DUVAL COUNTY
PUBLIC SCHOOLS

RETIREE BENEFITS GUIDE

2024

Connect to Your

HEALTH

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ONLINE RESOURCES:

DCPS Benefits Website:

dcps.fbmcbenefits.com/retiree

Connect With Us:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 21 for more details.

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Benefits Directory

BENEFITS MANAGEMENT COMPANY

FBMC Benefits Management, Inc.
Benefits Service Center
Mon. - Fri., 7 a.m. - 7 p.m. ET
1-855-5MY-DCPS (1-855-569-3277)

EMPLOYER

Duval County Public Schools
Employee Benefits Department
Mon. - Fri., 7:30 a.m. - 4:30 p.m. ET
1-904-390-2351
duvalschools.org/benefits

PROVIDER COMPANIES

Allstate Benefits,
AHL American Heritage Life Ins. Co.
1-800-348-4489
allstatebenefits.com

American Family Life Assurance Company of Columbus (AFLAC)
1-800-992-3522
aflac.com

Optum
(Employee Assistance Program)
This benefit is available to retirees covered by a DCPS Medical Plan.
24-Hour Careline 1-866-248-4096
liveandworkwell.com
Access Code: DUVAL

Ameritas Hearing
1-877-359-8346
ameritas.com

Davis Vision by MetLife
1-833-EYE-LIFE (393-5433)
metlife.com/mybenefits

Delta Dental Deltacare
1-800-422-4234
deltadentalins.com

Delta Dental PPO
1-800-521-2651
deltadentalins.com

Florida Blue
1-800-664-5295
floridablue.com

Florida Blue On site Representative:
Jennie Cruz,
1-904-390-2323

Florida Blue Personal Health Advocate:
Nancy Byers, RN
904-905-0901

Florida Retirement System (FRS)
1-844-377-1888
myfrs.com

IDCommander (Identity Theft)
Membership Services
1-855-592-7941
idcommander.com

ITPlease (Technology Support)
Membership Services
1-888-384-7935
itplease.com

PetPlus is brought to you by Pet Benefit Solutions
1-800-891-2565
www.petbenefits.com
www.petbenefits.com/land/duvalcpsr

Prime Therapeutics (Under 65 Pharmacy Plan)
1-888-723-7451
myprime.com

Amazon (Mail-Order Pharmacy Provider)
24/7 Customer Service
800-201-7575 or 855-965-7539
https://www.amazon.com/primerx

Accredo (Speciality Pharmacy)
Group# 3651

Customer Service
Mon. - Fri., 8 a.m. - 11 p.m. ET,
888-425-5970
https://accredo.com/flblue

Selman & Company (TRICARE Supplement)
1-800-638-2610
selmanco.com

Standard Insurance Company
1-800-348-3226
standard.com

Trustmark Insurance Company
1-800-918-8877
Claims
1-877-201-9373, Option 2
trustmarksolutions.com

UnitedHealthcare® Insurance Company
1-877-776-1466. TTY 711,
8 a.m. - 8 p.m. Local time, 7 days a week

Unum Life Insurance Co. of America
Whole Life: 1-800-635-5597
Long Term Care: 1-800-227-4165
unum.com

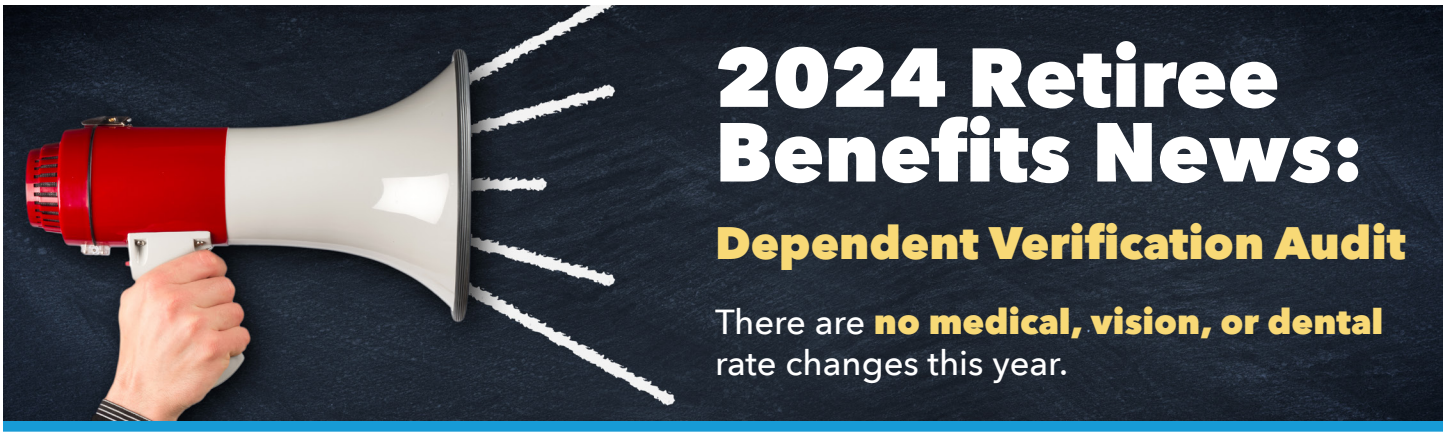
Zurich North America
1-866-841-4771
zurichna.com

MEDICARE

For assistance with your Medicare plan, contact: FSRBC Call Center

Florida Schools Retiree Benefits Consortium (FSRBC)
1-833-686-0983
myfsrbc.com

Key Things to Know



Welcome To Your Plan Year 2024 DCPS Retiree Benefits Open Enrollment

It's time for you to enroll in your health-related benefits for Plan Year 2024.

Duval County Public Schools is grateful for your dedication to the children of Duval County and your years of service to the school system, and we are pleased to offer these benefits.

In an effort to continue providing optimal benefits at the lowest possible cost to you, we are conducting a ***Full Medical Verification Audit for the 2024 plan year. Be prepared to verify dependents enrolled on your DCPS medical plan during enrollment.*** Dependents added PRIOR to the 2022 plan year will need to be verified. For more information on DVA acceptiable documents please visit: **dcps.fbmcbenefits.com/dependent-verification**

Your current benefits will automatically continue for the 2024 Plan Year if you do not make any changes.

If you would like to make a benefit change, please download the 2024 Enrollment Form by visiting: **dcps.fbmcbenefits.com/retiree/** -OR- contact FBMC's Benefits Service Center at **1-855-569-3277** to request an enrollment form, or email at svccenter@fbmc.com. Please complete and return the form to FBMC, postmarked by **Nov. 3, 2023**. Mailing instructions are included on the enrollment form. If you make any changes, you must complete the enrollment form in its entirety. This includes all elected benefits you have selected – even those you wish to continue.

If you or your spouse is approaching age 65, please contact the Social Security office about applying for Medicare Plans A & B or visit www.ssa.gov.

IMPORTANT DATES TO REMEMBER

Your open enrollment dates are:

Oct. 16, 2023 through Nov. 3, 2023

Your period of coverage dates are:

Jan. 1, 2024 through Dec. 31, 2024

What's New This Year:

- **No rate changes to Medical, Dental, or Vision**
- **Dependent Verification Audit (DVA)**: For more information on DVA acceptiable documents please visit: **dcps.fbmcbenefits.com/dependent-verification**

If You are Over Age 65

The Florida Schools Retiree Benefits Consortium (FSRBC) will continue to oversee the enrollment and management of your **Medicare Advantage Plans, Supplemental Plans, and PDP.** If you are currently enrolled in any of these plans and wish to make changes, or if you wish to enroll in any of these plans, you will need to follow the enrollment instructions provided to you by FSRBC. If you have any questions regarding your 2024 FSRBC benefits, please contact FSRBC directly at 1-833-686-0983.

The information in this guide is a summary and does not include all terms and conditions of the benefits. Please refer to the policy and certificate of coverage for complete details.

Eligibility & Payment

Who is Eligible?

Retirees – A retiree is a former employee of Duval County Public Schools (DCPS) who has met the definition of retirement under the Florida Retirement System (FRS).

Retiree's Spouse – A person to whom you are legally married and currently enrolled in a DCPS-sponsored plan.

Retiree's Child(ren) – A biological child, legally adopted child, stepchild, child for whom you have legal guardianship, or foster child, and currently enrolled in a DCPS-sponsored plan. Children are eligible for Medical, Vision, and Dental coverage until the end of the month they turn 26.

Disabled Child(ren) – Current dependent children are eligible for continued coverage after they reach age 26 provided their disability occurred prior to their 26th birthday. A physician's statement must be provided to substantiate the dependent's disability status.

Payment and Billing
FRS Deductions

Premium payments can be submitted through FRS payroll deduction. FBMC requires a completed and signed FRS payroll deduction authorization form if this method of payment is used (see bottom of the form for submission instructions). FRS deductions are scheduled to deduct on the 22nd of the month prior to the month premium is due.

If you are a new retiree, until FRS deductions begin, payment by personal check or money order is required.

If you are currently under FRS deductions for your insurance and your premium(s) exceed your retirement check, partial deductions will not be taken.

If you have a change in coverage that results in an increase in the premium to be deducted from your FRS retirement benefit, or if there is a delay from when you enroll in a benefit and your premiums start being deducted from your FRS check, you may need to pay the difference by check or money order until your deductions are paid-to-date. FBMC will automatically deduct up to $100.00 monthly in additional funds from your FRS check until your account is paid-to-date if you do not send in payment. If you wish to send in a payment for your premium should you owe a balance due to a new benefit enrollment or change in premium or coverage, please remit your premium(s) to FBMC Benefits Management, Inc.

Be sure to monitor your January 1, 2024 FRS check to verify that your new premium deductions took place. If you have any questions regarding your premiums, please contact FBMC Service Center toll free at 1-855-5MYDCPS (1-855-569-3277).

ACH Deductions

If you wish to make a payment via an automatic deduction from your bank account, please fill out the ACH Authorization Form that is included in this packet and return to FBMC (see bottom of the form for submission instructions). ACH deductions are scheduled to deduct on the 22nd prior to the month premiums are due. Please allow two to three business days for the ACH deduction to clear your account.

Direct Bill

If you choose Direct Bill, you will receive a monthly statement. You must pay your premiums by the 1st of each month, and FBMC must receive your payment no later than the 5th of each month so that your benefits will not be terminated.

Payment Not Received

If payments have not been received by the end of the month, FBMC will terminate your coverage. If your benefit is terminated with FBMC, you will no longer be able to participate in your retiree benefits plans. Please send payments to:

FBMC Benefits Management
PO Box 746907
Atlanta, GA 30374-6907

If we receive a check from you, and your check does not clear for insufficient funds or a closed bank account, you will receive a notice from us. You will need to re-submit a payment to us within 10 days from the date of notice in order for your coverage to remain active.

Changes to Coverage

Any changes to your retiree benefit(s) will require your written authorization, and submitted to FBMC Retiree and Direct Bill Department at: directbill@fbmc.com or fax to 866-836-9943. As soon as FBMC Benefits Management, Inc., receives your written request and processes your change, any excess premiums will be refunded within 60 days.

If you would like to change or cancel your Allstate Critical Illness, AFLAC, Trustmark or Unum benefits, **you must contact the provider directly**. You can locate their contact information in the provider directory included in this reference guide. To cancel PetPlus, Identity Theft Protection, IT Please Whole-Home Technical Support or Ameritas - SoundCare, use the form in this book.

If you are having FRS deductions for premium payments, any required refunds will be completed as soon as verification is received that FRS has changed your deduction. Any coverage you elect to cancel cannot be reinstated after 30 days.

Please send all written cancellation requests to:

FBMC Benefits Management, Inc
Retiree and Direct Bill Department
PO Box 10789, Mail Slot 32
Tallahassee, FL 32302-2789

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

How to Enroll

How to Enroll

Contact the FBMC Service Center or the DCPS Benefits office to request an enrollment form or download it at dcps.fbmcbenefits.com/retiree.

NOTE: If you are making changes to your benefits, you must request or download an enrollment form, complete and return post marked no later than November 3, 2023. If you are not making changes, your benefits will roll over unless you are Medicare-eligible.

FBMC Service Center
Mon. - Fri., 7 a.m. - 7 p.m. ET
1-855-5MY-DCPS (1-855-569-3277)

Duval County Public Schools
Employee Benefits Department
Mon. - Fri., 7:30 a.m. - 4:30 p.m. ET
1-904-390-2351

Benefit Options

HMO, PPO 1, PPO 2 and High Deductible Health Plans (Under 65 or Over 65 and Ineligible for Medicare)

- If you would like to change plans i.e., change from PPO 1 (prev. Low Deductible) to PPO 2 (prev. No Deductible), you must complete the FBMC enrollment form.
- See the Important Facts About High Deductible Health Plan (HDHP) with HSA section of the 2024 Retiree Benefits Reference Guide before enrolling in the High Deductible Health Plan (HDHP) with HSA.

Dental, Vision, Identity Theft Protection, IT Technology Support, Hearing Aid Benefit, and PetPlus

If you would like to enroll in or change plans (i.e., change from DeltaCare USA to Delta Dental PPO; add Identity Theft Protection, etc.), you must complete the FBMC enrollment form.

Cancellations

If you do not wish to continue your Florida Blue Medical, Group Term Life, Dental, Vision, Hearing, PetPlus, Identity Theft Protection, and/or IT Technology Support, place an "X" in the box next to "cancel" on the enrollment form. If you choose to cancel your coverage, your spouse and/or dependent child(ren) cannot remain on the canceled plan.

If you have an existing policy with Allstate, UnitedHealthCare®, Unum, AFLAC or Trustmark and wish to cancel or change coverage, you must contact the providers directly – see the Retiree Benefits Directory for contact information.

Cancellations completed during Open Enrollment will be processed effective Jan. 1, 2024 unless request is made for sooner date.

Changing Your Coverage

Changes during the year

If you experience a permitted qualifying event you may be allowed to change your benefit elections during the year. Permitted election change events include, but are not limited to, change in marital status, number of dependents, employment status, residence, HIPAA special enrollment rights, etc. See full terms and conditions at **dcps.fbmcbenefits.com/changing-your-benefits**.

Election changes will be effective on a prospective basis only, meaning that the District will process all approved mid-year changes on the first day of the month after you have completed a benefits change form and have submitted all required supporting documentation.

Health + Wellness (Under 65 Only)

Optum is an employer-sponsored program, available at no cost to retirees, their spouses, dependent children, parents and parents-in-law. Services are completely confidential and available 24 hours a day, seven days a week. Retiree must be enrolled in a DCPS Medical Plan.

Employee Assistance Program (EAP)

To access services, call the
CARELINE: 1-866-248-4096
Or visit: **liveandworkwell.com**
Access Code: **Duval**

Counseling and Relationship Support

- You can talk to licensed behavioral health professionals for support with issues, such as family relationship issues, depression, conflict management, alcohol/substance abuse, stress management, and more

Web-based Resources

- Child care/parenting/adoption/special needs
- Care for older adults
- General, family, criminal law
- Elder law/estate planning/will preparation
- Divorce/mediation
- Retirement/other financial planning

Did You Know?

If you participate in one of the Diabetes Management Programs you can receive:

- **FREE** diabetic-related generic prescription medications (cholesterol, blood pressure and diabetic)
- **FREE** approved diabetic supplies (needles and syringes)
- **FREE** for certain insulin
- **FREE** ongoing support from nurse health educators

Florida Blue On-site Representative
Jennie Cruz: **904-390-2323**

Did You Know?

Florida Blue 365 offers discounts on products and services, including: travel, gifts, electronics, theme parks, movie tickets, apparel, flowers, jewelry, fitness centers, and more.

District Wellness Program

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

- Weight management programs
- Diabetes management programs
- Diabetes Prevention program
- Educational lunch-and-learns
- Better You Strides online wellness solution
- On-site flu shot clinics/health screenings
- Smoking cessation resources

Contact

Call our Employee Wellness team, they will explain the wellness program eligibility requirements and answer any questions you may have.

Location: **District Administration Building:**
1701 Prudential Drive, 3rd Floor, Room 345
Jacksonville, FL 32207

Phone: **904-390-2351**

Website: **dcps.fbmcbenefits.com/health-wellness**

DCPS Personal Health Advocate

Florida Blue understands that each person has unique healthcare needs, and navigating the healthcare system is not always easy. To help, we offer a Personal Health Advocate for DCPS members. This is available to you at no extra cost, and can help you:

- Locate and research treatments for medical conditions
- Find “best-in-class” doctors, specialists and facilities
- Navigate within Florida Blue
- Get referrals
- Find answers about test results and treatment plans

Contact Nancy Byers, RN, your Personal Health Advocate, at 904-905-0901 or email **nancy.byers@floridablue.com**.

Medical Plans (Under 65 Only)

Florida Blue will continue providing medical administrative services for the new plan year (January – December 2024) to those members who are under the age of 65 or for retirees who are over 65 and not Medicare-eligible. An HMO option is available, but you must select a primary care provider. Also, there are two PPO plans with Low Deductibles, and a High Deductible Health Plan which are open-access plans that do not require you to choose a primary care physician. You may pick the physician of your choice. However, to receive your maximum benefit, you should select an in-network doctor from participating Florida Blue, Blue Options (Network Blue) providers found at floridablue.com.

65 and Over: Retirees age 65+ and Medicare eligible are given the option to enroll in one of the Medicare Supplement or Medicare Advantage Plans and/or one of the Medicare Part D Pharmacy Plans through the Florida School Retiree Benefits Consortium (FSRBC). Please contact FSRBC directly at 1-833-686-0983 or visit **myfsrbc.com**.

DCPS Medical - PPO 1 Plan

Plan Highlights:

- Participants have the freedom to choose an in- or out-of-network service provider at the time of service.
- Deductibles and coinsurance apply to all services that do not have set copays. For example:
  - Inpatient Hospitalization
  - All Out-of-Network Services
- Deductible, coinsurance and copays (including Rx) count towards the maximum out-of-pocket limit.

DCPS Medical - PPO 2 Plan

Plan Highlights:

- Participants have the freedom to choose an in-or out-of-network provider at the time of service.
- There is an in-network deductible.
- Coinsurance applies to all services that do not have set copays. For example:
  - Inpatient and Outpatient Hospitalization
  - Ambulatory Surgical Center Facility
  - All Out-of-Network Services
- Coinsurance and copays (including Rx) count towards the maximum out-of-pocket limit.

DCPS Medical - HDHP

Plan Highlights:

- Participants have the freedom to choose an in- or out-of-network service provider at the time of service.
- Deductibles and coinsurance apply to all services including Rx (excluding routine services).
- For coverage other than retiree-only, the family deductible must be met before coinsurance/copayments are applicable.
- After you reach your out-of-pocket maximum, all covered services, including Rx, are paid at 100% by the health plan.
- For Medicare Part D coverage, the prescription drug coverage offered by the High Deductible Health Plan is considered non-creditable.
- You may waive the HSA under the HDHP.
- HSA funds may be used based on what's available in the account.
- Money left in your HSA account rolls over from year to year.
- Changes to your HSA may be made once per month.
- Participant must be under age 65 and not entitled to Medicare to qualify for HSA.

How are funds placed into my HSA?

Step 1: Retiree enrolls in HDHP and HSA

Step 2: Retiree opens HSA with bank

Step 3: Retiree contributes funds to HSA account

Step 4: Retiree uses HSA debit card or check to pay expenses.

DCPS Medical - HMO Plan

(In-state Only)

Plan Highlights:

- You must use an in-network provider for services to be covered, unless you are in an emergency situation.
- There is a deductible.
- You must select a primary care provider(PCP)
- Coinsurance applies to all services that do not have set copays. For example:
  - Inpatient and Outpatient Hospitalization
  - Ambulatory Surgical Center Facility
- Deductible, coinsurance and copays (including Rx), count toward the maximum out-of-pocket limit.

This is an Employer Benefits Highlights Summary and not a contract. All benefits are subject to the provisions and exclusions of the master contract. Please check with your provider for more detailed information.

Medical Plans (Under 65 Only)

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

What is a High Deductible Health Plan (HDHP)?

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

Plan Benefits

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

Selecting In-Network Care:

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

Selecting Out-of-Network Care:

You pay 100% of the ineligible fees for all out-of-network services. You may be balance billed.

NOTE: You will be responsible for all ineligible charges. Ineligible charges do not count towards the deductible and they do not count towards the out-of-pocket maximum.

- Once you meet the out-of-network deductible, the plan pays 50% of the allowed amount for covered out-of-network services.
- Your deductible and coinsurance apply to your out-of-pocket maximum.
- After you reach your out-of-pocket maximum, all covered services are paid at 100% of the allowed amount by the health plan.

Health Savings Account

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

Qualifying for an HSA

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

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

Annual HSA Contributions

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

2024 contribution limits are $4,150 for single and $8,300 for family.

Catch-Up Contributions

HSA owners age 55 and older can make additional contributions to their HSA called "catch-up contributions." For 2024, the allowed catch-up contribution is $1,000.

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Medical Plans (Under 65 Only)

	HMO		PPO 1		PPO 2		HDHP* (High Deductible Health Plan)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Monthly Rates								
Retiree Only	$696.81		$696.81		$885.09		$625.26	
Retiree & Spouse	$1176.00		$1176.00		$1494.12		$1060.51	
Retiree & Child(ren)	$1053.91		$1053.91		$1346.22		$948.37	
Retiree & Family	$1592.47		$1592.47		$1998.59		$1443.09	
Spouse Only*	$696.81		$696.81		$885.09		$625.26	
Child(ren) Only*	$349.33		$349.33		$382.30		$315.10	
CYD - Calendar Year Deductible (Includes CYD, Copays, Coinsurance)								
(Single/Family)	$500/$1,000	Not Covered	$600/$1,800	$1,000/$2,000	$200/$600	$500/$1,000	$1,600/$3,200	$3,000/$6,000
Coinsurance (COINS)								
(Inpatient/All Others)	25% Inpatient / 20% All Others	Not Covered	25% Inpatient/ 20% All Others	50% COINS	20% COINS	50% COINS	25% In Patient / 20% All Others	50% COINS
Out-of-Pocket Maximum (OOP)								
(Single/Family)	$5,000/$10,000	Not Covered	$4,500/$8,500	$6,000/$12,000	$3,000/$5,500	$3,250/$6,500	$5,000/$10,000	$10,000/$20,000
Hospital								
Inpatient	CYD + 25% COINS	Not Covered	CYD + 25% COINS	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS	CYD + 25% COINS	CYD + 50% COINS
Out-of-State	Not Covered***	Not Covered	CYD + 25% COINS	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS	CYD + 25% COINS	CYD + 50% COINS
Outpatient Hospital Facility	$250 Copay	Not Covered	$300 Copay	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS	CYD + 25% COINS	CYD + 50% COINS
Physician Services	CYD + 20% COINS	Not Covered	CYD + 20% COINS		CYD + 20% COINS		CYD + 20% COINS	
Emergency Room	$300 Copay	$300 Copay	$300 Copay	$300 Copay	$300 Copay	$300 Copay	CYD + 25% COINS	
Urgent Care Center	$60 Copay	Not Covered	$60 Copay		$50 Copay		CYD + 20% COINS	CYD + 20% COINS
Ancillary								
Ambulatory Surgical Center Facility	$150 Copay	Not Covered	$150 Copay	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS
Physician Services	$45 Copay	Not Covered	$45 Copay	Deductible + 50%	CYD + 20% COINS	Deductible + 50%	CYD + 0% COINS	Deductible + 50%
Independent Diagnostic Testing Facility (X-Ray/Imaging)	$80 Copay	Not Covered	$90 Copay	CYD + 50% COINS	$55 Copay	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS
Independent Clinical Lab (Quest Diagnostic is the Participating Clinical Lab)	$0 Copay	Not Covered	$0 Copay	CYD + 50% COINS	$0 Copay	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS
Mammograms	$0	Not Covered	$0		$0		$0	
Preventative Services	$0	Not Covered	$0		$0		$0	
Physicians								
Office Services (Physician/Specialist)	$25 Copay/ $45 Copay	Not Covered	$30Copay/ $55 Copay	CYD + 50% COINS	$20 Copay/ $45 Copay	CYD + 50% COINS	CYD + 20% COINS	CYD + 50% COINS
Routine Physicals	$0	Not Covered	$0	50% COINS	$0	50% COINS	$0	50% COINS
Rx Drugs - Retail (Out-of-Network Not Covered)								
Generic Drugs	$10 Copay		$7 Copay		$7 Copay		CYD + $7 Copay	
Preferred Brand Drugs	$30 Copay		$50 Copay		$50 Copay		CYD + $50 Copay + COINS	
Non-Preferred Drugs	$50 Copay		$80 Copay		$80 Copay		CYD + $80 Copay + COINS	
Specialty Injectables	$80 Copay[3]		$100 Copay[3]		$100 Copay[3]		CYD + $100 Copay + COINS	
Rx Drugs - Mail Order (Out-of-Network Not Covered)	$20 Copay / $60 Copay / $100 Copay		$14 Copay / $100 Copay / $160 Copay		$14 Copay / $100 Copay / $160 Copay		$14 Copay + 10% Coins. / $100 Copay + 10% Coins. / $160 Copay + 10% Coins.	
Narrow Pharmacy Network[1]	Removed CVS from Network		Removed CVS from Network		Removed CVS from Network		Removed CVS from Network	
Narrow Formulary Medications[2]	National Drug Exclusion		National Drug Exclusion		National Drug Exclusion		National Drug Exclusion	
Specialty Rx Coupon Program[3]	SaveOnSP Program		SaveOnSP Program		SaveOnSP Program		Not Eligible	

* DME deductible and/or COINS will apply. HDHP still offered and only available to ADMIN, EXEMPT, FOP, IBEW, JSA, LIUNA.

** If a Brand drug is prescribed without any Provider dispensing instructions, an equivalent Generic drug will be dispensed, unless the Member chooses the Brand drug. If the Brand drug is dispensed, the Member will pay the difference in the cost of the Brand and Generic drug. The cost difference between the generic and brand-name medication will not apply toward your deductible and/or out-of-pocket maximums.

*** Away From Home Program available for out-of-state plan participants where BCBS HMO Plan is available. Must enroll to benefit from this program.

1. CVS no longer in-network. You can use another in-network pharmacy such as Walgreens, Publix, Walmart, Winn Dixie etc.
2. National Drug Code Exclusion- Removes certain medications with alternative.
3. SaveOnSP Program provides certain specialty medications discount reducing copay to a $0.

TRICARE Supplemental Medical

We are pleased to make available the TRICARE Supplement coverage for all eligible retirees entitled to TRICARE. Combined with your TRICARE coverage, the TRICARE Supplement is a valuable asset.

Eligibility

Eligibility is limited to the following individuals:

- Military Retirees
- Retired Guard and Reserve members between the ages of 60 and 65 and entitled to retired pay
- Retired Guard and Reserve members under age 60 and enrolled in TRICARE Retired Reserve (TRR)
- Spouses/Surviving Spouses (widow or widower) of the above.

These individuals cannot be age 65+ or eligible for Medicare unless they are one of the following:

- Age 65 or older but ineligible for Medicare and received a Statement of Disallowance from the Social Security Administration.
- Age 65 or older but resides outside the United States or its territories (must be eligible for Medicare Part A and enrolled in Medicare Part B).

Active duty spouses and dependents, TRICARE Reserve Select members and dependents and former spouses are no longer eligible.

Dependent eligibility:

- Unmarried dependent children under age 21 (23 if a full-time student)
- Under age 26, if enrolled in TRICARE Young Adult (TYA) program
- Incapacitated dependents previously enrolled in an employer sponsored plan

Plan Benefits

The TRICARE Supplement Plan provides the following benefits for TRICARE covered services:

When TRICARE Standard/Extra is used:

- 50% of the TRICARE Standard Outpatient Deductible of $150 individual (maximum $300 family)
- 100% of the TRICARE Standard/Extra cost share
- 100% of Excess Charges up to TRICARE Legal Limits (non-participating provider expenses)

When TRICARE Prime/Point of Service (POS) is used:

- 100% of the TRICARE Prime cost share or copayments
- 25% of the POS deductible of $300 individual (maximum $600 per family)
- 100% of the POS cost share
- 100% of Excess Charges up to the TRICARE Legal Limits (non-participating provider expenses).

Covered expenses are subject to supplement plan deductible of $100 per individual (maximum $200 per family). Exclusions and limitations apply.*

The TRICARE Supplement is portable and there is no preexisting condition limitation.

*See your group's Plan Design for Employees brochure for more details

TRICARE Supplemental Rates

Monthly Rates	
Retiree Only	$67.50
Retiree Plus Spouse	$132.50
Retiree Plus Child(ren)	$132.50
Retiree Plus Family	$178.50

Filing a Claim

The supplemental insurance pays secondary to TRICARE. Therefore, your claims for medical expenses must be submitted to TRICARE for primary processing. After processing your claim, TRICARE will send you an Explanation of Benefits (EOB). To obtain your supplement benefits, a claim should be submitted to Selman & Company either by you or by your medical provider.

Claim submissions MUST include the following:

1. Claim form (completed and signed)
2. Copy of the provider's bill showing the diagnosis, provider's name, address, and Tax ID Number
3. Copy of the corresponding TRICARE EOB; write your Identification Number (found on your Supplement ID card) on your TRICARE EOB.

Send all of the above via mail to:

Selman & Company
Attn: Claims
PO Box 29151
Hot Springs, AR 71903-3351

The TRICARE Supplement Plan is administered by Selman & Company. Call Center Representatives are available to answer your questions about your TRICARE Supplement Plan at 1-800-638-2610 or by email at memberservices@selmanco.com.

Dental Plans

Dental Care Benefit Options

Delta Dental Insurance Company offers two choices for dental coverage: the Delta Dental PPO Option Plan and the DeltaCare USA Plan.

Added Value

Lasik and hearing aid discounts are now available to all Delta Dental enrollees. You can save an average of 62% off of top-brand hearing aids, and 40-50% off the national average price for traditional Lasik.

Delta Dental PPO Option Plan

How the PPO Program Option Plan Works

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

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

In addition to PPO Dentists, Delta Dental has Participating Delta Dental Premier® Dentists. PPO dental providers provide the most savings.

Although you are responsible for deductibles, coinsurances and any expenses above the maximum, Premier dentists have an agreement with Delta Dental not to charge you more than the approved amount.

In Florida, the Delta Dental PPO is underwritten and administered by Delta Dental Insurance Company.

Contact Information for Delta Dental PPO

After you enroll, you can get answers by calling Delta Dental's Customer Service department at 800-521-2651, Monday-Friday from 8 a.m. to 8 p.m. ET. You can print ID cards from the Delta Dental website: **deltadentalins.com**.

Get the App

Access your insurance and the tools to help you use it anytime, anywhere with the Delta Dental mobile app.

Download on the App Store

ANDROID APP ON Google play

-OR- Search for:

DELTA DENTAL MOBILE APP

DeltaCare USA Plan

How the DeltaCare USA Plan Works

The DeltaCare USA Plan features include:

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

Accident injury benefit

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

Contact Information for DeltaCare USA Plan

After you enroll, you can get answers by calling Delta Dental's Customer Service department at 800-422-4234, Monday-Friday, from 8 a.m. to 9 p.m. ET. You can print ID cards from the Delta Dental website: **deltadentalins.com**.

Dental Plans

	DELTACARE USA		DENTAL PPO
Rates	**Monthly**	**13B*** (*Only for retirees residing outside of FL)	**Monthly**
Retiree	$21.53	$29.91	$37.96
Retiree + One	$36.06	$49.81	$75.62
Retiree + Family	$53.06	$73.43	$97.94
Benefit (Calendar Year: Jan. 1, 2024 through Dec. 31, 2024)			
Dentist	Choose A Panel Dentist		Use Dentist Of Choice**
Deductible*	None		$75 Per Year, Individual & $150 Per Year, Per Family
Calendar Year Maximum	None		$5,000 Per Person
Claim Forms	None		None If Using Delta Dental Dentists
Procedures	**You Pay**		**Plan Pays**
Office Visit	$0 - $20		100% for PPO & Premier providers
Routine Exams	No Cost		100% for PPO & Premier providers
Prophylaxis (Cleaning)	Basic - No Cost (1 per 6 Months)		Basic - 100% (Limit 2 per Calendar Yr.) for PPO & Premier providers
X-Ray and Complete Series	No Cost (Including Bitewings)[1]		100% (1 every 3 Years - Full), Under 18: 2 per Calendar Yr. - Bitewing, Over 18: 1 Per Calendar Yr. - Bitewing
Fluoride Application	No Charge To Age 19 (1 per 6 Months)		100% (2 per Calendar Year, Children Under 19 Only)
Basic/Restorative Procedures			
Simple Extractions	$6		80%
Amalgam Fillings	No Cost - 1 Surface Perm, Resin Based Fillings - Posteriors $15 - $35		80%
Root Canal	Anterior[2] $75; Molar[2] $180		80%
Major Procedures			
Crowns	Crowns - Porcelain, Base Metal $195; Crowns - Porcelain, $295 High Noble Metal		50%
Dentures	Upper/Lower $225		50%
Bridges	Porcelain, Base Metal $195 (Per Unit) Resin, High Noble Metal $295 (Per Unit)		50%
Periodontics	Scaling And Root Planing $45 Per Quadrant		50%
Implants	Covered***		50%
Orthodontics	Start Up Fee: $350, Routine 24 Month Fully Banded Case: Adult $2,000, Child $1,800		75% Up To $1,000 Lifetime Maximum (After 1 Year Waiting Period Dependent Children Under Age 19 Only)
Waiting Period	N/A		Applies To New Participants (Orthodontics Only)
TMJ Benefits			
TMJ	N/A		50% Up To $1,000 Lifetime Maximum (Effective October 2006)

* Note the deductible does not apply to diagnostic and preventative services, orthodontics.
**PPO Dentists are limited to the PPO fee. Delta Dental Premier® Dentists are limited to the least of: the dentist's filed fee, submitted fee, or Delta Dental's MPA (Maximum Plan Allowance) fee. Non-Delta Dental Dentists may balance bill for amounts over Delta Dental's MPA-TJM Benefits (Maximum Plan Allowance) fee.
***See DeltaCare schedule of benefits for co-payment amounts
[1]Under the DeltaCare USA plan, bitewing X-rays (code D0274) are limited to not more than one series of four films in any six-month period.
[2]Excluding final restoration

Vision Plans

Davis Vision Plan by MetLife

A comprehensive vision benefit ensuring low out-of-pocket cost to members and their families. Our vision plan helps you care for your eyes while saving you money. Our goal is 100% member satisfaction.

- **Convenient Network Locations** - A national network of credentialed preferred providers throughout the 50 states.
- **Freedom of Choice** - Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

The Premiere plan includes all of the features offered in the Low Plan plus members can receive coverage for frames every year and $500 once per member/per lifetime allowance toward Lasik eye surgery.

These plans offer a network of providers that service your eyecare needs with only a modest member copayment shown in the Schedule of Benefits on the next page.

Out-of-Network Benefits

The out of-network-benefit allows you to select any provider and reimburses a fixed dollar amount based on the schedule shown for the out-of-network services*.

You will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. However, you may choose an out-of-network provider, but you must pay the provider directly for all charges and then submit a claim for reimbursement to: applicable copayments, up to a maximum of $1,600 in any 12-month period.

*This is not a contract: This is a benefits highlights summary. All benefits are subject to the provisions and exclusions of the master contract.

Contact

For more details about the plan, log on to the Open Enrollment section at **metlife.com/mybenefits** or call Customer Service at 1-833-393-5433 or 1-800-GET-MET8.

Vision Plan Rates

	LOW PLAN	PREMIERE PLAN
MONTHLY RATES		
Retiree	$5.83	$7.62
Retiree + 1	$12.52	$16.28
Retiree + Family	$17.75	$23.08

Get the App

Find a provider, check your claim status, track your glasses order, print an ID card and more with the MetLife mobile app.

Download on the App Store

ANDROID APP ON Google play

-OR- Search for:

MetLife US App

Did You Know?

- You can locate a provider by calling Davis Vision by MetLife customer service at 1-833-EYE-LIFE (393-5433), using the app, or by logging on to the Open Enrollment section of our Member site at **metlife.com/mybenefits** and click "Register."
- You have access to a Member Online Portal.

Vision Plans

The following chart indicates the benefits the plan pays for the services you receive. For more information, see the Davis plan literature.

	PREMIERE PLAN	LOW PLAN	BOTH PLANS
	In-Network	In-Network	Out-of-Network
SERVICES			
Eye Examination	Every Jan. 1, covered in full after $10 copayment.	Every Jan. 1, covered in full after $10 copayment.	Up to $35
Laser Surgery Benefit	$500 Lifetime Reimbursement	N/A	N/A
EYEGLASSES			
Spectacle Lenses	Every Jan. 1, covered in full for standard single-vision, lined bifocal, or trifocal lenses after $15 copayment.	Every Jan. 1, covered in full for standard single-vision, lined bifocal, or trifocal lenses after $15 copayment.	Spectacle Lenses (per pair) up to: Single Vision: $25, Bifocal/progressive: $40, Trifocal: $60, and Lenticular: $100.
Frames	$150[6] Retail allowance toward any frame from provider, plus 20% off balance[2]. Also, up to $200 frame allowance at Visionworks, plus 20% on any overage OR Every Jan. 1, covered in full any fashion or designer frame from Davis Vision's collection[1] (value up to $175).	$130[6] Retail allowance toward any frame from provider, plus 20% off balance[2]. Also, up to $180 frame allowance at Visionworks, plus 20% on any overage OR Every other Jan. 1, covered in full any fashion or designer frame from Davis Vision's collection[1] (value up to $175).	Up to $50
CONTACT LENSES			
Contact Lens Evaluation, Fitting & Follow Up Care	Every Jan. 1, collection contacts: covered in full OR Non collection contacts: standard contacts: 15% discount[2], specialty contacts[3]: 15% discount[2].	Every Jan. 1, collection contacts: covered in full OR Non collection contacts: standard contacts: 15% discount[2], specialty contacts[3]: 15% discount[2].	Elective Contacts: up to $150 Medically necessary contacts: up to $210
Contact Lenses (In Lieu of Eyeglasses)	$150 retail allowance toward provider supplied contact lenses, plus 15% off balance[2] OR Every Jan. 1, covered in full any contact lenses from Davis Vision's contact lens collection[1].	$150 retail allowance toward provider supplied contact lenses, plus 15% off balance[2] OR Every Jan. 1, covered in full any contact lenses from Davis Vision's contact lens collection[1].	N/A
ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS Most Popular options - savings based on in-network usage and average retail values.			**ESTIMATED RETAIL COST**
Scratch-Resistant Coating (Standard/ Premium)	$0 / $30	$0 / $30	$40
Polycarbonate Lenses	$0[4] - $30	$0[4] - $30	$64
Standard Anti-Reflective (AR) Coating	$35	$35	$62
Standard Progressives (no-line bifocal)	$50	$50	$154
Plastic Photosensitive (Transitions®[5])	$65	$65	$123
FRAMES - ADDITIONAL OPTIONS			**ESTIMATED RETAIL COST**
Fashion Frame (From the Davis Vision Collection)	$0	$0	$125
Designer Frame (From the Davis Vision Collection)	$0	$0	$175
Premier Frame (From the Davis Vision Collection)	$0	$25	$225
LENSES			**ESTIMATED RETAIL COST**
All Ranges of Prescriptions and Sizes	$0	$0	$90
Plastic Lenses	$0	$0	$33
Oversized Lenses	$0	$0	$20
Tinting of Plastic Lenses	$0	$0	$20
Scratch-Resistant Coating (Standard/ Premium)	$0 / $30	$0 / $30	$40

Vision Plans

	PREMIER PLAN	LOW PLAN	BOTH PLANS
LENSES (CONTINUED.)			**ESTIMATED RETAIL COST**
Polycarbonate Lenses	$0[7] or $30	$0[7] or $30	$64
Ultraviolet Coating	$12	$12	$28
Standard Anti-Reflective (AR) Coating	$35	$35	$62
Premium AR Coating	$48	$48	$80
Ultra AR Coating	$60	$60	$113
Standard Progressive Additional Lenses	$50	$50	$154
Premium Progressives (Varilux®[8], etc.)	$90	$90	$248
Ultra[9] Progressive Addition Lenses	$140	$140	$430
High-Index Lenses (1.67 / 1.74)	$55 / $120	$55 / $120	$120
Polarized Lenses	$75	$75	$103
Plastic Photosensitive Lenses (Transitions® [5])	$65	$65	$123
Scratch Protection Plan Single Vision/Multifocal Lenses	$20 / $40	$20 / $40	N/A

1. The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Collection is inclusive of select toric and multifocal contacts.
2. Additional discounts not applicable at Walmart, Sam's Club or Costco® locations.
3. Including, but not limited to toric, multifocal and gas permeable contact lenses.
4. For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
5. Transitions® is a registered trademark of Transitions Optical Inc.
6. Enhanced frame allowance of $180 only available at Visionworks® locations nationwide.
7. Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.
8. Varilux® is a registered trademark of Societe Essilor International.
9. Category includes digital free-form progressive lenses.

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

Ancillary Benefits

Hearing Plan: Ameritas - SoundCare®

Life's getting louder.® Thanks to the cranked up volume of modern life, hearing loss is becoming a major health problem.

Policy Features

- This plan provides access to EPIC Hearing Healthcare, the largest ENT and Audiologist network in the country.
- While you have the freedom to choose any hearing provider to receive benefits, choosing an EPIC in-network provider by calling **1-877-359-8346** gives you the best discounts and most benefit possible on hearing aids.
- The advantage of seeking services through an EPIC provider includes:
  - No claims to be filed for the member
  - Up to 60% discount on all name-brand and private-labeled hearing aids
  - Hearing wellness program
  - EPIC Customer Service line 9 a.m.-9 p.m. ET
  - Finance options available
- Hearing Exam: A full audio metric hearing exam is covered at 100% through EPIC providers once every benefit period. This comprehensive exam is also available if you choose not to use EPIC with reimbursement up to $75 per benefit period.
- Hearing Aid Maintenance: You are also eligible for 100% of hearing aid maintenance up to $40 per benefit period. Maintenance covers batteries, service contracts, fittings, ear molds and repairs.
- No Deductibles: Hearing exams, hearing aids and hearing aid maintenance are all deductible-free.
- Increasing Hearing Benefits: The hearing aid benefit is progressive, rewarding you with benefits that increase over time based on your enrollment effective date. If you require a hearing aid, your DCPS plan covers 50% of the hearing aid cost per ear up to the annual benefit amount.
- Once you use your hearing aid coverage at any level, you become re-eligible for benefits at the top level, after five years, as long as there is no break in coverage.

Questions?

SoundCare customer service representatives are available Monday-Thursday, 7 a.m. to 12 a.m. and Friday, 7 a.m. to 6:30 p.m. (CST) to answer your questions. Please call 877-359-8346.

Ameritas SoundCare

Monthly Rates	
Retiree	$6.00
Retiree + Spouse	$12.00
Retiree + Child(ren)	$9.00
Retiree + Family	$15.00

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

Pet-Focused Benefits PetPlus

Brought to you by Pet Benefit Solutions

PetPlus is a Prescription Discount Plan that will save retirees money on all prescriptions and preventatives including flea and tick preventatives, heartworm preventatives, and dietary supplements. PetPlus is available at a low cost per month.

Plan Benefits

- **Savings:** Guaranteed savings; members-only pricing (up to 40% off) on flea & tick preventatives, Rx medications, vitamins and supplements, heart worm products, specialty/Rx food, and more.
- **AskVet 24/7 Pet Telehealth:** 24/7 access to US-based veterinarians for unlimited support on your pet's health, wellness, behavior, and more.
- **Convenience:** PetPlus will get the prescription script; no need to call or ask the vet; free delivery always, no restrictions; convenient Rx pick up at more than 60,000 pharmacies nationwide.

What is PetPlus?

With PetPlus, retirees get wholesale pricing on prescriptions, preventatives and other products which are almost never covered by insurance. It's instant savings without any paperwork.

Are there any exclusions?

All dogs and cats are eligible for PetPlus. There are no restrictions on breed, health, or age.

When can retirees start using their membership?

Immediately! All participating retirees will receive instructions how to activate their online account before the benefit start date. Just login to the PetPlus account, register pets, and start shopping immediately.

PetPlus Rates

Monthly Rates	
PetPlus Single Pet	$4.50
PetPlus Multiple Pets	$8.50

Ancillary Benefits

Identity Theft Program
ID Commander

Identity theft is the fastest growing crime in America, with an identity stolen once every four seconds.

Plan Benefits

ID Commander, a leader in proactive identity theft protection, uses a variety of industry-leading tools to help protect you from the threat of identity theft:

- Advanced Identity Monitoring and Alerts
- $1 Million Identity Theft Insurance Policy, with $0 deductible
- Full-service Identity Restoration
- 24/7 Lost Wallet Assistance
- Award-winning Computer Protection Software

ID Commander's comprehensive identity theft protection plans are available to both individuals and families, with complete access to benefits the moment membership begins. The ID Commander Family Protection Plan provides a truly managed household program and empowers individual family members with the tools and data they need to proactively manage the health and well-being of their identities.

If the worst happens, and you become the victim of identity theft while covered by ID Commander, we will restore your identity and any related credit accounts to pre-theft status. No limits, no fine print, no "service guarantee." In addition, if you suffer any covered out-of-pocket expenses as a result of a breach, you're covered by a real insurance policy that will put money in your hands for qualified losses.

Take command of your future with ID Commander – sign up today!

ID Commander Rates

	PREMIUM	ULTIMATE
MONTHLY RATES		
Retiree Only	$7.00	$10.50
Retiree + Family	$15.00	$22.50

Technology Support Program
IT Please - Whole-Home Technical Support Program

IT Please is a whole-home technology support program that gives members unlimited 24/7/365 remote support access via the internet, chat, or phone, for everything from virus removal and wireless network troubleshooting to gaming console setup.

Product Details

- **24/7 Remote Technical Support -** Experienced and qualified technicians are standing by 24/7 to instantly resolve your technical issue. Technicians will utilize cutting edge technology to fix your computer over the internet.
- **On-site Support -** We have over 14,000 technicians who can be dispatched to your home or office as soon as the same business day.
- **Antivirus Software -** BitDefender Total Security will protect you from viruses, Trojans, spyware and other malicious software.
- **Online Data Backup -** Our data back up service provides secure, enterprise-class remote data backup solutions.
- **Self-Help Database -** Our self-help database contains more than 120,000 use solutions to common computer problems.
- **Best Practices Assessment -** You will receive an online analysis of your computing environment and recommendations to improve performance and security.

UNLIMITED SUPPORT PLAN

- Unlimited remote support
- On-site support (up to 50% off retail rates)
- Self-help solution library
- Best practices assessment
- Computer protection software

UNLIMITED PLUS SUPPORT PLAN

- Unlimited remote support
- On-site support (up to 50% off retail rates)
- Self-help solution library
- Best practices assessment
- Computer protection software
- **Secure data backup (100GB)**

IT Please Rates

MONTHLY RATES	
Unlimited Support Plan	$10.00
Unlimited Plus Support Plan	$14.00

FSRBC Medicare Information

POST-65 MEDICARE ELIGIBLE RETIREES

FSRBC 2024

DUVAL COUNTY PUBLIC SCHOOLS

The Florida School Retiree Benefits Consortium (FSRBC) is committed to providing Retirees of Duval County Public Schools with a program that is both comprehensive and competitive. FSRBC provides Medicare eligible retirees with access to high-quality Medicare Medical plans tailored especially for those age 65 or older, who have retired from the Florida public school system.

Who is FSRBC?

The FSRBC was established in 2012, under the Florida Statute 163.01, to provide benefits for Retirees and Dependents eligible for Medicare. Since its inception, FSRBC has grown and is now comprised of 19 School Districts throughout Florida and providing coverage to over 16,000 school district retired employees.

Retirees benefit from the Consortium's collective purchasing power and retirees health insurance subsidy dollars are not considered taxable income by FRS and could save as much as $270 a year in taxes. FSRBC is able to offer Group Medicare Advantage Plans with Prescription Drug at a National rate, which do not require medical underwriting unlike Medicare Supplement plans. Each year, FSRBC works with carriers to review group plan offerings to customize, as needed, based on Retiree needs.

Who is eligible for FSRBC?

FSRBC Medicare Medical Plans—Currently, Medicare-eligible retirees and Medicare-eligible spouses from Duval County Public Schools that are enrolled in Medicare Parts A and B.

FSRBC
Better Benefits · Better Retirement
FLORIDA SCHOOL RETIREE BENEFITS CONSORTIUM

Want to Learn More?

Attend one of FSRBC's Weekly Virtual Classrooms!

The FSRBC Virtual Classroom provides you with opportunity to learn more about Medicare, what Medicare medical plans FSRBC has to offer, and ask questions based on your unique situation!

Visit

https://myfsrbc.com/

to view the schedule and RSVP Today!

FSRBC Medicare Information

2024 Monthly Premiums

FSRBC Medicare Advantage Prescription Drug (MAPD)		
Carrier	**Plan Name**	**2024 Monthly Premium per Retiree**
United Healthcare	Group National PPO	$0.00
	Low Premium National PPO	$76.98
	Comprehensive National PPO	$238.10
	Premier National PPO	$357.58

FSRBC Medicare Supplement Plans		
Carrier	**Plan Name**	**2024 Monthly Premium per Retiree**
United Healthcare	Plan A, F, G, and N	Cost varies based on age, gender, zip code and health status. Monthly Premium will be provided during enrollment process.

FSRBC Prescription Drug Plans (PDP)		
Carrier	**Plan Name**	**2024 Monthly Premium per Retiree**
United Healthcare	Comprehensive PDP	$125.58
	Premier PDP	$310.94
	AARP Saver (FL rate)	$80.60
	AARP Preferred (FL rate)	$103.50

How to Enroll In FSRBC Medicare Medical Plans:

- Enrollment in a FSRBC Medicare Plan can be completed independently online or over the phone with one of our FSRBC Medicare Customer Service Representatives.
- To enroll online visit www.myfsrbc.bswift.com and register for an account.
- To enroll over the phone or for assistance with the online enrollment system, call our FSRBC Medicare Customer Service Center at 1-833-686-0983. Open from 8:00am—8:00pm EST, Monday-Friday, throughout Annual Enrollment from October 16th, 2023— November 3rd, 2023.
- For specific questions or to setup an individual consultation please reach out to Shannon Shepherd and Alyssa Castillo, from FSRBC, by emailing benefits@myfsrbc.com.

Payment Methods Available:

- FRS (Pension), ACH and Checks are acceptable forms of payments for all plans available
- Payments for FSRBC Medicare plans are setup through bswift

Notices

COBRA Overview

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event, also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy that was previously given to you. A copy of this notice is available upon request.

HIPAA SPECIAL ENROLLMENT NOTICE

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Plan Administrator.

CREDITABLE COVERAGE NOTICE

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oct. 15 to Dec. 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Florida Blue coverage will be affected. You can keep this coverage if you elect to join a Medicare drug plan, and your Florida Blue health plan will coordinate your benefits with Medicare for drug coverage. See pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at **http://www.cms.hhs.gov/CreditableCoverage/**), which outlines the prescription drug plan provisions/options that Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Florida Blue coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Florida Blue and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Florida Blue/CHP changes. You also may request a copy of this notice at any time.

For More Information about Your Options:

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 8/14/2023
Name of Entity/Sender: Duval County Public Schools
Contact--Position/Office: Employee Benefits Department
Address: 1701 Prudential Drive, Jacksonville, FL 32207
Phone Number: 1-904-390-2351

Notices

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA) ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator for more information.

NEWBORN AND MOTHERS HEALTH PROTECTION ACT

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

The length of stay may not be limited to less than: 48 hours following a vaginal delivery OR 96 hours following a cesarean section.

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

- For an in the hospital delivery: The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center): The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.

These rules do not mandate hospital stay benefits on a plan that does not provide that coverage. The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

NOTICE OF PATIENT PROTECTIONS

The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your plan administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Duval County Public Schools or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan administrator.

Forms

CANCELLATION OF DCPS RETIREE INSURANCE

FBMC Retiree & Direct Bill
Attn: Mail Slot 32
PO Box 10789 •Tallahassee, FL 32302-2789
Fax: 866-836-9943

NAME: _____

SOCIAL SECURITY NO: _____

I elect to cancel the insurance coverage(s) indicated below, effective:
(end of month)

HEALTH	OPTIONAL INSURANCES	Indicate Coverage Level Self/Spouse/Child(ren)
___Self	___Dental	_____
___Spouse	___Vision Care	_____
___Dependents	___AHL Group Hospital Indemnity	_____
	___AHL Individual Hospital Indemnity	_____
	___Unum Long Term Care	_____
	___ID Commander	_____
	___IT Please	_____
	___Standard Life Group Term Insurance	_____
	___PetPlus	_____
	___SoundCare Hearing	_____

You must contact the provider company to cancel any of the following plans:

- Allstate Benefits Critical Illness - 1-800-348-4489
- AFLAC Cancer/Hospital Intensive Care: 1-800-992-3522
- Trustmark Accident/Cancer/Universal Life: 1-800-918-8877
- Unum Whole Life: 1-800-635-5597

Reason for Cancellation:

_____

_____

Signature _____ **Date** _____

Notice of Social Security Disclosure

State laws require agencies that are required to collect employee Social Security numbers (SSN) to disclose the purpose for collecting the SSN. Duval County Public Schools is allowed to collect SSN's when specially authorized by law to do so or when the collection is imperative for the performance of the District's duties and responsibilities. Pursuant to Federal and State Laws, the District is collecting your Social Security number for the purpose of processing employee and dependent benefits; this collection is Mandatory. If you do not provide your SSN, Duval County Public Schools cannot process your application/request. Duval County Public Schools will not disclose your SSN to anyone outside of the District except as authorized by law.

Glossary of Terms

Annual Enrollment - Designated period of time during which an employee may enroll in group health coverage.
Carrier - Refers to the insurance company.
Claim - The request for payment of benefits received in accordance with an insurance policy.
Copay - A copayment is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.
Coinsurance - A payment for covered charges shared on a percentage basis between the covered person and the health plan. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.
Deductible - A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan there is usually a separate higher deductible for using out of network providers.
Dependent - A person or persons relying on the policyholder for support. May include the spouse and/or unmarried children (whether natural, adopted or step) of an insured policyholder.
Elimination Period - This is the time period between injury or illness and the receipt of benefit payments.
EOB - **Explanation of Benefits**. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.
EOI - **Evidence of Insurability**. The medical information you must provide that requires review and approval by the insurance company before coverage becomes effective. This may include medical records and a physical exam.
HIPAA - **Health Insurance Portability and Accountability Act**. A law passed in 1996 that gives citizens both the right to privacy of their medical records, and a certain level of control over how, when, and with whom those records are shared. This also includes the right to be notified of how, when, and with whom sharing takes place.
HMO - **Health Maintenance Organization**. This type of medical plan is Network exclusive. A participant must receive services from in-network providers except in the case of a medical emergency.
In-Network - Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.
Mail Order Prescriptions - Refers to maintenance drugs. members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.
Maintenance Drugs - A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure, and asthma. This also includes birth control.
Maximum Out-Of-Pocket - The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out-of-pocket, depending on the plan.
Out-Of-Network - The use of healthcare providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point of Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.
Participating Provider - Contracted individual physicians, hospitals, and professional healthcare providers that provide services to its members at a discounted rate.
PCP - **Primary Care Physician**. A doctor elected by the insurance plan member and is part of the plan network. They provide routine care and coordinate other specialized care. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist, or pediatrician.
PPO - **Preferred Provider Organization**. A network of healthcare providers that contract with a carrier to provide care at a discounted rate. Benefits can be paid for out-of-network doctors at a higher rate. Plans feature office visit copays, deductibles at a variety of levels, and coinsurance to a maximum out-of-pocket expense. Usually includes copays for prescription drugs.
Preventive Care - Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.
Premium - The regular fee to pay for an insurance plan. Employees pay premiums deducted pretax from their paycheck.
Referral - A written recommendation by a physician that a member may receive care from a specialty physician or facility.
Specialist - A participating physician who provides nonroutine care, such as a dermatologist or orthopedist.
SPD - **Summary Plan Description**. This is the definitive document that outlines the complete terms of a policy.

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