a.m. - 7 p.m. EST
1-800-918-8877
Trustmark Claims
1-877-201-9373, Option 2
www.trustmarksolutions.com

Disability/Income Protection

Unum Short & Long Term Disability
1-800-633-7479
Short Term Disability Claim
(Group# 23310)
1-888-857-0157
Long-Term Care
(Group# 24463)
1-800-227-4165

Other Benefits

Allstate Benefits,
AHL American Heritage Life
Insurance Co.
Group# 63103
Group Voluntary Hospital Indemnity
Insurance
(Hospital Indemnity Insurance)
(Critical Illness Insurance)
Claims (Allstate Benefits)
Mon. - Fri., 8 a.m. - 8 p.m. ET
1-800-348-4489
www.allstatebenefits.com/mybenefits

* Allstate Benefits individual SHOP policies are no longer sold. If you are a current Allstate Benefits individual SHOP customer, you may continue the policy currently in force.

Trustmark Insurance Co.
(Accident Insurance)
(Critical Illness)
Customer Service
Mon. - Thurs., 8 a.m. - 8 p.m. ET
Fri. 8 a.m. - 7 p.m. EST
1-800-918-8877
Trustmark Claims
1-877-201-9373, Option 2
www.trustmarksolutions.com

American Family Life Assurance
Company of Columbus (AFLAC)
(Personal Cancer Expense*)
(Hospital Intensive Care*)
Customer Service
Mon. - Fri., 8 a.m. - 8 p.m. ET
1-800-992-3522
www.aflac.com

* AFLAC policies are no longer sold. If you are a current AFLAC customer, you may continue the policy currently in force.

Retirement Planning

TSA Consulting Group, Inc.
(3rd Party Administrator Tax
Sheltered Plans)
P.O. Box 4037
Fort Walton Beach, FL 32549-4037
Toll-free: 1-888-796-3786
Toll-free: 1-866-908-7582
www.tsacg.com

Florida Retirement System (FRS)
Bureau of Retirement Calculations
1-844-377-1888
www.myfrs.com

Beyond Your Benefits

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



2018 BENEFITS OPEN ENROLLMENT SEPTEMBER 25–OCTOBER 27, 2017

Welcome to the 2018 Benefits Open Enrollment. This Open Enrollment is for benefits effective January 1, 2018 through December 31, 2018. Open Enrollment is your annual opportunity to switch, add, adjust or cancel insurance, and add or remove a spouse or dependent(s) from insurances.

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

Plan Year Updates and Important Information Rates

- No rate changes for the 2018 Enrollment Year!

Employee Contributions to a Medical Flexible Spending Account (MFSA) or Dependent Flexible Spending Account (DFSA)

- Employee contributions through payroll deductions to the MFSA/DFSA must be elected at your enrollment session.
- Employees **WILL LOSE** any DFSA and/or FSA funds that are not used by December 31, 2017.
- Prior year contributions **WILL NOT** roll over to 2018.

Employee Contributions to a Health Savings Account (HSA)

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

Flex Dollars

- As an employee, you receive \$250 per year in Flex Dollars to help pay for most of your pre-tax benefits.
- Flex dollars not used to offset pre-tax benefits will be added to your payroll check.

Deductions

- The first deduction for your 2018 benefits will be on the December 8, 2017 paycheck. To ensure your deductions are correct, your enrollment must be completed by October 27, 2017. Please don't forget to pay close attention when completing your enrollment and confirm that you are enrolled in the correct plans and that the correct dependents, if applicable, are attached to those benefits. **Please review your confirmation statement carefully.**

Employees Hired During the Open Enrollment Season:

- If you are a new hire, you must complete your new hire enrollment before you complete your open enrollment. Please contact the Benefits Department at (904) 390-2351 to complete your new hire enrollment.

Additional Benefits Information

- Visit the Employee Benefits webpage of the DCPS website for benefit information and updates that may happen throughout the year at dcps.duvalschools.org/benefits. If you do not have a computer at home, there are kiosks available at all worksites, in the Employee Benefits Department, and available at all public libraries. You may also access the website with your smart phone, or tablet.
- If you have any questions regarding this letter or continuing your benefits coverage, please contact Customer Care at 1-855-569-3277.

Enrollment Appeals

Enrollment Appeals will only be granted under very narrow circumstances as provided by IRS guidelines and consistent with the district and insurance carrier practices. All appeals must be submitted to DCPS Employee Benefits Dept. by Thursday, November 9, 2017.

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

- Failure to complete an enrollment during the Open Enrollment Period
- Accidentally electing or dropping a plan
- Deleting a dependent in error

See the Appeal section of the 2018 online interactive Flexible Benefits Plan Reference Guide for more information.

DCPS Employee Benefits

1701 Prudential Drive, 2nd Floor

Jacksonville, FL 32207

Phone: 904-390-2351 Fax: 904-390-2370

Office Hours: 7:30 a.m. – 4:30 p.m.

Saturday and Evening Appointments Available for Your Convenience at the Administration Building (3001)

Evening	Dates	Hours
Monday	10/23/17	5:30 p.m. – 8 p.m.
Tuesday	10/24/17	5:30 p.m. – 8 p.m.
Wednesday	10/25/17	5:30 p.m. – 8 p.m.
Thursday	10/26/17	5:30 p.m. – 8 p.m.

Saturday Dates

Saturday Dates	Hours
Saturday – 10/7/17	8 a.m. – 4 p.m.
Saturday – 10/14/17	8 a.m. – 4 p.m.

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

*Limited appointments available

Open Enrollment Process - What Do I Need To Do?

1: Review current benefits

Read this newsletter and review this 2018 online interactive Flexible Benefits Plan Reference Guide.

Review your current benefits and dependent/beneficiary information online at www.myfbmc.com. If you are a new user to myfbmc.com or have not signed in since 2008, you must register as a new user.

If you do not remember your user ID and/or password, assistance is available on the login screen.

Gathering your Documentation for Enrollment:

Employees who are adding dependents will be required to show the documents to the Enrollment Counselor at your location during open enrollment or to the Benefits Office.

- Social Security Numbers
- Birth Certificates
- Marriage Certificates
- Address

For a full list of required documentation and additional information on verification guidelines, please review the Eligibility section of this guide.

2: Select your benefits

Two Options to Enroll

1. Schedule an appointment with a Benefits Counselor now at www.myenrollmentschedule.com/duval.

Meet with a Benefits Counselor for your chance to win exciting prizes:

- Florida-Georgia Tickets
- Fine Dining Gift Certificates
- Fitbits, iPads or an Apple Watch
- Visa gift cards

or

2. Enroll on your own via the internet.

Access the Online Enrollment website:

1. Log in to www.myFBMC.com
2. Follow the instructions to set up your own user name and password.

(See below for information regarding adding dependents.)

If You are Not Making Any Changes:

If you **DO NOT** wish to make any changes to your current benefit elections **AND** you **DO NOT** make employee contributions to a MFSA, DFSA, or HSA, your current benefit elections will automatically carry forward to the 2018 plan year.

Enrollments that Require you to see a Benefits Counselor:

1. Waiving Medical Coverage

- If you are waiving medical coverage, you must see a Benefits Counselor and submit the following information:
 - A completed Declination of Medical Coverage Affidavit; and
 - Proof of other group employer coverage; or
 - Proof of government-funded coverage (e.g., Medicaid, Medicare, TRICARE)

2. Adding Dependents

- If you are adding a new dependent, you must see a Benefits Counselor and submit the appropriate documentation.

3. Voluntary Benefits

- Guaranteed Issue for the 2018 Plan Year:
 - Allstate Benefits Group Critical Illness
 - Allstate Benefits Group Hospital Indemnity
 - Trustmark Universal Life (New Hire Only)
 - UNUM Whole Life
 - Trustmark Accident Insurance
- Employees who enroll online and are interested in increasing or adding voluntary benefits will be required to make an appointment with a Benefits Counselor for those selections only.

4. Medical and Dependent Care Flexible Spending Accounts and Health Savings Account

- Employees' contributions to the Medical Flexible Spending Account (MFSA), Dependent Flexible Spending Account (DFSA), and Health Savings Account (HSA) do not automatically carry forward from year to year. Employees must complete an enrollment to contribute their own dollars to the MFSA, DFSA, or HSA.
- Enrolling in the High Deductible Plan will not automatically open your Health Savings Account (HSA). Please contact the Benefits Department for additional instructions.

3: Verify your benefits

Verify the benefit selections you made are correct.

Print your confirmation statement containing all your benefit elections for you and your family.

All enrollment changes must be completed during the Open Enrollment Period (September 25 - October 27, 2017).

After Open Enrollment has ended, you will not be able to make changes unless you experience a permitted election change event. However, you can submit an enrollment appeal to DCPS Employee Benefits Office for review. Additional information regarding permitted election changes throughout the plan year can be found on the Benefits Department website at

dcps.duvalschools.org/benefits.

Benefits Snapshot

For the 2018 Benefit Plan Year, Duval County Public Schools will provide the following free benefits to all benefit-eligible employees:

- DCPS Board paid medical insurance depending on which medical plan you choose (see medical insurance section).

Note: Employees who can demonstrate and attest to having other employer-sponsored group health insurance or government-funded health insurance (i.e. Medicaid, Medicare, TRICARE) may elect to opt out of DCPS's Medical Plan Options.

- \$10,000 Group Term Basic Life insurance
- \$250 Flex Dollars to defray the cost of voluntary pretax benefits, excluding life insurance. (\$12.50 per pay for 20 deduct employees and \$10.42 per pay for 24 deduct employees)

Note: Flex dollars not used to offset pre-tax benefits will be added to the employee's payroll check.

- DCPS contributes to the Medical Flexible Spending Account (MFSA) for employees who elect the DCPS Contributory medical plan. Contributions to the MFSA will be \$450 for employee only coverage and an additional \$300 for dependent/family coverage. This contribution is designed to be used towards the annual deductible and any other medically necessary, out-of-pocket expenses not covered by your insurance.

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

- **Florida Blue** — provides comprehensive medical and pharmacy benefits.
- **Delta Dental Care** — provides valuable dental benefits with both a Managed Care and PPO plan.
- **Davis Vision Care** — offers paid-in-full eye examinations (after \$10 co-pay), eyeglasses and contacts and one-year eyeglass breakage warranty included on the plan eyewear at no additional cost!
- **Medical Expense Flexible Spending Accounts** — can help you save tax dollars on qualified medical expenses and certain Over-the-Counter drugs and medicines.
- **Dependent Care Flexible Spending Accounts** — can help you save tax dollars on care for your dependents while you are working or actively looking for work.
- **Standard Insurance Company Group Term Life** — In addition to the \$10,000 Group Term Basic Life, offerings of up to three times annual salary or a flat \$50,000 are available.
- **UNUM Whole Life Insurance** — features affordable fixed premiums, guaranteed for life. Accumulates cash value. You own the policy and it has living benefit options.
- **Trustmark Universal Life Insurance** — is the traditional life insurance product, which offers a flexible premium, builds cash value and features level death benefits throughout the life of the product.

- **Trustmark Universal LifeEvents** — is a cost effective alternative to the traditional life insurance product, which offers a flexible premium, builds cash value and for the same premium pays a higher death benefit during working years that reduces at age 70 (or your 15th policy year, if later).
- **Zurich Accidental Death and Dismemberment Insurance** — offered to newly hired employees only - provides protection against financial hardship when death is result of an accident or help during recovery and rehabilitation if you suffer an accidental dismemberment.
- **UNUM Disability Income Protection (STD/LTD)** — can provide you with an adequate income if you become disabled and are unable to work. You do not have to exhaust your sick leave before taking advantage of this benefit.
- **UNUM Long-Term Care (current UNUM Long-Term Care participants only)** — provides benefits for nursing homes, assisted living facilities and home healthcare for you and your parents.
- **Allstate Benefits Group Voluntary Hospital Indemnity Insurance** — provides daily benefits for continuous hospital confinement, up to 365 days per period.
- **Allstate Benefits Group Critical Illness Insurance** — pays a lump sum benefit upon diagnosis of a covered critical illness.
- **Trustmark Critical Illness and Cancer (current Trustmark participants only)** — designed to pay you a lump-sum cash benefit (\$5,000 - \$100,000) upon first diagnosis of a covered critical illness or condition.
- **Trustmark Accident Insurance** — helps cover unexpected expenses that result from many kinds of off-the-job accidents, even sports related and household ones. It provides cash benefits to cover deductibles, co-payments, transportation and lodging cost and everyday bills.

Advantage of Pre-tax versus Post-tax deductions

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

The following voluntary benefits are being offered Guaranteed Issue* for the 2018 Plan Year:

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

*** Modified or Simplified Guaranteed Issue is available for existing policy holders and newly eligible employees. See a Benefits Counselor for details.**

Participation in the District Benefit Program

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

1. You authorize the District to deduct premiums for the benefits rolled over or elected for the plan year.
2. You certify that the information you supplied on the online enrollment website is true and complete to the best of your knowledge.
3. You understand that health, dental, vision, and Flexible Spending Account(s) contributions will be pre-tax to the extent possible and that your income subject to federal income tax and Social Security withholding (FICA) will be reduced, and that this may affect your Social Security benefits in the future.
4. You acknowledge that you cannot stop or change benefits paid for on a pre-tax basis during the plan year unless you experience a relevant qualifying event.
5. All benefits are subject to change. All benefits are subject to the provisions and exclusions of the master contract.
6. You understand that a Section 125 Flexible Spending Account (Medical Expense and Dependent Care) can be used only to reimburse payment of eligible expenses incurred during the plan year while participating in the plan and that any amount remaining in either spending account, that is not used during the plan year, will be forfeited. Funds in one spending account cannot be used to reimburse expenses covered by another account. Expenses for which you are reimbursed cannot be claimed.
7. You understand and agree that the District and the Third Party Administrator (TPA) will not incur any liability resulting from failure to read all rules pertaining to benefit enrollment; to enroll online accurately or to submit elections; or in the administration of your flexible spending accounts. You also understand that elections for benefits on a pre-tax basis are irrevocable and cannot be changed after the established deadline date. Subsequent changes can only be made upon experiencing a qualifying event.
8. You agree for yourself and covered members of your family under District insurance plans to be bound by the benefits, deductibles, co-payments, exclusions, limitations, eligibility requirements and other terms of the plan contracts, agreements and plan documents for the plans in which you enroll.
9. Chapter 207-251 Laws of Florida requires agencies to notify individuals of the purpose(s) that required the collection of Social Security numbers. Duval County Public Schools collects Social Security numbers (SSNs) of employee and dependents for enrollment in health insurance, life insurance, and other miscellaneous insurances. The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

10. Your contributions to the Flexible Benefits Plan do not reduce your future Florida Retirement System (FRS) benefits or current contributions to FRS. Any salary directed to your Flexible Benefit Plan is included in the compensation reported to the FRS.
11. Social Security consists of two components: FICA and Medicare. A separate maximum wage to which the tax is assessed applies to both tax components. The maximum taxable annual wage for FICA varies from year to year. There is no maximum taxable annual wage for Medicare. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.

How to Find Information About Your Benefits

There are four ways to receive benefit information:

1. You may contact the individual providers' customer service department about the specific plan for which you are inquiring (refer to the Benefits Directory).
2. Visit www.myFBMC.com to view a listing of your current benefits and to submit questions via e-mail to Customer Care.
3. For personal assistance, call the Service Center 1-855-5MY-DCPS (855-569-3277), Monday-Friday, 7 a.m. - 7 p.m. ET.
4. You can log on to your DCPS Employee Self Service Portal: <https://ess.duvalschools.org/irj/portal>

Eligibility and Coverage

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

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

Default Plan Enrollment

All newly hired benefits eligible employees are automatically enrolled into the default employer-paid employee only Non-Contributory medical plan, 10k basic term life insurance and \$250 flex dollars.

Eligible Employees

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

Eligible Dependents

An individual who meets the eligibility criteria specified below is an Eligible Dependent and is eligible to apply for coverage under this plan:

- The employee's spouse under a legally valid existing marriage;
- The employee's natural, newborn, adopted, foster, or stepchild(ren) (or a child for whom the employee has been court-appointed as legal guardian or legal custodian) who:
 - is under the age of 26 or is still within the calendar month in which he or she reaches age 26.
 - in the case of a disabled dependent child, such child is eligible to continue coverage beyond the limiting age as a covered dependent if the dependent child is:
 - otherwise eligible for coverage under the Group Master Policy;
 - incapable of self-sustaining employment by reason of mental or physical disability; and
 - chiefly dependent upon the covered employee for support and maintenance provided that the symptoms or causes of the child's disability existed prior to the child's 26th birthday. This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a disabled child.
- The newborn child of a Covered Dependent child who has not reached the end of the Calendar Month in which he or she becomes 26. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child and/or if the parent of the newborn child's coverage terminates.

Flex to Spouse Employees (Dual Spouse)

If both you and your spouse are employed by DCPS and have benefit-eligible dependents on your medical plan, you are defined by DCPS as "Flex to Spouse" employees which means you are eligible for a significant medical insurance premium reduction. All "Flex to Spouse" employees are required to meet with a Benefits Counselor to complete their enrollment.

If both of you are employees of DCPS, but are NOT insuring dependent children on your medical plan, you are not considered as "Flex to Spouse" employees and each of you must enroll separately and select your own plan(s).

Note: If your "Flex to Spouse" status changes at any time during the year, you must notify the Employee Benefits Department immediately.

Terminating Employees

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

Note: If an employee is in active pay status on the last working day of the month, the insurance is in effect through the end of the following month **unless** the last working day is the day before a holiday (paid or unpaid), in which case the employee's insurance will terminate at the end of the month of separation.

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

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

Terminations Due to Change in Status

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

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

Retirement

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

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

COBRA Coverage

Under certain qualifying events, covered employees may be eligible for continuation of group health plans covered under the COBRA law (See COBRA Q&A page for more details).

Benefits While on Leave of Absence

Types of leave

- Family and Medical Leave Act (FMLA)
- Personal Health Leave
- OJI (On the job injury)
- FMLA/Military Exigency
- FMLA/Military Caregiver
- Military Leave

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

- Contact your immediate principal/administrator/supervisor of your intent to go on unpaid LOA.
- Apply for LOA by contacting Human Resource department at 904-390-2065. LOA paperwork is also available at <https://dcps.duvalschools.org/Page/21361>.
- Contact the Employee Benefits department at 904-390-2887 for information about your benefits and how to continue insurance premiums/coverage while you are on LOA.
- Contact the Payroll Department at 904-390-2022 to advise the Payroll Technician assigned to your work location of your intent to go on LOA.

When will your active coverage end?

Employer Paid Health coverage:

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

Employer Paid Group Life Insurance:

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

When Should You Apply for a Leave of Absence?

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

Continuing Benefits While on Leave Of Absence

We encourage employees going on leave of absence to contact the Employee Benefits department at 904-390-2887 if you have any questions about paying for benefits and how to cancel benefits while on LOA. The type of leave an employee is on dictates how long a benefit may be paid by the employer; can be continued by the employee; and can be reinstated if cancelled due to non-payment.

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

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

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

Benefit Changes While on LOA

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

Short Term/Long Term Disability Income Protection for personal illness

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

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

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

Flexible Spending Accounts (FSA) while on leave

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

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

Important Reminder...

Any left over Flex Dollars not used to offset pre-tax benefits will be added to your payroll check.

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

Flex Dollars

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

Using Your Flex Dollars

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

How your Flex Dollars work for you

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

DeltaCare Dental Employee and Family	\$ 29.04
Vision Employee and Family	<u>\$ 8.57</u>
Total before Flex Dollars	\$ 37.61
Less Flex Dollars	<u>- 12.50</u>
Total Payroll Deduction	\$ 25.11

Newly Added Dependent Verification

DCPS requires that all dependents be verified as eligible for benefits coverage when enrolling new dependents (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 employee and you are enrolling 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 the required documentation at your enrollment session, the dependent will not be added to your coverage. This is only for adding dependents; it is unnecessary to provide documentation for dependents who are currently enrolled.

How does dependent verification work?

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

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

How do I know if my dependents are eligible?

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

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.

NOTE: It is your responsibility to respond to insurance companies and DCPS periodic inquiries about dependent eligibility. Failure to provide timely dependent verification information will result in loss of dependent coverage.

Official documents of birth, marriage and/or death certificates from anywhere in the United States may be obtained through

www.vitalchek.com or by calling

1-800-255-2414, Option 3. Some fees apply.

Acceptable Documents:

Dependent Relationship	Documentation Required
Spouse (Married Prior to Current Calendar Year)	<ul style="list-style-type: none"> • Copy or Original government issued marriage certificate; AND • Copy or Original IRS 1040 Tax Return from the prior year reflecting married filing jointly or married filing separately; AND • Social Security number
Spouse (Married on or After January 1st of Current Calendar Year)	<ul style="list-style-type: none"> • Copy or Original government issued marriage certificate; AND • Social Security number
Natural Child(ren): Ages 0-26 years of age	<ul style="list-style-type: none"> • Copy or Original government issued birth certificate (Hospital Certificate of Birth is acceptable for Newborns) that shows proof of relationship; AND • Social Security number
Stepchild(ren): Ages 0-26 years of age	<ul style="list-style-type: none"> • Copy or Original government issued marriage certificate; AND • Copy or Original government issued birth certificate(s) that shows proof of relationship; AND • Social Security number <p>Note: If the last name of the child(ren) is different from the employee's current last name, the employee must also provide proof of the name change (i.e. marriage certificate or legal name change documentation)</p>
Child(ren) under Legal Guardianship, Adopted, Custody or Foster Care: Ages 0-26 years of age	<ul style="list-style-type: none"> • Copy or Original government issued birth certificate (Hospital Certificate of Birth is acceptable for Newborns) that shows proof of relationship; AND • Copy or Original legal guardianship/adopted/custody document from Courts naming employee as legal guardian/adoptive parent/custodian; OR • Copy or Original foster care documentation from Courts naming employee as foster parent; AND • Social Security number <p>If spouse (not employee) is legal guardian/adoptive parent/custodian/foster parent: Copy or Original government issued marriage certificate.</p>
Grandchild(ren) 0-18 months	<ul style="list-style-type: none"> • Copy or Original government-issued birth certificate of child(ren) stating child(ren) was/were born to an insured dependent child(ren) of the District employee; AND • Copy or Original government issued birth certificate of insured dependent birth parent who is also enrolled in the plan; AND • Social Security number
Incapacitated or Disabled Dependents (Over age 26)	<ul style="list-style-type: none"> • Copy or Original government issued birth certificate(s) that shows proof of relationship; AND • Social Security number; AND • Statement from the dependent's physician certifying that the dependent is incapable of self-sustaining employment by reason of mental or physical disability, AND is chiefly dependent upon the employee or retiree for support AND maintenance; OR • Copy or Original Social Security papers
Birth outside of USA (not Adoption): Ages 0-26 years	<ul style="list-style-type: none"> • Naturalization papers presented to DCPS Employee Benefits Department

Declination of Medical Coverage Opt-out Program

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

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

If you do not provide the affidavit and proof of other group employer or government-funded coverage, your employee-only medical coverage will automatically carry forward to the 2018 plan year.

Note: *If you choose to opt-out of medical coverage, you are still eligible for all other benefits.*



Declination of Healthcare Coverage Affidavit

I hereby certify that:

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

Reason for Declining Coverage:

- ☐ Covered by another employer's health plan
Carrier name _____
ID Number _____
Name(s) _____
- ☐ Covered under government-funded medical coverage (i.e. Medicaid, Medicare, TRICARE)
Specify plan name _____
ID Number _____
Name(s) _____

Special Enrollment Period

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

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

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

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

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

Employee Name (Print): _____ Personnel #: _____

Employee Signature: _____ Date: _____

Return form to:


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

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

Employee Responsibilities

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

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



How to Enroll

How to Enroll

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

Enrollment Options

Enroll On Your Own Via the Internet at www.myFBMC.com:

By exercising this option, you are not required to meet with a Benefits Counselor to complete the enrollment process unless you are opting out of medical coverage, enrolling in one of the voluntary benefits, and/or enrolling a dependent in the medical, dental and/or vision plan (see Dependent Eligibility Requirements section for more information).

Enrollment Appointment with a Benefits Counselor:

If you prefer to meet one-on-one with a Benefits Counselor, you must make an appointment for an Open Enrollment session at any of the designated locations. The Benefits Counselor will review your current benefits selections and assist with any changes that you wish to make. Visit www.myenrollmentschedule.com/duval to view the available dates Benefits Counselors are scheduled at your location.

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

You Must complete an enrollment if any of these apply:

- Opt-out of Medical Insurance Coverage
 - Employee must meet with a Benefits Counselor to complete a Declination of Medical Coverage Affidavit
 - Employee must provide proof of other group employer or government funded medical coverage (i.e. Medicaid, Medicare, TRICARE) at the time of your enrollment session.
- Employee contributions to a Medical Flexible Spending Account (MFSA) or Dependent Care Flexible Spending Account (DFSA).
 - Prior year employee contributions **WILL NOT** automatically roll-over to 2018.
 - Employee-contributions through payroll deductions to the Medical FSA must be made at your enrollment session.
 - Employees **WILL LOSE** any Medical Flexible Spending Account funds that are not used by December 31.
- Employee-contributions to a Health Savings Account (HSA)
 - Employee-contributions through payroll deductions to the HSA must be made at your enrollment session.
 - Employees **WILL NOT** lose any unused HSA funds.

If you **DO NOT** wish to make any changes to your current benefit elections **AND** you **DO NOT** make employee contributions to a MFSA, DFSA, or HSA, your current benefit elections will automatically carry forward to the 2018 plan year.

All employees adding new dependent coverage will be required to show documentation of their dependent's eligibility to a Benefits Counselor.

Online Enrollment

Benefit eligible employees have the ability to make benefit elections and changes online during open enrollment for the 2018 Plan Year. The website is accessible 24 hours a day during the open enrollment period.

Accessing the Online Enrollment website:

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

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

Whether you choose to individually enroll online or meet with a Benefits Counselor, it is your responsibility to carefully review your confirmation statement. All enrollment changes must be completed during the open enrollment period (**September 25 – October 27, 2017**). After open enrollment has ended, you **will not be able** to make changes; however, you can submit an enrollment appeal to DCPS Employee Benefits Office for consideration.

Enrollment Appeals will only be granted under very narrow circumstances as provided by IRS guidance and consistent with district and insurer practices. **All appeals must be submitted to DCPS Employee Benefits Dept. by Thursday, November 9, 2017.**

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

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

See the Appeal section for more information.

Accessing Your Benefits

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

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

Benefits

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

Accounts

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

Profile

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

Resources

Looking for a copy of your enrollment materials? Want to know exactly what an FSA is, and how it can benefit you? Check out the resources section for answers to these questions and more.

PayFlex Card

Log on to **www.payflex.com** to submit and check the status of your claim, download forms, get more information about mailing and faxing your claim or see transactions that need documentation. You can also download a card fact sheet and read detailed instructions on proper use and review our Inventory Information Approval System (IIAS) Store List to maximize card convenience. When a participant swipes the PayFlex Card at a participating merchant, the system automatically validates eligible items purchased at the point of sale, and requires an alternate method of payment for ineligible items purchased at the same time. You may also contact PayFlex at 1-800-284-4885.

Qualifying Events for Changing Your Coverage

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

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

How do I make a change?

Election changes must be consistent with and on account of the event. The district will, in its sole discretion, review on a uniform and consistent basis the facts and circumstances of each properly completed and timely submitted mid-plan year election change form.

To make a change: Within **60 calendar days** of a qualifying event, you must complete and submit a benefit change form to Employee Benefits. Documentation supporting your election change request is required.

Once your request has been reviewed, approved and processed, your existing elections and contribution amount will change (as appropriate). Approved changes will become effective on the first of the month following receipt of the benefits change form and all required documentation.

What is my period of coverage?

Your period of coverage for incurring expenses is your full plan year (Jan 1 - Dec. 31), unless you make a permitted plan year election change.

For a Health Care FSA, a mid-plan year election change will result in split periods of coverage, creating more than one period of coverage in a plan year with expenses reimbursed from the appropriate period of coverage. Money from a previous period of coverage can be combined with amounts after a permitted mid-plan year election change.

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

If your FSA election change is denied, you will have 30 calendar days from the date you received the denial to file a written appeal with FBMC. For more information, refer to the “FSA Appeals” section.

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

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

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

Is enrolling into or terminating out of an individual plan offered through the Health Care Exchange a valid change in status event?

Enrolling into or terminating out of individual plans offered through the Health Care Exchange is a valid change in status event. Note: Failure to enroll in the Health Care Exchange after canceling DCPS health insurance does not qualify for reinstatement of Health Insurance Benefits with DCPS.

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

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

How do I apply for Florida KidCare?

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

Special Enrollment Period

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

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

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

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

Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
I. CHANGE IN STATUS						
A. Change in Employee's Legal Marital Status						
1. Gain Spouse (Marriage)	<ul style="list-style-type: none"> • Marriage Certificate; and • Recent IRS Tax Return required (if married prior to current calendar year) 	Employee may enroll or increase election for newly eligible spouse and dependent children as well as pre-existing dependents; employee may also revoke or decrease own or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan. HIPAA special enrollment rights may also apply.	Employee may enroll or increase election for newly eligible spouse and dependents; employee may also decrease election if employee or dependents become eligible under new spouse's health plan.	Employee may enroll or increase election for newly eligible spouse and dependents; employee may also decrease election if employee or dependents become eligible under new spouse's Dependent Care FSA plan; or, employee may cease coverage if new spouse is not employed or makes a Dependent Care FSA coverage election under spouse's plan.	Employee may enroll in coverage when eligibility is affected.	
2. Lose Spouse (Divorce, legal separation, annulment, or death of spouse)	<ul style="list-style-type: none"> • Divorce Decree • Court documentation stating legally separated or marriage annulled • Death certificate 	Employee may revoke election only for spouse; employee may also elect coverage for self or dependents that lose eligibility under spouse's plan if such individual loses eligibility; employee may also enroll new and pre-existing dependents so long as at least one dependent has lost coverage under the spouse's plan. HIPAA special enrollment rights may also apply.	Employee may decrease election to reflect loss of spouse's eligibility; employee may also enroll or increase election where coverage is lost under spouse's health plan.	Employee may enroll or increase election to accommodate newly eligible dependents (e.g., due to death of spouse); employee may also cease coverage if eligibility is lost (e.g., because dependent now resides with ex-spouse).	Employee may cease coverage when eligibility is affected.	

18 CHANGING YOUR COVERAGE

Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
B. Change in the Number of Employee's Dependents						
1. Gain Dependent (Birth, adoption, legal custody)	<ul style="list-style-type: none">Birth Certificate or Hospital Certificate with Foot PrintsAdoptions papers or placement for adoption papersLegal custody papersMarriage certificate - if spouse (not employee) is legal guardian/ adoptive parent/ custodian / foster parent	Employee may enroll or increase election for newly eligible dependents and/or enroll any pre-existing dependents; employee may also revoke or decrease own or dependent's coverage if employee or dependent become eligible under spouse's plan. HIPAA special enrollment rights may also apply			Employee may enroll or increase election to accommodate newly eligible dependents and any other non-covered dependents	Employee may increase coverage when eligibility is affected
2. Lose Dependent (Death, dependent no longer meets eligibility requirements)	<ul style="list-style-type: none">Death CertificateBirth Certificate	Employee may drop coverage only for the dependent who loses eligibility			Employee may decrease election for dependent who lost eligibility	Employee may decrease or cease coverage even when eligibility is not affected
C. Change in Employment Status of Employee, Spouse, or Dependent that Affects Eligibility						
1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) that Triggers Eligibility						
a. Commencement of employment by employee or other change in employment status (e.g., PT to FT) triggering eligibility under component plan	Letter from employer verifying employment status change	Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents				No change permitted
b. Commencement of employment by spouse or dependent or other employment event triggering eligibility under their employer's plan	Letter from employer verifying employment event triggering eligibility under the employer's plan	Employee may revoke or decrease election under employee's, spouse's, or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's coverage	Employee may decrease or cease election if he or she gains eligibility for health coverage under spouse's or dependent's plan	Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work); employee may also revoke election for dependent's coverage if dependent is added to spouse's plan	No change permitted	
2. Termination of Employment by Employee, Spouse or Dependent (or Other Change in Employment Status) That Causes Loss of Eligibility						
a. Termination of employee's employment or other change in employment status (e.g., unpaid leave, FT to PT) resulting in loss of eligibility	Letter from employer verifying employment termination or employment status change	Employee may revoke or decrease election for employee, spouse or dependent that loses eligibility under the plan	Employee may revoke election to reflect loss of eligibility (note that under most health FSAs, employee loses coverage automatically)	Employee may revoke or decrease election to reflect loss of eligibility	Employee may revoke or decrease election to reflect loss of eligibility	
i. Termination of rehire within 30 days	Letter from employer verifying employment termination	Prior elections at termination are reinstated unless another event has occurred that allows a change				
ii. Termination and rehire after 30 days	Letter from employer verifying employment termination and rehire	Employee may make new elections				
b. Termination of spouse's or dependent's employment (or other change in employment status resulting in a loss of eligibility under their employer's plan)	Letter from employer verifying employment termination	Employee may enroll or increase election for employee, spouse or dependent that loses eligibility under spouse's or dependent's employer's plan; employee may also enroll previously eligible dependents. HIPAA special enrollment rights may also apply	Employee may enroll or increase election to reflect loss of eligibility for health coverage	Employee may enroll or increase election if spouse or dependent loses eligibility for Dependent Care FSA; employee may also decrease or cease election to reflect loss of eligibility for coverage (e.g., if spouse stops working)	No change permitted	

Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
D. Event Causing Employee's Dependent to Satisfy Eligibility Requirements						
1. Event by which dependent ceases to satisfy eligibility requirements under another employer's plan (attaining a specified age, getting married, ceasing to be a student, etc.)	Letter from employer indicating dependent no longer meets eligibility requirements	Employee may enroll or increase election for affected dependent, employee may also add previously eligible but not enrolled dependents		Employee may increase election or enroll only if dependent gains eligibility under health FSA	Employee may increase election or enroll to take into account expenses of affected dependent	No change permitted
E. Change in Place of Residence of Employee, Spouse, or Dependent						
1. Move triggers eligibility	Documentation of the move	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area			N/A – Dependent Care FSA eligibility is not generally affected by place of resident	No change permitted
2. Move causes loss of eligibility (e.g. employee or dependent moves outside HMO service area)	Documentation of the move	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area			N/A – Dependent Care FSA eligibility is not generally affected by place of resident	No change permitted
F. Change in Coverage Under Other Employer Cafeteria Plan or Qualified Benefits Plan						
1. Other employer plan increases coverage	Letter from employer verifying coverage increase.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under another employer plan.			No change permitted	
2. Other employer's plan decreases or ceases coverage	Letter from employer verifying decrease or cease of coverage	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer plan Other previously eligible dependents may be enrolled			No change permitted	
3. Open Enrollment under other employer plan/ different year	Letter from employer verifying open enrollment	Corresponding changes can be made under employer's plan permitted			No change permitted	
4. Loss of group health coverage sponsored by Governmental or Educational Institution	<ul style="list-style-type: none"> Letter from Governmental or Educational Institution verifying loss of group health coverage Certificate of Creditable Coverage 	Employee may enroll or increase election for employee, spouse, or dependent if employee, spouse, or dependent loses group health coverage sponsored by governmental or educational institution			No change permitted	
G. Florida Kidcare, Medicaid, Medicare or TRICARE						
1. Employee, spouse, or dependent enrolled in employer's health plan become entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines)	<ul style="list-style-type: none"> Letter from Florida Kidcare, Medicaid, Medicare or TRICARE verifying enrollment Florida Kidcare, Medicaid, Medicare or TRICARE ID card reflecting effective date of coverage 	Employee may cancel or reduce coverage for employee, spouse, or dependent as applicable	Employee may cancel or reduce coverage for employee, spouse, or dependent, as applicable	Employee may decrease or revoke election under employer plan		No change permitted

Event	Supporting Document	Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
2. Employee, spouse, or dependent loses eligibility for Medicare or Medicaid (other than coverage solely for pediatric vaccines.	Letter from Florida Kidcare, Medicaid, Medicare or TRICARE verifying loss of eligibility.	Employee may elect to commence or increase coverage for employee, spouse, or dependent, as applicable and add previously eligible (but not yet enrolled) dependents.	Employee may cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Employee may commence or increase election under employer plan.	No change permitted.	
H. FMLA Leaves of Absence						
1. Employee's commencement of FMLA leave.	Documentation verifying employee is on LOA.	Employee can make same election changes as employee on non-FMLA leave. Employer must allow employee on unpaid FMLA leave either to revoke coverage or to continue coverage, but allow employee to discontinue payment of his or her share of the contribution during the leave. The employer may recover the employee's share of contributions when the employee returns to work.		Same as previous column. Upon return, employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) .	Employee may make a new election if coverage terminated while on FMLA leave. Employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from non-FLA leave are required to be reinstated in their elections.	
2. Employee's return from FMLA leave	N/A	Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from a non-FMLA leave are required to be reinstated in their elections		Same as health insurance column. Upon return, employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make unpaid premiums)	Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from a non-FMLA leave are required to be reinstated in their elections.	
J. Judgment, Decree or Orders						
1. Order that requires coverage for the child under employee's plan.	Court order.	Employee may change election to provide coverage for the child. Though unclear, it appears tag-along rule concepts may apply.		No Change.		
2. Order that requires spouse, former spouse or other individual to provide coverage for the child.	Court order.	Employee may change election to cancel coverage for the child provided the child is enrolled in the plan of the spouse, former spouse or other individual required to provide coverage.		No Change.		
K. HIPAA Special Enrollment Rights						
1. Special enrollment for loss of other coverage.		Employee may elect coverage for employee, spouse, or dependent who lost other coverage. Though unclear, it appears that tag-along concepts may apply.		Same as health insurance if plan is subject to HIPAA portability rules.	No Change.	
2. Special enrollment for acquisition of new dependent by birth, marriage, adoption or placement for adoption. (If newborn or newlyadopted child is enrolled under HIPAA's special rules, child's coverage may be retroactive to date of birth, adoption or placement for adoption; employee may change salary reduction election within 30 days to pay for cost of child's coverage retroactive to date of birth, adoption or placement for adoption. (For marriage, salary reductions may only be changed prospectively.)		Employee may elect coverage for employee, spouse, or dependent. Under the tag-along rule, coverage may also extend to previously eligible (but not yet enrolled) dependents.		No change permitted unless plan is subject to HIPAA	No Change.	



Medical Plan Options

NON-CONTRIBUTORY/CONTRIBUTORY

Florida Blue will continue providing Duval County Public School's medical administrative services for the New Plan Year (Jan – Dec, 2018). The following medical options are available for you to choose from based upon your Bargaining Union or Non-Bargaining Group representation.

DCPS Non-Contributory Plan

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

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

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

Plan highlights include:

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

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

DCPS Contributory Plan

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

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

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

Plan highlights include:

- There is a cost for Employee-Only coverage.
- Your School District continues to offset a portion of the dependent coverage cost.
- Employees have the freedom to choose an in or out of network service provider at the time of service.
- Does not have an in-network deductible.
- Co-insurance applies to all services that do not have set co-pays; for example:
 - Inpatient and Outpatient Hospitalization
 - Ambulatory Surgical Center Facility
 - All Out-of-Network Services.
- Co-insurance and copays (including Rx) count towards the maximum out-of-pocket limit.
- Medical Flexible Spending Account established (Employer Contribution: \$450 individual, \$750 Dep/Family).
- PayFlex Card accounts will not roll over the amount elected in the prior plan year.

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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

DCPS High Deductible Health Plan

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

Administrative, Exempt, FOPD, IBEW, JSA, and LIUNA.

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

Plan highlights include:

- Your School District continues to provide employee only medical coverage at no premium cost to you.
 - Your School District continues to offset a portion of the dependent coverage cost.
 - Employees have the freedom to choose an in or out of network service provider at the time of service.
 - For coverage other than employee only, the family deductible must be met before co-insurance or co-payments are applicable.
 - Your School District contributes \$678.52 to your Health Savings Account. Per IRS Regulations, the maximum 2018 HSA contribution is \$3,400 for single and \$6,750 for family. This maximum includes the \$678.52 contributed by DCPS.
- Note: If you are ineligible to participate in an HSA, you may elect a High Deductible Health Plan and contribute to FSA.*
- HSA Funds may be used based on what's available in the account.
 - HSA Funds are not use it or lose it. **Employees who contribute their own money to the HSA must make that election again at the enrollment session.**
 - Changes to your HSA contribution amount may be made once per month. Contact the DCPS Employee Benefits Department if a request to change is desired.
 - For Medicare Part D coverage, the prescription drug coverage offered by the High Deductible Health Plan is considered Non-Creditable.

ID Cards

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

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) AND HEALTH SAVINGS ACCOUNT (HSA)

What is a High Deductible Health Plan (HDHP)?

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

Plan Benefits

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

Here is how the plan works in-network:

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

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

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

Health Savings Account

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

Qualifying for an HSA

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

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

Annual HSA Contributions

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

2018 contribution limit is \$3,450 for single and \$6,900 for family.

Catch-Up Contributions

HSA owners age 55 and older can make additional contributions to their HSA called "catch-up contributions". For 2018, the allowed catch-up contribution is \$1,000.

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

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

- If you enrolled in Medicare or Medicaid, you cannot open an HSA.
- If you have Tricare, you cannot have a HSA because Tricare does not offer a HDHP.
- If you are receiving medical care from the Veteran's Administration for a non-service related disability, 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. 2018 limits are \$3,450 for single and \$6,900 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 their FSA account is empty.
- 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.

Use It or Save It

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

Opening a Health Savings Account

Enrolling in an HDHP will not automatically open your HSA. To open an HSA, please call the Benefits Department at 904-390-2351.

Contributing to Your HSA

The 2018 contribution limits are \$3,450 for single and \$6,900 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.

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.
- **Online Bill Pay:** Payments for your account can be made online using the online bill pay feature. Please visit www.PayFlex.com.
- **Request for Check Reimbursement:** Fill out an HSA Distribution Form to instruct PayFlex to issue a check from your account on your behalf. Mailing instructions are on the form.

Banking or Custodian Fees

A \$2.50 monthly custodial fee will be applied to the member's HSA account. A \$5.00 monthly fee will be applied if you are no longer enrolled in an employer sponsored HDHP, but continue to maintain your PayFlex HSA account.

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 participant is responsible for all record keeping of money spent from their HSA.

SUMMARY OF HEALTH PLAN OPTIONS

Benefit Category	DCPS Contributory Plan (No In-network Deductible)	DCPS Non-Contributory Plan (Low Deductible)	DCPS HDHP (High Deductible Health Plan) Only available to ADMIN, EXEMPT, FOP, IBEW, JSA, LIUNA)
HOSPITAL			
Inpatient			
In-Network (Network Blue)	20% Coins	CYD + 25% Coins	CYD + 25% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Out-of-State			
In-Network	20% Coins	CYD + 25% Coins	CYD + 25% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Outpatient Hospital Facility			
In-Network	20% Coins	\$250 Co-pay	CYD + 25% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Emergency Room			
In-Network	\$250 Co-pay	\$300 Co-pay	CYD + 25% Coins
Out-of-Network	\$250 Co-pay	\$300 Co-pay	CYD + 25% Coins
ANCILLARY			
Urgent Care Center			
In-Network	\$35 Co-pay	\$60 Co-pay	CYD + 20% Coins
Out-of-Network	\$35 Co-pay	\$60 Co-pay	CYD + 20% Coins
Ambulatory Surgical Center Facility			
In-Network	20% Coins	\$150 Co-pay	CYD + 20% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Independent Diagnostic Testing Facility (X-Ray / Imaging)			
In-Network	\$35 Co-pay	\$80 Co-pay	CYD + 20% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Independent Clinical Lab (Quest Diagnostics is the Participating Clinical Lab)			
In-Network	\$0	\$0 Co-pay	CYD + 20% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Mammograms	\$0	\$0	\$0
PHYSICIAN			
Office Services			
In-Network Family Physician	\$15 Co-pay	\$25 Co-pay	CYD + 20% Coins
In-Network Specialist	\$35 Co-pay	\$45 Co-pay	CYD + 20% Coins
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Routine Physicals			
In-Network	\$0	\$0	\$0
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Physician Services Other than Office			
In-Network Family Physician	\$15 Co-pay	CYD + 20% Coins	CYD + 20% Coins
In-Network Specialist	\$35 Co-pay	CYD + 20% Coins	CYD + 20% Coins
Out-of-Network Physician/Specialist	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
PRESCRIPTION DRUGS			
Retail			
Generic Drugs	\$7 Co-pay	\$7 Co-pay	CYD + \$7 Co-pay
Preferred Brand Drugs	\$25 Co-pay	\$25 Co-pay	CYD + \$25 Co-pay + 10% Coins
Non-Preferred Brand Drugs	\$40 Co-pay	\$40 Co-pay	CYD + \$40 Co-pay + 10% Coins
Specialty Injectables	\$55 Co-pay	\$55 Co-pay	CYD + \$55 Co-pay + 10% Coins
Mail Order (excludes specialty injectables)	2 x Retail	2 x Retail	2 x Retail
DED / COINS / OOP			
Calendar Year Deductible (CYD)			
In-Network (INN)	Single/Family \$0/\$0	Single/Family \$500/\$1,000	Single/Family \$1,350/\$2,700
Out-of-Network (OON)	\$500/\$1000	\$1,000/\$2,000	\$2,600/\$5,200
Coinsurance (Coins)			
In-Network	20% Coins	25% Inpatient/ 20% All others	25% Inpatient/ 20% All others
Out-of-Network	50% Coins	50% Coins	50% Coins
Out-of-Pocket Maximum (OOP) (Includes CYD, Copays, Coins)			
In-Network (Network Blue)	Single/Family \$2,500/\$5,000	Single/Family \$4,000/\$8,000	Single/Family \$5,000/\$10,000
Out-of-Network	\$3,250/\$6,500	\$6,000/\$12,000	\$10,000/\$20,000

2018 Bi-Weekly Contribution Rates

DCPS Contributory Plan Rates		
DCPS Contributory Rates apply to employees represented by the following Bargaining Unit and Non-Bargaining Group: Administrative, AFSCME, Exempt, FOP, IBEW, JSA, LIUNA, Paraprofessionals, Teachers, UOPD		
Coverage Tier Levels	Employee 20-Deductions	Employee 24-Deductions
Employee Only	\$58.30	\$48.58
Employee & Spouse	\$337.49	\$281.24
Employee & Child(ren)	\$263.07	\$219.23
Employee & Family	\$591.34	\$492.79
Medical FSA/PayFlex Card	Employer Contributions to Medical FSA \$450-Individual or \$750-Dep/Family	

DCPS Non-Contributory Plan Rates		
DCPS Non-Contributory Plan Rates apply to employees represented by the following Bargaining Units and Non-Bargaining Group: Administrative, AFSCME, Exempt, FOP, IBEW, JSA, LIUNA, Paraprofessionals, Teachers, UOPD		
Coverage Tier Levels	Employee 20-Deductions	Employee 24-Deductions
Employee Only	\$0.00	\$0.00
Employee & Spouse	\$239.28	\$199.40
Employee & Child(ren)	\$171.29	\$142.74
Employee & Family	\$471.23	\$392.70
Medical FSA/PayFlex Card	Employee Contributions Only	

DCPS HDHP Plan Rates		
DCPS HDHP Rates apply to employees represented by the following Bargaining Units and Non-Bargaining Group: Administrative, Exempt, FOP, IBEW, JSA, LIUNA		
Coverage Tier Levels	Employee 20-Deductions	Employee 24-Deductions
Employee Only	\$0.00	\$0.00
Employee & Spouse	\$215.66	\$179.72
Employee & Child(ren)	\$153.75	\$128.13
Employee & Family	\$426.86	\$355.71
Health Savings Account	Employer Contribution: \$678.52	
Medical FSA/PayFlex Card	Employee Contributions only if employee is not eligible to open an HSA.	

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



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

QUESTIONS	RESOURCES	HOW TO ACCESS
Why pay more?	Know Before You Go Use our online Medical Cost Comparison Tool to shop around for health care services. You can save money and still get the quality care you deserve.	Go to www.floridablue.com and log into your Member Account - select Tools - select Medical Care Comparison
Questions about your treatment options?	Care Consultants Our team of Care Consultants is standing by to answer questions about your benefits, treatment choices and cost saving options.	Toll Free at 1-888-476-2227 Monday through Friday 8 a.m. to 9 p.m.
Want help face-to-face?	Florida Blue Center Visit or call the Florida Blue Center Retail Store nearest you with two Jacksonville locations, providing great customer service, in person. No appointment needed.	River City Marketplace 13141 City Station Drive #106 St. Johns Town Center 4855 Town Center Parkway Open 10 a.m. – 8 p.m. (Monday – Saturday) Toll Free at 1-877-352-5830
ER or doctor's office?	Health Dialog 24-hour Nurse Line Questions about health can come up at any time, including times when doctors' offices are closed. Our 24-hour nurse line can help you make informed health care choices.	Toll Free at 1-877-789-2583
Plan benefits or claim question?	On-Site Customer Service The Florida Blue on-site Customer Service Representative is available to assist members with Benefit Issues including plan design questions and claim inquiries.	Resa Askew Located on the 5th floor – DCPS Admin. Bldg. 904-390-2323 resa.askew@bcbsfl.com
Need help with a claim or have other questions?	Customer Service Ask your customer service representative how to: Find out what's covered and how much you'll pay. Shop for the best value on upcoming medical procedures. Maximize your health plan benefits to save money. Access online tools and resources to help you better manage your health. Receive support for a health condition (like diabetes or asthma).	Toll Free at 1-800-664-5295 Monday – Thursday 8 a.m. – 6 p.m. Friday 9 a.m. – 6 p.m.
Prefer online help?	Register your online Member Account to: <ul style="list-style-type: none"> • Review your plan benefits • See your deductible • Find a participating doctor or hospital • View claim activity, status and history • Use your personalized WebMD site • Understand your upfront medical costs • Find tools to improve your health • Access our exclusive discount program 	Go to www.floridablue.com and register. All you need to register is a valid email address, your SSN and your Member Number (located on your Florida Blue Member ID card).

All enrollment & eligibility questions should be directed to DCPS Employee Benefits Department at 1-904-390-2351.



Pharmacy Benefits

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

Member Services

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

Benefit ID Cards

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

Covered Expenses

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

Medications

Generic Medications

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

Formulary and Non-Formulary Medications

The Prime Therapeutics Formulary List is a guide for you and your doctor to refer to when filling out your prescriptions. If

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

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

Retail Pharmacies

Network Retail Pharmacies

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

Mail Order Pharmacy

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

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

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

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

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

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

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

Medication Step Therapy

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

Prior Authorization

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

Quantity Limits

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

Formulary Exception

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

Rx Copay Summary

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

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

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

Florida Blue 
In the pursuit of health[®]

DCPS PERSONAL HEALTH ADVOCATE

and a helping hand
and a helping hand



We understand that each person has unique health care needs and navigating the health care system is not always easy. So we've set up specialized care teams, including a **Personal Health Advocate for DCPS members**, to make it easier to manage your health and maximize your health plan benefits. These services are available to you at no extra cost to help you in your pursuit of health.

Nancy Byers, RN is your dedicated Personal Health Advocate.

A few ways that Nancy can help you:

- Assist with complex medical conditions
- Locate and research treatments for medical conditions
- Find “best-in class” doctors, specialists and facilities
- Navigate within Florida Blue
- Assist with referrals
- Answer questions about test results and treatment recommendations.
- Help prepare patients for health care appointments.
- Help members understand their conditions and become active participants in their health care.
- Develop care plans
- Serve as the advocate and informational resource for members

Call Nancy today at 904-905-0901 or nancy.byers@floridablue.com.

Note: The availability of care programs and services vary by plan. Please refer to your benefit materials for details. Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770).



Dental Care

Dental Care Benefit Options

Delta Dental Insurance Company offers two choices for dental coverage:

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

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

Selecting a Dentist

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

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

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

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

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

Family Coverage

This plan covers:

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

Your Tax-free Rates*

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

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

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

DeltaCare USA Benefits

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

For the 2018 Plan Year (January 1, 2018 through December 31, 2018), all rates are shown for 20 or 24 payroll deduction cycles.

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

Delta Dental PPO:

Monday - Friday,
7:15 a.m. - 7:30 p.m. ET at
800-521-2651
deltadentalins.com

DeltaCare®USA:

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

DeltaCare USA - Accident Injury Benefit

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

Plan Features

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

Limitations

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

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

Exclusions

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

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

What if I have questions about this benefit?

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

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

DeltaCare USA

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

Benefit DeltaCare USA Plan FLM08

Choose a panel dentist

Deductible none
(Calendar Year is Jan. 1 - Dec. 31)

Calendar Year Maximum none

Claim Forms none

Diagnostic Procedures You Pay

Office visit \$0 - \$20

Routine exams no cost

Prophylaxis (cleaning) - basic no cost
(2 per calendar yr.)

Emergency treatment \$10 (regular office
hours)
X-ray and complete
series no cost

including bitewings**

Fluoride application no charge to age 19
(one per 6 months)

Basic/restorative procedures

Simple extractions \$6

Amalgam fillings - no cost

1 surface perm

Resin based fillings - posteriors \$15 - \$35

Root canal - anterior*** \$75

Root canal - molar*** \$180

Major procedures

Crowns - porcelain, base metal \$195

Crowns - porcelain, \$295

high noble metal

Dentures - upper/lower \$225

Bridges - porcelain, base metal \$195 (per unit)

Bridges - resin, high noble metal \$295 (per unit)

Periodontics

Scaling and root planing \$45 per quadrant

Orthodontics

Start up fee \$350

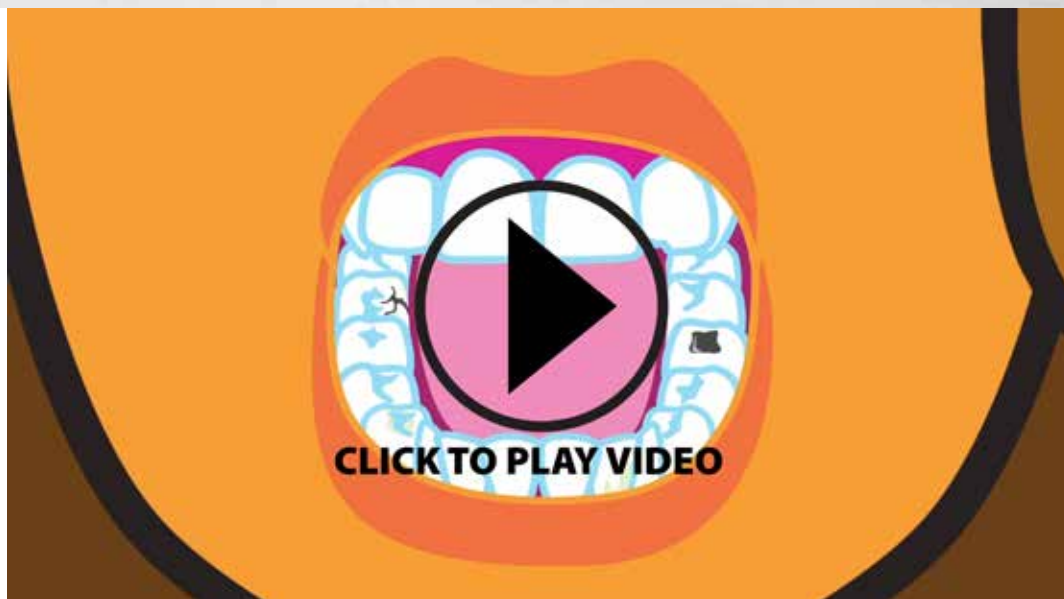
Routine 24 month fully banded case

Adult \$2,000

Child \$1,800

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

*** Excluding final restoration



Temporomandibular Joint (TMJ) Dysfunctions for DeltaCare USA Plan

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

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

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

To locate a dental provider or facility

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

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

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

Sample Claim Payment

(Assuming deductible and contract provisions are met)

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

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

Delta Dental PPO and Premier Providers

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

PPO Dentist Benefits

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

How the PPO Program Option Plan Works

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

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

In addition to PPO Dentists, Delta Dental has Participating Delta Dental Premier® Dentists. PPO dental providers provide the most savings as seen in the example on the previous page. You can search for a Delta Dental Dentist (Premier and PPO) by visiting our website at www.deltadentalins.com.

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

Family Coverage

This plan covers:

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

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

Delta Dental PPO Option

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

BENEFIT**DELTA DENTAL INDEMNITY (PPO OPTION)****

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

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

** PPO Dentists are limited to the PPO fee.

Delta Dental Premier® Dentists are limited to the least of: the dentist's filed fee, submitted fee, or Delta Dental's MPA (Maximum Plan Allowance) fee.

Non-Delta Dental Dentists may balance bill for amounts over Delta Dental's MPA-TJM Benefits (Maximum Plan Allowance) fee.

Vision Care



Davis Vision Plan

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

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

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.¹

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.¹

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

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



For more details about the plan, just log on to the Open Enrollment section of our Member site at **davisvision.com** or call **1-877-923-2847** and enter Client Code **3651**

Your Rates*

	20 Pay	24 Pay
Employee	\$3.01	\$2.51
Employee + family	\$8.57	\$7.15

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

Value for Davis Vision Members

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

Convenient Network Locations

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

Freedom of Choice

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

Value-Added Features:

Replacement contacts through Davis Vision contact lens replacement service, saving both time and money.

Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.



In-Network Benefits

Eye Examination	Every January 1, Covered in full after \$10 co-payment	
Eyeglasses		
Spectacle Lenses	Every January 1, Covered in full For standard single-vision, lined bifocal, or trifocal lenses after \$15 co-payment	
Frames	\$130 ⁶ retail allowance toward any frame from provider, plus 20% off balance ² Also, up to \$180 frame allowance at Vision-works, plus 20% on any overage OR Every other January 1, Covered in full Any Fashion or Designer frame from Davis Vision's Collection ¹ (value up to \$175)	
Contact Lenses		
Contact Lens Evaluation, Fitting & Follow Up Care	Every January 1, Collection Contacts: Covered in full OR Non Collection Contacts: Standard Contacts: 15% discount ² Specialty Contacts ³ : 15% discount ²	
Contact Lenses (in lieu of eyeglasses)	\$150 retail allowance toward provider supplied contact lenses, plus 15% off balance ² OR Every January 1, Covered in full Any contact lenses from Davis Vision's Contact Lens Collection ¹	
ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	\$40	\$0
Polycarbonate Lenses	\$64	\$0 ⁴ - \$30
Standard Anti-Reflective (AR) Coating	\$62	\$35
Standard Progressives (no-line bifocal)	\$154	\$50
Plastic Photosensitive (Transitions® ⁵)	\$123	\$65



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

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

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

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

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

Out-of-Network Benefits

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

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

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE

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



Contact Info

For more details about the plan, just log on to the Open Enrollment section of our Member site at **davisvision.com** or call 1-877-923-2847 and enter Client Code 3651.



**DISTRICT WELLNESS
PROVIDES SUPPORT FOR
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FOR ALL MEMBERS OF OUR
SCHOOL COMMUNITIES -
STAFF, STUDENTS, AND THEIR
FAMILIES!**



DUVAL COUNTY
PUBLIC SCHOOLS

District Wellness For You. For Us. For Life.

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

Staff Program and Services include:

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

For more information on District Wellness programs and services, please visit our website at **www.duvalschools.org/wellness**

The DCPS Wellness Office is located in the District
Administration Building:
1701 Prudential Drive, 3rd Floor, Room 345
Jacksonville, FL 32207
(904) 390-2499



we make healthcare easier

Our experts can:

- **Provide confidential help** with personal issues, 24/7
- **Consult with you in person**, by telephone or secure video
- **Help** with stress, anxiety, depression and family problems
- **Support you** with grief and loss, anger and substance abuse
- **Find local services** to help make your life easier
- **Research and locate** legal specialists and financial counselors
- **Find local resources** for child care, adult day care and eldercare
- **Direct you** to your comprehensive EAP member website
- **Refer you** to more long-term support as needed
- **Lower bills** for non-covered medical/dental services



Available at no cost to employees, their spouse, dependent children, parents and parents-in-law. Completely confidential.

We're not an insurance company. West's Health Advocate Solutions is not a direct healthcare provider, and is not affiliated with any insurance company or third party provider.

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Web: HealthAdvocate.com/members

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HealthAdvocateSM

Flexible Spending Accounts



Medical FSA

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

Dependent Care FSA

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

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

Annual Contribution Limits

For Medical Expense FSA:

Minimum Annual Deposit: None

Maximum Annual Deposit: \$2,600

For Dependent Care FSA:

Minimum Annual Deposit: \$250

The maximum contribution depends on your tax filing status.

- If you are married and filing separately, your maximum annual deposit is \$2,600.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

Typical FSA-Eligible Expenses

Use your FSA to save on hundreds of products and services for you and your family. Eligible expenses are defined by the IRS and your employer.

Eligible medical expenses

Typically, your Medical FSA covers:

Acupuncture
Ambulance service
Birth control pills and devices
Breast pumps
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment

Over-the-counter items (some require prescription)
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Wheelchairs
X-rays

Eligible dependent care expenses

Your Dependent Care FSA typically covers expenses, such as:

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

Typical Ineligible Expenses

For Medical FSA:

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

For Dependent Care FSA:

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

Using Your FSA Dollars

When you pay for an eligible health care or dependent care expense, you want to put your account to work right away. Using your FSA is easy with PayFlex.

Examples of how to use your FSA

Medical FSA Example:

Paying an office visit

After paying for your care at a service provider's office, obtain an Explanation of Benefits (EOB) or detailed receipt of the completed services. Submit these documents, along with a claim form to PayFlex. Once your claim is processed and approved, you'll receive payment by check or direct deposit.

If you don't want to pay for the office visit out of your pocket, you can use your PayFlex debit card. Only use your card after insurance has covered their portion of the expense. Be sure to save your documentation from your card purchases. You may be asked to provide documentation to verify that your expenses were eligible. Failure to submit proper documentation can result in deactivation of your card and you may have to pay back the funds at the end of the plan year.

Dependent Care FSA Example:

Paying for dependent care services

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

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

If you don't have documentation to support your day care expense, you can have your provider sign a completed claim form and send to PayFlex. Once your claim is processed and approved, payment will be sent to you by check or direct deposit.

Use your PayFlex Card®, Your Account Debit Card

The PayFlex debit card is a convenient way to pay for eligible health care expenses. The card knows when the expense is eligible and whether you have funds available. When you use the card, save your Explanations of Benefits, itemized statements and detailed receipts. There may be times when PayFlex asks you to provide documentation to verify you used your card for an eligible expense. If you have a health care FSA, you'll automatically receive one card in the mail before the beginning of the plan year. The card is not available for the dependent care FSA. If you need an additional debit card for your spouse or dependent, over the age of 18, you are able to request an additional card online or contacting customer service. You can order an additional card for your spouse or dependent online at no cost.

Filing a claim

Those who participate in a Flexible Spending Account can visit **www.payflex.com** to access their account information. For 2018 FSA claims to PayFlex, if you pay for an eligible expense with cash, check or personal credit card, you can file a claim online at **www.payflex.com** or through the PayFlex Mobile® app to pay yourself back for your out of pocket expenses. Or you can fill out a paper claim form and fax or mail it to PayFlex. This form can be found in the Resource Center at **www.payflex.com** or you may call PayFlex at **1-800-284-4885** to request a form.

After you log in to **www.payflex.com**, click on the Financial Center tab and select your account from the drop down. Click on File a Spending Account Claim to get started. If you're a first time user, be sure to register first. Please see below for how to register online and for claim filing tips.

When you submit a claim, you need to include supporting documentation that shows the following:

- | | |
|-------------------------------|-------------------|
| ✓ Date of service or purchase | ✓ Patient name |
| ✓ Detailed description | ✓ Patient portion |
| ✓ Provider or merchant name | (or amount owed) |

How to Register Online

- Go to **www.payflex.com** and select "CREATE YOUR PROFILE." You will be asked to enter your last name, mailing address, zip code, last four characters of your ID number and date of birth.
- Once your information is authenticated, you can create a username and password, provide your phone number and e-mail address and select security questions/answers.

Note: If you already have a username and password for **www.healthhub.com**, you'll use that to log in to **www.payflex.com**.

Claim Filing Tips

To receive your claim payments quickly, sign up for direct deposit through the PayFlex member website. Log in to **www.payflex.com**. Click on the "Financial Center" tab. Select your account from the drop down menu and click on Enroll in Direct Deposit to get started.

FSA Worksheets

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

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

Medical FSA Worksheet

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

UNINSURED MEDICAL EXPENSES

Health insurance deductibles \$ _____

Coinsurance or co-payments \$ _____

Vision care \$ _____

Dental care \$ _____

Prescription drugs \$ _____

Travel costs for medical care \$ _____

Other eligible expenses \$ _____

TOTAL (cannot exceed \$2,600) \$ _____

DIVIDE by the number of paychecks you will receive during the plan year.* ÷ _____

This is your pay period contribution. \$ _____

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

Dependent Care FSA Worksheet

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

CHILD CARE EXPENSES

Day care services \$ _____

In-home care/au pair services \$ _____

Nursery and preschool \$ _____

After school care \$ _____

Summer day camps \$ _____

ELDER CARE SERVICES

Day care center \$ _____

In-home care \$ _____

TOTAL Remember, your total contribution cannot exceed IRS limits. \$ _____

DIVIDE by the number of paychecks you will receive during the plan year.* ÷ _____

This is your pay period contribution. \$ _____

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

Direct Deposit delivers your money to you faster, and unlike with a check, the funds are in your account automatically – no waiting in bank or ATM lines, no waiting for it to clear. Once you're an FSA member, you can enroll in Direct Deposit through PayFlex's member website at www.payflex.com.

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

The PayFlex Card®

Instant Access to Your Money

The PayFlex Card makes it easy for you to spend the money in your Health care FSA. When you use this debit card, it uses the money in your account to pay for eligible health care expenses.

Frequently Asked Questions

How Does the Card Work?

Your PayFlex Card may be used to pay for eligible health care products and services. When you receive your card, follow the activation instructions. To use your card, simply swipe and select either “debit” or “credit.” However, some merchants may ask you to select “debit.” This means you will need to enter a personal identification number (PIN) to complete the transaction. To get a PIN, call Card Services at 1-888-999-0121. A PIN can be created at any time. If you order a card for your spouse or dependent, they will use the same PIN you use. After you swipe the card, our system automatically confirms whether you have enough funds to pay for the expense. If you have funds available, your expense will be taken out of your account. You can view all of your card transactions online.

Where Can I Use the Card?

You can use your card at qualified merchants where MasterCard® is accepted. This includes doctor and dental offices, hospitals, pharmacies (including mail-order prescriptions), and hearing and vision care centers. You may also use your card at some discount and grocery stores. These stores must have a system that can process health care cards.

What Can I Pay for with my Card?

You can use the card to pay for eligible expenses allowed under your plan. These generally include copays, prescriptions, vision and hearing products, and much more. To view a list of common eligible expenses, visit www.payflex.com. Click on Individuals and select explore expenses. The list of eligible expense items is found via the resource center.

What if I Don't Use my Card to Pay for an Expense?

If you pay for an eligible expense with cash, check or a personal credit card, you can submit a claim for reimbursement online or through the PayFlex Mobile® app. You can also fill out a paper claim form and fax or mail it to PayFlex®.

Note: You must include supporting documentation when you submit your claim.

Can I Use My Card for Prescription and Over-the-Counter (OTC) Expenses?

You may use your PayFlex Card at most retail or online locations to pay for prescriptions and certain OTC items. Such OTC items include bandages, contact lens solution, first aid kits, hot and cold packs, and thermometers. You cannot use the card to pay for OTC drugs and medicine such as pain relievers, cold and flu remedies, or allergy and sinus products. To get reimbursed for OTC drugs and medicine, you'll need a written prescription from your doctor. After you get the prescription, you must pay for the OTC drug or medicine with cash, check or personal credit card. Then submit a claim for reimbursement. Be sure to include the receipt and written prescription when you submit your claim.

Quick Tips

- Spending made simple for the family — If you are a new member, you will automatically receive one card. You can order a card online for your spouse or dependent at no cost.
- Save your receipts — If you receive a Request for Documentation letter or see an alert message on your account, this means we need documentation for a card purchase.
- Access your account balance — Log in to your account through www.payflex.com. You can view your available balance on “My Dashboard”.
- Check your card's expiration date — Your card is valid for five years, as long as you are an active member. Before your card expires, you will receive a new card in the mail.
- Replace lost or stolen cards — Please call us right away at 1-800-284-4885 to report a lost or stolen card. Do not order another card online.

IMPORTANT: Request for Documentation Alerts and Letters

There may be times that PayFlex needs documentation from you for your card transactions. If documentation is needed, PayFlex will post an alert message online or send you a Request for Documentation letter. This is done when PayFlex needs to verify that you used your card to pay for an eligible item or service. If you do not respond to the request, your card will be suspended.

To stay up to date on your card transactions, we encourage you to sign up to receive debit card notifications through e-mail, web alert or both. Log in to www.payflex.com and click on My Settings. Click on the notifications link and enter your e-mail address. Then select the notifications you wish to receive. Be sure to sign up for the Debit Card Substantiation Notification. This e-mail notification will let you know when we need documentation from you.

The PayFlex Card® and PayFlex Mobile® App How to Respond to a Request for Documentation Alert or Letter

If PayFlex needs more information on a debit card purchase, you have three options.

1. Send us the Explanation of Benefits (EOB) or detailed receipt for the card payment. You can upload to **www.payflex.com** as a PDF file, send through the PayFlex Mobile app, or fax or mail it to PayFlex.
2. Substitute another expense for the one in question. Upload, fax or mail* the EOB or detailed receipt for another eligible item or service. You must have incurred this expense in the same plan year. (Note: This option is only available if you have not been reimbursed for the item or service. And if you haven't already paid for it with your PayFlex Card®.)
3. Pay back your account for the amount in question. Send a personal check or money order directly to PayFlex.

Note: If you do not respond to the request, your card will be suspended until you either send in the requested documentation or pay back the account. If your card is suspended, you can still pay for eligible expenses with another form of payment. You will then need to submit a claim for reimbursement. Once we receive and process your documentation or repayment, your card will be active again.

*If you choose to fax or mail documentation, include a copy of your Request for Documentation letter.

PayFlex Mobile® Helping You Stay Connected to Your FSA

Get access to your FSA with our free** PayFlex Mobile application. This app makes it easy for you to manage your account virtually 24/7. It's available for iPhone® and iPad® mobile digital devices, as well as Android™ and BlackBerry® smartphones.

The PayFlex Mobile app lets you:

- View your account balance and manage your account funds.
- Request reimbursement and view transaction history.
- View PayFlex Card®, your account debit card, purchases and submit documentation (if applicable).
- View your benefits plan information (if applicable).
- View a list of common eligible expense items.

Security is our Priority

PayFlex Mobile is a secure and safe way to view your account information. PayFlex uses the same security for the app as the PayFlex member website.

Account Alerts at Your Fingertips

Receive important account alerts about the status of your account. You can also find out when you need to take action.

Note: Not all of the PayFlex Mobile functionality is available for BlackBerry smartphones. Menu layouts, designs and screen displays may vary on your device.

Learn More About How to Use the App

After you enroll in an FSA, be sure to check out our PayFlex Mobile Quick Reference Guide to help you get started. You can find this guide on **www.payflex.com** via the resource center.

Questions?

Visit **www.payflex.com** or call us at 1-844-PAYFLEX (1-844-729-3539). Customer service representatives are available Monday - Friday, 8 a.m. - 8 p.m. ET and Saturday, 10 a.m. - 3 p.m. ET.

**Standard text messaging and other rates from your wireless carrier still apply.

Using an HDHP with an HSA

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

Use It or Save It

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

Opening a Health Savings Account

Enrolling in an HDHP will not automatically open your HSA. To open an HSA, you can visit PayFlex's website: **www.PayFlex.com**.

Contributing to Your HSA

The 2018 contribution limits are \$3,450 for single and \$6,900 for family. This is the maximum including the amount contributed by Duval County Public Schools.

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

- **Payroll Pre-tax Deductions:** One of the most common ways people deposit funds into their HSA is by using scheduled deductions. Talk to your Benefits Department to set up or change deductions to your HSA. Changes will be allowed once per month.
- **Regular Recurring Electronic Deposits Post-tax**
- **Mail-In Deposits:** Fill out an HSA Contribution Form to make a deposit through the mail. Mailing instructions are on the form. These deposits would be post-tax.

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.
- **Online Bill Pay:** Payments for your account can be made online using the online bill pay feature. Please visit **www.PayFlex.com**.

- **Request for Check Reimbursement:** Fill out an HSA Distribution Form to instruct PayFlex to issue a check from your account on your behalf. Mailing instructions are on the form.

Banking or Custodian Fees

This fee does not apply.

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.

Health Savings Account FAQs

How are funds placed into my HSA?

- Step 1: Employee enrolls in HDHP and HSA.
- Step 2: Employee opens HSA with bank.
- Step 3: Employee contributions taken via pre-tax payroll deduction.
- Step 4: Employer Contributes to Employee's HSA.
- Step 5: FBMC deposits employee and employer contributions via Deposit File to CitiBank.
- Step 6: Employee uses HSA debit card or check to pay for medical expenses.

How may I change my HSA contribution?

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

How do I get funds out of my HSA?

PayFlex will establish an individual account for you and mail one VISA® Check Cards to your home address at no charge. You may order additional cards by contacting PayFlex at 1-844-729-3539. 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?

No, DCPS pays the fees.

How are my HSA funds invested?

Your funds will initially be held in an interest-bearing checking account at CitiBank. 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 \$1,000 or more, CitiBank will communicate the investment opportunities available to you through their broker.

I currently have an HSA account through Synovus Bank, will PayFlex continue making my HSA contribution to Synovus Bank instead of switching to Citibank?

Contributions would only be made to the new PayFlex Citibank account.



Group Term Life/ AD&D Insurance

Group Term Life Insurance

DCPS provides board-paid \$10,000 Group Term Life and Voluntary Accidental Death and Dismemberment (AD&D) insurance for all full-time benefit-eligible employees and underwritten by The Standard Insurance Company.

New Hires Guaranteed Life Insurance Coverage

All newly-hired employees of Duval County Public Schools are able to elect up to three times their annual salary in life insurance coverage with no medical questions asked, not to exceed \$310,000.

Existing Employees

During Open Enrollment, you may upgrade your coverage by one level without medical review. For example, if you currently have coverage equal to one times your salary, you may increase to two times your salary without EOI (Evidence of Insurability). Employees wishing to upgrade your coverage two times or more of their current coverage level, must complete an Evidence of Insurability packet. The packet is located at **www.duvalschools.org/benefits** under the Forms link. This packet must be submitted to The Standard Insurance Company for approval.

Additional Purchasing Options

You can purchase additional term life coverage equal to one, two, or three times your salary, up to a maximum of \$310,000. This includes your board-paid \$10,000 of basic life insurance.

Instead of a multiple of annual salary, you may purchase a flat \$50,000. This is in addition to your basic board-paid coverage. Equal amounts of accidental death and dismemberment insurance is also provided.

Premium Waiver

If you become totally disabled while insured under this plan and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium

payment, subject to the terms of the group policy. Visit **<https://dcps.duvalschools.org/>** website to obtain the Standard Life Insurance Premium Waiver packet. It is located under the Forms link. If you have any questions, you may contact the Employee Benefits Department at 904-390-2351.

Insurance Amounts in Excess of \$50,000

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

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

Terminating Employment

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

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

All current employees who retire with Duval County Public Schools may retain their Basic Life amount under the Retiree group insurance plan. A retiree may also elect to convert any portion of optional coverage to an individual Whole Life

contract. Regardless of the elected option upon retirement, you will pay the premium.

Visit <https://dcps.duvalschools.org/> to obtain the Portability/Conversion packets. The packets are located under the Standard Life Insurance link. If you have any questions, you may contact the Employee Benefits Department at 904-390-2351.

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

Plan Provider

Standard Insurance Company insures this plan. The Standard is a nationally recognized provider of group life insurance. We provide insurance to more than 23,000 groups, covering approximately 6 million employees nationwide*

* As of March 31, 2015, based on internal data developed by Standard Insurance Company.

Beneficiary

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

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

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

Designating a minor as beneficiary

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

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

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

Designating an Ex-Spouse as beneficiary:

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

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

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

How to Change Your Beneficiary

1. Log in to www.myFBMC.com.
2. Click the **"Web Enrollment"** link.
3. Click the **"Beneficiary Update"** link.
4. Complete the required fields and select the allocation of your life insurance benefit, not to exceed 100%.

How to File a Death Claim

To file a death claim, please contact the DCPS Employee Benefits Office at 904-390-2143.



Unum Whole Life Insurance

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

Plan Features

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

Eligibility

Employee

- Issue ages: 15 – 80
- Must be actively at work at time of application
- Full-time DCPS employee

Being “actively at work” means that on any day the employee applies for coverage, he/she is working at one of their company's business locations, or is working at a location where he/she is required to represent the company. If he/she is applying for coverage on a day that is not a scheduled workday, then he/

she will be considered actively at work if he/she meets this definition as of the last scheduled workday. Employees are not considered actively at work if their normal duties are limited or altered due to their health, or if they are on a leave of absence.

Spouse

- Issue ages: 15 – 80

Child – Standalone Policy

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

Underwriting Levels

Guaranteed Issue (GI)

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

Conditional Guaranteed Issue (CGI)

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

Re-enrollment Underwriting Guidelines:

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

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

UNUM Whole Life Insurance

Employee Weekly Premium Limits

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

Spouse Weekly Premium Limits

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

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

Current and newly eligible employees

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

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

Participants with existing coverage

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

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

Coverage Levels

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

Family Coverage Options

Spouse Coverage

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

Children's Coverage

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

Children's Voluntary Whole Life Insurance

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

Children's Term Rider

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

UNUM Whole Life Insurance

Additional Coverage Options

Accidental Death Benefit Rider

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

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

Waiver of Premium

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

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

Exclusions

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

Terminations

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

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

Plan Provider

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



The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. Unum Corporation complies with Act 91, the Vermont Civil Union Endorsement Law and the California Insurance Equity Act.

Unum is the marketing brand of Unum Corporation's insuring subsidiaries. Provident Life and Accident Insurance Company, 1 Fountain Square, Chattanooga, TN 37402

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Trustmark Voluntary Universal Life Insurance Plan



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

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

Who is eligible?

- Full-time DCPS employee
- Employees between the ages of 18 and 75

What does the plan offer?

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

- Death Benefit
- LTC Living Benefits
- Interest-earning Cash Value
- EZ Value Plan Option*
- Death Benefit Restoration Rider
- Modified Guaranteed Issue or Simplified Issue is available for all eligible employees and spouses (See a Benefits Counselor for details)

How do I apply?

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

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

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

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

This Universal Life Insurance plan complements any group

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

What payroll deduction premiums will I pay?

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

How do I make changes to my election?

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

Plan Provider

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

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

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

Policy Form UL-205

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

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



Trustmark Universal LifeEvents[®] Insurance

How does LifeEvents work?

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

Death Benefit

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

Long-Term Care Insurance Rider

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

The LifeEvents Advantage

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

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

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

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

Features you'll appreciate

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

Separately priced benefits:

Children's term life insurance rider — Covers Accidental Death Benefit and Waiver of Premium Payments for newborns to age 23.

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

How Living Benefits Add Up

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

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

Unum Disability Income Protection Insurance Plans

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

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

Length of Benefit

Age at the time Long Term Disability Benefits
of disability payable for the following maximum*

Under 60	To Age 65, but not less than 5 years
60	60 Months
61	48 Months
62	42 Months
63	36 Months
64	30 Months
65	24 Months
66	21 Months
67	18 Months
68	15 Months
69 and Over	12 Months

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

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C, FP, et al.

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

What are Deductible Sources of Income?

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

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

The Short-Term Disability Insurance plan can provide:

Injury and Sickness Benefits

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

The Long-Term Disability Insurance provides:

Injury and Sickness Benefits

The Long-Term Disability monthly benefit may be payable during each period of disability. Long Term Disability benefits begin after you meet the definition of disability as defined in the policy and satisfy a benefit waiting (elimination) period of 180 days. You can satisfy your elimination period if you are working, as long as you meet the definition of disability. Your disability will be treated as continuous as long as you do not exceed 30 return-to-work days during the elimination period.

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

In addition, the long-term disability minimum monthly benefit is 25% of your gross disability payment. Under no circumstance will a benefit be payable which exceeds 66 ⅔% of your monthly earnings.

Mental Illness and Self-reported Systems Limitation

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

What's Not Covered

Benefits will not be paid for disabilities resulting from:

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

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

DEFINITIONS

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

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

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

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

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

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

DISABILITY INSURANCE

Money for when you can't work due to
illness, injury or some other

Long-Term & Short-Term Income Protection Insurance Plans

What is a Pre-Existing Condition?

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

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

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

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

Waiver of Premium

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

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

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

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

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

Coverage Levels

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

Policy Provider

Unum Life Insurance Company of America underwrites these plans. The A.M. Best Company, an organization that rates the financial strength and performance of insurance companies rates Unum Life Insurance Company of America "A" Excellent (rating effective as of January, 2015).

Submitting a claim for Short-Term Disability

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

Submitting a claim for Long-Term Disability

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

Long-Term & Short-Term Income Protection Insurance Plans

Your Rates and Disability Benefit Amount

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

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

UNUM Long-Term Care Protection

Available to New Hires & Current Participants Only

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

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

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

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

Eligibility Requirements

Long-Term Care is available to:

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

Plan Description

You may choose one of the following plans:

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

Optional Benefits

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

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

Your Coverage Levels

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

Plan Features

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

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

What's Not Covered

This plan will not pay benefits for:

- a chronic illness caused by any act of declared or undeclared war
- a chronic illness caused by self-destruction or attempted suicide (while sane or insane)
- a chronic illness caused by a commission of a crime for which you have been convicted under state or federal law or attempting to commit a crime under state or federal law
- chronic illnesses or confinements during which you are outside the United States, its territories or possessions for longer than 30 days
- a chronic illness caused by alcoholism and alcohol abuse
- a chronic illness caused by voluntary use of any controlled substance (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments)
- any days over 15 days in each calendar year during which you are confined in any facility for acute care (acute care is medical care obtained as a result of an injury or a sickness requiring immediate medical intervention)
- a chronic illness caused by psychological, psychiatric or mental conditions, which include depression, generalized anxiety disorders, personality disorders, schizophrenia, manic depressive disorders whether treated by drugs, counseling or other forms of therapy. However, Unum will make payments to you for conditions that are not psychological or psychiatric in nature, including Alzheimer's disease, multi-infarct dementia, or Parkinson's disease.
- a chronic illness caused by pre-existing conditions.

UNUM Long-Term Care Protection

Available to New Hires & Current Participants Only

Pre-existing Conditions

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

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

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

Loss of Functional Capacity Defined

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

Rates

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

Plan Provider

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

For use with Policy series TQB.LTC

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

Elimination Period: 60 days

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

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

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

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



Allstate Benefits Group Voluntary Hospital Indemnity Insurance

Group Hospital Indemnity Insurance Policy GVSP1FL

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

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

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

Terms of Coverage

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

Effective Date

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

Pre-Existing Condition Limitation

Allstate Benefits does not pay for any loss due to a pre-existing condition as defined during the 12-month period beginning on the date that person became a covered person. A

Pre-Existing Condition is a disease or physical condition for which: symptoms existed within the 12 month period prior to the effective date of coverage; or medical advice or treatment was recommended or received from a member of the medical profession within the 12 month period prior to the effective date of coverage. A pre-existing condition can exist even though a diagnosis has not yet been made.

Policy Limitations and Exclusions

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

injury or sickness incurred prior to the covered person's effective date of coverage subject to the Pre-Existing Condition Limitation and Incontestability provisions; or

any act of war whether or not declared, participation in a riot, insurrection or rebellion; or

suicide, or any attempt at suicide, whether sane or insane; or

any injury sustained while the covered person is under the influence of alcohol or any narcotic, unless administered upon the advice of a physician; or

participation in any form of aeronautics (including parachuting, parasailing and hang gliding) except as a fare-paying passenger in a licensed aircraft provided by a common carrier and operating between definitely established airports; or

injury incurred while engaging in an illegal occupation or committing or attempting to commit an assault or felony; or

dental or plastic surgery for cosmetic purposes except when such surgery is required to:

(a) treat an injury; or

(b) correct a disorder of normal bodily function; or

alcoholism, drug addiction, or dependence upon any controlled substance; or

mental or nervous disorders; or

intentionally self-inflicted injuries; or

a newborn child's routine nursing or routine well baby care during the initial hospital confinement; or

childbirth occurring within the first 10 months of the covered person's effective date of coverage (complications of pregnancy are covered to the same extent as a sickness); or

hospitalization that begins before the covered person's effective date of coverage; or

the reversal of a tubal ligation and vasectomy; or

artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or physician services, unless required by law; or

routine eye examinations or fitting of eye glasses; or

hearing aids or fitting of hearing aids; or

dental examinations or dental care other than expenses resulting from an accident; or

driving in any organized or scheduled race or speed test or while testing an automobile or any vehicle on any racetrack or speedway.

Termination of Coverage

The insured employee's/member's coverage under the policy ends on the earliest of: the date the policy is canceled; or the last day of the period for which any required premium payments were made; or the last day the insured employee/member is in active employment, except as provided under the "Temporary Layoff, Leave of Absence or Family and Medical Leave of Absence" provision in the policy; or the date the insured employee/member is no longer in an eligible class; or the date the insured employee's/member's class is no longer eligible.

If your spouse is a covered person, the spouse's coverage ends upon valid decree of divorce or your death. Coverage for your child will end on the issue day of the month that follows when the child reaches age 26 or otherwise does not meet the requirements of an eligible dependent.

Portability Privilege

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

Coverage Subject to Policy

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

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

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.



Initial Hospitalization Confinement Benefit	Year	Low Plan	Medium Plan
Allstate Benefits pays the benefit amount shown for the first confinement to a hospital during a coverage year, provided a benefit is paid under the Daily Hospital Confinement Benefit. The benefit is payable only once per covered person per continuous hospital confinement and per coverage year. The benefit is not paid for normal pregnancy or complications of pregnancy, or for a newborn child's initial hospitalization after birth.	1	\$415.00	\$1,245.00
	2	\$435.75	\$1,307.25
	3	\$456.50	\$1,369.50
	4	\$477.25	\$1,431.75
	5	\$498.00	\$1,494.00
	6+	\$518.75	\$1,556.25
Daily Hospital Confinement Benefit	Year	Low Plan	Medium Plan
Allstate Benefits pays the benefit amount shown for each day a covered person is admitted to and confined as an inpatient in a hospital as a result of an injury or sickness. Maximum of 180 days for each period of continuous hospital confinement. The benefit is not payable for a newborn child's routine nursing or routine well baby care during the initial hospital confinement.	1	\$165.00/day	\$495.00/day
	2	\$173.25/day	\$519.75/day
	3	\$181.50/day	\$544.50/day
	4	\$189.75/day	\$569.25/day
	5	\$198.00/day	\$594.00/day
	6+	\$206.25/day	\$618.75/day
Hospital Intensive Care Benefit	Year	Low Plan	Medium Plan
Allstate Benefits pays the amount shown for each day a covered person is confined to a hospital intensive care unit, provided a benefit is also paid under the Daily Hospital Confinement Benefit. The covered person must provide proof for each day that a hospital intensive care room and board charge is incurred. Paid in addition to the Daily Hospital Confinement Benefit. Maximum of 60 days for each period of continuous hospital confinement.	1	\$165.00/day	\$495.00/day
	2	\$173.25/day	\$519.75/day
	3	\$181.50/day	\$544.50/day
	4	\$189.75/day	\$569.25/day
	5	\$198.00/day	\$594.00/day
	6+	\$206.25/day	\$618.75/day
Surgery Benefit	Year	Plan	
Allstate Benefits pays a benefit up to the amount shown, depending on the surgery, for a surgical operation performed in a hospital or an ambulatory surgical center. Two or more procedures performed at the same time through one incision are considered one operation; Allstate Benefits pays the amount shown in the Schedule of Operations for the operation with the largest benefit. If any operation other than those listed is performed, Allstate Benefits pays an amount based upon the amount stated in the Schedule of Operations for the most comparable procedure.	1	\$33.00 to \$825.00	
	2	\$34.65 to \$866.25	
	3	\$36.30 to \$907.50	
	4	\$37.95 to \$948.75	
	5	\$39.60 to \$990.00	
	6+	\$41.25 to \$1,031.25	
Anesthesia Benefit	Benefit Amount – All Plans		
Pays 25% of surgical benefit for anesthesia received by a covered person during the course of a covered surgical operation.	25% of Surgery Benefit		

Inpatient Physician's Treatment Benefit		Year	All Plans
Allstate Benefits pays the amount shown for each day a covered person requires and receives the services of a physician (other than a surgeon) during a covered hospital confinement. The benefit is payable for the number of days the Daily Hospital Confinement Benefit is payable.		1	\$41.00/day
		2	\$43.05/day
		3	\$45.10/day
		4	\$47.15/day
		5	\$49.20/day
		6+	\$51.25/day
Outpatient Emergency Accident Benefit		Year	All Plans
Allstate Benefits pays the amount shown for each day a covered person, as a result of an injury, requires medical or surgical treatment in an emergency treatment center. Limited to 2 days per covered person per coverage year.		1	\$415.00/day
		2	\$435.75/day
		3	\$456.50/day
		4	\$477.25/day
		5	\$498.00/day
		6+	\$518.75/day
Outpatient Physician's Treatment Benefit		Year	All Plans
Allstate Benefits pays the amount shown if a covered person is treated by a physician for any cause outside of a hospital. Limited to 5 days per covered person per coverage year; and a maximum of 10 days per coverage year for Individual and Spouse coverage or Individual and Children coverage; or a maximum of 15 days per coverage year if Family Coverage.		1	\$41.00/day
		2	\$43.05/day
		3	\$45.10/day
		4	\$47.15/day
		5	\$49.20/day
		6+	\$51.25/day
At Home Nursing Benefit		Year	All Plans
Allstate Benefits pays the amount shown for each day a covered person requires at home nursing care during the 60 days following a hospital confinement covered under the policy. At home nursing services must be required and authorized by the attending physician. The benefit is limited to a total of 30 days within the 60 days following a covered hospital confinement.		1	\$83.00/day
		2	\$87.15/day
		3	\$91.30/day
		4	\$95.45/day
		5	\$99.60/day
		6+	\$103.75/day
Ambulance Benefit		Year	All Plans
Allstate Benefits pays the amount shown for transfer by a licensed ambulance service or hospital owned ambulance to a hospital or emergency treatment center (for air ambulance, the benefit pays 2 times the amount stated). Limited to a maximum of 3 days per covered person, per coverage year.		1	\$249.00/day
		2	\$261.45/day
		3	\$273.90/day
		4	\$286.35/day
		5	\$298.80/day
		6+	\$311.25/day
Non-Local Transportation Benefit			
Allstate Benefits pays the amount shown when a covered person requires hospital confinement for treatment prescribed by the local attending physician that cannot be obtained locally. Non-local treatment must be received beyond a 100-mile radius from the home of the covered person. Limited to 3 round trips (days) per covered person per coverage year.		1	\$249.00/day
		2	\$261.45/day
		3	\$273.90/day
		4	\$286.35/day
		5	\$298.80/day
		6	\$311.25/day

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

20 Pay

Low Plan Option

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

Medium Plan Option

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

24 Pay

Low Plan Option

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

Medium Plan Option

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

Allstate Benefits Hospital Indemnity Insurance

Policy CHCFL with SAR1FL and IHR1 Riders

For Current Participants Only

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

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

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

How Does This Benefit Help?

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

Waiver of Premium

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

What's Not Covered

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

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

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

Surgery and Anesthesia Benefit Rider

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

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

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

Optional Initial Hospitalization Rider

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

Family Coverage

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

Renewability

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

Taxable Benefits and the IRS

Please refer to Beyond Your Benefits section for further details.

Pre-existing Conditions

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

Policy Provider

Allstate Benefits is the marketing name for American Heritage Life Insurance Company (Home Office: Jacksonville, FL), a subsidiary of The Allstate Corporation. American Heritage Life Insurance Company underwrites the policy and riders. Benefits are provided by Policy CHCFL and riders IHR1 and SAR1FL. The policy and riders are not a Medicare Supplement Policy. If eligible for Medicare, review Medicare Supplement Buyer's Guide, available from Allstate Benefits.

Coverage is provided by Limited Benefit Supplemental Insurance. The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.



Allstate Benefits Group Voluntary Critical Illness Insurance

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

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

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

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

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

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

OFFERED DURING OPEN ENROLLMENT ONLY.

Policy GVCIP1

Benefit Category 1 - Group Critical Illness Coverage

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

Illness	Percentage of the Basic Benefit Amount	Maximum Total Percentage of Basic Benefit Amount for Category
Major Organ Transplant (other than heart)	100%	100%
End Stage Renal Failure	100%	100%
Paralysis (2 or more limbs, not as a result of a stroke)	100%	100%
Alzheimer's Disease	25%	25%

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

Wellness Benefit (Cancer Screenings or Heart Screenings)

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

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

Visit www.duvalschools.org/benefits to obtain the Allstate Benefits Wellness Claim form. It is located under the Forms link.

Recurrence Benefit

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

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

True Guaranteed Issue

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

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

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

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

Portability Privilege

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

Current Allstate Benefits Critical Illness Participants

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

Pre-Existing Condition Limitation

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

Exclusions and Limitations

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

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

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

Stroke: Transient ischemic attacks (TIAs) are excluded.

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

Heart Attack: A cardiac arrest is not a heart attack, and is not covered by this benefit.

Heart and/or Major Organ Transplant: Must be from a human donor.

Alzheimer's Disease: Must be diagnosed by a psychiatrist or neurologist and the insured must be unable to perform at least 2 activities of daily living. Activities of daily living are bathing, dressing, toileting, eating, and taking medication.

Maximum Benefit by Category: After 100% of the basic-benefit amount has been paid within a category, no more benefits will be paid. Once a covered person has received 100% of the basic-benefit amount in each category, coverage ends.

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

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

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

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

Policy Provider

The coverage is provided by limited benefit supplemental insurance. This material is valid as long as information remains current, but in no event later than February 1, 2019. Group Critical Illness benefits provided by policy form GVCIP1, or state variations thereof, which provides stated benefits for specified illnesses. The policy does not provide benefits for any other sickness or condition. The policy is not a Medicare Supplement Policy. This brochure highlights some features of the policy but is not the insurance contract. Only the actual policy provisions control. The policy sets forth in detail, the rights and obligations of both the policyholder (employer) and the insurance company. For complete details, including premiums, contact your Allstate Benefits Representative. This is a brief overview of the benefits available under the Group Voluntary Policy underwritten by American Heritage Life Insurance Company. Details of the insurance, including exclusions, restrictions and other provisions are included in the certificates issued.

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

The coverage does not constitute comprehensive health insurance coverage (often referred to as "major medical coverage") and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

Trustmark Critical Illness Insurance

For Current Participants Only

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

The plan provides an immediate pre-selected lump sum cash benefit upon first diagnosis¹ of a covered critical illness or cancer after the plan's effective date. Your benefit is paid in full regardless of whether you have started treatment.

Who is eligible?

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

Plan Features

- The Critical Illness Plan includes cancer coverage.
- Waiver of Premium Rider available.
- You may add the EZ Value Plan Option to this plan, which automatically increases your coverage annually on each of the first five policy anniversaries. The increase is equal to the amount of protection an additional \$1 per week of deduction would purchase.*

* Maximum issue age is 60.

Optional Health Screening Benefit

Pays the cost of one screening test per calendar year (your choice \$50 or \$100 benefit). Eligible tests include:

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

Visit www.duvalschools.org/benefits to obtain the Trustmark Critical Illness Health Screening Claim form.

Issue Ages

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

What payroll deduction premiums will I pay for this plan?

You can review your current coverage to select the benefit and premium that best fits your budget and needs. Premiums are based on age, coverage selected and tobacco use. As a Duval County Public Schools employee, you may receive a high insurance value at an affordable cost. See a Benefits Counselor for more information.

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

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

How do I make changes to my election?

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

What if I have questions about my certificate?

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

Plan Provider

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

Policy Form CACI-82001

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

Trustmark Non-Occupational Accident Insurance

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

Who is Eligible?

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

Plan Features

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

Wellness Benefit

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

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

Visit www.duvalschools.org/benefits to obtain the Trustmark Wellness Claim form. It is located under the Forms link.

Accidental Death Benefit

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

Catastrophic Accident Benefit

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

Definitions

Covered Accident

An accident causing injury, which:

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

Elimination Period

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

Injury or Injuries

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

Maximum Benefit Period

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

Non-occupational Injury

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

Waiting Period

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

Trustmark Non-Occupational Accident Insurance

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

Trustmark Non-Occupational Accident Insurance

Accident/Injury	Benefit Amount Florida
Loss of finger, toe, hand, foot or sight of an eye	
Loss of both hands, feet, sight of both eyes or any combination of two or more losses	\$40,000
Loss of one hand, foot or sight of one eye	\$20,000
Loss of two or more fingers, toes or any combination of two or more losses	\$4,000
Loss of one finger or one toe	\$2,000
Physical Therapy (per accident)	\$100 per visit, up to six visits
Prosthetic Device or Artificial Limb	
More than one	\$2,000
One	\$1,000
Skin Grafts	25% of burn benefit
Surgery	
Open, abdominal, thoracic	\$2,000
Exploratory	\$200
Tendon/Ligament/Rotator Cuff	
Repair of more than one	\$1,500
Repair of one	\$1,000
Exploratory without repair	\$200
Torn Knee Cartilage	\$1,250
Exploratory	\$250
Transportation	\$600 (100+ miles up to three trips)
Wellness Benefit Two per person annual routine physicals, immunizations and health screening tests. 60-day waiting period applies.	\$100

Exclusions

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

- During any involvement in any period of any type of armed conflict;
- While riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- While operating, learning to operate, serving as a crew member of or jumping or falling from any aircraft, including those which are not motor-driven. This does not include flying as a fare paying passenger in a scheduled or chartered flight operated by a commercial airline;
- While engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, or parakiting;

- While participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received;
- While participating or attempting to participate in an illegal activity, whether or not You are charged with a crime;
- While committing or attempting to commit suicide or injuring Yourself intentionally, whether You are sane or not;

No benefits will be payable for:

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

Plan COMPARISON CHART



Florida Retirement System

Duval County Public Schools (DCPS) provides retirement benefits for eligible employees through the Florida Retirement System (FRS). All processing of retiring DCPS employees is completed in the Employee Benefits Department. A retirement coordinator is available to meet with you and provide estimates of benefits to employees planning to retire or join the Deferred Retirement Option Program. Call 904-390-2351 for more information.

Comparing the Plans: Investment Plan and Pension Plan

For complete plan details, refer to the Summary Plan Descriptions on *MyFRS.com*.

	Investment Plan	Pension Plan
This is a ...	401(k)-type investment plan. It is designed primarily for employees who want greater control over their retirement plan and who want flexibility in how their benefit is paid at retirement.	Traditional retirement pension plan. It is designed for employees who are not comfortable with choosing investments and managing their own portfolio, and who want a guaranteed monthly retirement benefit.
You qualify for a benefit after ...	1 year of service. Once you complete 1 year of service, you own all contributions and earnings in your account. If you leave FRS employment sooner, you own your employee contributions and any earnings on your contributions.	8 years of service. Once you complete 8 years of service, you qualify for a benefit which is payable when you reach retirement age as defined by the plan. If you leave FRS employment sooner, you own your employee contributions.
Plan investment choices are made by ...	You. You are responsible for choosing investments from a diversified set of funds and for managing your account.	The State. The State is responsible for managing the Pension Plan Trust Fund.
Your benefit is ...	Based on your account balance. Your account balance is based on your and your employer's contributions, the performance of your investments, and account fees and expenses.	Based on a formula. Your benefit is guaranteed and is based on a formula using your salary, years of service, FRS membership class, and age.
When you retire, your benefit can be paid to you as ...	A lump sum, a rollover, an annuity, a customized payment schedule, or any combination of these.	Monthly payments for your lifetime. You will have options that provide continuing payments to your qualified beneficiary after your death.
Who contributes to the plan?	Both plans require you to contribute 3% of your salary, beginning with your first paycheck. You cannot change the amount you contribute. Your employer also contributes a fixed percentage of your gross salary to the plan you choose. Contribution rates are set by the Florida Legislature.	

Have Questions?

Get answers from an experienced, unbiased financial planner. There is no charge to you.

MyFRS Financial Guidance Line • 1-866-446-9377, Option 1 (TRS 711)

9:00 a.m. to 8:00 p.m. ET, Monday through Friday, except holidays.

Plan COMPARISON CHART

Additional Plan Features

	Investment Plan	Pension Plan
What happens if I work long enough to qualify for a benefit, but leave and go to work for ...	<p>... another FRS-participating employer?</p> <p>You remain enrolled and contributions will continue to be made to your account.</p> <p>... an employer that doesn't participate in the FRS?</p> <p>You will have the option of leaving your money in the plan or taking a distribution.</p>	<p>You remain enrolled and your benefit will continue to grow.</p> <p>Your benefit will be frozen until you either begin receiving monthly retirement benefits or return to an FRS-participating employer.</p>
Is there a survivor benefit if I die in the line of duty?	Yes.	Yes.
Will my benefit payments be adjusted to reflect increases in the cost of living?	Only if you purchase a fixed annuity that offers it.	No.
Would I be eligible to participate in the Deferred Retirement Option Program (DROP)?	No.	Yes, as of your normal retirement date.
Would I receive the Health Insurance Subsidy (HIS) to help me pay for health insurance in retirement?	Yes, if you satisfy the service requirements.	Yes, if you satisfy the service requirements.
Are there any benefits if I become permanently disabled?	Yes.	Yes.
<p>Once I'm enrolled in one plan, can I switch to the other?</p> <p>While you are actively working for an FRS-participating employer, <i>regardless of the plan you choose</i>, you may switch plans once by using your 2nd Election. Reemployed retirees in the Investment Plan as of July 1, 2017 or after are not eligible to use a 2nd Election.</p>	<p>Yes. If you are actively working, earning salary and service credit, you can switch from the Investment Plan to the Pension Plan. You will have to buy into the Pension Plan, using the money in your Investment Plan account. If your balance doesn't cover the cost, you will have to make up the difference out of your own pocket.</p>	<p>Yes. If you are actively working, earning salary and service credit, you can switch from the Pension Plan to the Investment Plan. You may either leave your Pension Plan benefit in place (if you have at least 8 years of service) or transfer it into the Investment Plan. Transferred amount is subject to the Pension Plan's vesting requirements.</p>

This publication is a summary of the retirement options available to new FRS-covered employees and is written in non-technical terms. It is not intended to include every program detail. Complete details can be found in Chapter 121, Florida Statutes, the rules of the State Board of Administration of Florida in Title 19, and the Department of Management Services in Title 60, Florida Administrative Code. In case of a conflict between the information in this publication and the statutes and rules, the provisions of the statutes and rules will control. Before you make an election or select any investment funds, you should review the Fund Profiles, the Investment Fund Summary, and the Annual Fee Disclosure Statement posted in the "Investment Funds" section on MyFRS.com.

RETIREMENT PLANNING

Duval County Public Schools (DCPS) provides retirement benefits for eligible employees through the Florida Retirement System (FRS). All processing of retiring DCPS employees is completed in the Employee Benefits Department.

A retirement coordinator is available to meet with you and provide estimates of benefits to employees planning to retire or join the Deferred Retirement Option Program.

Employees can call 904-390-2351 for more information.

Duval County Public Schools Authorized 403(b) and 457 Vendor Companies and Agents

AUTHORIZED 403(b) PLAN TAX SHELTERED ANNUITY COMPANIES				
Vendor	Type	Agent of Record	Contact Information	Payroll Reduction Code
American Century Investment	Mutual Funds		1-800-345-3533 www.americancentury.com/fl	3611
AXA Equitable	Annuities	Jeffery Williard 904-524-1832	904-353-5611 www.axa-equitable.com	3616
Plan Member Financial	Mutual Funds	Rich Rush	1-800-874-6910 ext.2323 www.planmemberfinancialcorporation.com	3612
Security Benefits	Annuities		1-800-888-2461 www.securitybenefits.com	3610
TIAA- CREF			1-800-842-2273 enroll.tiaa-cref.org/floridamodelplan/enrollment.asp	3617
VALIC	Annuities	Gerald M. Tyson 904-448-7200	904-448-7200 www.valic.com	3615
Voya (formerly ING Retirement)	Annuities	Ron Summers	1-904-444-8515 www.voya.com	3613
AUTHORIZED 457 – DEFERRED COMPENSATION PLAN COMPANIES				
Vendor	Type	Agent of Record	Contact Information	Payroll Reduction Code
American Century Investment	Mutual Fund		1-800-345-3533 www.americancentury.com/fl	3716
AXA Equitable	Annuities	Jeffery Williard 524-1832	904-353-5611 www.axa-equitable.com	3718
Community First Credit Union		Lisa Nevin 904-371-8110	904-371-8110 or 1-800-342-8416 www.communityfirstfl.org/personal-banking/savings/ira-457	3711
Security Benefits	Annuities		1-800-888-2461 www.securitybenefits.com	3717
TIAA- CREF			1-800-842-2888 enroll.tiaa-cref.org/floridamodelplan/enrollment.asp	3715
VALIC	Annuities	Gerald M. Tyson 904-448-7200	904-448-7200 www.valic.com	3713

Retiree Q&A

What should I do when I am ready to retire?

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

When I retire, to whom do I send payments?

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

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

I am retiring, when does my active employee insurance end?

Your benefits as an active employee end on the last day of the month in which you retire. However, for all employees who retire at the end of a school year and work through their contract period, coverage will end on August 31st of that year.

As a retiree am I eligible to continue my health and voluntary insurance?

You are eligible to continue your health, dental, vision, basic life, and some voluntary benefits once you retire. In order to continue benefits as a retiree, your retirement date must take place in a month in which you are covered under the District's benefits plan.

Once you reach age 65 and become a Medicare recipient, your healthcare benefits under the Duval County Public Schools (DCPS) benefits umbrella will end. DCPS has joined the Florida Schools Retiree Benefits Consortium (FSRBC) to provide you and your Medicare eligible dependents with access to high quality Medicare plans, tailored especially for retirees age 65 or older.

**If you have any questions,
call FBMC Service Center at
1-855-5MY-DCPS (855-569-3277).**

Important Reminder:

If you are scheduled to retire during the 2018 Plan Year, please plan and select your benefits accordingly.

FBMC Benefits Management, Inc. is the benefits administrator for the FSRBC and will be your primary point of contact for enrollment and billing for all of your DCPS retiree healthcare benefits.

Have questions about Medicare plans offered under FSRBC?

Please contact UnitedHealthcare at 1-877-776-1466.

Note: If you are enrolling in a Medicare plan, you will need to cancel your Florida Blue plan.

How do I sign up for Medicare?

You must sign up for Medicare through Social Security. If you are already receiving Social Security benefits, you will automatically get Medicare Parts A and B beginning on the first day of the month you turn 65.

If you are under 65, but have already been receiving disability benefits from Social Security for at least 24 months, you will be automatically enrolled in Medicare Parts A and B.

If you are turning 65 but not currently receiving Social Security benefits, you must sign up for Medicare Parts A and B. Contact your local Social Security office three months before you turn 65 to learn more about your enrollment options. You can also apply for Medicare Parts A and B online at: www.socialsecurity.gov/retirement.

Continue Basic Life Insurance

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

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.

Life Insurance Premiums and the IRS

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

Social Security

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

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

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

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

FBMC Privacy Notice

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

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

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

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

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

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

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

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

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

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

Notice of Administrator's Capacity

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

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

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

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

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

COBRA Q&A

Important Continuation Coverage Information

COBRA Administrator

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

What is continuation coverage?

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

How long will coverage last?

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

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

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

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

How can I extend the length of coverage?

For Group Health Plans (Except Medical Expense FSAs):

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

Disability

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

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs

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

How can I elect continuation coverage?

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

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

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) 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 those 45 days, you will lose all continuation coverage rights under the Plan.

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

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

Periodic Payments for Continuation Coverage

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

Grace Periods for Periodic Payments

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

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

Can you elect other health coverage besides continuation coverage?

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

How do I continue coverage on voluntary benefits?

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

For More Information

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

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

Keep Your Plan Informed of Address Changes

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

Paperwork Reduction Act Statement

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

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

Creditable Coverage Notice

DCPS Contributory Plan

DCPS Non-Contributory Plan

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

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

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

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

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

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

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

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

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

Creditable Coverage Notice

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

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

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

You should also know that if you drop or lose your current coverage with DCPS Medical Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. Your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, 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) 390-2351 for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through DCPS Group Medical Plan changes. You also may request a copy.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

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

Date: October 1, 2017
 Name of Entity/Sender: Duval County Public Schools
 Contact--Position/Office: Employee Benefits Department
 Address: 1701 Prudential Drive, Jacksonville Florida 32207
 Phone Number: 904-390-2351

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

Non-Creditable Coverage Notice

DCPS HIGH DEDUCTIBLE HEALTH PLAN

Important Notice from DUVAL COUNTY PUBLIC SCHOOLS About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Duval County Public Schools has determined that the Prime Therapeutics Prescription Drug coverage offered by the DCPS High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from Prime Therapeutics. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**

You can keep your current coverage from Duval County Public Schools. However, because the DCPS High Deductible Health Plan is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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

Since the coverage under DCPS High Deductible Health Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

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

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

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

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

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

Non-Creditable Coverage Notice

To learn more about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
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If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: October 1, 2017

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility.

FLORIDA – Medicaid	GEORGIA – Medicaid
Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPPP) Phone: 404-656-4507

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Employee Benefit Plan and Cafeteria Plan

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

This Notice describes the legal duties privacy practices of the group health plans sponsored by Duval County Public Schools as required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). It specifically describes how the Duval County Public Schools Employee Benefit Plan and the Duval County Public Schools Cafeteria Plan (the “Plans”) may use or disclose your protected health information to carry out treatment, payment, or health care operations, or for any other purposes permitted or required by law. You are receiving this Notice because you participate in either one or both of the Plans as an employee of Duval County School Board (the “School Board”). This Notice refers the School Board as the “Plan Sponsor.”

HIPAA protects only certain medical information known as “protected health information.” Generally, protected health information is information collected by a health care provider, health care clearinghouse or group health plan that identifies you and relates to your past, present or future physical or mental health or condition; the provision of health care to you; or the past present or future payment for health care furnished to you.

It’s important to note that HIPAA’s privacy rules apply to the Plans listed above, not the Plan Sponsors as employers—that is the way HIPAA works. The terms “we” and “our” in this Notice refer to the Plans.

If you have any questions about this Notice or the Plans’ privacy practices, please contact DCPS Employee Benefits Department at (904) 390-2351.

Our Responsibilities

The Plans are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- give you a copy of this Notice; and
- follow the terms of the Notice that is currently in effect.

This Notice and the Plans’ privacy practices may change, as allowed or required by law. If this Notice changes significantly, the Plans will provide you with a copy of the revised Notice of Privacy Practices by posting a copy of the current notice on the Plan Sponsors’ websites, www.duvalschools.org.

How the Plans are Operated

The Plans themselves do not have employees. Therefore either DCPS and/or a third party administrator administer the Plans. Currently, for example, Florida Blue administers our major medical plan. Third party administrators administer the Plans in a way similar to the way a commercial health insurance company would administer an insured health plan. We have provisions in

our contracts with the third party administrators requiring them to keep your protected health information confidential. When DCPS employees conduct plan administration functions on behalf of the Plans, they are acting as an administrator of the Plans. These Plan administrators keep your protected health information separate and do not share it with other departments of the Plan Sponsors except in very limited cases described in this Notice.

Because the Plans are all sponsored by the Plan Sponsors, they are part of an organized health care arrangement. This means the Plans may share your protected health information with each other as needed for the purposes of treatment, payment and health care operations, as described below.

How We May Use and Disclose Your Protected Medical Health Information

The law allows the Plans to use or disclose your protected health information in some cases without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category is listed. However, all of the ways we are allowed to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose protected health information to assist health care providers, such as a hospital or physician, in treating you. We do not plan to make disclosures “for treatment” purposes. However, if necessary, the Plans may make such disclosures without your authorization.

For Payment. Our third party administrators (like Florida Blue) will use your protected health information to pay claims from providers for any treatment and services provided to you that are covered by the Plans or to process payments from your health care reimbursement benefit. Payment also includes using or disclosing information to make determinations on disputed claims, to determine eligibility for benefits, and to coordinate benefits.

- For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plans will cover the treatment.

Payment also includes making decisions regarding cost sharing and responsibility for paying a claim or obtaining reimbursement, examining medical necessity, obtaining payment under stop loss insurance, and conducting utilization review.

- For example, you may have a question regarding payment of a claim. We may need to access your claim information to assist in answering questions necessary to ensure the payment of the claim.

Employee Benefit Plan and Cafeteria Plan Notice of Privacy Practices

The “we” we are talking about is our third party administrators or selected employees in the DCPS Employee Benefits Department.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plans. For example, we may use protected health information in connection with quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. We may hire third parties such as third party administrators, auditors, attorneys, and consultants to help administer the Plans. These third parties are known as Business Associates. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to Florida Blue, as a third party administrator, to administer claims or to provide support services, such as utilization management.

As Required by Law. We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To the Plan Sponsors. We may disclose protected health information to certain employees of the Plan Sponsors for purposes of administering the Plans. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. For example, we may disclose to certain School Board employees that you are enrolled in, or disenrolled from, one of the Plans. Your protected health information cannot be used for employment purposes without your specific permission.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not

every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers’ Compensation. We may release your protected health information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official

Employee Benefit Plan and Cafeteria Plan

Notice of Privacy Practices

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity,
- description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide

you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for treatment, payment or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- (2) treating such person as your personal representative could endanger you; or
- (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee.

This includes mail relating to the employee's spouse and other family members who are covered under the Plans, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plans has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing,

Employee Benefit Plan and Cafeteria Plan Notice of Privacy Practices

or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plans.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plans;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a time period of not longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You may also have the right to request a limit on your protected health information that we disclose to someone

who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request in most cases. We will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full. If we agree or must comply with your request, we will honor the restriction until you revoke it or we notify you.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of your unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our websites, www.duvalschools.org.

To obtain a paper copy of this notice contact:

Duval County Public Schools, Employee Benefits Department, 1701 Prudential Drive, Jacksonville, Florida 32207, 904-390-2351.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plans or with the Office for Civil Rights of the United States Department of Health and Human Services. You will not be penalized, or in any other way retaliated against, for filing a complaint. All complaints made to us must be in writing and sent to Duval County Public Schools, Employee Benefits Department, 1701 Prudential Drive, Jacksonville, Florida 32207, 904-390-2351.

Notice of Social Security Number Disclosure

Chapter 2007-251 Laws of Florida, requires agencies to notify individuals of the purpose(s) that require the collection of Social Security numbers. Duval County Public Schools collects Social Security numbers (SSNs) for the following purposes:

- **The Internal Revenue Service and Social Security Administration require a Social Security number on a Form W-4, that is used to determine how much federal withholding tax is to be collected and Federal Insurance Contribution Act (FICA) tax on wages paid and later reported in a W-2 Wage and Tax Statement.**
- **The Internal Revenue Service requires a Taxpayer Identification Number on Form W-9 which could be a Social Security or an Employer Identification number that could be used to generate a 1099 Miscellaneous Income Statement based on expenditures processed through accounts payable. Vendors with Social Security numbers are captured in the Vendor Application process.**
- **The SAP Human Resources/Finance software program requires use of Social Security numbers as the primary personal identification of employees for wages, leaves, payroll deductions, etc.**
- **Social Security numbers are also used as identifiers for processing fingerprints with the Federal Bureau of Investigation and the Florida Department of Law Enforcement.**
- **Social Security numbers are required by the Florida Agency for Workforce Innovation to report wages on a quarterly basis to determine unemployment taxes due to the state by Duval County Public Schools.**
- **Social Security numbers are requested by the National School Lunch Act from parents on the free or reduced price meal application and household verification process as part of determining a family's eligibility for their child(ren) for free or reduced price meals.**
- **Social Security numbers for employees, retirees and dependents are required for enrollment in health insurance, life insurance, and other miscellaneous insurances**
- **Social Security numbers are used by the Florida Department of Education as a standardized identification number for the required reporting of yearly certification and training information.**
- **Social Security numbers are required by the Florida Division of Retirement to report earnings used to document creditable years of service in the Florida Retirement System.**
- **Social Security numbers are used by the Florida Department of Education as a standardized identification number to track students from year to year and when they move from one school or county to another. Social Security numbers are used for students in grades 10 through 12 as identifiers for colleges and scholarship programs such as Bright Futures. For students in grades Pre-Kindergarten through 12, Social Security numbers are used as identifiers for enrollment and attendance, funding reports (such as FTE), tracking of achievement gains, and standardized testing such as FCAT. Student Social Security numbers are included in all Florida Department of Education required reporting.**
- **For adult students and approved GED Exit Option students taking the GED exam for graduation purposes, Social Security numbers are used by the Florida Department of Education as a standardized identification number to track students.**
- **Social Security numbers are used in the Magnet Web application.**
- **Student Social Security numbers are also used to report to the State Department of Licenses that students have passed the written test and completed the Drinking and Driving course requirement for their Restricted Driver's License.**

The Social Security numbers of all current and former employees are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator, Blue Cross Blue Shield of Florida, at 1-800-664-5295 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.

Special Enrollment Notice

Notice of Special Enrollment Rights

This Notice is being provided to ensure you understand your right to apply for the Duval County Public School District Group Health Care Plan. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining for yourself and/or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. If you notify us within 60 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth or Adoption

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, or placement for adoption.

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. During the year, you get married. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 60 days from the date of your marriage.

If you are losing coverage under Medicaid or CHIP, this is also a special enrollment right, and you must request enrollment under the DCPS Group Health Care Plan within 60 days of the date you and/or your dependents lose Medicaid or CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact: DCPS Employee Benefits Department at (904) 390-2351.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Duval County Public Schools Employee Benefits Department (904) 390-2351.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Duval County Public Schools		4. Employer Identification Number (EIN) 59-6000589	
5. Employer address 1701 Prudential Drive		6. Employer phone number (904) 390-2351	
7. City Jacksonville	8. State FL	9. ZIP code 32207	
10. Who can we contact about employee health coverage at this job? Jacqueline Watkins			
11. Phone number (if different from above) 904-390-2351		12. Email address watkinsj3@duvalschools.org	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

A full-time employee who is employed for a regular work week for the number of hours each day as established by the Board for that position or job, but not less than 30 hours a week, except for employees approved for job-sharing and food service employee who work ten (10) months/four (4) hours.

- With respect to dependents:

☐ We do offer coverage. Eligible dependents are:

☐ We do not offer coverage.

- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Glossary of Terms

Allowable Charge - This is the dollar amount typically considered payment-in-full by an insurance company. The Allowable Charge is typically a discounted rate rather than the actual charge. For example: You visit your doctor for the flu. The total charge for the visit is \$100. If the doctor is a member of your health insurance company's network of providers, he or she may be required to accept \$80 as payment in full for the visit - this is the Allowable Charge. Your health insurance company will pay all or a portion of the remaining \$80, minus any co-payment or deductible that you may owe. The remaining \$20 is considered provider write-off. But, if the doctor you visit is not a network provider then you may be held responsible for everything that your health insurance company will not pay, up to the full charge of \$100.

Benefit period - The annual cycle in which a health insurance plan operates. At the beginning of your benefit year, the health insurance company may alter plan benefits and update rates. Some benefit years follow the calendar year, renewing in January, whereas others may renew in late summer or fall.

Bi-weekly contributions - This is the amount deducted per pay period for your benefits.

Coinsurance - An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment - A set amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug.

Declination of Medical Coverage/Opt Out Program - Benefit-eligible employees may choose to opt-out of medical insurance coverage during Open Enrollment by meeting with a Benefits Counselor. Employees must provide a completed declination of Medical Coverage Affidavit and proof of other group employer coverage or proof of government-funded coverage. Employees remain eligible for all other benefits.

Deductible - The amount you must pay for health care before your insurance begins to pay.

Flex Dollars - Employees receive \$250 per year in "Flex Dollars" from DCPS to help pay for their benefits. This is funded bi-weekly in accordance with the payroll deduction schedule. Any left over Flex Dollars not used to offset pre-tax benefits will be added to your payroll check.

Formulary - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Generic drug - A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs.

Health Flexible Spending Account - This benefit lets you use pre-tax dollars to pay for eligible healthcare expenses for you, your spouse, and your eligible dependents. Money is set aside from your paycheck before taxes are taken out. Money remaining in the account cannot be returned or carried forward to the next year.

Health Savings Account - A type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses. A Health Savings Account can be used only if you have a High Deductible Health Plan (HDHP). HSA funds roll over year to year if you don't spend them and may earn interest.

High Deductible Health Plan - A type of health insurance plan that, compared to traditional health insurance plans, requires greater out-of-pocket spending, although premiums may be lower.

In-network - Doctors, hospitals, pharmacies, and other health care carriers that have agreed to provide members of a certain insurance plan a discounted price if they use an in-network carrier.

Network - The facilities, carriers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

Non-Formulary - Prescription drugs not covered by a prescription drug plan or another insurance plan offering prescription drug benefits.

Out-of-network - Healthcare rendered to a patient outside of the health insurance company's network of preferred providers. In many cases, the health insurance company will not pay for these services or pay only a portion.

Out-of-pocket costs - Health or prescription drug costs that aren't covered by insurance and must be paid for by the employee.

Out-of-Pocket Maximum - This is the most you'll have to pay during a policy period for healthcare services. Once you've reached your out-of-pocket maximum, your plan begins to pay 100% of the allowed amount for covered services.

Appeals Process Information and Deadlines

Open Enrollment Appeals

It is our goal to process your elections correctly. We need your help to make sure we do so. That is why we ask that you pay careful attention to plan details and dependent information as you enroll.

You have until the close of business on October 27, 2017, to review and confirm your benefit elections whether you enroll with an enroller or complete the enrollment yourself and make any adjustments that may be needed. You should pay close attention and confirm that you are enrolled in the correct plans and that the correct dependents, if applicable, are attached to those benefits.

After Open Enrollment has ended, Enrollment Appeals must be submitted by November 9, 2017. Appeals are granted under very narrow circumstances as provided by IRS guidance and consistent with district and insurer practices. It is important to note that failure to provide dependent verification information during enrollment, or accidentally electing or dropping a plan, adding or deleting a dependent in error are not errors that will be considered as an appeal and if submitted will be returned to you unprocessed.

If you experience one of the following types of enrollment errors FBMC/Employee Benefits staff will review and consider your request:

- Enrolling in a Dependent Flexible Spending Account and you do not have dependents who attend daycare/eldercare.
- Any extenuating circumstances related to the enrollment process that would otherwise be deemed outside of your control by the plan and the IRS.

To assure your appeal is handled promptly and with due consideration:

- Include your name, address, phone number (cell and home), email address and employee personnel number.
- Provide a detailed description of the reason for the appeal.
- Include any additional supporting documents, information or comments you think may have a bearing on your appeal.

Generally, within 30 business days, FBMC will notify you if additional information is needed and will provide the final determination. **All enrollment appeal decisions are final.**

ALL APPEALS MUST BE SUBMITTED BY THURSDAY, NOVEMBER 9, 2017

Direct Enrollment Appeals to:

Duval County Public Schools
Attn: Employee Benefits Dept. 2nd Floor
Enrollment Appeals
Jacksonville, FL 32207
Fax: 904-390-2370

FSA Appeals

To Appeal a Denied Medical FSA or Dependent Care FSA Claim

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

PayFlex
P.O. Box 981158
El Paso, TX 79998-1158

Your appeal must be received within 180 days of the date you receive notice that your claim was denied.

Note: If you had a MFSA or DFSA the prior benefits year and failed to complete an enrollment to make your election to contribute to those accounts for the 2018 benefits plan year, your appeal will not be approved.

Mid-year Plan Change Appeals

If you have an enrollment change request for a mid-plan year election change, you have the right to appeal the decision by sending a written request for a review within 30 days of the initial denial.

Your appeal must include:

- The name of your employer
- Your contact information, including an email address so that you may be contacted easily and timely
- Why you believe your request for a variance should be considered
- Any additional documents, information or comments you think may have a bearing on your appeal

Submit your appeal as follows:

Appeals involving mid-year changes must be submitted in writing and mailed to:

Duval County Public Schools
Attn: Employee Benefits Dept. 2nd Floor
Enrollment Appeals
Jacksonville, FL 32207
Fax: 904-390-2370

NOTES



Contract Administrator
FBMC Benefits Management, Inc.
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Service Center 1-855-5MY-DCPS (1-855-569-3277)
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.

www.myFBMC.com