

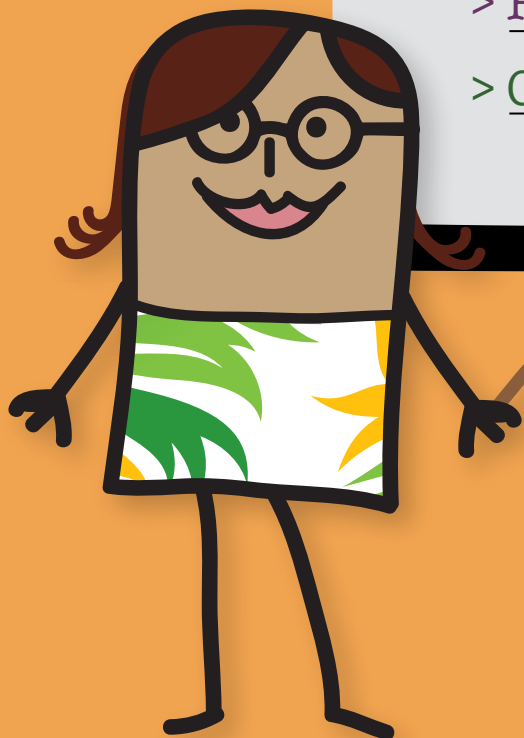


YOUR **2015** ENROLLMENT GUIDE

It's about your health and well-being.

To get started, click a link below:

- > [Full-Time](#)
- > [Part-Time B, E, F, L](#)
- > [Part-Time Food Service](#)
- > [COBRA](#)



what's inside?

You will find information about how to enroll in your benefits, and answers to all your benefits questions.

Directory

Benefits Helpline:

Enrollment Help Line

7 a.m. - 8 p.m. ET / Seven days a week
1.305.995.2777

Enrollment Website

www.dadeschools.net

Benefits Inquiry

FBMC Service Center
Mon - Fri, 7 a.m. - 8 p.m. ET
1.855.5MDC.PS4U(1.855.632.7748)

Paper Enrollment Form Assistance for Retirees • COBRA • Part-Time (B,E,F,L):

Office of Risk and Benefits Management
1501 NE 2nd Avenue, Suite 335
Mon - Fri, 8 a.m. - 4:30 p.m. ET
1.305.995.2777, www.dadeschools.net

Medicare

1.800.MEDICARE or 1.800.633.4227,
24 hours / Seven days a week
TTY: 1.877.486.2048
www.medicare.gov

Social Security Administration

1.800.772.1213
TTY: 1.800.325.0178
www.SSA.gov

Florida Retirement System (FRS)

1.800.377.7687

Florida Kidcare

1.888.540.5437
www.floridakidcare.org

FlexPlan Providers

Dental Plans

Delta Dental

Mon - Fri, 8 a.m. to 9 p.m. ET
Customer Service at 1.800.693.2589
Multilingual representatives are available.
www.deltadentalins.com/mdcps

UnitedHealthcare (UHC) Dental

Dental Member Services
Mon - Fri, 7 a.m. - 10 p.m. CDT
1.800.955.4137
www.myuhcdental.com

Vision Plans

Davis Vision

Customer Service: 1.800.999.5431
During Open Enrollment: 1.877.923.2847
Client Code: 4954
www.davisvision.com

UnitedHealthcare Vision

Customer Service
Mon - Fri, 8 a.m. - 11 p.m. ET
Sat, 9 a.m. - 6:30 p.m. ET
1.800.638.3120

Healthcare Providers

Over Age 65 (Medicare Eligible) Healthcare Plans

Cigna (Leon Medical Center)

Medicare Advantage
Customer Service
1.866.266.8917 (TTY: 711)
Seven days a week, 8 a.m. - 8 p.m.

UnitedHealthcare®

Customer Service (for all plans, including prescriptions)
1.877.776.1466, TTY 711
Seven days a week
8 a.m. - 8 p.m. ET

Enrollment materials for the Medicare Supplement Plan should be returned to:

UnitedHealthcare Enrollment Division
P.O. Box 105331
Atlanta, GA 30348-5337

Under Age 65 (Not Medicare Eligible) Healthcare Plans

Cigna Healthcare

24-hours / Seven days a week
1.800.806.3052
www.Cigna.com

Florida Retirement System (FRS)

1.800.377.7687

Directory

Legal Plans

ARAG® Legal Plan

Customer Care
Mon - Fri, 8 a.m. - 8 p.m. ET
1.800.360.5567
www.araglegalcenter.com
Access Code: 10287mds

ARAG SeniorAdvocate® Plan

Mon - Fri, 8 a.m. - 8 p.m. ET
1.800.360.5567
www.araglegalcenter.com
Access Code: 10287mds

MetLaw Legal Plan

Mon - Fri, 8 a.m. - 7 p.m. ET
1.800.821.6400
info.legalplans.com
Access Code: 8900010

MetLaw Senior Plan

Mon - Fri, 8 a.m. - 7 p.m. ET
1.800.821.6400
info.legalplans.com
Access Code: 8890010

The Short-Term & Long-Term Disability Plans

Hartford Life and Accident Insurance Company

Customer Service 1.305.995.4889
To File a Claim 1.800.741.4306
Medical Underwriting 1.800.331.7234
www.thehartfordatwork.com

Identity Theft Plan

ID Watchdog, Inc.

Customer Service
24 hours / Seven days a week
1.866.513.1518
www.idwatchdog.com

Hospital Indemnity Coverage

Life Insurance Co. of North America, a Cigna Company*

Customer Service / Claims
Mon - Fri, 7 a.m. - 8 p.m. ET
1.855.MDC.PS4U (1.855.632.7748)

Voluntary Life Insurance and Accidental Death and Dismemberment (AD&D)

MetLife Voluntary Life Claims

Customer Service
Mon - Thurs, 8 a.m. - 4:30 p.m. ET
1.305.995.7029

Claims

Mon - Thurs, 8 a.m. - 8 p.m. ET
Fri, 8 a.m. - 5 p.m. ET
1.800.638.6420, option #2

Flexible Spending Accounts (FSA)

TASC
Customer Service
1.800.422.4661
Mon - Fri, 8 a.m. - 5 p.m.
www.tasconline.com

401(k)

VISTA 401(k) Plan

P.O. Box 1878
Tallahassee, Florida 32302-1878
Customer Service
1.866.325.1278
Fax: 1.850.425.8345
IVR: 1.800.213.2310
E-mail: 401k@vista401k.com
www.vista401k.com

Other Important Phone Numbers

For general benefit and enrollment information throughout the year:

Miami-Dade County Public Schools

Office of Risk and Benefits Management
Automated Phone System
Mon - Fri, 8 a.m. - 4:30 p.m. ET
1.305.995.7129
1.305.995.7130
Fax: 1.305.995.7190

Office of Retirement/Leave/
Unemployment
1.305.995.7090

Payroll Deduction Control
Automated Phone System
Mon - Fri, 8 a.m. - 4:30 p.m. ET
1.305.995.1655
Fax: 1.305.995.1644

Life Insurance

MetLife Group Life Claims


Customer Service
Mon - Fri, 8 a.m. - 4:30 p.m. ET
1.305.995.7029

Claims

Mon - Thurs, 8 a.m. - 8 p.m. ET
Fri, 8 a.m. - 5 p.m. ET
1.800.638.6420, option #2
information throughout the year.
Fax: 1.305.995.7190

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NOTE: The product descriptions in this benefits 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 exclusion of coverage for each benefit plan are contained in the certificates of coverage.

Certificate(s) of Coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of Coverage are document(s) issued by the insurance company for benefits registered with the State of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee. To view or print a copy of a Certificate of Coverage for any benefit, log on to www.dadeschools.net. If you prefer to have a hard copy mailed to your home address, please contact the appropriate insurance company directly. Their phone numbers are listed on the M-DCPS website under "Important Phone Numbers."

Open Enrollment Frequently Asked Questions

If you do not re-enroll during this Open Enrollment period, your healthcare and your dependents' healthcare coverage, along with your disability benefits, will continue. Your flexible benefits will terminate December 31, 2014. To continue your flexible benefits, you will have to re-enroll during this Open Enrollment period.



1Q. What is the Open Enrollment Period?

A. The Open Enrollment period is a period of time, determined by your employer, during which you are allowed to make any changes to your current benefits.

2Q. When are benefits for the new plan year effective and for how long?

A. The benefits are effective January 1, 2015 through December 31, 2015.

3Q. Must I re-enroll?

A. Yes. You must enroll during this Open Enrollment period if you would like to select, add or delete your healthcare or flexible benefits to continue covering your dependents.

4Q. What changes can I make during this Open Enrollment?

A. During this period, you may purchase benefits, delete or add dependents. Any dependent child who turned 26 in the year 2014 (born in 1988) cannot be covered or be added for 2014 benefits during the open enrollment period as a regular dependent. See Page 49 for provision for adult dependents. If a covered dependent is disabled, proof must be submitted in order for coverage to continue beyond 26 years of age.

Disabled Children: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. However, if coverage is terminated, it can never again be reinstated. Proof of disability must be provided to FBMC - P.O. Box 12241 Miami, Florida 33101.

5Q. What do I need to submit to ensure that my dependents have coverage?

A. You will need to submit dependent eligibility verification before the start of this plan year. If not, your dependent may be terminated. (See the Dependent Eligibility section of this guide for the list of acceptable documents.) Additionally, you will need your dependents' Social Security number to complete the enrollment.

6Q. Can I select coverage for myself through one healthcare plan and another for my family?

A. No. You and your eligible dependents must be covered with the same healthcare plans.

7Q. Can I select coverage for myself through one Flex Plan benefit provider and another for my family?

A. No. You and your eligible dependents must be covered with the same Flex Plan benefit and provider.

8Q. How do I view the Cigna Healthcare or Flex Plan provider directories?

A. For participating providers in the Cigna plans, log-in to www.cigna.com, then click on "Find a Physician." For Flex Plan Providers, log-in to www.dadeschools.net, then click on the Provider Directory links.



Full-Time Employee Benefits Update



If you do not re-enroll during this Open Enrollment period, your healthcare and your dependent(s)' healthcare coverage, along with your disability benefits, will continue. Your flexible benefits will terminate on December 31, 2014. To continue your flexible benefits, you will have to re-enroll during this Open Enrollment period. You will need your dependent(s)' Social Security numbers to successfully enroll your dependent(s).

>> How to use your benefits guides:

We consolidated all group benefits information, including full-time and part-time employees and COBRA participants into the following three benefits guides:

Your Enrollment Guide - provides clickable access to benefits updates, dependent eligibility information, frequently asked questions pertaining to your group and other supporting documentation.

Healthcare Benefits Guide - provides clickable access to healthcare plans and Healthcare Q&A information.

Flexible Benefits Guide - provides clickable access to flexible benefits information.
Note: Applies to retirees.

To view your benefits, simply click on the active links and directional tabs located throughout the guides to easily navigate pages within each guide and seamlessly link from one guide to another.



It's Benefits Enrollment Time for Full-Time Employees!

**Your Open Enrollment dates are:
November 25, 2014, through December 10, 2014**

**Your Period of Coverage dates are:
January 1, 2015, through December 31, 2015**

About Your 2015 Plan Year Open Enrollment

This Open Enrollment is for benefits effective January 1, 2015 through December 31, 2015.

M-DCPS benefits-eligible, active employees continue to be offered a free healthcare option, access to providers of their choice and to specialists without a referral. The Cigna LocalPlus plan is the free option, and this year both OAP 10 and OAP 20 will have a cost share for employee-only coverage based on the employee benefits base salary. Also, in accordance with the Affordable Care Act (ACA), medical, Rx costs, deductibles and co-insurance will continue to be counted toward your Annual Maximum Out-of-Pocket (MOOP). Employees save more because once the MOOP has been reached; there are no other costs to pay.

Additionally, dependent premiums will continue to be subsidized by the District and employees covering a domestic partner of the same sex and legally married are able to add their eligible domestic partner on a tax-free basis with a marriage certificate.

All dependents must have a valid social security number. If you are currently covering a dependent without a valid social security number, you will need to enter a valid number during this open enrollment.



Full-Time Employee Benefits Update

2015 Open Enrollment

- Three plans will be offered for Calendar Year 2015
- The Cigna LocalPlus is comprised of a network of physicians that have demonstrated the best outcomes.
- Effective January 1, 2015 the Cigna LocalPlus Plan will be enhanced to include all Vital MD contracted physicians including obstetricians/ gynecologists, primary care physicians, and selected specialists.
- Employees are not required to select a Primary Care Physician and referrals are not needed when seeking services from a specialist.
- All UHealth physicians continue to be in Cigna LocalPlus Network. Primary medical care at UHealth Medical Center at Miami-Jackson Senior High School for all Health care plans is provided at a \$10 co-payment.

2015 Plan Year Prescription Enhancements for all three Cigna Healthcare Plans

- Opportunity for enrollment in CoachRx, providing direct access to Pharmacists, including assistance with adherence, side effects, drug to drug interaction, financial assistance, a free pill box, as well as financial assistance related to co-pay assistance program utilization and slow pay.
- Establishment of automated refill reminder for phone or e-mail.
- All temperature sensitive pharmaceuticals, including insulins which do not require a signature, will be sent overnight with the employee having the opportunity to select an alternative delivery address.
- In the event the mail ordered pharmaceutical delivery is not completely successful, the affected employee may request another delivery and/or an interim dispensing until a successful mail delivery can occur.
- Class II and III narcotics can be either shipped via home delivery or dispensed at a retail pharmacy, depending upon the wishes of the employee with the concurrence of their physician.
- Automated refill reminder program will move from opt-in to default during the course of calendar year 2015.
- Ability to utilize Cigna ID card to obtain Box Store Rx pharmaceuticals at free or low co-payment price points to obtain information for purposes of case management, gaps in care, disease management

and health coaches with eligible maintenance medications which are subject to mandatory mail away to be subject to the maximum three (3) fills at retail.

- Enhanced home delivery communication to District employees with specific telephonic prompt to facilitate delivery problems and problem solving.
- Issuance of reminder letters to employees who have eligible maintenance medications filled at a retail pharmacy that they will need to switch to mail away after three retail fills.
- Educational Session at the work locations: November 18th – November 24th
- Open Enrollment Period: November 25th- December 10th
- 2015 Open Enrollment first payroll: January 9, 2015
- Benefits Salaries will remain at the present levels, which are Benefits Salaries determined during calendar year 2011.

2015 Wellness Initiatives

In our continuous effort to increase awareness and wellness engagement, the wellness initiatives deadline has been extended until September 30th (applies only to the unions that agree to include this extension in their contracts), 2015, in order to provide all employees the opportunity of completing the following four initiatives and being eligible to enroll in any employee-only no cost healthcare option.

Benefits eligible employees enrolled in healthcare are required to complete the following:

- Register on www.mycigna.com
- Have an annual physical - preventive visit
- Have biometric screenings (blood work) performed
- Complete the Health Risk Assessment

Benefits eligible employees must complete the above requirements no later than September 30, 2015 (applies only to the unions that agree to include this extension in their contracts). **Failure to meet this deadline will result in the inability to enroll in an offered healthcare option without a cost share (free option) effective January 1, 2016.** All collected medical data will be in accordance with the Federal HIPAA Laws protecting the integrity of personal medical data.

- All employees must view their 2015 Benefits Statement via the Internet.
- Employees will be able to determine the value of their dental and vision plan by answering questions. The tool will calculate and display the anticipated cost for each plan personalizing your selection.



Full-Time Employee Benefits Update

This is a changes only enrollment for healthcare. If you do not make changes during this open enrollment period:

- Your current benefits will continue. Both plan design and premium changes will automatically be changed effective January 1, 2015 and deducted from the first 2015 Plan Year payroll, on January 9, 2015.
- If you are currently enrolled in Cigna OAP 20 Employee Only – you will automatically be charged the employee cost share, a per pay deduction determined by your benefits salary band.
- If you are currently enrolled in Cigna OAP 10 Employee Only- your current employee cost share will automatically be adjusted.
- If you are covering dependents, your dependent coverage will continue and plan design changes and premiums will automatically be adjusted.

NOTE: If you did not submit your dependent documentation in 2014, you will have to submit it after the 2015 Open Enrollment. If you do not submit your documentation, your dependents will be terminated after being provided the opportunity to submit your documentation.

Additionally, employees covering a domestic partner of the same sex could pay for their dependent premiums on a tax free basis by providing a copy of their marriage certificate.

- Changes made during this enrollment period will be effective January 1, 2015 and the changes will be reflected on the January 9, 2015 paycheck.
- If you are currently opting out of healthcare and do not elect to enroll in healthcare during this enrollment period, your current opt out selection will continue. You will have to submit your proof of other group healthcare plan or state-funded program.

New Employees:

A new employee is defined as an employee without active benefits. If you are a new employee hired during this open enrollment period, you enroll for both plan years. You will receive an email prompting you to enroll online for your benefits. You must enroll online by the due date. Otherwise, you will be automatically assigned for the remainder of the 2014 Plan Year in Cigna LocalPlus (employee-only) coverage and the Standard Short-Term Disability Plan.

However, if you do not make a change during the 2015 Open Enrollment period, you will be automatically assigned, effective January 1, 2015, to the Cigna LocalPlus Plan (employee-only).

Benefits Update

- The Board provides Cigna LocalPlus at no cost to the employee.
- Cigna OAP 20 & OAP 10 has an employee cost share determined by the employee's benefits salary band.
- Benefits salaries will remain at the present levels for one additional year which are benefits salaries determined during calendar year 2011.
- The Board will continue to subsidize a portion of your dependent's healthcare coverage.
- In accordance with the Affordable Care Act (ACA) medical, Rx costs, deductibles and co-insurance are counted toward your Annual Maximum Out-of-Pocket (MOOP). Employees save more because once the MOOP has been reached. The employee will be covered 100% and will have no other healthcare costs to pay.
- New-hire employees hired after January 1, 2015 will continue to have their healthcare coverage effective the day of hire and will start paying for the cost share if enrolling in either Cigna OAP 20 or OAP 10 on the first paycheck following the effective date of the healthcare plan.
- All benefits eligible employees are provided with Board-paid Standard Short Term Disability (STD) coverage.
- The School Board provides a Term Life and Accidental Death and Dismemberment (AD&D) program with Metropolitan Life Insurance Company for all full-time employees. The coverage amount is either one or two times your annual base salary, rounded up to the next \$1,000. Administrators and Confidential Exempt employees receive two times the annual base salary. All other employees receive one times their annual base salary. The minimum benefit for employees represented by AFSCME is \$10,000. Additional life insurance may be purchased through payroll deduction to bring maximum benefits to an additional, one times the amount provided by the School Board. You will be eligible to increase your coverage to a maximum of five times the annual base salary after the first year of participation in the optional life program. Evidence of Insurability will be required for any increases in coverage. To find out more about Board-Paid Term Life and Accidental Death and Dismemberment, contact the MetLife Representative at 1.305.995.7029.

All employees must view their 2015 benefits statement via the Internet. To make changes to your current benefits and view your benefits statement, log-in to www.dadeschools.net.

- Log-in to the Employee Portal
- Enter your login username and password
- Check on the "2015 Open Enrollment" link.



Full-Time Employee Benefits Update

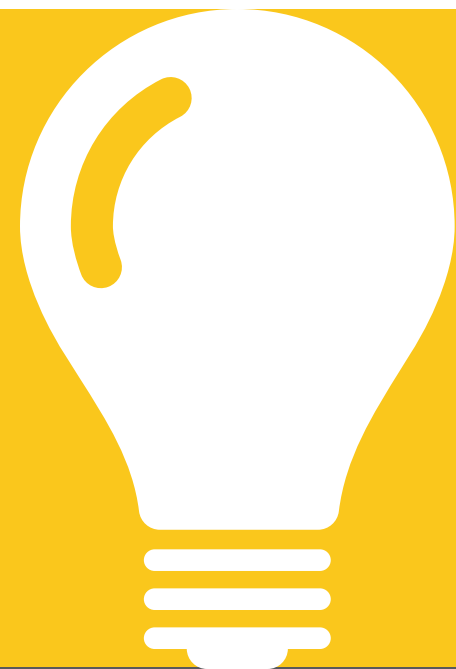
(Eligible for Board-Paid Healthcare)

Dependent Coverage

- Dependent premiums continue to be based on the employee's benefits salary.
- Benefits salaries will remain at the present levels which are the benefits salaries determined during calendar year 2011.
- M-DCPS continues to subsidize the cost of dependent premiums.
- Dependent Social Security numbers are required during this open enrollment. If your dependent's Social Security number is not provided, coverage for the dependent cannot be processed via the online enrollment. For assistance with this enrollment call FBMC Benefits Management at 1.855.MDC.PS4U (1.855.632.7748).
- Dependent documentation must be provided, eligibility requirements can be found in the Dependent Eligibility section of this guide.
- Children include: natural born, stepchildren, adopted and children for whom you have legal custody.
- Unmarried children are eligible from birth until the end of the year in which the child reaches age 26, if the child is: 1) dependent on the employee for support, 2) lives in the employee household; or 3) is enrolled full-time or part-time in a accredited school, college or university.
- If currently covering an adult child, you do not need to re-enroll your dependent. Your adult child coverage will automatically continue, premium and plan design changes will be applied. However, you must re-submit your adult child dependent documentation. If not, your adult child coverage will be terminated.
- Children of the Domestic Partner are eligible to be cover if the Domestic Partner is also included in the coverage.
- According to IRS (Internal Revenue Services) Section 125 Regulations, all deductions for employee-paid benefits for domestic partner coverage must be taken on a post-tax basis. Additionally, the employee must pay the tax liability on the monthly subsidy that the Board pays on behalf of the employee for any Domestic Partner coverage.
- Therefore, the value of these benefits will be added to the employee taxable income and the W-2 will be adjusted to reflect the higher income level annually.
- Taxation for the monthly Board-paid dependent subsidy contributed on the employee's behalf for domestic partner coverage, will occur on the last pay statement of each month.
- Employees covering a domestic partner and children of the domestic partner will continue to be taxed on the full, Board-paid dependent subsidy. Employees covering their own children, a domestic partner and children of a domestic partner will also be taxed on the entire Board-paid dependent subsidy.
- Employees covering a domestic partner of the same sex and legally married are able to add their eligible domestic partner on a tax free basis with the proper dependent documentation.

AFSCME - Flex Credit

Employees represented by the AFSCME Union and enrolled in healthcare will continue to receive an annual flex credit. This annual flex credit of \$230 can be used to offset the cost of your flexible benefits.



>> Domestic
Partner
Eligibility
Update:

**Employees covering
a domestic partner
of the same sex and
legally married are able
to add their eligible
domestic partner on
a tax free basis with
proper documentation
(marriage certificate)!**



Full-Time Employee Frequently Asked Questions



Full-Time Employee: A full-time employee is defined as an employee with active benefits.

1Q. What is the Open Enrollment Period?

A. The Open Enrollment Period is a period of time, determined by your employer, during which you are allowed to make any changes to your current benefits.

Notice: No changes are allowed after the commencement of a new plan year (see the Change in Status section for exceptions).

2Q. Must all eligible employees enroll for benefits effective January 1, 2015?

A. Yes. You must enroll during this Open Enrollment period if you would like to select your healthcare or flexible benefits, or add, delete or continue covering your dependents.

3Q. What happens if I do not re-enroll by the enrollment deadline?

A. Note the following:

- Your current healthcare coverage will continue.
- Your dependent(s)' healthcare coverage will continue.
- Your disability benefit will continue.
- Yours and your dependent(s)' flexible benefits will terminate December 31, 2014.
- If you are currently opting out of healthcare, this election will continue and you will have to submit proof of other group or state-funded healthcare coverage.
- If you are currently enrolled in Cigna OAP 10, your current deductions will automatically be adjusted.

4Q. How will I know when I can enroll?

A. You will be permitted to enroll during your Bargaining Unit's open enrollment period. You will receive an email specifying your Bargaining Unit's enrollment dates.

5Q. When is the last day to make changes for benefits effective January 1, 2015?

A. If making changes, you must complete your online enrollment selections by 10 p.m. on December 10, 2014.

6Q. When is the online enrollment application available?

A. The application is available during the Open Enrollment period from 7 a.m. – 10 p.m.

7Q. What if I do not have a computer or Internet access available?

A. During the open enrollment period: if you do not have an access to the Internet, you may visit an Open Enrollment Representative for assistance at iTech@Thomas A. Edison Educational Center, 6101 N.W. 2nd Avenue Miami, Florida 33120.

Additionally, representatives will be at selected work locations through the District to assist you with your enrollment.

After the enrollment period: you may visit the Office of Risk and Benefits Management at P.O. Box 12241 Miami, Florida 33101.



Full-Time Employee Frequently Asked Questions

8Q. What if I enroll and I want to change my benefits selection?

A. You may log on to the Internet and change your benefits selection as many times as you want throughout the open enrollment period. Your last saved and submitted selections will be your benefits, effective January 1, 2015. Changes made during the open enrollment period of November 25, 2014 - December 10, 2014 will be effective, January 1, 2015. For full-time employees, the first deductions will be taken on the payroll January 9, 2015.

9Q. What changes can I make during the Open Enrollment?

A. During this period, you may purchase benefits, delete or add dependent. Any dependent child who turned 26 in the year 2014 (born 1988) cannot be covered or added for 2015 as a regular dependent. See the Dependent Eligibility section for provision for adult dependents (age 26-30). If a covered dependent is disabled, proof must be submitted in order for coverage to continue beyond 26 years of age.

Disabled: coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. However, if coverage is terminated, it can never again be reinstated. Proof of disability must be provided to FBMC - P.O. Box 12241, Miami, Florida 33101.

10Q. Can I select coverage for myself through one healthcare plan and another for my family?

A. No. You and your eligible dependents must be covered with the same healthcare plan.

11Q. Can I select coverage for myself through one FlexPlan benefit provider and another for my family?

A. No. You and your eligible dependents must be covered with the same FlexPlan benefits and provider.

12Q. Can I decline healthcare?

A. Yes. You may decline healthcare coverage. You must provide proof of other group or state-funded program coverage. Enrollment in an individual healthcare plan coverage does not qualify. Additionally, you must agree to the provision set forth in the affidavit. Refer to the Dependent Eligibility section of this guide.

13Q. If I decline healthcare coverage, what happens to the Board contribution toward my healthcare coverage?

A. In lieu of healthcare coverage, you will receive \$100 per month paid on a bi-weekly through the payroll system, based on our deduction pay schedule (subject to withholding and FICA) as follows:

- 10-month employees will receive their payment in 20 pay checks
- 11-month employees will receive their payment in 24 pay checks
- 12-month employees will receive their payment in 26 pay checks

If you do not provide proof of other group healthcare coverage, you will be automatically assigned to the Cigna LocalPlus (employee only) healthcare plan and standard Short Term Disability.

If electing during this open enrollment, to decline healthcare coverage you are required to submit proof of enrollment in other group or state-funded program, even if previously submitted.



Full-Time Employee Frequently Asked Questions

14Q. Will I be able to view and print a confirmation of my 2015 benefits selection?

A. Yes. Everyone is able to view and print their Benefits confirmation Statement online, immediately after benefits selections are successfully saved. A benefits notice is automatically generated and presented at the end of your enrollment sessions.

Additionally, you can view your 2015 Benefits Confirmation Statement and verify you are enrolling in the benefits you need for the next year. The 2015 Benefits Confirmation Statement will reflect the new rates for 2015.

15Q. What do I need to submit to ensure that my dependents have coverage?

A. If not submitted in 2014, you will need to submit dependent eligibility verification before the start of the 2015 Plan Year. If not, your dependent may be terminated. (See the Dependent Eligibility section of this guide for the list of acceptable documents.)

16Q. If I take a Board-approved leave of absence, whom do I contact about my benefits?

A. Once your leave is approved and the Office of Risk and Benefits Management receive notification, you will be eligible for applicable benefits according to your Bargaining Unit and type of leave. You will be billed for employer-paid benefits in accordance to the type of leave and labor contract. Additionally, you will be billed for all employee-paid benefits.

Miami-Dade County Public schools implement the Family and Medical Leave Act of 1993(FMLA) through provisions contained in the School Board Rules and collective bargaining agreements.

For questions regarding your benefits while on leave, please call 1.305.995.7129 and ask to speak with a Leave Billing Specialist.

17Q. What happens to my benefits if I terminate employment?

A. Should employment terminate, coverage will cease at the end of the calendar month in which employment terminates. Benefits will remain in effect through August 31st for 10-month employees who terminate employment during the last month of the school year.

Note: An individual who loses coverage under the plan becomes entitled to elect COBRA. The individual has the right to continue his or her medical, dental and vision coverage under COBRA law for a period of 18 months and/or Medical Expense FSA deposits until the end of the plan year following termination of employment. The individual must notify the COBRA specialist at the Office of Risk and Benefits Management.

18Q. If I am hired during this Open Enrollment period, must I enroll for the current plan year as well as the next plan year?

A. For Plan Year 2014, you will be automatically assigned to Cigna LocalPlus Plan (employee only). However, you must enroll during this Open Enrollment period for benefits effective January 1, 2015.

19Q. If I take a board-approved leave of absence, whom do I contact about my insurance?

A. Once your leave is approved and the Office of Risk and Benefits Management receives notification, you will be eligible for applicable benefits according to your Bargaining Unit and type of leave. You will be billed for employer-paid benefits in accordance to the type of leave and labor contract. Additionally, you will be billed for employee-paid benefits.

Miami-Dade County Public Schools implements the Family and Medical Leave Act of 1993 (FMLA) through provisions contained in the School Board Rules and collective bargaining agreement.

For questions regarding your benefits while on leave, please call 1.305.995.7129 and ask to speak with a leave billing specialist.



Full-Time Employee Frequently Asked Questions

20Q. Is there a free healthcare option being offered?

A. Yes. The Cigna LocalPlus Plan is being offered at no cost to all benefits eligible employees.

21Q. Will OAP 10 and OAP 20 continue to be offered at a cost to the employee for employee-only coverage?

A. Yes. OAP 10 and OAP 20 will continue to be offered with an employee cost share, based on the employee's benefits salary.

22Q. If enrolling in the Cigna LocalPlus, will I be required to select a Primary Care Physician?

A. No. You are not required to select a Primary Care Physician. However, we encourage all covered members to establish a relationship with a physician. If you do not have a physician, choose a participating in-network physician and schedule your appointment in 2015.

23Q. How do I view the Cigna Healthcare or FlexPlan provider directories?

A. To view the participating provider in the Cigna Plan: log-in to www.cigna.com and click on "Find a Provider".

To view the participating providers in the FlexPlan benefits: log-in to www.dadeschools.net, click on "Employee Benefits" and then on Flex Plan providers.

Confirmation of Benefits

24Q. Will I be able to view and print a confirmation of my 2015 benefits selection?

A. Yes. Everyone is able to view and print their Benefits Confirmation Statement online, immediately after benefit selections are saved successfully.

A benefits notice is automatically generated and presented at the end of your enrollment session.

Additionally, you can view your Benefits Confirmation Statement and verify you are enrolled in the benefits you need for the next year. The Benefits Statement will reflect the new rates for 2015.

Reminder! Be sure to turn off your online "pop-up blocker."

Effective Date of Coverage

25Q. When are benefits for the new plan year effective and for how long?

A. This enrollment is for benefits, effective January 1, 2015, through December 31, 2015. Changes made during the open enrollment period of November 25, 2014 through December 10, 2014, become effective January 1, 2015 and will continue through December 31, 2015 as long as your full-time employment continues.



Full-Time Employee Frequently Asked Questions



>> Important Beneficiary Notes:

- **Be sure to review your beneficiary designation during Open Enrollment.**
- **Update your beneficiary info when changes happen to ensure your distributions are appropriately designated.**

Termination Date

Should employment terminate, coverage will cease at the end of the calendar month in which employment terminates. Benefits will remain in effect through August 31, for 10-month employees who terminate employment during the last month of the school year.

NOTE: An individual who loses coverage under the plan becomes entitled to elect COBRA. The individual has the right to continue his or her medical, dental and vision coverage under COBRA law for a period of 18 months and/or Medical Expense FSA deposits until the end of the plan year following termination of employment. The individual must notify the COBRA Specialist at the Office of Risk and Benefits Management.



New Full-Time Employee Frequently Asked Questions

What's a New Employee? A new employee is defined as an employee without active benefits. If you are a new employee hired during this open enrollment period, you must enroll for both plan years.



Open Enrollment Facts For New Employees

1Q. Must all new employees enroll?

A. Yes. You must complete your enrollment by logging in to www.dadeschools.net. As a new employee, you will receive an e-mail prompting you to enroll online for your benefits. You must enroll online by the due date. Otherwise, you will be automatically assigned to Cigna LocalPlus Plan (employee-only) coverage and the Short-Term Disability plan. Additionally, if you want to make a change for 2015, you must enroll by Dec. 10, 2014 for the remainder of the 2014 calendar year.

2Q. What is the deadline for completing my online enrollment?

A. Your initial enrollment period is 30 calendar days from the date of hire. Enrolling in this time frame will ensure that you receive the benefits of your choice.

3Q. Can I elect not to be covered?

A. In lieu of healthcare coverage, you will receive \$100 per month paid bi-weekly through the payroll system based on your deduction pay schedule (subject to withholding and FICA) as follows:

- 10-month employees will receive their payment in 20 pay checks.
- 11-month employees will receive their payment in 24 pay checks.
- 12-month employees will receive their payment in 26 pay checks.

If you do not provide proof of other group healthcare coverage, you will be automatically assigned the Cigna Local Plus (employee-only) healthcare plan and standard Short-Term Disability coverage.

If electing to decline healthcare coverage during this open enrollment, you are required to submit proof of enrollment in another group or state-funded program, even if previously submitted.

4Q. What if I do not enroll?

A. If you do not complete your enrollment in the allotted time:

- You will automatically be assigned to Cigna LocalPlus (employee-only) healthcare plan and no dependent healthcare coverage.
- You will automatically receive Standard Short-Term Disability coverage and Life Insurance at one times your annual base salary (amount is decided per your Bargaining Contract).
- You will not have any flexible benefits (i.e. dental, legal, etc.) and no dependent coverage.
- These benefits will be effective for the remainder of this plan year, as long as your full-time employment with Miami-Dade County Public Schools continues.

5Q. What if I do not have a computer or Internet access available?

A. If you do not have access to the Internet, you may visit the Office of Risk and Benefits Management for assistance at 1501 NE 2nd Avenue, Suite 335, weekdays from 8 a.m. to 4:30 p.m. ET.

6Q. What if after I enroll I want to change my benefits selection?

A. You may change your benefits selection as many times as you wish until the end of your initial enrollment period.

7Q. Can I select coverage for myself through one healthcare plan benefit and another for my family?

A. No. You and your eligible dependents must be covered with the same Healthcare plans.



New Full-Time Employee Frequently Asked Questions



>> Important Beneficiary Notes:

- **Be sure to review your beneficiary designation during Open Enrollment.**
- **Update your beneficiary info when changes happen to ensure your distributions are appropriately designated.**

8Q. Can I select coverage for myself through one FlexPlan benefit provider and another for my family?

A. No. You and your eligible dependents must be covered with the same FlexPlan benefit and providers.

9Q. How do I view the Cigna or FlexPlan Provider Directories?

A. Go to the www.dadeschools.net Employee Link button, then click on the Provider Directory of the company you desire.

Confirmation of Enrollment

10Q. If electing dependent coverage or employee-paid benefits, when will my first deduction be taken and what's the effective date on these benefits?

A. The first deduction for benefits will be taken on the last paycheck of the month in which you enroll and your benefits are processed. The effective date is the first of the following month after that first deduction is taken.



New Employee (hired after 1/1/15) Frequently Asked Questions

Get answers to frequently-asked new employee questions.



1Q. What is my deadline to enroll in benefits?

A. Your initial enrollment period is 30 calendar days from the date of hire. Enrolling in this time frame will ensure that you receive the benefits of your choice.

2Q. Can I elect not to enroll?

A. In lieu of healthcare coverage, you will receive \$100 per month paid bi-weekly through the payroll system based on your deduction pay schedule (subject to withholding and FICA) as follows:

- 10-month employees will receive their payment in 20 pay checks.
- 11-month employees will receive their payment in 24 pay checks.
- 12-month employees will receive their payment in 26 pay checks.

If you do not provide proof of other group healthcare coverage, you will be automatically assigned to Cigna LocalPlus (employee-only) healthcare plan and standard Short-Term Disability coverage.

If electing to decline healthcare coverage during this open enrollment, you are required to submit proof of enrollment in another group or state-funded program, even if previously submitted.

3Q. What if I do not enroll?

A. If you do not complete your enrollment in the allotted time:

- You will automatically be assigned to Cigna LocalPlus Plan healthcare plan and no dependent healthcare coverage.
- You will automatically receive Standard Short-Term Disability coverage and Life Insurance at one times your annual base salary (amount is decided per your Bargaining Contract).
- You will not have any flexible benefits (i.e. dental, legal, etc.) and no dependent coverage.
- These benefits will be effective for the remainder of this plan year, as long as you are a full-time employee.

4Q. What if I do not have a computer or Internet access available?

A. If you do not have access to the Internet, you may visit the Office of Risk and Benefits Management for assistance at 1501 NE 2nd Avenue, Suite 335, weekdays from 8 a.m. to 4:30 p.m. ET.

5Q. What if after I enroll I want to change my benefits selection?

A. You may change your benefits selection as many times as you wish until the end of your initial enrollment period.

6Q. Can I select coverage for myself through one healthcare plan benefit and another for my family?

A. No. You and your eligible dependents must be covered with the same Healthcare plans.

7Q. Can I select coverage for myself through one FlexPlan benefit provider and another for my family?

A. No. You and your eligible dependents must be covered with the same FlexPlan benefit and providers.

8Q. How do I view the Cigna or FlexPlan Provider Directories?

A. Go to the www.dadeschools.net Employee Link button, then click on the Provider Directory of the company you desire.



New Employee (hired after 1/1/15) Frequently Asked Questions

9Q. If electing dependent coverage or employee-paid benefits, when will my first deduction be taken and what's the effective date on these benefits?

A. The first deduction for benefits will be taken on the last paycheck of the month in which you enroll and your benefits are processed. The effective date is the first of the following month after that first deduction is taken.

10Q. What if I am unable to pay premiums while on leave?

A. The benefits for which you have been billed will be cancelled, if payment is not received by the due date. Any claims incurred will not be paid, unless otherwise provided by law. If you return to work and your coverage is still active, owed premiums will automatically be taken from your paychecks.

Cancelled employer-paid benefits will be automatically reinstated upon your return to work. However, in order to reinstate any employee-paid benefits cancelled, due to non-payment while on leave, you must request a Change in Status Election form. See the Changes in Status event information on Page 52 for further details.

11Q. If I retire, whom do I contact for benefits information?

A. When you complete your retirement papers, the Retirement Office will notify the Office of Risk and Benefits Management and a package, containing the information you need to continue your healthcare coverage, life insurance benefits and flexible benefits plans after you retire will be mailed to your home.

You will have 30 days from the date of notification to select your benefits. Only those dependents who were covered under your medical and flexible benefits plan, at the time of your retirement, will be eligible to continue coverage. You may add or drop dependents during the annual Open Enrollment for retirees. You may only continue life insurance and accidental death and dismemberment at the same level in effect at your retirement. If you retire while on a leave of absence and have no active healthcare and/or flexible benefits at retirement, you will not be eligible to enroll in any benefits not in effect. If you retired and had declined healthcare coverage, you will not be eligible to enroll as a retiree in healthcare coverage, even if you are Medicare eligible. You may contact the Office of Risk and Benefits Management at 1.305.995.7129 for questions.

12Q. Can I continue my own and my dependents' medical, dental and vision coverage if I terminate employment?

A. Yes. According to federal and state law, you can continue your own and/or your dependents' coverage for currently enrolled medical, dental and/or vision for a period of 18 months following a termination of employment by applying for COBRA. You will be notified of these rights when you terminate. You may also call the Office of Risk and Benefits Management at 1.305.995.7169, 1.305.995.1285 or 1.305.995.1738 and speak to a COBRA Representative to inquire further on what benefits will be available to you.

13Q. Can I continue my Board Life insurance if I terminate?

A. You may apply for a conversion policy for all or any portion of your or your dependents' life insurance in effect at termination. You must complete a conversion application, which is available from Metropolitan Life Insurance Company by calling 305.995.7029 within 31 days of termination.

14Q. What happens to my FSA contributions if I terminate employment or retire?

A. If you terminate employment or retire, your FSA contributions will stop with the pay period preceding your last day of employment. Use of your Payment Card will be suspended. You cannot continue to submit expenses incurred after your benefits end date for reimbursement from your Medical Expense FSA, unless you continue to make post-tax contributions to your account through COBRA. Eligible Dependent Care FSA expenses incurred after termination of employment are reimbursable until funds in your account are exhausted.

~~Remember, you have until April 15, 2014 (DATE PENDING due to Affordable Care Act effective date (October 31, 2014)), to submit a request for reimbursement for expenses incurred before your benefits end date. See the Flexible Spending Accounts section of the Flexible Benefits Guide for more details.~~



New Employee (hired after 1/1/15) Frequently Asked Questions

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. 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.

However, the tax savings realized through the Flexible Benefits plan generally outweigh the Social Security reduction. Call the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748) for an approximation.

Itemized Deductions

The portion of your salary set aside for benefit premiums and FSAs through the FlexPlan will not be included in the taxable salary reported to the IRS on your W-2 form. However, your contributions to your Dependent Care FSA will appear on your W-2 form for informational purposes only. You will not have to claim these payments as deductions at the end of the year. Your pre-tax FlexPlan reductions cannot be used as itemized deductions for income tax purposes at the end of the year.

Pre-tax/Post-tax

Employees who wish to have their 2015 premiums deducted POST-TAX may do so by indicating so during their enrollment. If a selection is not made, applicable deductions and employer contributions will continue on a pre-tax basis. Regardless of your selection, Flexible Spending Accounts are always PRE-TAX. Your Legal Plan, SeniorAdvocate Plan, and Long-Term Disability (LTD) are always POST-TAX.

When an employee elects pre-tax deductions, all employee-paid premiums will be taken prior to federal withholding tax. All benefits are subject to pre-tax deductions except those that are not exempt from taxation — Legal Coverage, LTD and the SeniorAdvocate Program. When an employee elects post-tax deductions, all employee-paid premiums will be taken after federal withholding tax has been taken. All benefits are subject to post-tax deductions except those that are exempt from taxation.

If you elect to upgrade your Board-Paid Standard Short-Term Disability plan, your premiums will be deducted on a PRE-TAX basis and you will receive a W-2 form for the calendar year in which benefits were paid. However, if your premiums were paid on a POST-TAX basis, benefits paid to you will not be taxed. The premiums paid by the School Board for the Standard Short-Term Disability plan will be on a PRE-TAX basis.

A Domestic Partner and the child(ren) of a Domestic partner are eligible. According to IRS (Internal Revenue Service) Section 125 Regulations, all deductions for employee-paid benefits for domestic partner coverage must be taken on a post-tax basis. Additionally, employees must pay the tax liability on the monthly contribution (subsidy) the Board pays on the employee's behalf for any type of Domestic Partner coverage. Therefore, the value of these benefits will be added to your taxable income and your W-2 will be adjusted to reflect the higher income level annually.

****Please see each product page for specific dependent eligibility information.** Eligibility for healthcare, dental, and vision will be verified by the contract administrator, FBMC Benefits Management. For a list of required documentation, see the Dependent Eligibility section. If proof is not submitted by December 31, 2014, the dependent coverage will be terminated and claims will not be paid. If dependent coverage is terminated and premiums were deducted, refunds will not be automatically issued. To request a refund, if applicable, contact Payroll Deduction Control at 1. 305.995.1655. All other benefits will be verified by the individual insurance company at the time a claim is filed. Please refer to the Dependent Eligibility section of this guide for required documentation.



Part-Time (B,E,F,L) Employee Benefits Update

(Ineligible for Board-Paid Benefits)



Open Enrollment for 2015 Employee Benefits will be held from November 25, 2014 through December 10, 2014. If you do not enroll during this open enrollment period, your current healthcare coverage will continue. We will automatically adjust the benefits changes and premiums; you will receive a bill in January reflecting the 2015 rates. Additionally, your current flexible benefits will terminate December 31, 2014; you must re-enroll to have benefits in plan year 2015.

>> How to use your benefits guides:

We consolidated all group benefits information, including full and part-time employees and COBRA participants into the following three benefits guides:

Your Enrollment Guide - provides clickable access to benefits updates, dependent eligibility information, frequently asked questions pertaining to your group and other supporting documentation.

Healthcare Benefits Guide - provides clickable access to healthcare plans and Healthcare Q&A information.

Flexible Benefits Guide - provides clickable access to FlexPlan benefits information.

To view your benefits, simply click on the active links and directional tabs located throughout the guides to easily navigate pages within each guide and seamlessly link from one guide to another.



It's Benefits Time for Part-Time (B,E,F,L) Employees!

Your Open Enrollment dates are:
November 25, 2014, through December 10, 2014

Your Period of Coverage dates are:
January 1, 2015, through December 31, 2015

Healthcare Benefits

You may select from two Cigna healthcare plans. Dependents must be covered under the same plan as the employee. The healthcare plans are:

- Cigna Open Access Plus (OAP) 20
- Cigna Open Access Plus (OAP) 10
- Cigna LocalPlus Plan

To enroll in a Cigna plan, effective January 1, 2015, you must request an enrollment form. If you are adding dependents, you must include your dependent's Social Security number on the form and submit dependent eligibility documentation (i.e. marriage certificate for a spouse and birth certificate for a child, etc.). Mail your completed form, with your first month premium, payable to The School Board of Miami-Dade County, Florida to:

Miami-Dade County Public Schools
P.O. Box 12241
Miami, Florida 33101

To obtain a healthcare benefits enrollment form, contact Miami-Dade County Public Schools:

- 1.305.995.2883, Monday - Friday, 8 a.m. - 4:30 p.m. ET

NOTE: There is no Board contribution toward the employee's or dependent(s) coverage. Part-Time employees are responsible for the full, monthly cost of the Board-approved healthcare plans.



Part-Time (B,E,F,L) Employee Benefits Update

(Ineligible for Board-Paid Benefits)

Flexible Benefits

To enroll in any of the flexible benefits, effective January 1, 2015, you must request a flexible benefits enrollment form. Mail your completed enrollment form ,with your first month premium, payable to FBMC Benefits Management, Inc. to:

FBMC Benefits Management, Inc.
P.O. Box 12241
Miami, Florida 33101

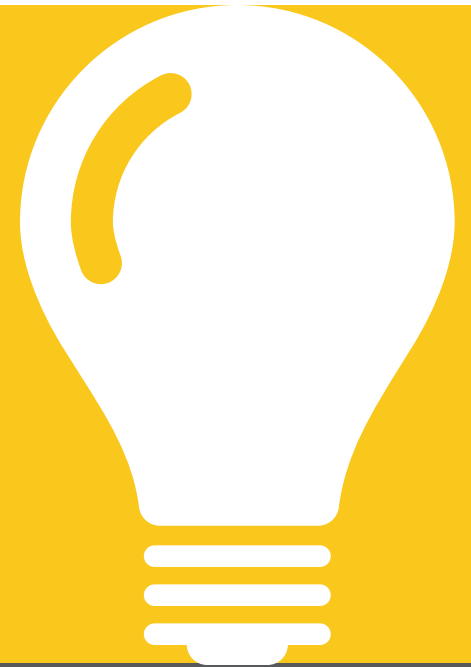
To obtain a flexible benefits enrollment form, contact FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday - Friday, 7 a.m. - 8 p.m. ET.

To learn more about the healthcare and /or flexible benefits, you may log-in to www.dadeschools.net. Under "Highlights," click on the Benefits Guides.

NOTE: If you choose not to enroll in one of the disability plans (Short-Term Disability or Long-Term Disability) at this time, future enrollments will require that you complete Evidence of Insurability (EOI) before you are considered for coverage.

Dependent Coverage for 2015

- Dependent Social Security numbers are required during open enrollment. If your dependent's Social Security number is not provided, coverage for the dependent cannot be processed. For additional information, call 1.855.MDC.PS4U (1.855.632.7748).
- Documentation of your dependent's eligibility must be provided. Eligibility documentation requirements can be found in the Dependent Eligibility section of this guide.
- Children may include: natural-born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Your unmarried children are eligible from birth until the end of the year in which the child reaches age 26, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university. See also Adult Child section of this guide.
- Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.



>> Benefits Eligibility Note:

Part-Time (B,E,F,L) employees and qualifying dependents are eligible to enroll in:

- **Healthcare Plans**
- **Flexible Benefits**
- **Voluntary Benefits**



Part-Time (B,E,F,L) Employee Benefits Update



Get answers to commonly-asked Part-Time (B,E,F,L) employee questions!

1Q. Do I need to enroll?

A. If you do not re-enroll during this enrollment period your current healthcare will continue but your flexible benefits will terminate December 31, 2014. Therefore, to continue your participation in the flexible benefits, you must re-enroll in them during this enrollment period.

2Q. What is this Open Enrollment Period?

A. This is the period of time determined by your employer, during which you are allowed to make any changes to your current benefits.

3Q. What changes can I make during this enrollment period?

A. You could change your current medical plan, add an eligible dependent or delete a currently covered dependent.

4Q. How do I enroll?

A. This year your open enrollment will take place on paper. You must request, complete and return the form by December 10, 2014.

5Q. Can I enroll in Accidental Death & Dismemberment Coverage?

A. Yes, except if you are represented by the AFSCME labor unit. AFSCME employees CANNOT enroll in this benefit. You must request, complete and return the form by December 10, 2014.

To obtain a healthcare benefits enrollment package, contact Miami-Dade County Public Schools:

- 1.305.995.2883, Monday - Friday, 8 a.m. - 4:30 p.m. ET

To obtain a flexible benefits enrollment form, contact FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748) , Monday - Friday, 7 a.m. - 8 p.m. ET.

Healthcare

You may select to receive coverage through Cigna. Dependents must be covered under the same plan as the employee. You must include your dependent's Social Security Number on the enrollment form. The healthcare plans are:

- Cigna Open Access Plus (OAP) 20
- Cigna Open Access Plus (OAP) 10
- Cigna LocalPlus

To obtain a healthcare benefits enrollment package, contact Miami-Dade County Public Schools:

- 1.305.995.2883, Monday - Friday, 8 a.m. - 4:30 p.m. ET

NOTE: There is not Board contribution towards the employee's nor dependent's coverage. Part-Time employees are responsible for the full, monthly cost of the Board-approved healthcare plan.

Flexible Benefits

To enroll in any of the flexible benefits, effective January 1, 2015, you must request a flexible benefits enrollment form. Mail your completed enrollment form, with your first month premium, payable to FBMC to:

FBMC Benefits Management, Inc.
P.O. Box 12241
Miami, Florida 33101

To obtain a flexible benefits enrollment form, contact FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748) , Monday - Friday, 7 a.m. - 8 p.m. ET.



AFSCME Part-Time Food Service Employee Benefits Update (Eligible for Healthcare)

Your enrollment is pending union ratification and you will be informed of when your enrollment starts.



It's Benefits Time for AFSCME Part-Time Food Service Employees!

~~Your Open Enrollment dates are:
November 25, 2014, through December 10, 2014~~

**Your Period of Coverage dates are:
January 1, 2015, through December 31, 2015**

About Your 2015 Healthcare Benefits

The diligent efforts of the Superintendent of Schools and School Board Members, in conjunction with your employee union, have resulted in a plan that continues to offer you quality coverage and direct access to hospitals and specialist.

This Open Enrollment is for benefits effective January 1, 2015 through December 31, 2015. All benefits eligible employees represented by the AFSCME bargaining union will remain enrolled in the Cigna OAP 20 healthcare plan for the 2014 plan year. This plan has a cost share, a per pay deduction amount determined by the employees benefit salary band. In addition, employees represented by the AFSCME union and enrolled in the Cigna OAP 20 healthcare plan will receive an increased annual flex credit in the amount of \$340. The flex credit is to be used to offset the employees' healthcare cost, flexible benefits such as Dental, Vision, Legal, Term Life, Long Term Disability, ID Watchdog Identity Theft and Hospital Indemnity Insurance or receive in cash on a payroll basis.

This is a changes only enrollment. Any changes made to your benefits during this enrollment period will be retroactive to January 1, 2015 and premium adjustments (arrearages/refunds) will be required. **Note: Any benefits used prior to the open enrollment period and terminated during open enrollment will be retroactive to January 1, 2015 therefore, if claims have been incurred, the employee will be responsible for all claims.** During this open enrollment, all AFSCME employees must select a Primary Care Physician (PCP) for the Cigna OAP 20 plan. This selection is for informational purposes only, not a restriction on the plan usage. This requires all AFSCME employees to log into the enrollment application and select a PCP of their choice for their healthcare plan. In addition, employees are encouraged to complete an annual physical or biometrics screenings no later than December 31, 2015.

>> How to use your benefits guides:

We consolidated all group benefits information, including full and part-time employees, COBRA participants and retirees into the following three benefits guides:

Your Enrollment Guide - provides clickable access to benefits updates, dependent eligibility information, frequently asked questions pertaining to your group and other supporting documentation.

Healthcare Benefits Guide - provides clickable access to healthcare plans and Healthcare Q&A information.

Flexible Benefits Guide - provides clickable access to FlexPlan benefits information.

To view your benefits, simply click on the active links and directional tabs located throughout the guides to easily navigate pages within each guide and seamlessly link from one guide to another.



AFSCME Part-Time Food Service Employee Benefits Update

(Eligible for Healthcare)

In accordance with the Affordable Care Act (ACA), medical, Rx cost, deductibles and co-insurance are counted towards your Annual Maximum Out-of-Pocket (MOOP). Once the MOOP has been satisfied, the member will be covered 100% and will have no additional cost to pay. Additionally, dependent premiums will continue to be subsidized by the District and employees covering a domestic partner of the same sex and legally married are able to add their eligible domestic partner on a tax-free basis with a marriage certificate.

Eligibility

Eligibility is defined in the Collective Bargaining Agreement between M-DCPS and AFSCME as stated in the labor contract.

After the initial eligibility, you must be regularly scheduled to work to continue the coverage. The coverage will expire on the last day of the month of your employment or the end of the month in which you were last paid, unless you are a 10-month employee who terminates during the last month of the school year. Then your coverage will continue through the summer until the end of the month in which the school year starts. COBRA benefits, rights, and responsibilities will be offered to all eligible employees, according to Federal Law.

AFSCME - Flex Credit

Employees represented by the AFSCME Union and enrolled in a healthcare plan will receive an annual flex credit of \$230. The flex credit will be added to the employees' gross income and paid through the payroll system based on the number of payroll checks the employee receives:

10-month employee (20 paychecks) - \$11.50

11-month employees (24 paychecks) - \$9.58

12-month employees (26 paychecks) - \$8.85

Declining Health Coverage

If you are currently covered by Medicaid, Medicare or other group healthcare coverage and wish to maintain this coverage, you may decline your group offered healthcare coverage, provided you complete the Declination of Healthcare Affidavit and submit proper proof that you are enrolled in this coverage. Enrollment in an Individual healthcare plan does not qualify. In lieu of the healthcare coverage, you will receive \$100.00 a month, paid bi-weekly through the payroll system based on the deduction pay schedule (subject to withholding and FICA) as follows:

10-month employees will receive a \$60.00 payment in 20 paychecks

11-month employees will receive a \$50.00 payment in 24 pay checks

12-month employees will receive a \$46.15 payment in 26 pay checks

If you DO NOT submit the Declination of Healthcare Affidavit and proof of other group or state-funded healthcare coverage, you will be assigned to the Cigna OAP 20 (Employee only) healthcare plan and will receive the \$230 annual flex contribution.

Benefits While on Leave

If you are currently on leave, contact the Leave office at 1.305.995.7090. You may be eligible for benefits.

Dependent Coverage

- You and your family must be covered under the same healthcare plan.
- If you are adding new dependents, you will need to enter their Social Security numbers in the enrollment application and submit dependent eligibility verification before the start of the plan year. If not, your dependents coverage may NOT take effect January 1, 2015. Dependent eligibility documentation requirements can be found in the Dependent Eligibility section of this guide.
- Dependent premiums continue to be based on the employees' benefits salary.
- M-DCPS continues to subsidize the cost of dependent premiums.
- Children may include: natural-born children, stepchildren, adopted children and children for whom you have been appointed legal guardian.
- Unmarried children are eligible from birth until the end of the year in which the child reaches age 26, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university. See also Adult Child section of this guide.
- Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is included in the coverage.
- Adult Child: A provision in the Patient Protection and Affordable Care Act (PPACA) Healthcare Reform allows for an employee's dependent to be covered under the employee's healthcare plan until the end of the calendar year they reach age 26. However, the School Board will continue to provide coverage for regular dependents until the end of the calendar year in which they reach the age of 26. The dependent will be deemed an Adult Child the following calendar year. Under Florida law, a dependent adult child ages 26–30 may be considered an eligible dependent for the purpose of "health" insurance.



AFSCME Part-Time Food Service Employee Benefits Update

(Eligible for Healthcare)

For medical coverage offered under the M-DCPS plan, you may add or continue to cover your dependent until the end of the calendar year in which the child reaches the age of 26–30, if the adult child:

- Is dependent upon you for support;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

In addition, the following dependent eligibility documents must be submitted when you complete the enrollment application, prior to the adult child dependent being added to your healthcare coverage:

- Affidavit of Eligibility
- Birth certificate or court documents of adoption/guardianship/legal custody
- Social Security number
- Driver license number

NOTE: A currently covered adult child may not automatically remain covered next year. You may have to re-enroll your adult child.

Domestic Partner Coverage

- According to IRS (Internal Revenue Service) Section 125 Regulations, all deductions for employee-paid benefits for domestic partner coverage must be taken on a post-tax basis. Additionally, you must pay the tax liability on the monthly contribution (subsidy) the Board pays on your behalf for any type of domestic partner coverage. Therefore, the value of these benefits will be added to your taxable income and your W-2 will be adjusted to reflect the higher income level annually.
- Taxation for the monthly, board-paid dependent subsidy contributed on the employee's behalf for domestic partner coverage, will occur on the last pay statement of each month.

Flexible Benefits

- If you wish to enroll in employee-paid flexible benefits such as Dental, Vision, Legal, Term Life, Long Term Disability, ID Watchdog Identity Theft and Hospital Indemnity Insurance, you must request a flexible benefits enrollment form by contacting FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday through Friday, 7 a.m. – 8 p.m. The deadline to return your enrollment form is XXXXXXXXXXXX.
- Return your completed flexible benefits form with your first month payment, payable to FBMC Benefits Management, Inc, in the enclosed envelope to:
FBMC Benefits Management, Inc.
P.O. Box 12241
Miami, FL 33101-2241

NOTE: To enroll your dependent(s), you must enter their Social Security numbers on the enrollment application. You must also submit dependent eligibility documentation (i.e. marriage certificate for spouse, birth certificate for natural children, etc.), if not previously submitted.

For more information about your healthcare and flexible benefits, you may log-in to www.dadeschools.net. Under “Highlights” click on the 2015 Employee Benefits link and click on one of the following guides:

- Your Enrollment Guide
- Healthcare Benefits Guide
- Flexible Benefits Guide

For questions or additional information in Spanish and/or Creole, please call FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday through Friday, 7 a.m. – 8 p.m.



>> Domestic
Partner
Eligibility
Update:

**Part-Time (B,E,F,L)
employees and
qualifying dependent's
are eligible to enroll in:**

- **Healthcare Plans**
- **Flexible Benefits**
- **Voluntary Benefits**



AFSCME Part-Time Food Service Employee Benefits Update



Your enrollment is pending union ratification and you will be notified when your enrollment starts.

1Q. Must I enroll during this Open Enrollment period?

A. No, this is a changes only enrollment. If you have no changes, you will remain enrolled in the Cigna OAP 20.

2Q. If I'm enrolled in the Cigna OAP 20 plan, do I need to select a Primary Care Physician (PCP)?

A. Yes, you are required to select a Primary Care Physician if enrolled in this plan.

3Q. What is this Open Enrollment Period?

A. This is the period of time determined by your employer, during which you are allowed to make any changes to your current benefits.

4Q. What changes can I make during this enrollment period?

A. You can add eligible dependents to your medical plan or delete currently covered dependents.

5Q. How do I enroll?

A. This year your open enrollment will take place online; no paper form required. You must log on to the enrollment website if you wish to make changes and to view your 2015 Employee Benefits Statement.

6Q. Is there a free healthcare option offered?

A. No, Employees represented by the AFSCME Union will only be eligible to enroll in the Cigna OAP 20 healthcare plan. This plan has a cost share, a per pay deduction amount determined by the employees benefits salary band.

7Q. Will I continue to receive the Flex Credit Dollars?

A. Employees represented by the AFSCME Union and enrolled in a healthcare plan will receive an annual flex credit of \$230. The flex credit will be added to the employees' gross income and paid through the payroll system based on the number of payroll checks the employee receives:

10-month employee (20 paychecks) - \$11.50

11-month employees (24 paychecks) - \$9.58

12-month employees (26 paychecks) - \$8.85

8Q. What are my choices if I have healthcare coverage outside the School Board (group healthcare, Medicare or Medicaid)?

A. You can opt-out of the Board offered healthcare plan and in lieu of healthcare coverage, the Board will contribute \$100 per month. You will receive \$100.00 a month, paid bi-weekly through the payroll system based on the deduction pay schedule (subject to withholding and FICA) as follows:

- 10-month employees will receive a \$60.00 payment in 20 paychecks
- 11-month employees will receive a \$50.00 payment in 24 pay checks
- 12-month employees will receive a \$46.15 payment in 26 pay checks



AFSCME Part-Time Food Service Employee Benefits Update

9Q. If I am opting out of the Board offered healthcare plan, must I submit any additional documentation?

A. Yes, if you are opting out of the Board offered healthcare plans you must provide proof of the other group, Medicare or Medicaid enrollment. In addition, you will need to submit and sign the Declination of Healthcare Coverage affidavit with the proof.

10Q. Will the School Board continue to subsidize my dependent healthcare premium?

A. Yes, the Board will continue to pay a portion of your dependent healthcare coverage.

11Q. Can I enroll in Accidental Death & Dismemberment Coverage?

A. No, AFSCME employee CANNOT enroll in this benefit.

12Q. Can I purchase flexible benefits?

A. Yes, you can purchase flexible benefits by completing the enrollment form enclosed in your package or by calling FBMC at 1.855.MDC.PS4U (1.855.632.7748) and request an enrollment form.

13Q. How would I pay for my dependent coverage?

A. The medical dependent premiums will be deducted from your paycheck and FBMC will bill for the flexible benefits.

14Q. Will my healthcare benefits continue if I am on a Board-approved leave of absence?

A. If you are out on a Board-approved leave that's eligible for benefits, your healthcare coverage will continue. If you are out on a leave of absence that does not provide you with healthcare benefits, you will be given the opportunity of continuing your benefits at your cost.

For additional information regarding your current leave status or you want to apply for a leave contact the Leave Office at 1.305.995.7090.

15Q. Must I complete the 2014 Wellness Initiatives?

A. The District encourages its employees to establish a relationship with a physician and have an annual physical.



COBRA Participant Benefits Update



This is a changes only enrollment. If you do not make changes, your current benefits will continue. Plan design and premium changes will automatically be adjusted effective January 1, 2015. Your Flexible Benefits will terminate on December 31, 2014. To continue your dental and/or vision benefits, you will have to re-enroll during the Open Enrollment period.

>> How to use your benefits guides:

We consolidated all group benefits information, including full and part-time employees, COBRA participants and retirees into the following three benefits guides:

Your Enrollment Guide - provides clickable access to benefits updates, dependent eligibility information, frequently asked questions pertaining to your group and other supporting documentation.

Healthcare Benefits Guide - provides clickable access to healthcare plans and Healthcare Q&A information.

Flexible Benefits Guide - provides clickable access to FlexPlan benefits information.

To view your benefits, simply click on the active links and directional tabs located throughout the guides to easily navigate pages within each guide and seamlessly link from one guide to another.



It's Benefits Enrollment Time for current COBRA Participants!

**Your Open Enrollment dates are:
November 25, 2014, through December 10, 2014**

**Your Period of Coverage dates are:
January 1, 2015, through December 31, 2015**

It's Benefits Enrollment Time

COBRA participants enrolled in a Cigna Healthcare plan have direct access to hospital and specialists. This year, the Cigna LocalPlus Plan is being introduced as a third healthcare plan option. However, the Cigna plans you are being offered at this time are subject to both Board approval and union ratification. If plan design and premium changes occur, you will be notified and given the opportunity to make any necessary changes. Cigna Healthcare continues to be offered only to eligible COBRA participants.

Also, in accordance with the Affordable Care Act (ACA), medical, Rx costs, deductibles and co-insurance are counted toward your Annual Maximum Out-of-Pocket. Employees save more because once the MOOP has been reached; the employee will be covered 100% and will have no other healthcare costs to pay.



COBRA Participant Benefits Update

Covering Your Dependents

If you are covering your dependents, you must indicate your dependents' Social Security number(s) in the dependent section of the enrollment form. You must also submit proof of eligibility documentation (i.e., marriage certificate for spouse, birth certificate for natural children, etc.) for all covered dependents.

Well Way

(Offered only to Cigna participants)

The District's wellness program provides resources on healthy eating, healthy lifestyle, and disease management programs emphasizing the importance of preventing illnesses.

Additionally, three Lifestyle Management Programs are offered free of charge with both on the phone and online coaching. These programs are for weight management, tobacco secession and stress management. Cigna Healthy Rewards is a separate program offering discounts for wellness programs. For a complete list of Healthy Rewards vendors and programs, visit www.mycigna.com or call 1.800.870.3470.

Dependent Coverage for 2015

- Dependent Social Security numbers are required during open enrollment. If your dependent's Social Security number is not provided, coverage for the dependent cannot be processed. For additional information, call the Office of Risk and Benefits Management.
- Documentation of your dependent's eligibility must be provided. Eligibility documentation requirements can be found in the Dependent Eligibility section of this guide.
- Children may include: natural-born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Your unmarried children are eligible from birth until the end of the year in which the child reaches age 26, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university. See also Adult Child section of this guide.
- Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.

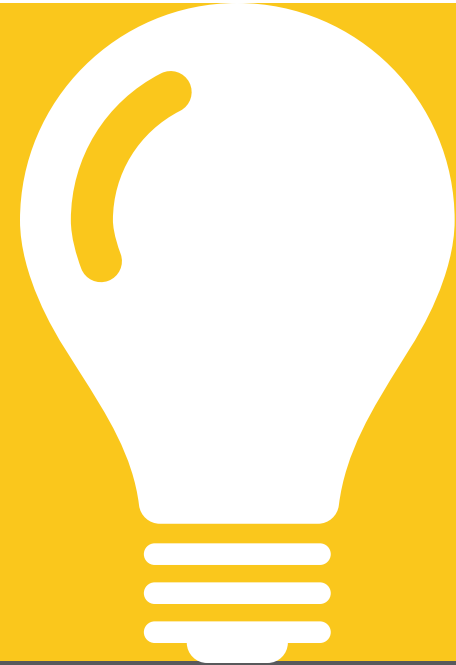
Important Note:

In order for your 2015 benefits to be effective, premiums for medical coverage must be paid current through November 30, 2014. Benefits will not take effect if your account is not paid in full by November 30, 2014. All premium payments should be made payable to: The School Board of Miami-Dade County, Florida and sent to:

The Office of Risk and Benefits Management
P.O. Box 12241
Miami, Florida 33101

Should you have any questions concerning the balance of your account, please contact the Office of Risk and Benefits Management, Monday – Friday, 8:00 a.m. – 4:30 p.m. ET, at the phone numbers below:

1.305.995.7129
1.305.995.7137
1.305.995.7169



>> Benefits Eligibility Note:

COBRA Participants and qualifying dependent's are eligible to enroll in:

- Healthcare Plans
- Dental Plans
- Vision Plan

COBRA Participants and dependents are ineligible to enroll in any other FlexPlan products.



COBRA Frequently Asked Questions



Get answers to commonly-asked COBRA Participant questions about my healthcare!

1Q. Do I have to enroll?

A. If you do not re-enroll during this open enrollment period your medical will continue and both benefits and premium changes will automatically be applied. Your flexible benefits will terminate December 31, 2014, so if you wish to continue your participation in the flexible benefits, you must re-enroll during this open enrollment period.

2Q. How can I make changes to my current selections?

A. You will need to submit your enrollment form by the 2015 Open Enrollment deadline of December 10, 2014.

3Q. If I make no changes, will I receive new coupons for next year?

A. You will receive new billing coupons reflecting the new premium for the billing period of January 1, through December 31, 2015.

4Q. What if I do not want to continue my current coverage for the 2015 Plan Year?

A. If you do not want your current coverage to continue for 2015, you must send a written cancellation request by December 10, 2014 to:

The Office of Risk and Benefits Management
COBRA Desk
P.O. Box 12241
Miami, Florida 33101

5Q. If I need help in completing my enrollment form or have additional questions, where can I go to get help?

A. You can contact the COBRA representatives at the Office of Risk and Benefits Management at 305.995.1691 or 305.995.7129 from 8 a.m. to 4:30 p.m. ET, Monday through Friday. You may also visit our office at 1501 NE 2nd Avenue, Suite 335.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to offer continued group health care coverage to individuals who would otherwise lose coverage as a result of certain "COBRA Qualifying Events." M-DCPS offers you, the COBRA participant, the opportunity to make changes to your coverage through an Open Enrollment period.

6Q. What is COBRA?

A. COBRA is the Consolidated Omnibus Budget Reconciliation Act passed by Congress in 1986. COBRA provides the continuation of group healthcare coverage that has been lost due to certain, specific events.

7Q. Which employers are required to offer COBRA coverage?

A. Employers with 20 or more employees are required to offer COBRA coverage and notify in writing the COBRA Qualified Beneficiaries of their entitlement.

8Q. Who is entitled to COBRA coverage?

A. Individuals covered by a group health plan that experienced a valid qualifying event.

9Q. What are qualifying events?

A. Certain valid events that cause a covered participant to lose their healthcare coverage.

10Q. What events are qualifying?

- A.**
1. Separation/termination
 2. Change in employment status resulting in the loss of healthcare coverage
 3. Divorce of a covered member
 4. Death of a covered member
 5. Loss of dependent eligibility under plan rules/guidelines



COBRA Frequently Asked Questions

11Q. What benefits could be continued under COBRA?

A. The benefits offered are: healthcare, dental and vision benefits. These benefits are the same benefits the member had when covered under the group plan.

12Q. What is the cost for COBRA benefits?

A. The cost for the benefits cannot exceed 102 percent of the premium previously being paid by the employer, participant or the combination of them both.

13Q. When are COBRA premiums due?

A. Initial premium must be made within 45 days after the day the election is made by the Qualified Beneficiary. The first payment must include the premium for retroactive coverage to the date the coverage was lost until the month the payment is being made. Subsequent payments are due 30 calendar days from the date the initial payment is made. If payment is not received by the due date, coverage will be terminated and cannot be reinstated.

14Q. Who is an eligible dependent?

A. An eligible dependent is defined as:

SPOUSE: Your spouse is considered your eligible dependent for as long as you are lawfully married. However, if he/she is also employed by M-DCPS full time, you cannot cover him/her under your healthcare plan.

DOMESTIC PARTNER: Your Domestic Partner and his/her children are eligible for COBRA coverage. Your Domestic Partner is eligible for coverage as long as he/she:

- Is of the same or opposite sex;
- Shares your permanent residence;
- Has resided with you for no less than 12 months;
- Is no less than 18 years of age and is not related to you by blood in a manner that would bar marriage under applicable state laws;
- Is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
 - » Joint mortgage or lease for a residence.
 - » Joint ownership of a motor vehicle.
 - » Joint bank or investment account, joint credit card or other evidence of joint financial responsibility.
 - » A will and/or life insurance policies which designates the other as primary beneficiary, beneficiary for retirement benefits, assignment of durable power of attorney or healthcare proxy.

To add a Domestic Partner, a participant must register, under applicable state or municipal laws or provide a duly sworn Affidavit of Domestic Partnership confirming the eligibility above. In addition, the definition of domestic partner will be met as long as neither partner:

- Has signed a domestic partner affidavit or declaration with any other person within 12 months before designating each other as domestic partner
- Is not legally married to another person, or
- Does not have any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

CHILDREN: Children can include natural born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.

Your unmarried children are eligible from birth until the end of the year in which the child reaches age 26, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university.

OVER 26 YEARS OF AGE: A provision in the new Patient Protection and Affordable Care Act (PPACA) Healthcare Reform allows for a participant's adult child to be covered under the participant's healthcare plan until they reach age 26. Coverage applies whether an adult child is/is not married or is/is not a student. There is no requirement to cover children of dependent children. This provision went into effect on March 30, 2011. For the full definition of an eligible child, view the FSA FAQs at www.tasconline.com. Dependents who reach age 26 are covered through the end of the calendar year in which they reach age 26. As covered dependents, you are offered the opportunity to continue your health, dental and vision coverage for up to 36 months from the first of January following the year you reach age 26.

NEWBORN CHILDREN: A natural born child, adopted child, the child of your Domestic Partner, or a child for whom you have been appointed legal guardian who is born or becomes eligible while a policy is in effect will be covered from date of birth/event. However, coverage is not automatic. You must request a Change In Status form within 30 days of the event and add your newborn child(ren)'s information.

NOTE: Your newborn will be covered free of charge for the first 31 days. However, you must call and request a Change in Status (CIS) form within the 30 days for coverage to become active.

- If you request your dependent's coverage be terminated within the first 31 days, the termination is effective the day you request it, but no later than the 31st day. You will have to submit your cancellation in writing.



COBRA Frequently Asked Questions

- If you do not submit your dependent's termination of coverage in writing, your dependent will remain actively enrolled and you will be billed from the 32nd day. You will pay the daily newborn rate until the day prior to the next month.
- If you add your dependent after the 31st day but within 60 days from birth/event, your dependent will be effective retroactive to the day of birth and you will be charged the full coverage amount.

DISABLED CHILDREN: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the plans. Proof of disability (Social Security disability documentation) must be provided to the Office of Risk and Benefits Management - P.O. Box 12241, Miami, Florida 33101.

GRANDCHILDREN: A newborn child of a covered dependent is eligible from birth until the end of the month in which the child reaches 18 months of age. However, if the parent becomes ineligible during the grandchild's 18 month eligibility period, coverage for both the parent and the child will terminate.

ADULT CHILD: A provision in the new Patient Protection and Affordable Care Act (PPACA) Healthcare Reform allows for a participant's dependent to be covered under the participant's healthcare plan until they reach age 26. However, the School Board will continue to provide coverage for regular dependents until the end of the calendar year in which they reach the age of 26. The dependent will be deemed an Adult Child the following calendar year. For the full definition of an eligible child, view the FSA FAQs at www.tasconline.com. Under Florida law, a dependent adult child ages 26 – 30 may be considered an eligible dependent for the purpose of "health" insurance.

For medical coverage offered under the M-DCPS plan, you may add or continue to cover your dependent until the end of the calendar year in which the child reaches the ages of 26 - 30, if the adult child:

- Is dependent upon you for support;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

In addition, the following dependent eligibility documents must be submitted with your completed enrollment form prior to the adult child dependent being added to your healthcare coverage:

- Affidavit of Eligibility (See Dependent Eligibility section)
- Birth certificate or court documents of adoption/guardianship/legal custody
- Social Security number
- Driver license

NOTE: A currently covered adult child will not automatically remain covered for next year; they must be re-enrolled.

15Q. Can I choose one healthcare plan or one dental company for myself and another for my family?

A. No. You must cover your family with the same medical plan and/or dental company as you cover yourself.

16Q. Will I receive a written Confirmation Statement of my Plan Year 2015 benefit selections?

A. Yes, all 2015 COBRA participants will receive billing coupons, which will serve as confirmation of your 2015 benefits. You must keep the gold participant copy of your enrollment form for reference.

17Q. When are my monthly premiums due?

A. You must refer to your billing coupon for due date, amount due and where to mail your payment. If payment is not received by the due date, coverage will be terminated and you will lose your COBRA eligibility. Please note that any 2014 premiums for medical, dental and/or vision coverage must be paid in order for your 2015 coverage to become effective.

18Q. Can I cancel my coverage OR my dependent coverage at any time during the year?

A. Yes, you may cancel your coverage and your dependent's coverage any time during the year. However, if you cancel your coverage, you will not be able to re-enroll at any time. If you cancel your dependents' coverage only, you may re-enroll them during the next Open Enrollment. You must send a written cancellation request to:

Office of Risk and Benefits Management
COBRA Desk
P.O. Box 12241
Miami, Florida 33101

19Q. Can my family continue their coverage if I die?

A. Yes. A dependent who is covered under the plan at the time of the COBRA participant's death will be eligible to continue their coverage for the duration of the period of initial eligibility.



COBRA Frequently Asked Questions

20Q. Who do I contact to make my mid-year change?

A. You need to contact a COBRA Specialist at the Office of Risk and Benefits Management at 1.305.995.7169, 1.305.995.7137 or 1.305.995.1738, 1.305.995.1691 or 1.305.995.7129 from 8 a.m. to 4:30 p.m. ET, Monday through Friday, and request a Change In Status Form (CIS).

21Q. Can I select coverage for myself through one healthcare plan and another for my family?

A. No. You and your eligible dependents must be covered with the same healthcare plans.

22Q. Can I select coverage for myself through one FlexPlan benefit provider and another for my family?

A. No. You and your eligible dependents must be covered with the same FlexPlan benefit and provider.

23Q. How do I view the Cigna Healthcare or FlexPlan Provider Directories?

A. Go to the www.dadeschools.net Employee Link button, then click on the Provider Directory of the company you desire.

24Q. When are benefits for the new plan year effective and for how long?

A. This enrollment is for benefits through December 31, 2015. Changes made during the open enrollment period of November 25, 2014 through December 10, 2014, become effective January 1, 2015 and will continue through December 31, 2015.

Important Note:

In order for your 2015 benefits to be effective, premiums for medical coverage must be paid current through December 1, 2014. Benefits will not take effect if your account is not paid in full by December 1, 2014. All premium payments should be made payable to: The School Board of Miami-Dade County, Florida and sent to:

The Office of Risk and Benefits Management
P.O. Box 12241
Miami, Florida 33101

Should you have any questions concerning the balance of your account, please contact the Office of Risk and Benefits Management, Monday – Friday, 8:00 a.m. – 4:30 p.m. ET, at the phone numbers below:

1.305.995.1285
1.305.995.7137
1.305.995.7169



Before You Enroll Online

www.dadeschools.net



Preparing to Enroll Online: These **How to Enroll Online** instructions serve as a quick reference to help you enroll in your 2015 Plan Year benefits through your employee portal. Before you begin your online enrollment, be sure to gather pertinent information in the checklist below.

>>Important Note:

The following M-DCPS groups may enroll online:

- **Full-Time Employees**
- **Food Service (AFSCME) Part-Time Employees**
- **Leave Employees**

All other groups must enroll via paper enrollment form.

How to submit a Heat Ticket:

- **Go to <http://selfservice.dadeschools.net> and**
- **Select ASK ITS A QUESTION from the drop-down list.**
- **Type the word BENEFITS in the Contact Name box.**

Checklist to Enroll Online

- Your M-DCPS Portal Username and Password
- Dependents' Name(s)
- Dependents' Date(s) of Birth
- Dependents' Relationship(s)
- Dependents' VALID Social Security Number(s)
- Proof of dependent eligibility must be submitted to the Office of Risk and Benefits Management for all added dependent(s), if not previously submitted. Otherwise, coverage may be terminated for any dependent whose eligibility has not been verified; claims incurred will not be paid and any premiums deducted will not be automatically issued.
- You and your dependent's Primary Dental Provider (PDP), if selecting the Safeguard DHMO Standard or High Plan
- Beneficiaries' Percentage of Coverage
- Beneficiaries' Name (**or Will/Trust or Charity Organization Name**)
- Beneficiaries' Relationship(s)/Date(s) of Birth
- Beneficiaries' VALID Social Security Number(s)
- **If selecting a local charity organization, their address is required.**
- Disable the Pop-Up-Blocker on your computer to allow your Confirmation Notice to display at the end of your enrollment session.
- If electing to decline healthcare coverage, proof of other group or state-funded healthcare must be submitted to the Office of Risk and Benefits Management. Proof must include the effective date of group coverage. Otherwise, coverage will be terminated and the employee will automatically be assigned to Cigna LocalPlus employee-only coverage.
- Employees covering a domestic partner of the same sex and legally married are able to add their eligible domestic partner on a tax free basis with a copy of a marriage certificate.



Benefits through the Employee Portal

www.dadeschools.net

Taxation of Board-Paid Benefits

Taxation of monthly, Board dependent subsidy toward any type of domestic partner coverage occurs every month on the last paycheck of the month.

Employees enrolled in either medical, dental or vision coverage for a domestic partner or domestic partner and family will have the deduction taken from the employee's paycheck as a post-tax deduction.

Employees covering a domestic partner of the same sex and legally married are able to add their eligible domestic partner on a tax free basis with the proper documentation (marriage certificate).

The cost of Board-paid Life Insurance in excess of \$50,000 will be taxed on every paycheck.

The taxable benefits are:

1. The cost of life insurance premiums in excess of \$50,000.00, which are paid/subsidized by the Board.
2. The monthly contribution (subsidy) that the Board pays on the employee's behalf for any type of Domestic Partner coverage and/or children of the domestic partner.

Medical Opt Out

Employees who have declined to participate in the District's medical insurance plan (Medical Opt Out) will receive \$100.00 per month, based on the employee's deduction schedule, as follows:

1. 10-month employees will receive their payment in 20 bi-weekly pay checks.
2. 11-month employees will receive their payment in 24 bi-weekly pay checks.
3. 12-month employees will receive their payment in 26 bi-weekly pay checks.

Employees Returning to Work After a Leave Status

Employees in a Board-approved leave of absence will be billed for employee-paid benefits in accordance to the type of leave. The benefits for which you have been billed will be cancelled, if payment is not received by the end of the grace period. If you return to work prior to receiving a Grace Period Notice, the premiums due will be automatically deducted from your bi-weekly check (one regular deduction plus one arrears) until the full amount of the outstanding premiums are paid in full.

Viewing your Benefits in SAP

Listed below are steps to view your benefits in the new SAP system:

1. Log-in to www.dadeschools.net, then the employee portal.
2. Click on the ERP Tab.
3. Click on the Employee Self Service tab.
4. Click the Benefits link.
5. Then, click on Participation Overview.
6. You may view benefits as of a specific period of time by clicking on the box "display your benefits as of." Please note, the benefits displayed will be per your last selection or, if not making changes, your current benefits that are rolling over with the 2015 rates.

Steps to Update Beneficiaries

1. Log-in to Employee Portal.
2. Click on **SAP/ERP** Tab.
3. Click **Employee Self Service** Tab.
4. Click **Benefits** Tab.
5. Click on **Dependents/Beneficiary** - To add or edit Dependents/Beneficiaries (please note that you are not able to delete records from SAP). Once complete, click on the Exit button.
6. Click on **Anytime Enrollments** - This is where you designate percentages and/or beneficiaries. Click Enroll or Change.
7. Click on **Select Beneficiaries**.
8. Each plan requires that you designate a percentage for your beneficiaries. Once complete, click on **Next Step**.
9. Once all plans have been edited (Sick/Vacation, Voluntary Life, Accidental Death & Dismemberment, Basic Life and/or Optional Life) click on **Review Enrollment**.
10. Click **Submit**.
11. An updated employee benefits confirmation will appear confirming changes.

Your last submission is your record on file



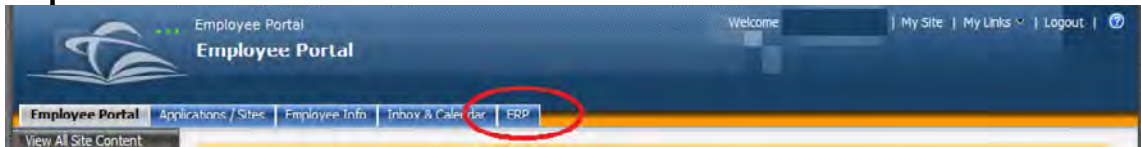
Benefits through the Employee Portal

www.dadeschools.net

Steps to Update Beneficiaries

Login to Employee Portal

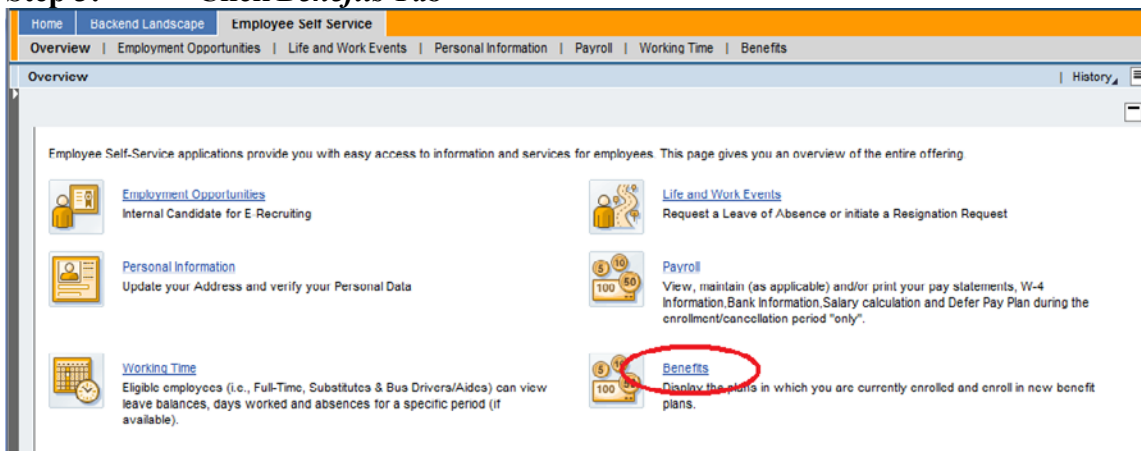
Step 1: Click on *ERP* Tab



Step 2: Click *Employee Self Service* Tab

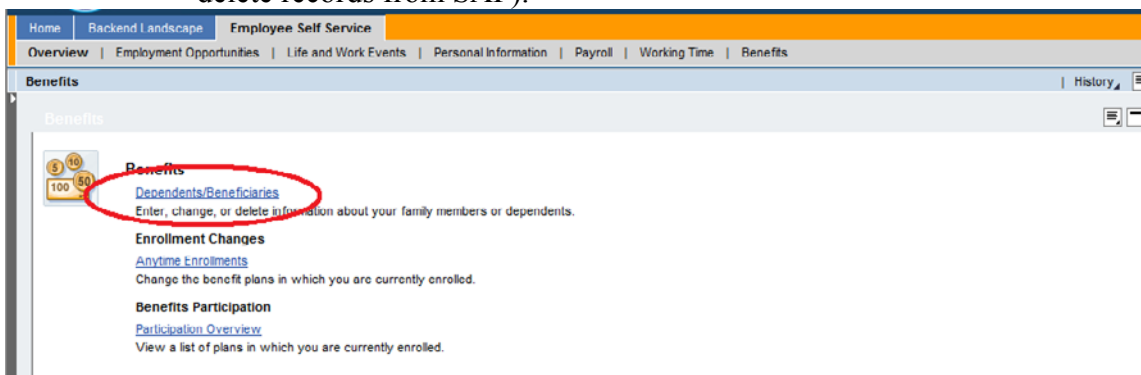


Step 3: Click *Benefits* Tab



Step 4: Click on *Dependents/Beneficiary*

To add or edit Dependents/Beneficiaries (please note that you are not able to delete records from SAP).



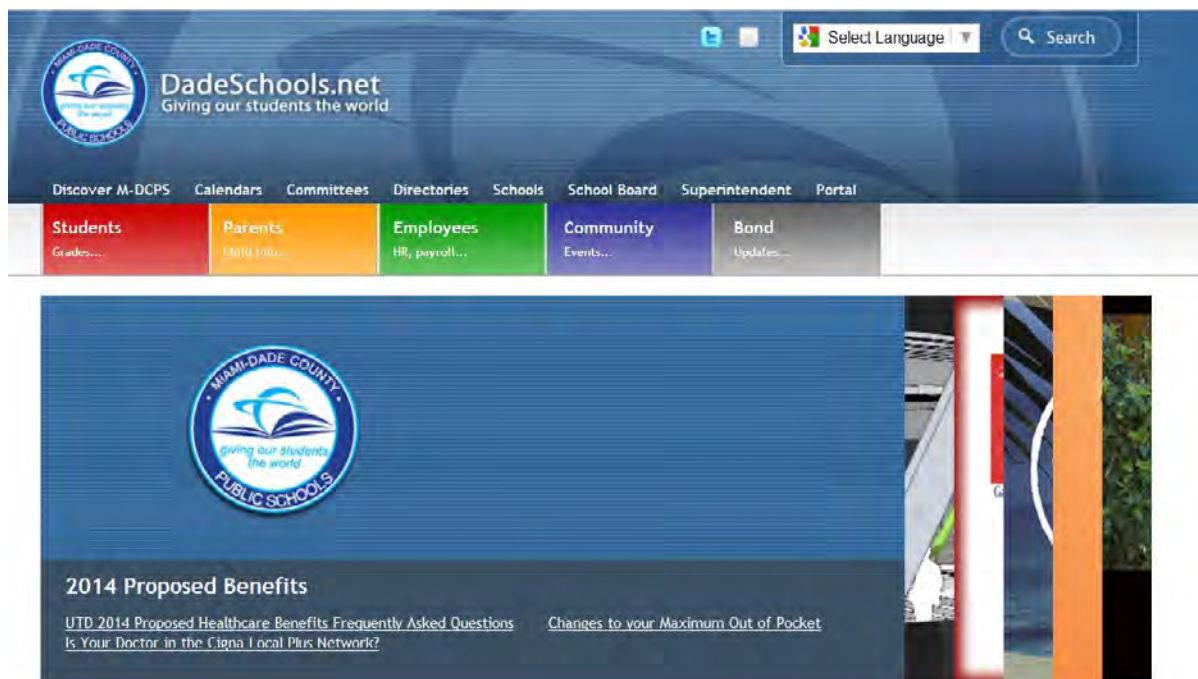
Before You Start Your Web Enrollment

www.dadeschools.net

Prior to enrolling in your benefits online, it is to your advantage to thoroughly review this benefits guide. If you are ready to enroll, but need assistance, contact the Enrollment Help Line at 1.305.995.2777 (to connect to the FBMC Service Center, call 1.855.MDC.PS4U (1.855.632.7748)). Once you have the answers you need, you may begin the enrollment process.



Before you begin your enrollment session, it is important for you to disable the "Pop-Up-Blocker" of your computer. If you do not take this step, you will not be able to print your Confirmation Statement at the close of your enrollment session.



Welcome to Miami-Dade County Public Schools

Miami-Dade County Public Schools is the fourth largest school district in the United States, comprised of 392 schools, 345,000 students and over 40,000 employees. Located at the southern end of the Florida peninsula, the school district stretches over 2,000 square miles of diverse and vibrant communities ranging from rural and suburban to urban cities and municipalities. A truly global community, district students speak 56 different languages and represent 160 countries.

Superintendent [Alberto M. Carvalho](#) has led the school district since the fall of 2008. During his tenure, the

Highlights

- ▶ 2013 FCAT Results
- ▶ 5 yr Capital Plan
- ▶ Charter School Information
- ▶ Employee Benefits
- ▶ Employee Wellness
- ▶ Employment Opportunities

Resources

- ▶ Legislative Resource Center
- ▶ 2013 FAFSA Assistance
- ▶ ACCEL Option
- ▶ Adult Ed. Classes
- ▶ Adult Tech. Ed.
- ▶ Assistive Technology

Your benefits and new payroll deductions are effective January 1, 2015.

Click here to login and begin your enrollment.



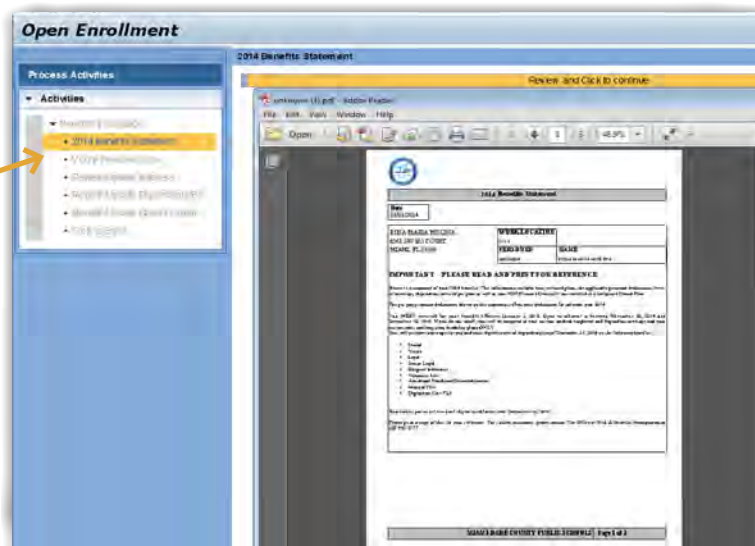
How to Enroll Online

www.dadeschools.net

1 REMINDER! You must re-enroll to receive benefits for 2015.

At the beginning of your enrollment session, you must review and print a copy of your 2014 Benefits Statement for reference during your Open Enrollment session.

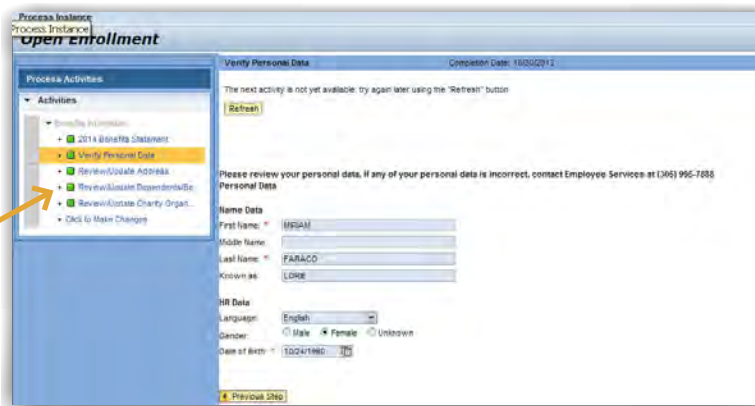
To proceed, you must click **Review and click to continue.**



2 Review your personal data.

Please review your personal data. If any of your personal data is incorrect, contact Employee Services at 1.305.995.7888.

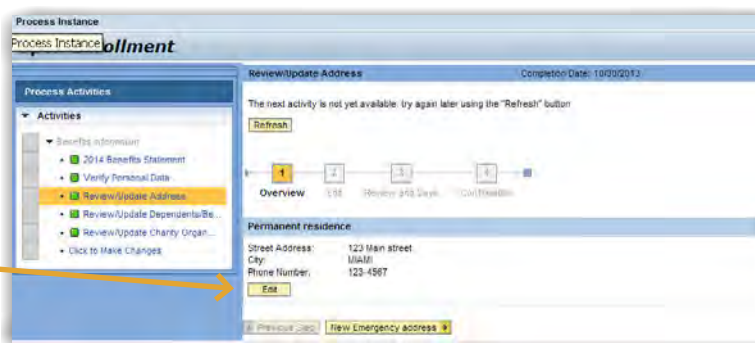
Click **Review and click to continue** to proceed to your enrollment.



3 Update your address.

If you do NOT have changes, click **Review and click to continue** to the next step. After reviewing your changes to each section, ALWAYS click to save your entries.

If your address or phone number is not correct, use the **EDIT** button to make corrections. You may add an Emergency Contact person in this section.



How to Enroll Online

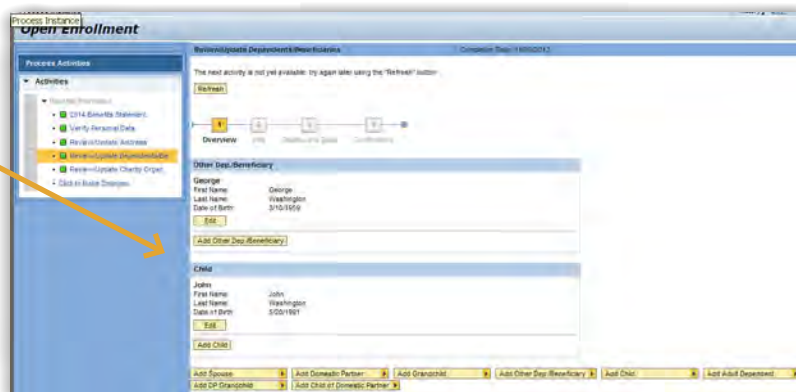
www.dadeschools.net

4 Update your dependent and/or beneficiary information.

If you DO NOT have changes, click **Review and click to continue to the next step.**

If you wish to select coverage for your dependents or list them as a beneficiary on any plan, you must add their information in this section. You may also correct the address for any dependent already listed. Adding a dependent or beneficiary in this section DOES NOT provide them insurance coverage or list them as your beneficiary. This is the list of people you will be able to select from during your enrollment session.

If you need to make any other type of correction, please contact The Office of Risk & Benefits Management at 1.305.995.7129.



5 Add or change your charity organization, will or trust.

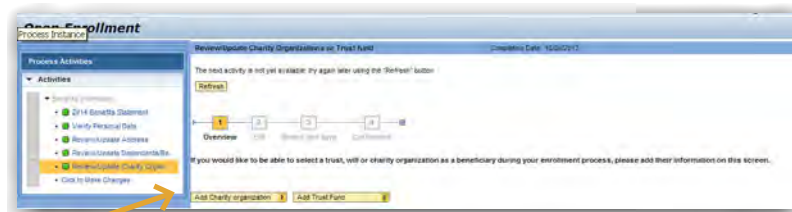
If you DO NOT have changes, click **Review and click to continue to the next step.**

You may add or change a charity organization or add or change a will or trust designation by **clicking on the appropriate box.**

If you would like to select a trust, will or charity organization as a beneficiary during your Employee Benefits enrollment process, please add their information in this section.

You do not need to include an address when adding a **NATIONAL** charity or organization.

Review your selection carefully before you click **SAVE.**



How to Enroll Online

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6 Enrolling In Your Benefits Plan Coverage for 2015

You may select whichever plan type you wish to enroll in for 2015. The highlighted selections that appear on the screen are your assigned plans for 2015 and your 2015 per pay deductions.

To enroll in a benefit, click the **Change** button.

Open Enrollment

Click to Enroll

Plan Selection

Before you begin your enrollment, please make sure you have added the dependents and/or beneficiaries you would want to select from during the enrollment process.

To change a benefit selection, click the "Change" button. If you select to change the following plans, you will be prompted to re-enroll in the corresponding plans. Employees only Medical/Dependent Medical, Legal Plan/Senior Legal, Employee Hospital Indemnity/Dependent Hospital Indemnity Plan. You may do so by clicking on the "Enroll" button that will appear.

Click on the "Review Enrollment" button to proceed to your enrollment submission.

Plan Type	Enroll	Coverage Option	Pre-Tax	Post-Tax	Remarks	Change
Employee Med	Waive Employee Medical	Waived Coverage	\$0.00	\$0.00		Change
Dependent Med	Waive Dependent Medical	Waived Coverage	\$0.00	\$0.00		Change
Dental	Waive Dental (DMO) High	Employee + Family	\$12.75	\$0.00		Change
Vision	Waive Vision Plan	Employee + Family	\$0.64	\$0.00		Change
Identity Theft	Waive Identity Theft Plan	Waived Coverage	\$0.00	\$0.00		Change
Disability S	STD High Upgrade	STD High Upgrade	\$4.31	\$0.00		Change
Disability L	LTD Level Three	LTD Level Three	\$0.00	\$17.72		Change
Legal Plan	Waive Legal Plan	Waive Legal Plan	\$0.00	\$0.00		Change
Senior Legal	Waive Sr Legal Plan	Waive Sr Legal Plan	\$0.00	\$0.00		Change
Emp Hosp Ind	Waive Emp Hosp Indemnity Plan	Waive Emp Hosp Indemnity Plan	\$0.00	\$0.00		Change
Fam Hosp Ind	Waive Family Hosp Indemnity Plan	Waive Family Hosp Indemnity Plan	\$0.00	\$0.00		Change
Voluntary Life	Waive Voluntary Life	Waive Voluntary Life	\$0.00	\$0.00		Change
AD&D	AD&D	\$250,000 Employee Only	\$1.50	\$0.00		Change

If you select to enroll in the following plans, you will be prompted to re-enroll in the corresponding plans, Employee only Medical/Dependent Medical, Legal Plan/Senior Legal, Employee Hospital Indemnity/Dependent Hospital Indemnity Plan.

If you wish to have your per pay deduction from your paycheck, on a post-tax basis. **Just unclick the X in the box** next to pre-tax deductions.

Click **Next Step** to continue.

Open Enrollment

Click to Enroll

Plan Selection

This screen is for enrolling in a plan selection only. The dependent medical plan selection is made on a separate page. If you select "Waive Employee Medical" you will be required to provide proof of other medical coverage.

Offer for Employees Med

Employee Only (EMP) High
Employee Only (EMP) Low
Employee Only (EMP) Plan
Waive Employee Medical This is not covered on a plan

Waive Employee Medical - Choose Plan Options (valid from 1/1/2015 to 12/31/2015)

Option: Dependent Coverage: \$0.00
Employee Only Medical: \$0.00

Pre-Tax Deductions

If you select a plan that requires a deduction from your paycheck and you wish to have the deduction taken on a post-tax basis, please unclick the Pre-Tax Deductions box. If a Pre-Tax Deduction box does not appear, the premium deduction is only eligible to be taken on a post-tax basis.

Next Step

7 Enroll or Waive Your Dependent's Coverage

Be sure to review your dependent coverage selections carefully.

PLEASE NOTE: Your plan selection prompted you to take an additional step to verify whether you wish to change or continue with the same coverage for your dependents.

You must click on **Enroll** and save your decision.

Open Enrollment

Click to Enroll

Plan Selection

Before you begin your enrollment, please make sure you have added the dependents and/or beneficiaries you would want to select from during the enrollment process.

To change a benefit selection, click the "Change" button. If you select to change the following plans, you will be prompted to re-enroll in the corresponding plans. Employees only Medical/Dependent Medical, Legal Plan/Senior Legal, Employee Hospital Indemnity/Dependent Hospital Indemnity Plan. You may do so by clicking on the "Enroll" button that will appear.

Plan Type	Enroll	Coverage Option	Pre-Tax	Post-Tax	Remarks	Change
Employee Med	Employee Only Local Plan	Employee Only	\$0.00	\$0.00		Change
Dependent Med	Employee Med a Plan Decided	Enroll	\$0.00	\$0.00		Change
Dental	Waive Dental (DMO) High	Employee + Family	\$12.75	\$0.00		Change
Vision	Waive Vision Plan	Employee + Family	\$0.64	\$0.00		Change
Identity Theft	Waive Identity Theft Plan	Waived Coverage	\$0.00	\$0.00		Change
Disability S	STD High Upgrade	STD High Upgrade	\$4.31	\$0.00		Change
Disability L	LTD Level Three	LTD Level Three	\$0.00	\$17.72		Change
Legal Plan	Waive Legal Plan	Waive Legal Plan	\$0.00	\$0.00		Change
Senior Legal	Waive Sr Legal Plan	Waive Sr Legal Plan	\$0.00	\$0.00		Change
Emp Hosp Ind	Waive Emp Hosp Indemnity Plan	Waive Emp Hosp Indemnity Plan	\$0.00	\$0.00		Change
Fam Hosp Ind	Waive Family Hosp Indemnity Plan	Waive Family Hosp Indemnity Plan	\$0.00	\$0.00		Change
Voluntary Life	Waive Voluntary Life	Waive Voluntary Life	\$0.00	\$0.00		Change
AD&D	AD&D	\$250,000 Employee Only	\$1.50	\$0.00		Change

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8

If you do not wish to cover your dependent for the 2015 Plan Year, you must select to **WAIVE dependent coverage**.

The per pay deduction amount is listed.

Based on your dependent's benefits eligibility, different levels of dependent coverage will appear highlighted on the screen.

9 Making Changes To Dental Plans

To select a dental plan, click on the **Change** button next to dental plans.

10

To select your dental plan for 2015, click next to the plan you wish to enroll in and then click below on whether you want Employee only coverage or Employee + Family coverage.

You must click on **Next Step** to proceed.

11

If you select DeltaCare DHMO Low or High, you will need to select a PDP. Click on the small box next to PDP Name and search for your dentist then click next to their name to populate.

You must click on **Next Step** to proceed.

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12 Making Changes

Click on the **Review Enrollment** button to proceed to your enrollment submission where you can review your selections and make changes.

NOTE: The per pay deductions amount are included in this section.

Process Instance: **Review Enrollment**

Plan Selection: **Review Enrollment**

Before you begin your enrollment, please make sure you have added the dependents and/or beneficiaries you would want to select from during the enrollment process.

To change a benefit selection, click the "Change" button. If you select to change the following plans, you will be prompted to re-enroll in the corresponding plans: Employee Only Medical, Dependent Medical, Legal Plan Senior Legal, Employee Hospital Indemnity, Dependent Hospital Indemnity Plan. You may do so by clicking on the "Re-enroll" button that will appear.

Click on the "Review Enrollment" button to proceed to your enrollment submission.

Plan Type	Selection	Coverage Option	Pre-Tax	Post-Tax	Remarks
Employee Med	Employee Only LocalPlus Plan	Employee Only	\$0.00	\$0.00	Change
Flex Credit	Employee Medical Plan Elected		\$0.00	\$0.00	Change
Dependent Med	Waive Dependent Medical	Waived Coverage	\$0.00	\$0.00	Change
Dental	DentaCare USA CH-MCH High	Employee Only	\$6.14	\$0.00	Change
Vision	Denta Vision Plan	Employee + Family	\$5.64	\$0.00	Change
Identity Theft	Waive Identity Theft Plan	Waived Coverage	\$0.00	\$0.00	Change
Disability S	STD High Upgrade	STD High Upgrade	\$4.31	\$0.00	Change
Disability L	LTD Level Three	LTD Level Three	\$0.00	\$17.72	Change
Legal Plan	Waive Legal Plan	Waive Legal Plan	\$0.00	\$0.00	Change
Senior Legal	Waive Sr Legal Plan	Waive Sr Legal Plan	\$0.00	\$0.00	Change
Emp Hosp Ind	Waive Emp Hosp Indemnity Plan	Waive Emp Hosp Indemnity Plan	\$0.00	\$0.00	Change
Fam Hosp Ind	Waive Family Hosp Indemnity Plan	Waive Family Hosp Indemnity Plan	\$0.00	\$0.00	Change
Voluntary Life	Waive Voluntary Life	Waive Voluntary Life	\$0.00	\$0.00	Change
AD&O	AD&O	\$250,000 Employee only	\$1.50	\$0.00	Change
Medical FSA	Medical FSA		\$28.85	\$0.00	Change
Dep Care FSA	Waive Dep Care FSA		\$0.00	\$0.00	Change
TOTAL			\$46.14	\$17.72	

[Previous Step](#) [Review Enrollment](#) [Submit](#)

13 Submit

Click on the **Submit** button to save your enrollment selections.

Review your selections **carefully** before submitting.

Process Instance: **Submit**

Plan Selection: **Submit**

Click on the "SUBMIT" button to save your enrollment selections.

Plan Type	Selection	Coverage Option	Pre-Tax	Post-Tax	Remarks
Employee Med	Employee Only LocalPlus Plan	Employee Only	\$0.00	\$0.00	
Flex Credit	Employee Medical Plan Elected		\$0.00	\$0.00	
Dependent Med	Waive Dependent Medical	Waived Coverage	\$0.00	\$0.00	
Dental	DentaCare USA CH-MCH High	Employee Only	\$6.14	\$0.00	
Vision	Denta Vision Plan	Employee + Family	\$5.64	\$0.00	
Identity Theft	Waive Identity Theft Plan	Waived Coverage	\$0.00	\$0.00	
Disability S	STD High Upgrade	STD High Upgrade	\$4.31	\$0.00	
Disability L	LTD Level Three	LTD Level Three	\$0.00	\$17.72	
Legal Plan	Waive Legal Plan	Waive Legal Plan	\$0.00	\$0.00	
Senior Legal	Waive Sr Legal Plan	Waive Sr Legal Plan	\$0.00	\$0.00	
Emp Hosp Ind	Waive Emp Hosp Indemnity Plan	Waive Emp Hosp Indemnity Plan	\$0.00	\$0.00	
Fam Hosp Ind	Waive Family Hosp Indemnity Plan	Waive Family Hosp Indemnity Plan	\$0.00	\$0.00	
Voluntary Life	Waive Voluntary Life	Waive Voluntary Life	\$0.00	\$0.00	
AD&O	AD&O	\$250,000 Employee only	\$1.50	\$0.00	
Medical FSA	Medical FSA		\$28.85	\$0.00	
Dep Care FSA	Waive Dep Care FSA		\$0.00	\$0.00	
TOTAL			\$46.14	\$17.72	

[Previous Step](#) [Submit](#)

How to Enroll Online

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14 Employee Benefits Confirmation Statement

Click to print a copy of your Employee Confirmation Statement.

When done printing, click **X** to close this window and return to the Enrollment Process.



15 Congratulations on successfully completing your enrollment

When you see this message, it confirms that your submissions have been received.

If you need to make changes before the enrollment deadline date, please return to **Click and Make Changes** and you will automatically be redirected to the selection screen.

To exit this page, please click **X** in the upper, right corner.



Dependent Eligibility



Get valuable information regarding dependent eligibility rules for your dependents. Pay particular attention to changes to eligibility for Domestic Partners.

>> Important Note:

If you do not re-enroll during this Open Enrollment period, your healthcare and your dependents' healthcare, along with your disability benefits, will continue.

Your flexible benefits will terminate on December 31, 2014.

To continue your flexible benefits, you will have to re-enroll during this Open Enrollment period.

Who Is Eligible for Coverage*

Who is an eligible dependent? An eligible dependent is defined as:

Spouse: Your spouse is considered your eligible dependent for as long as you are lawfully married.

Domestic Partner: Your Domestic Partner is eligible for coverage as long as he/she:

- Is of the same or opposite sex
- Shares your permanent residence
- Has resided with you for no less than 12 months
- Is no less than 18 years of age and is not related to you by blood in a manner that would bar marriage under applicable state laws
- Is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements:
 - » Joint mortgage or lease for a residence
 - » Joint ownership of a motor vehicle
 - » Joint bank or investment account, joint credit card or other evidence of joint financial responsibility
 - » A will and/or life insurance policies which designates the other as primary beneficiary, beneficiary for retirement benefits, assignment of durable power of attorney or healthcare proxy.
 - » Proof of registered domestic partner under applicable state or municipal laws

To add a Domestic Partner, an employee must register, under applicable state or municipal laws and provide a duly sworn Affidavit of Domestic Partnership confirming the eligibility above. In addition, the definition of domestic partner will be met as long as neither partner:

- Has signed a domestic partner affidavit or declaration with any other person within 12 months before designating each other as domestic partner
- Is not legally married to another person, or
- Does not have any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

NOTE: A Domestic Partner (opposite or same sex) and not married and the child(ren) of a Domestic Partner are eligible for benefits coverage. They do not qualify for pre-tax deductions per IRS Section 125. All employee-paid benefits will be taken on a post-tax basis. Additionally, you must pay the tax liability on the monthly contribution (dependent subsidy) that the Board pays on your behalf. Therefore, the value of these benefits will be added to your taxable income and your W-2 will be adjusted to reflect the higher income level annually. Domestic Partners or their child(ren) who do not



Dependent Eligibility

meet the eligibility criteria, will have benefit(s) coverage terminated and any claims incurred will not be paid. All other selected employee-paid benefits will continue for the remainder of the plan year on a post-tax basis. The Domestic Partner must also be included in that coverage. Domestic Partners and/or their children do not qualify as eligible dependents for FSA Reimbursement. Domestic Partners and children of a Domestic Partner of the same sex will be covered on a tax free basis with proof of marriage certificate.

Children: Children can include natural born children, stepchildren, adopted children and children for whom you have been appointed legal guardian. Children of your Domestic Partner are eligible for coverage only if the Domestic Partner is also included in the coverage.

- Your dependent is eligible for coverage through the end of the year that they turn 26. Coverage applies whether they are/are not married or is/is not a student.
- Your unmarried children are eligible from birth until the end of the year in which the child reaches age XX, if the child is: (1) dependent on you for support; or (2) lives in your household; or (3) is enrolled full time or part time in an accredited school, college or university.

Newborn Children: A natural born child, adopted child, the child of your Domestic Partner, or a child for whom you have been appointed legal guardian who is born or becomes eligible while a policy is in effect will be covered from date of birth/event. However, coverage is not automatic. You must request a Change In Status election form within 30 days of the event and add your newborn child(ren)'s information.

NOTE: Your newborn will be covered free of charge (no premium) for the first 31 days. During these 31 days, you are still required to satisfy the deductible and co-insurance. However, You must call and request a Change in Status (CIS) form within the 30 days for coverage to become active.

- If you request your dependent's coverage be terminated within the first 31 days, the termination is effective the day you request it, but no later than the 31st day, You will have to submit your cancellation in writing.
- If you do not submit your dependent's termination of coverage in writing, your dependent will remain actively enrolled and you will be billed from the 32nd day. You will pay the daily newborn rate till the day prior to the next available payroll, then you will pay the full prepay deduction.
- If you add your dependent after the 31st day but within 60 days from birth/event, your dependent will be effective retroactive to the day of birth and then you will be charged the full prepay deduction.

Disabled Children: Coverage may be kept in force beyond the age limit for any child who becomes totally disabled while covered under any of the benefits. The eligible disabled dependent can only remain enrolled in the benefits they were enrolled in at the time of disability. However, if coverage is terminated, it cannot be reinstated even during Open Enrollment. Proof of disability (Social Security disability papers) must be provided to FBMC Benefits Management, Inc., Miami-Dade County Public Schools, P.O. Box 12241, Miami, Florida 33101.

Grandchildren: A newborn child of a covered dependent is eligible from birth until the end of the month in which the child reaches 18 months of age. However, if the parent becomes ineligible during the grandchild's 18 months eligibility period, coverage for both the parent and the child will terminate at the end of the month in which the parent became ineligible.

NOTE: Hospital Indemnity Plan Coverage **does not** cover grandchildren.

Adult Child: Rules governing dependent coverage have changed. A provision in the Patient Protection and Affordable Care Act (PPACA) Healthcare Reform allows for an employee's dependent to be covered under the employee's healthcare plan until they reach age 26. However, the School Board will continue to provide coverage for regular dependents until the end of the calendar year in which they reach the age of 26. The dependent will be deemed an Adult Child the following calendar year. Under Florida law, a dependent adult child ages 26–30 may be considered an eligible dependent for the purpose of "health" insurance.

For medical coverage offered under the M-DCPS plan, you may add or continue to cover your dependent until the end of the calendar year in which the child reaches the age of 26–30, if the adult child:

- Is dependent upon you for support;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

In addition, the following dependent eligibility documents must be submitted with your completed enrollment form prior to the adult child dependent being added to your healthcare coverage:

- Affidavit of Eligibility
- Birth certificate or court documents of adoption/guardianship/legal custody
- Social Security Number
- Driver License Number

NOTE: A currently covered adult child will not automatically remain covered for next year, they must be re-enrolled.



Dependent Documentation Requirements

Dependent documentation is required for all dependents for the 2015 Plan Year.

Dependent Relationship	Documentation Requirements	
Spouse	Marriage Certificate	
Natural Child	Birth Certificate (must list employee as a parent) NOTE: birth registration, SS card or passport is not valid proof	
Stepchild	Birth Certificate (must list employee's spouse as a parent) and Marriage Certificate.	
Adopted Child	Court Documentation of adoption	
Legal Custody or Guardianship	Court documentation defining guardianship or legal custody. NOTE: Notarized affidavit is not acceptable documentation. Temporary custody does not constitute legal custody.	
Disabled Dependents Over Age 26	Social Security Disability Documentation. Disabled dependents are eligible only if covered by a School Board Healthcare plan or Flexible Benefits plan prior to the date of disability. Additionally, if coverage is terminated, it cannot be reinstated.	
Adult Child (between the age of 26–30)	<ul style="list-style-type: none"> • Affidavit of Eligibility • Birth certificate or Court Documents of Adoption/guardianship/legal custody • Proof of Florida Residence (Florida Driver License) 	
Grandchildren For specific eligibility requirements, see each benefit's page.	UNDER 18 MONTHS OLD Birth Certificate (must list employee's child as a parent) NOTE: the parent must be a covered dependent; if not, same as Legal Custody or Guardianship	OVER 18 MONTHS OLD Legal Custody or Guardianship documentation

Dependent Eligibility Documentation

Print, complete and include this form with the required documentation.

Return To: School Mail: US Mail:
 WL 9112 Office of Risk & Benefits Management
 Suite 335 P.O. Box 12241, Miami, Florida 33101
 Fax To: 1.305.995.1425

Employee (if applicable) Number _____

Social Security Number _____

Employee/Retiree/Participant Name _____

Important Information

- If not previously submitted, proof of eligibility must be on file for all listed dependents.
- You must submit proof of eligibility by the deadline. Otherwise, coverage may be terminated for any dependent whose eligibility has not been verified. Claims incurred will not be paid and any premiums deducted will not be automatically issued.
- If not previously submitted, you must provide your covered dependent's Social Security number.

DEPENDENT NAME (print clearly)			BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	GENDER	DOCUMENT PROOF INCLUDED (birth certificate, marriage certificate, etc.)
Last Name	First Name	MI					

Employee/Retiree/Participant Signature _____ Date _____



Domestic Partner Eligibility

Relationship	Documentation Requirements
Domestic Partner (Not married opposite or same sex) A copy of the Domestic Partnership Affidavit is available on the following page of this online Benefits Guide.	Affidavit of Domestic Partnership and any two of the following, demonstrating a minimum of a year (12 consecutive months) partnership: <ul style="list-style-type: none"> Joint mortgage or lease of residence Joint ownership of a motor vehicle Joint bank or investment account Joint credit card or other financial responsibility Will naming the partner as the beneficiary Life Insurance policy naming the partner as the beneficiary Assignment of durable power of attorney or healthcare proxy OR: Affidavit of Domestic Partnership and copy of registration under applicable law state or municipality
Children of Domestic Partner	Birth Certificate (must list Domestic Partner as a parent) and Domestic Partner documentation as defined above. NOTE: Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children" coverage.
Grandchildren of Domestic Partner	Birth Certificate (must list Domestic Partner's child as a parent) and children of Domestic Partner documentation as defined above. NOTE: Domestic Partners must be included in coverage. You must select "Employee and Domestic Partner with children of a Domestic Partner" coverage. Legal Custody or Guardianship documentation
Domestic Partner Same Sex	A Domestic Partner of the same sex and legally married are covered on a tax-free basis with proper documentation (marriage certificate).

Important Information

Proof of eligibility must be provided for Domestic Partner and all listed Children or Grandchildren of Domestic Partner (Include this form with the required documentation and the completed notarized Affidavit).

Employee Number _____

Employee/Retiree/Participant Name _____

Social Security Number _____

Indicate the relationship of your dependent on the form below.

DP = Domestic Partner

DC = Child of Domestic Partner

DGC = Grandchild of Domestic Partner

PRINT AND RETURN BY U.S. MAIL TO:

Office of Risk & Benefits Management
P.O. Box 12241
Miami, Florida 33101

RETURN BY SCHOOL MAIL TO:

Work Location 9112, Suite 335

OR FAX TO: 1.305.995.1425

DEPENDENT NAME (print clearly)			BIRTH DATE	SOCIAL SECURITY #	RELATIONSHIP	GENDER	DOCUMENT PROOF INCLUDED (birth certificate, joint mortgage, etc.)
Last Name	First Name	MI					

Employee/Retiree/Participant Signature _____ Date _____

NOTE: This is not an enrollment form, you must still complete your benefits enrollment and return it with both the dependent documentation and the notarized Domestic Partner Affidavit.



Affidavit of Domestic Partnership

The undersigned, being duly sworn, depose and declare as follows:

- We are each eighteen years of age or older and mentally competent.
- We are not related by blood in a manner that would bar marriage under the laws of the State of _____.
- We have a close and committed personal relationship, and we are each other's sole domestic partner, not married to or partnered with any other spouse, spouse equivalent or domestic partner.
- NOTE: If you cover a Domestic Partner of the same sex and legally married, you can add your domestic partner and your deductions will be taken on a pre-tax basis. Additionally, you do not have to complete this Affidavit.
- For, at least, one year, we have shared the same regular and permanent residence in a committed relationship and intend to do so indefinitely.
- We have provided true and accurate required documentation, demonstrating a minimum of a year (12-consecutive months) of partnership.
- Each of us understands and agrees that in the event any of the statements set forth, herein, are not true, the insurance or healthcare coverage for which this Affidavit is being submitted may be rescinded and/or each of us shall jointly and severally be liable for any expenses incurred by the employer, insurer or healthcare entity.
- I understand that, per IRS Section 125, all deductions for employee-paid benefits will be taken on a post-tax basis.
- I understand that I must pay the tax liability on the monthly contribution (dependent subsidy) that the Board pays on my behalf.

Employee/Retiree/Participant Name (Print Name)

Domestic Partner (Print Name)

Signature

Signature

Sworn to before me this _____ day of _____, 20 _____.

NOTARY PUBLIC

Return To: School Mail: US Mail:
WL 9112 Office of Risk & Benefits Management
Suite 335 P.O. Box 12241
Miami, Florida 33101
Fax To: 1.305.995.1425



Adult Child Notice

In order to continue the coverage for your currently enrolled Adult Child, you must re-submit the dependent eligibility documentation by the open enrollment deadline.

In order to continue coverage of your currently enrolled Adult Child, you must re-submit the dependent eligibility documentation by the December 10, 2014 enrollment deadline. The dependent eligibility documentations can be faxed to 305.995.1425 or sent via school mail to WL9112 Office of Risk and Benefits Management.

In accordance with the Patient Protection and Affordable Care Act (PPACA) Healthcare Reform, an employee can cover their dependent under the School Board's healthcare plan until the end of the calendar year the dependent reaches age 26. The dependent will be deemed an Adult Child the following calendar year. Under Florida law, a dependent adult child ages 26 – 30 may be considered an eligible dependent for the purpose of "health" insurance.

For medical coverage offered under the M-DCPS plan, you may add or continue to cover your Adult Child until the end of the calendar year in which the adult child reaches the age of 26-30, if the adult child:

- Is dependent upon you for support;
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Title XVIII of the Social Security Act.

In addition, the following dependent eligibility documents must be submitted with your completed enrollment form prior to the adult child dependent being added to your healthcare coverage:

- Affidavit of Eligibility
- Birth certificate or court documents of adoption/guardianship/legal custody
- Social Security number
- Driver license

NOTE: To continue to cover or add your adult child dependent, you must re-submit dependent eligibility documentation with your enrollment form. If dependent eligibility is not received, your current, covered adult child will be cancelled December 31, 2014.

Adult Dependent Healthcare Premiums:

	PER PAY RATE PER ADULT DEPENDENT CHILD		
Cigna HEALTHCARE	10-Month	11-Month	12-Month
Open Access Plus (OAP) 20	\$352.80	\$294.00	\$271.38
Open Access Plus (OAP) 10	\$322.20	\$268.50	\$247.85
LocalPlus Plan	\$324.60	\$270.50	\$249.69

If you are covering other children, your adult child must be covered under the same healthcare plan, and the adult dependent premium is in addition to the under age 26 children rate. Adult child rates are not subsidized by the Board.

To add an Adult Child, you must request an Adult Dependent enrollment package. Call the Cigna Representative at 305.995.1273, Monday through Friday, 7 a.m. to 8 p.m. An enrollment form and Affidavit of Eligibility will be mailed to your home address the following business day. Your completed form, affidavit, and dependent eligibility documentation must be received by the due date noted on the form.



Adding/Dropping Your Dependents During the Plan Year

1Q. Can I add or delete dependent coverage and make changes in my benefit elections during the year?

A. A participant is permitted to make changes to his or her elections mid-plan year only for a legitimate Change in Status (CIS). Meaning, "on account of and corresponding with a Change in Status that affects eligibility for coverage." If you experience a qualifying CIS Event, the election changes must be requested and submitted with proper documentation within 30 days from the qualifying event and the change must be consistent with the type of event. However, you cannot change your medical or dental plan insurance provider. You may add dependents to your existing coverage or delete your dependents. Please refer to the Change in Status section of this guide.

2Q. If I experience a CIS event, how and when must I request the CIS form in order for the change to be approved?

A. You must call the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday - Friday, 7 a.m. - 8 p.m. ET, within **30 days** from the date of the valid event and request a Change In Status Election Form.

Documentation supporting the Change in Status must be submitted with the form. **Requests and form submissions made after the 30th day from the valid event date, will not be granted. You will have to wait until the following annual open enrollment period to make any changes to your benefits.**

3Q. When I add dependents through a CIS event, when do their benefits become effective?

A. Coverage for your dependents becomes effective on the 1st of the month following your first payroll deduction, except for newborns** and adopted dependents. Your newborn dependents are covered from their date of birth; adopted dependents are covered effective the date of placement. Documents validating the CIS event and dependent's eligibility are required at time of request.

**** Your newborn will be covered free of charge for the first 31 days. However, you are still responsible for the claims incurred on the date of birth.** Your newborn child is not automatically enrolled by your employer or group health plan. **You must add your newborn dependent within 30 days, even if your current coverage includes employee and children, or employee and family coverage or employee and Domestic Partner and their child(ren). Don't forget to include the proper documentation when adding a dependent. See the Dependent Eligibility section of this guide for more details.**

- If you request your newborn's coverage to be terminated within the first 31 days, the termination is effective the day you request it, or no later than the 31st day.
- If you do not request to terminate your newborn, your dependent will remain actively enrolled and you will be billed from the 32nd day. You will pay the daily newborn rate until the day prior to the commencement of the next available payroll, then you will pay the full premium.
- If you add your newborn after the 31st day, but within 60 days from birth, coverage will be effective retroactive to the day of birth and you will be charged the full premium.

4Q. When I delete a dependent through a Change In Status, when does their coverage terminate?

A. Coverage for your dependent(s) is terminated effective the last day of the month in which the form is processed – after receipt of a completed Change in Status form and supporting documentation. Coverage is never terminated retroactively.

NOTE: Any 10-month employee submitting a Change in Status form after the end of the school year will have the form processed with a benefits termination date of August 31.

5Q. If I decline School Board healthcare coverage, but I lose my other coverage, can I re-enroll under a School Board plan mid-year?

A. You may only enroll in a School Board healthcare plan mid-year if you have lost other **group or state funded** insurance coverage. Supporting documentation will be required. The effective date of your School Board healthcare plan is the first of the month following the processing of your Change In Status. Enrollment in an individual policy does not qualify.

For a mid-year benefit change in status, forms must be requested and submitted with proper documentation within 30 days from the date of the event listed below. You must contact the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday - Friday, 7 a.m. - 8 p.m. ET, for a CIS election form. Appropriate documentation supporting the Change in Status Event is required when returning the form.



Adding/Dropping Your Dependents During the Plan Year

Domestic Partners & their Child(ren)

Domestic Partner of Opposite or Same Sex and Not Married

The Internal Revenue Service (IRS) Section 125 "Change In Status: Rules and Guidelines" does not apply. An employee may terminate their Domestic Partners and/or child(ren) at any time of the year, but may not reinstate their coverage until the following open enrollment period (effective January 1 of the following plan year), as long as all of the eligibility criteria has been met again. An employee may add their Domestic Partner if eligibility requirements are met during the plan year or due to loss of other group coverage.

An employee and his or her Domestic Partner must sign an Affidavit of Domestic Partnership, which states that the employee and domestic partner are:

- Each eighteen years of age or older and mentally competent
- Have a close and committed personal relationship, and are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner
- Have provided true and accurate required documentation of their relationship, and
- Each understands and agrees that in the event any of the statements set forth on the affidavit are not true, the insurance or health care coverage for which the affidavit is being submitted may be rescinded and/or each shall jointly and severally be liable for any expense incurred by the employer, insurer or healthcare entity.
- Employee-paid benefits will be taken on a post-tax basis.
- Employee must pay tax liability on the monthly contribution (dependent subsidy) that the Board pays toward dependent coverage.
- Must present two forms of documentation demonstrating a minimum of a one year (12 consecutive months) of partnership.
- Must present two forms of documentation demonstrating a minimum of a one year (12 consecutive months) of partnership or a valid certificate from the county.

Domestic Partners & their Child(ren)

Domestic Partner of Opposite or Same Sex and Legally Married

An employee may add their same sex domestic partner. The employee is able to have their deductions taken on a tax-free basis with a copy of a marriage certificate. Marriage Certificate must be from a state in which same sex marriages have been legalized.

If the marriage certificate is submitted prior to **January 1, 2015**, your domestic partner relationship to spouse may change. Pre-tax deductions will occur the first of the month following receipt of marriage certificate.

An employee may add their same sex domestic partner. The employee is able to have his or her deductions taken on a tax-free basis with a copy of a marriage certificate. Marriage certificate must be from a state in which same sex marriage is acknowledged.



Change in Status Events (CIS)

Mid-Year Benefit Changes In Status (CIS)

Forms must be requested and submitted with proper documentation within 30 days from the date of the event listed below. You must contact the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday - Friday, 7 a.m. - 8 p.m. ET, for a CIS election form. Appropriate documentation supporting the Change in Status event is required when returning the form.

Marital Status

A change in marital status includes: marriage, domestic partner same sex marriage, death, divorce or annulment (legal separation is not recognized in the State of Florida).

Change in Number of Eligible Dependents

A change in number of dependents includes the following: birth, death, adoption and placement for adoption and change in marital status. Existing eligible dependents can also be added whenever a dependent gains eligibility as a result of a valid CIS event.

Change in Status of Employment Affecting Coverage Eligibility

Change in employment status of the employee, or a spouse or dependent of the employee that affects the individual's eligibility under an employer's plan, such as commencement or termination of employment.

Gain or Loss of Dependents' Eligibility Status

An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan due to: attainment of age; student status; marital status; employment status.

Change in Residence

A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan, such as moving out of the network service area (except for Medical Expense FSAs).

Open Enrollment Under Other Employer's Plan

You may make an election change when your spouse or dependent makes an Open Enrollment change in coverage under their employer's plan if*:

- their employer's plan year is different from your employer's plan year
- they participate in their employer's plan, and
- their employer's plan permits mid-plan year election changes under this event.

*Does not apply to a Medical Expense FSA.

* NOTE: If the dependent becomes an M-DCPS employee, the employee covering the dependent needs to cancel the dependent by completing a Change In Status form.

Judgement/Decree/Order

If a judgement, decree or order from a divorce, annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a grandchild who is your dependent), you may change your election* to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) cover the dependent child and provide coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.

*Does not apply to Dependent Care FSA.

Medicare/Medicaid/Kidcare

Gain or loss of Medicare/Medicaid eligibility and enrollment may trigger a permitted election change. Documentation indicating effective date of event and affected dependents must be presented with CIS form.

HIPAA

If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC Sec. 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a **pre-tax** basis, effective retroactive to the date of the CIS event, **if you enroll your new dependent within 30 days** of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is **not** subject to HIPAA's special enrollment provisions if it is funded **solely** by employee contributions.

Other Election Changes

Domestic Partner of the opposite or same sex and not married and their children: The Internal Revenue Service (IRS) Section 125 "Change in Status" rules and guidelines do not apply. An employee may terminate coverage for their Domestic Partner and/or their child(ren) at any time of the year, but may not reinstate their coverage until the following open enrollment period as long as all of the eligibility criteria has been met once again. You may add a dependent if eligibility requirements are met during the plan year or due to loss of alternative group coverage.

Domestic Partner of the same sex and legally married:

Employees covering a same sex domestic partner and legally married can have both the Domestic Partner's relationship to spouse and the post tax deductions changed to pre tax. The change will occur the first of the month after submitting the marriage certificate.



Change in Status (CIS) Cut-Off Effective Dates

Documentation supporting the qualifying CIS event and dependent eligibility documentation must be submitted with the CIS form before (FORM DUE DATE) to have an (EFFECTIVE DATE) effective date. Any form received after (FORM DUE DATE) will be processed for the next available effective date. Please be aware that the form and proper documentation must be submitted within 30 days of the Change in Status event for the changes above to take effect.

Change in Status (CIS) Cut-Off Effective Dates:

Form Due Date	Effective Date
01/9/2015	02/01/2015
02/6/2015	03/01/2015
03/06/2015	04/01/2015
04/03/2015	05/01/2015
05/1/2015	06/01/2015
06/12/2015	07/01/2015
07/10/2015	08/01/2015

Future cut-off effective dates will be provided as soon as the payroll processing schedule for Fiscal Year 2015-2016 has been made available.



Beyond Your Benefits

FBMC Privacy Notice - 4/14/03

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). 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.

- 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. Any employee who violates our Privacy Policy is subject to disciplinary action.
- 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 recordkeeper. 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, Inc. 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.

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 medical expenses 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.

Women's Health and Cancer Rights Act

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.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:

- 48 hours following a vaginal delivery; OR
- 96 hours following a cesarean section

Determination of when the hospital stay begins is based on the following:

For an in the hospital delivery:

- The stay begins at the time of the delivery.
- For multiple births, the stay begins at the time of the last delivery.

For a delivery outside the hospital (i.e. birthing center):

- The stay begins at the time of admission to the hospital.
- Requiring authorization for the stay is prohibited.
- If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:-

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.
- These rules do not mandate hospital stay benefits on a plan that does not provide that coverage.
- The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

Creditable Coverage Disclosure Notice/Medicare Enrollees

Important Notice

Creditable Coverage Disclosure Notice for Active Employees and/or Their Dependents

Please read this notice carefully and keep it for your records.

Under the Medicare Modernization Act of 2003, a new Medicare-Approved Drug Plan (Part D) took effect as of January 1, 2006. This is your notice of creditable coverage.

- Your prescription drug coverage offered by Cigna Healthcare Plans, is, on average, as good or better as the standard Medicare prescription drug coverage.
- If you select one of the Cigna Healthcare Plans, you will not be penalized by Medicare if you decline to enroll in Medicare Part D at this time and decide to enroll in it at a later date. You will not have to pay the increased premium of at least one percent for each month that you did not elect to enroll in this plan after December 31, 2014 for an effective date of January 1, 2015.
- Creditable coverage means that the prescription drug coverage offered to you by the healthcare plan is, on average, as good as Medicare Part D coverage.

Medicare enrollment in the Medicare Part D Prescription Drug Plan was from November 2014, through December 2014.

For more information refer to your "Medicare & You 2014" handbook provided to you by Medicare, or by logging in to www.medicare.gov or calling 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

When To Enroll In Medicare Parts A & B

You should enroll 60 days prior to turning 65. If not, you may experience a lapse in your coverage.

Enrollment in Medicare While Actively Working

Active Employees Eligible for Medicare Parts A & B:

- If you and/or your covered dependent are eligible for Medicare Parts A & B, you are provided the opportunity of enrolling in Medicare during the Special Enrollment Period.
- You do not need to enroll in Medicare while working and covered by a group healthcare plan through your employer. Please refer to your 2015 Medicare & You Book or by logging in to www.medicare.gov.
- However, if you do enroll in both Medicare Parts A & B, you can opt out of the School Board-sponsored healthcare plan (Cigna). In lieu of healthcare coverage, you will receive a monthly contribution of \$100 paid through the payroll system based on your deduction schedule (subject to withholding and FICA). For additional information on how to enroll in healthcare, call the FBMC Service Center at 1.855.MDC.PS4U (1.855.632.7748), Monday - Friday, 7 a.m. - 8 p.m. ET.

Social Security Notice

THE SCHOOL BOARD OF MIAMI-DADE COUNTY

Statement on the Collection, Use or Release of Social Security Numbers of Employees and Others***

The School Board of Miami-Dade County is authorized to collect, use or release social security numbers (SSN) of employees, employee dependents, and other individuals*** for the following purposes, which are noted as either required or authorized by law to be collected. The collection of social security numbers is either specifically authorized by law or imperative for the performance of the District's duties and responsibilities as prescribed by law [Fla. Stat. §119.071(5) (a) 2 & 3].

1. **Employment eligibility, report to IRS, SSA, UC, and FAWI , including for W-4's and I-9's** [Required by federal statute and regulation 26 U.S.C. 6051 and 26 C.F.R. 31.6011(b)-2, 26 C.F.R. 301.6109-1 and 31.3402(f)(2)-1, and Fla. Stat. § 119.071(5) (a) 6]
2. **Receipts to employees for wages and Statements required in case of sick pay paid by third parties** [Required by federal statute 26 U.S.C. 6051 and Fla. Stat. § 119.071(5) (a) 6]
3. **Verification of an alien's eligibility for employment, including I-9** [Authorized by 8 U.S.C. 1324 a(b) and 8 C.F.R. 274a.2]
4. **Income tax withholding (including for annuity and sick leave)/Payroll deductions on Form W-2** [Required by 26 U.S.C. 3402, 26 C.F.R. 31.6051-1 and Fla. Stat. § 119.071(5) (a) 6]
5. **Teacher retirement system benefits and contributions** [Authorized by Fla. Stat. § 238.01 et seq., including 238.07, and Fla. Stat. § 119.071(5) (a) 6]
6. **Retirement contributions required for enrollment in Florida Retirement System (FRS) Investment Plan, second election retirement plan enrollment, or for participation in and contributions to FRS** [Required by Fla. Admin. Code 19-11.010, 19-11.006 and 19-11.007 and Fla. Stat. § 119.071(5) (a) 2 & 6 or required by Fla. Stat. § 121.051 and 121.071 and Fla. Admin. Code 19-13.003 and Fla. Stat. § 119.071(5) (a) 2 & 6]
7. **Reports pertaining to deferred vested retirement programs** [Required by 26 C.F.R. 301.6057-1 and Fla. Stat. §119.071(5) (a) 6]
8. **Payments and plan relating to the retiree prescription drug subsidy under 42 C.F.R. § 423.34 and 42 C.F.R. § 423.886** [Authorized by 42 C.F.R. 423.884 and Fla. Stat. § 119.071(5) (a) 6]
9. **Educator Certification or licensure application, renewal, or add-on, or non-employee registration for professional development for in-service points or incentive pay** [Required by Fla. Stat. §§ 1012.56, and 119.071(5) (a) 6, and/or authorized by Fla. Stat. §§ 1012.21 and 119.071(5) (a) 6]
10. **Criminal history, Level 1 and level 2 background checks / Identifiers for processing fingerprints by Department of Law Enforcement/, if SSN is available** [Required by Fla. Admin. Code 11C-6.003 and Fla. Stat. § 119.071(5) (a) 6]
11. **Registration information regarding sexual predators and sexual offenders** [Authorized by Fla. Stat. § 943.04351 and required by Fla. Stat. § 119.071(5) (a) 2 & 6]
12. **Reports on staff required to be submitted to Florida Department of Education (DOE), including but not limited to Out-of-County/Out-of-State Verification of Highly Qualified** [Authorized and required by Fla. Stat. § 119.071(5) (a) 2 & 6 and/or EDGAR at 34 CFR 80.40(a) or Fla. Stat. § 1008.32]
13. **Social security contributions** [Required by Fla. Admin. Code 60S-3.010 and Fla. Stat. § 119.071(5) (a) 2 & 6]
14. **State directory of new hires (including for determining support obligations and eligibility for several federal and state programs)** [Required by federal law 42 U.S.C. 653a and Fla. Stat. § 409.2576 and Fla. Stat. § 119.071(5) (a)]
15. **Notice to Payor and Income Deduction notices for child support, or for alimony and child support** [Required by Fla. Stat. § 61.1301 (2)(e) and Fla. Stat. § 119.071(5) (a)]
16. **Child support enforcement** [Required by 45 C.F.R. 307.11 and Fla. Stat. § 61.13, 742.10 or 409.256.3 or 742.031]
17. **Garnishment payment pursuant to a Notice of Levy** [Required by Fla. Admin. Code 12E-1.028m and Fla. Stat. § 119.071(5) (a)]
18. **Request from depository for support payments** [Required by Fla. Stat. § 61.181 (3)(b) and Fla. Stat. § 119.071(5) (a)]
19. **Record of remuneration paid to employees** [Required by federal regulation 20 C.F.R. 404.1225, Fla. Admin. Code 60BB-2.032, and Fla. Stat. § 119.071(5) (a) 6]
20. **Unemployment benefits and short term compensation plan** [Required by Fla. Stat. Ch. 443, including 443.1116, and Fla. Stat. § 119.071(5)(a)6]
21. **Unemployment reports from District** [Required by Fla. Admin. Code 60BB-2.023 and Fla. Stat. § 119.071(5) (a) 6]
22. **Income information disclosure to HUD** [Required by federal regulation 24 C.F.R. 5.214 et seq. and Fla. Stat. § 119.071(5)(a)6]

Social Security Notice

23. **Vendors/Consultants that District reasonably believes would receive a 1099 form if a tax identification number is not provided including for IRS form W-9.** [Required by 26 C.F.R. § 31.3406-0, 26 C.F.R. § 301.6109-1, and Fla. Stat. § 119.071(5) (a) 2 & 6]
24. **Tort claims and tort notices of claim against the School Board** [Required by Fla. Stat. § 768.28 (6), and Fla. Stat. § 119.071(5) (a) 6]
25. **Reporting to and reports of worker's compensation injury or death, including for DWC-1** [Required by Fla. Stat. §440.185 and Fla. Admin. Code 69L-3.003 et seq. and Fla. Stat. § 119.071(5) (a) 6]
26. **Worker's compensation petitions for benefits and responses thereto** [Authorized by Fla. Admin. Code 60Q-6.103 and Fla. Stat. § 119.071(5) (a) 6]
27. **The disclosure of the social security number is for the purpose of the administration of retirement or health benefits for a District employee or his or her dependents** [Required by Fla. Stat. § 119.071(5)(a) 6]
28. **The disclosure of the social security number is for the purpose of the administration of a pension fund administered for the District employee's retirement fund, deferred compensation plan, or defined contribution plan** [Required by Fla. Stat. § 119.071(5)(a)6]
29. **Use of motor vehicle information from the Department of Motor Vehicles for the District to carry out its functions and to verify the accuracy of information submitted by agent or employee to District, including to prevent fraud, in connection with insurance investigations, and to verify a commercial driver's license** [Authorized allowed by federal law 18 U.S.C. 2721 et seq. and Fla. Stat. § 119.071(5) (a) 6]
30. **Authorization for direct deposit of funds by electronic or other medium to a payee's account** [Required by Fla. Admin. Code 6A-1.0012 and Fla. Stat. § 119.071(5) (a) 6]
31. **Identification of blood donors** [Authorized by 42 U.S.C. 405 (c)(2)(D)(i)]
32. **Employee's and former employee's request for report of exposure to radiation** [Authorized by 41 C.F.R. 50-204.33 and .3]
33. **Collection and/ or disclosure are imperative or necessary for the performance of the District's duties and responsibilities as prescribed by law, including but not limited for password identification to the District's network** [Authorized by Fla. Stat. § 119.071(5) (a) 6 and required by Fla. Stat. § 119.071(5) (a) 2]
34. **The disclosure of the social security number is expressly required by federal or state law or a court order** [Required by Fla. Stat. §§ 1012.56 and 119.071(5) (a) 6]
35. **The individual expressly consents in writing to the disclosure of his or her social security number** [Allowed by Fla. Stat. § 119.071(5) (a) 6]
36. **The disclosure of the social security number is made to prevent and combat terrorism to comply with the USA Patriot Act of 2001, Pub. L. No. 107-56, or Presidential Executive Order 13224** [Required by Fla. Stat. § 119.071(5) (a) 6]
37. **The disclosure of the social security number is made to a commercial entity for the permissible uses set forth in the federal Driver's Privacy Protection Act of 1994, 18 U.S.C. Sec. 2721 et seq.; the Fair Credit Reporting Act, 15 U.S.C. Sec. 1681 et seq.; or the Financial Services Modernization Act of 1999, 15 U.S.C. Sec. 6801 et seq., provided that the authorized commercial entity complies with the requirements of paragraph 5 in Fla. Stat. § 119.071** [Allowed by Fla. Stat. § 119.071(5)(a)6]
38. **The disclosure of the social security number is for the purpose of the administration of the Uniform Commercial Code by the office of the Secretary of State** [Required by Fla. Stat. § 119.071(5)(a)6]

****Note, this form states the reasons for collecting, using or releasing the social security numbers only of employees and individuals other than students, parents and volunteers. A separate written statement sets forth the reasons for collecting, using or releasing the social security numbers of students and parents, and a separate written statement exists for collecting, using or releasing the social security numbers of volunteers as part of the volunteer application.*

School Board Attorney's Office

New: October 1, 2009

Revised: April 12, 2010



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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.