



District Health Insurance Plans Dependent Eligibility Audit

Follow-Up of Audit Recommendations

Office of Internal Auditing
June 2014

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Director – Internal Auditing

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Preface

The Office of Internal Auditing serves to improve the fiscal accountability and enhance the public's perception of the management and operations of the Escambia County School District. This engagement strives to meet those objectives.

Audits, reviews, and other engagements are determined through a District-wide risk assessment process, and are incorporated into the annual work plan of the Office of Internal Auditing, as approved by the Audit Committee. Other assignments are also undertaken at the request of District management.

This engagement was conducted with the full cooperation of District operational staff. We did not encounter any restrictions to records or personnel, which would prohibit us from expressing an opinion or offering recommendations.

Any recommendations included in this engagement are designed to improve operations and serve as the basis for informed discussions related to policies and procedures.

This engagement was conducted in accordance with the International Standards for Professional Practice of Internal Auditing, as promulgated by the Institute of Internal Auditors.

We thank the Risk Management department staff for their cooperation and commitment. We look forward to reviewing their progress when we follow-up on our recommendations.



Office of Internal Auditing
Escambia County School District
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75 North Pace Blvd. – Suite 403
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Executive Summary

The District provides health benefits to its employees and their eligible dependents. The eligibility of a dependent for coverage is outlined in the District's Section 125 Flexible Spending Benefits Plan. Dependent eligibility is further defined in the Flexible Benefits Plan Reference Guide provided to all employees. It is the responsibility of the Employee Benefit Trust Fund trustees to ensure benefits are provided only for those dependents who meet the defined eligibility criteria.

In 2012, we performed an audit in an attempt to aid the trustees in this responsibility and issued our report dated August 2013. In this audit, we attempted to test the eligibility of dependents of all employees who elected either "+1" or "Family" coverage during open enrollment for the 2012 year; a 100% sample. Our audit resulted in recommendations and this report represents our follow-up to those recommendations.

Our audit identified two separate instances of ineligibility: One instance involved the ineligibility of an employee's domestic partner; the second instance involved the ineligibility of an employee's common law spouse. **We reviewed documentation verifying that Risk Management had terminated coverage relating to these two dependents, that claims incurred by them had been reversed by United Health Care, and that reimbursement to the District for any premiums due had been pursued and collected.**

As a result of our audit, we were also unable to verify the eligibility of the dependents (21 total) of 15 employees. These employees failed to provide the requested documentation to verify eligibility, despite numerous interactions with the employees. Our follow-up aimed to determine the status of these employees and their dependents. Our reviewed documentation included items such as marriage certificates, birth certificates, tax returns, adoption orders, dependent affidavits, and various other documents. We noted the following:

- **Eight dependents were able to be verified as eligible for coverage.**
- **Eight dependents were terminated as a result of our previous audit (or normal procedures going forward).**
- **One dependent was not terminated until employee's contract was not renewed in 2013.**
- **Four dependents were terminated as a result of this follow-up.**

For all dependents terminated, except one, we were able to verify that there were no claims processed during the period after our initial audit through termination by the District. The District has reversed charges with United Health Care for the one dependent with claims.

Additionally, we recommended Risk Management require documentation similar to that required in our previous audit when new hires are enrolled, as well as when current employees add dependents in the future, especially during the outsourced open enrollment period. Per discussion with Risk Management personnel, it appears that in lieu of requiring documentation, a “common sense” approach was taken when employees enroll their dependents. If a dependent had the same last name, they were typically deemed eligible and enrolled without providing documentation of eligibility. Only during unusual circumstances would Risk Management require documentation at the time of enrollment, either by their department or at open enrollment. **After our follow-up work, but prior to the issuance of this report, Risk Management developed enrollment procedures that require employees to provide documentation so that dependent eligibility can be confirmed. The procedures, which continue to be revised, include steps to remove dependents from coverage if the documentation is not provided.**

Also, we provided a recommendation to share the results of our previous audit with the third-party open enrollment firm and to continue to provide training related to District eligibility definitions. **We conducted interviews with Risk Management personnel who noted that our previous audit was shared with the third-party enrollment company. In addition, Risk Management personnel provided training to enrollers regarding the District’s eligibility criteria and documentation requirements.**

Finally, we were presented with the opportunity to assist the Auditor General’s office in their audit of dependent eligibility. We included that testing as a part of this follow-up by expanding our scope. We obtained a random sample of 25 employees (53 total dependents) from the total population of employees participating in District health coverage that selected either “+1” or “Family” coverage for the 2014 year. As Risk Management did not have the eligibility documentation, as previously requested in our original audit, we obtained and reviewed supporting documentation such as marriage certificates, birth certificates, tax returns, adoption orders, dependent affidavits, and various other documents. **We were able to verify the eligibility of the dependents (53 total) of the 25 employees selected (100%).**

Background

The District administers various health insurance plans in which employees, as well as eligible dependents, can participate. Eligibility criteria for dependent coverage is outlined in the District’s Section 125 Flexible Benefits Plan. Dependent eligibility is further refined in the Flexible Benefits Plan Reference Guide provided to all employees.

The receipt of premiums and payment of claims are managed through a dedicated trust known as the Employee Benefit Trust Fund (The Fund). The Fund is managed by a board of trustees, and is governed by the Escambia School District Benefit Trust Agreement. This agreement mandates that the trustees shall discharge their duties, “solely in the interest of the employees covered under the Plan and their dependents and for the exclusive purpose of providing benefits to such persons.”

In an effort to assist the trustees in performing their designated duties, we elected to verify the eligibility of all dependents enrolled during the 2012 open enrollment for medical coverage. Our audit, which was released in August 2013, resulted in recommendations. Open enrollment took place in October 2013 for the 2014 Plan year. Our follow-up to the recommendations related to our previous audit began in March 2014. In addition to the follow-up, testing was performed to assist the Auditor General’s office in their audit of dependent eligibility. This report represents our follow-up to those recommendations and the results of the testing to assist the Auditor General’s office.

Objective

Overall, our objective was to follow-up on our previous audit recommendations. Specifically, our 5 objectives were as follows:

- To follow-up on the recommendation for Risk Management to terminate coverage for the two instances of ineligibility involving a domestic partnership and a common law spouse, and reverse any claims incurred and collect any premiums due.
- To follow-up on the recommendation for Risk Management to follow through with the 15 employees who were unresponsive to our requests for verification documents.
- To follow-up on the recommendation that Risk Management require documentation similar to that required in our original audit and this follow-up, when new hires are enrolled, as well as when current employees add dependents in the future, especially during the open enrollment period.
- To follow-up on the recommendation to share the results of our original audit with the third-party open enrollment firm and conduct additional training with their representatives regarding the District’s dependent eligibility definition and required documents.
- To assist the Auditor General’s office in their audit by performing additional testing on the eligibility of 25 randomly-selected employees who have dependents participating in health coverage through the District.

Scope

The scope of this engagement was two-fold: For the follow-up related to the 2012 dependent eligibility audit, the scope included the two identified instances of ineligibility, 15 employees who were unresponsive to multiple requests for verification of eligibility of dependents, the enrollment process for dependents, and training of third-party enrollers. For the testing performed to assist the Auditor General's office, our scope consisted of selecting a sample of 25 employees, from all employees with dependents, participating in District health coverage as of March 14, 2014.

We conducted interviews with Risk Management personnel. We reviewed documents such as marriage certificates, birth certificates, tax returns, adoption orders, and dependent affidavits. In addition, we reviewed District enrollment forms, Risk Management memos, and claim history documents from United Health Care.

Methodology

Our previous audit identified two instances of ineligibility. For these, evidence was provided by Risk Management that their coverage had been terminated, related charges were reversed, and any premiums due had been collected by the District.

Our previous audit also identified 15 employees who had not been responsive to multiple requests for information to verify the eligibility of their dependent(s). We conducted interviews with Risk Management personnel on the current status of their dependent coverage. For those dependents that still had active health coverage at the time of our follow-up, we reviewed the required documentation verifying their eligibility. For those dependents whose coverage was terminated by Risk Management as a result of our audit, we reviewed system printouts demonstrating their date of termination from the health plan and verified whether or not any claims were processed on their behalf through this date. To verify whether or not any claims were filed on behalf of these dependents, we reviewed claim history documents from United Health Care covering the applicable date range.

Additionally, a recommendation was made that the Risk Management Department require documentation similar to that required in our previous audit when new employees enroll with dependents, as well as when current employees add dependents in the future, especially during the outsourced open enrollment period. We conducted interviews with

various Risk Management employees to follow-up on this recommendation.

Also, our office recommended Risk Management share the results of our previous audit with the third-party open enrollment firm, and conduct additional training with their representatives regarding the District's eligibility definition and required documents. To follow-up on this recommendation, we conducted interviews with various Risk Management employees.

To determine our sample for testing to assist the Auditor General's office, we obtained a list from Risk Management detailing all current District employees with dependents participating in health coverage. Per discussion with the Auditor General's office, it was determined that a sample of 25 employees with dependents would be sufficient for their purposes. As such, we assigned a number to each employee on the list and used Excel to randomly generate our sample of 25 employees, with a total of 53 dependents. We compared our sample to the previous audit performed by our office (where 100% of the population was tested). For any employees in our new sample that were tested in our previous audit, we compared their current coverage and dependents to their previous coverage and dependents. If there were no changes, we reviewed supporting documentation we previously obtained to verify eligibility. For any new hires or any newly-added dependents, a letter was sent to the employees requesting supporting documentation to verify the eligibility of their dependent(s).

As documentation was received by our office, an auditor logged the information and conducted the initial testing of the documents. The files were then reviewed by a second auditor for final determination and quality control.

We feel we have performed sufficient work and collected sufficient supporting documentation to reach a conclusion.

Follow-Up Testing Results

Follow-up of Instances of Ineligibility (2):

We verified Risk Management terminated the health insurance coverage related to the two instances of ineligibility. We also verified that Risk Management reversed any charges through United Health Care related to the two dependents and pursued any and all amounts owed to the District through payroll deductions.

Follow-Up of Unverified Dependent Eligibility (15 employees):

We interviewed Risk Management personnel to gain information on the

status of the 15 employees and their dependents' eligibility (total of 21 dependents). We obtained various documents to verify eligibility (marriage certificates, tax returns, birth certificates, etc.). Four dependents had not provided documentation and were still active. They were sent a final request letter by Risk Management seeking their eligibility verification. They were unresponsive and, as a result, were terminated. We noted the following:

- Eight dependents' eligibility was able to be verified.
- Eight dependents were terminated as a result of our previous audit (or normal procedures going forward).
- One dependent was not terminated after being unresponsive to original requests for verification, but was since terminated when the employee's contract was not renewed with the District.
- Four dependents were terminated as a result of being unresponsive to this follow-up.

For all dependents terminated, except one, we were able to verify that there were no claims processed during the period after our initial audit through termination by the District. We verified the District has reversed the charges filed on behalf of the one dependent with claims.

Follow-up of Requiring Documentation of Eligibility at Enrollment:

According to Risk Management personnel, they did not require documentation similar to that required in our original audit and this follow-up, when new hires were enrolled, as well as when current employees added dependents. Their department had taken a "common sense" approach when it came to eligibility documentation requirements at the time of enrollment. As long as dependents had the same last name, or nothing appeared unusual, the dependents were enrolled. Prior to the issuance of this report, Risk Management developed procedures to require the submission of documentation to verify dependent eligibility.

Follow-up of Third-Party Results/Training Recommendation:

According to Risk Management personnel, they shared the results of our previous audit with the third-party enrollment firm. They provided the typical annual training in regards to the District's eligibility definitions and documentation requirements.

Testing to Assist the Auditor General's Office (25 Employees):

We selected a sample of 25 employees (with a total of 53 dependents). For those in our original audit with no changes, we relied on our previous work where a 100% sample was tested. For those with changes, or new employees, Risk Management did not obtain eligibility documentation, as recommended in our previous audit. We sent a letter requesting the documentation necessary to verify eligibility. We noted the following:

- Forty total dependents were included in our previous audit with no changes in coverage.

- Seven total dependents were enrolled through Risk Management without submitting documentation proving eligibility.
- Two total dependents were enrolled by third-party enrollers without submitting documentation proving eligibility.
- Three total dependents provided “Dependent Affidavits” as they were now older than 19, but younger than 26. These dependents were deemed to be eligible.
- One employee had made changes in their coverage compared to the previous audit. They had removed several older dependents from their coverage, and only had a spouse remaining. This dependent was determined to be eligible.

Conclusions

Regarding the 2 dependents previously deemed ineligible, it appears that the Risk Management Department has terminated coverage and collected any premiums due and reversed charges with United Health Care.

For the previously unresponsive 15 employees (21 dependents) we noted the following:

- Sixteen dependents (76%) have either been verified as eligible, or terminated (as a result of our previous audit or normal procedures going forward).
- One dependent was not terminated after being unresponsive to original requests for verification, but was since terminated when the employee’s contract was not renewed with the District.
- Four dependents were terminated as a result of being unresponsive to this follow-up.

As of our follow-up work, Risk Management had not implemented procedures to require documentation similar to that required in our audit, when new hires are enrolled, as well as when current employees added dependents. **After our follow-up work, but prior to the issuance of this report, Risk Management developed enrollment procedures that require employees to provide documentation so that dependent eligibility can be confirmed. The procedures, which continue to be revised, include steps to remove dependents from coverage if the documentation is not provided.**

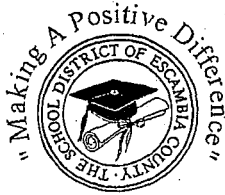
It appears that Risk Management has shared our previous audit with the third-party enrollment firm and has provided the typical annual training as it relates to the District’s eligibility definitions and documentation requirements.

For our testing to assist the Auditor General’s office, all 53 dependents

included in our sample were verified as eligible, either from the original audit or this follow-up. For the 9 new dependents requiring documentation, Risk Management did not have eligibility documentation, as previously recommended in our original audit.

Overall, it appears that the District has addressed the recommendations provided in the report for which this follow-up was intended.

Management Response



THE SCHOOL DISTRICT OF ESCAMBIA COUNTY

75 NORTH PACE BLVD.
PENSACOLA, FL 32505
PHONE (850) 432-6121
<http://www.escambia.k12.fl.us>
MALCOLM THOMAS, SUPERINTENDENT

Risk Management
Kevin T. Windham, CSRM, CFE, Director
(850) 469-6218/Fax: (850) 469-6293

September 2, 2014

Mr. David Bryant, Director
Internal Auditing

Re: Dependent Eligibility Follow-Up Audit

Dear Mr. Bryant:

I would like to express my appreciation to you and your staff for the quality and professionalism maintained during the most recent follow up audit of dependent eligibility. As always, I welcome any audit recommendations that could result in an improvement of efficiencies or cost savings to the Employee Benefit Trust Fund and/or District.

The Risk Management and Benefits Department has always worked extremely hard in developing internal controls and processes to assure that only those employees and dependents eligible for benefits are participating and utilizing the medical plan. Any employee or dependent not eligible for these benefits would be an unauthorized cost for both employer and employee from premiums paid into the Trust Fund. While there is an added exposure to fraud and misuse by using an external enrollment company for our annual open enrollment, I am very confident that both employees and dependents enrolled in the medical benefit plan by Risk Management staff at the time of employment are all eligible for benefits at the time enrolled.

The problem areas that we have experienced during my tenure in this position, and even in the past as an internal auditor, have occurred during the annual open enrollment period. The open enrollment period exposes the District to employees adding ineligible dependents since enrollment is occurring with agents and on-line self-enrollments. While these exposures exist, the Risk Management Department required the enrollers to collect paperwork documenting any new dependent being added and we conducted enrollment follow-up on new dependents added. This process has been successful in the past to identify, chargeback and recover any monies paid for ineligible employees or dependents.

I have reviewed the report in its entirety and offer the following comments:

1. Newly hired employees enrolling in benefits and enrolling dependents, have always been required to provide supporting documentation of a dependent's eligibility status for benefits. However, as a general rule in the past, the Risk Management staff has previously allowed new employees only to enroll a spouse or child(ren) without evidence of dependent verification as long as the status or

relationship code certified by the employee was "husband", "wife", "son" or "daughter" and with the same last name (the "common sense approach"). Any other relationship code or a different last name would trigger an exception and would require the supporting documentation (marriage license, birth certificate, etc..) to verify dependent eligibility. Employees are also told that disciplinary action could be taken and medical claim chargebacks would occur for employees found with ineligible dependents.

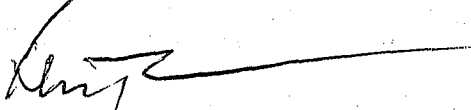
I would point out in two separate audits performed by Internal Auditing, no dependents were found where the Risk Management staff allowed a dependent with the before mentioned relationship codes that was not eligible for coverage. We believe that since employees are clearly provided information on who is eligible at the time of hire, the number of exceptions has been nonexistent. Our previous and current exposure still remains with our annual open enrollment period whereby employees may enroll on-line or with an external Enrollment Counselor. Enrollment Counselors are trained and provided the definition of an eligible dependent, however, we have found that controls do not exist at the same level as they do if enrolling in the Risk Management Department.

The Risk Management and IT Departments have been working on a new dependent database in Skyward that will provide us with better and more timely reporting. We will be better able to track dependent eligibility going forward using this new database and reporting. We are also moving to an on-line enrollment for new employees, beginning July 2014, and have also developed a reporting system that will track newly added dependents. This will provide us with a method and time frame deadline for employees to provide the required dependent verification. In addition, a notice has been given to the employees at the new hire orientation that the dependent eligibility documentation must be provided prior to the effective date of coverage, or the dependent will be removed and the employee will be converted to single coverage only (see noticed attached).

The Risk Management Department will continue to request documentation, when new hires are enrolled, as well as when current employees add dependents in the future, including the outsourced open enrollment period. We will again share the results of this audit with the third party open enrollment firm, and agreed to conduct additional training with their representatives regarding the District's dependent eligibility definition and required documents.

I agree with the audit findings and accommodations that the Risk Management Department has established effective procedures for ensuring health benefits are only provided to dependents eligible for coverage. The known instances of ineligibility noted were isolated events which resulted from either employee deception and/or third-party open enrollment staff deviating from established guidelines.

Sincerely,

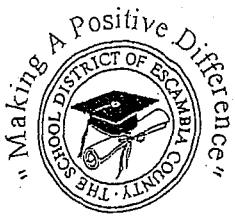


Kevin T. Windham, Director
Risk Management

(02)

DJB

9/2/14



Premier Enroll Online Enrollment Instructions

If your first day of work is on or before the 15th of the month, you must complete your online enrollment by the 20th of your first month of active employment. If your first day of work is after the 15th of the month, you will have 15 days from your first day of work to complete your online enrollment. An employee will usually be allowed to register and enroll following their New Hire Orientation. After 15 days of your work start date, employees who have not completed an enrollment will not be allowed to enroll in any of the District's Benefit Plans until the next Open Enrollment.

Welcome to your benefits online enrollment. A couple of important things to remember before you get started.

Consider all of your options before making your elections. Once you make your election, you will only be able to make changes during Open Enrollment or if you have a Qualifying Event.

If you are a Dual Spouse Couple (Both Spouses will be employees of the District) you must come to the Risk Management Department to complete your enrollment, Premier Enroll will not allow you to enroll.

1. Create a NEW USER login and password at www.myFBMC.com
2. Check the email address that you provided in your New User Profile for an automatic message that will be sent to your inbox immediately. Click the validation link in the email. Return to www.myFBMC.com, sign in and begin your enrollment.
3. Please temporarily allow pop ups on your computer. Please read all pop up information as this is important information regarding your enrollment.
4. If you are adding your spouse and/or children to your benefits, dependent verification documentation (marriage license, birth certificate, etc.) is required. Please see page 5 of your Escambia County School District Reference Guide and the dependent information sheet in your enrollment folder. You may also view the Reference Guide online at:

<http://ecsd-fl.schoolloop.com/riskmgt>.

5. Your enrollment session will "Pend" until the required documentation is submitted to the Employee Benefits Department. All required dependent documentation must be submitted to the Risk Management Department by the effective date of when your benefits go into effect. Failure to submit the dependent documentation will result in your selections being changed to "Employee only" for that benefit selection.
6. Dependent documentation may be brought to the Risk Management Department located at 75 N. Pace Blvd, Pensacola, FL 32505. Monday through Friday from 7:30am to 5:00pm 850-469-6267.

If you have any questions or trouble logging into Premier Enroll, you can call the FBMC Customer Care Department at 1-855-569-3262.



"Making a Positive Difference"

THE SCHOOL DISTRICT OF ESCAMBIA COUNTY, FLORIDA

75 NORTH PACE BOULEVARD

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MALCOLM THOMAS, SUPERINTENDENT

Risk Management
Kevin Windham, CFE, Director
850-469-6267/Fax: 850-469-6293

WELCOME to the School District of Escambia County, Florida! You have been given a packet containing lots of information regarding benefits offered by the District. We request you do the following before attending your scheduled benefits orientation:

- Review the information contained in your packet. The Flexible Benefits Plan (FBP) booklet details the majority of plans offered. Other booklets are included. We will go over this information during your benefits orientation.
- Bring your drivers license with you. We will need to make a photo-copy.
- Bring a social security number AND date of birth for each eligible dependent you wish to enroll. See page 6 in the FBP booklet for dependent eligibility. Contact the Registrar's office and obtain college verification for dependents 19 to 25 years of age for dental and vision care. This enrollment history should include all semesters attended AND enrollment status.
- Bring a date of birth AND address for each beneficiary (primary and contingent) that you list. This is for your basic life and additional life/AD*D.

NO ENROLLMENT FORM WILL BE ACCEPTED WITH INCOMPLETE INFORMATION

All employees have 30 days from the effective date of employment to make an enrollment election in the benefit plan. However, keep in mind you can not report to work until this Enrollment Form is completed or you waive enrollment. Employees that do not enroll during this time period will not be allowed to participate in the District's benefit plan until the next open enrollment date.

YOU WILL NOT BE ABLE TO REPORT TO YOUR WORK LOCATION UNTIL ALL OF YOUR PRE-EMPLOYMENT PAPERWORK IS COMPLETED. UPON COMPLETION OF YOUR ENROLLMENT FORM, RISK MANAGEMENT WILL GIVE YOU A GREEN SHEET WHICH IS YOUR APPROVAL TO REPORT TO WORK. YOU WILL GIVE THIS TO YOUR PRINCIPAL/SUPERVISOR ON YOUR FIRST DAY OF WORK (no green sheet.....no pay).

Again, on behalf of myself and my staff, WELCOME!!!!!! We look forward to seeing you at your scheduled benefits orientation on:

DATE

TIME

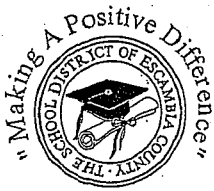
Sincerely,
Kevin T. Windham, Director
Risk Management

I have been given a benefits packet. I have scheduled my benefits orientation. I understand if I do not attend this meeting, I will have incomplete paperwork and can NOT report to work.

Signature

Social Security Number

Date



To: District Employees
From: Risk Management and Benefits
Subject: Open Enrollment & Updates

Info: Risk Management and Benefits
75 North Pace Blvd.
Pensacola, FL 32505
Phone: (850) 469-6267 Fax (850) 469-6293

It's that time of the year again! An Open Enrollment for a "New Plan Year" is scheduled for Monday, October 22 through Friday, November 9, 2012 for an effective date of January 1, 2013. The Plan Year for all benefit selections (Plan Year Deductibles, Out-of-Pocket Limits, Annual Benefit Levels, etc.) will be from January 1-December 31st each year. Any employee that needs to: 1) make changes to their current benefits or plans; 2) enroll in Voluntary Insurance Products that are ONLY available during Open Enrollment; or 3) enroll in one of the District's Flexible Spending Accounts (FSA) or Health Savings Accounts (HSA) must participate in Open Enrollment!

Who should participate and What can I change?

This is an Open Enrollment for active benefit eligible employees for a New Plan Year that will be in effect from January 1-December 31st, 2013. **ALL ACTIVE BENEFIT ELIGIBLE EMPLOYEES** will need to go to Open Enrollment to make any changes in their Medical plan selection, enroll in new voluntary products, or if they wish to participate in one of the District's Flexible Spending Accounts (Medical or Dependent Care FSA), or Health Savings Account. You will need to either meet with an Enrollment Counselor at your work location, enroll by phone, or again this year you may also go online to enroll at www.myFBMC.com to review current selections and choose benefits for the new plan year effective January 1, 2013.

What's New This Year?

1. The Board has approved continuing the four (4) major medical plans for 2013 (HSA, Base HRA, \$500 Choice HRA, PPO) with no increases in employee premiums and adding additional benefits or coverage for advance imaging scans (MRI, CT, PET, Nuclear) in the HRA Plans. Employees will need to review and compare all plans, premiums, and verify any existing HRA balances prior to making a medical plan selection. All Medical Plan Summaries will be available in your "2013 Employee Benefits Guide" delivered at your work location or on-line through the Employee Portal on the District's Risk Management website.
2. Any HRA funds remaining in your current HRA Plan (Base or \$500 HRA) account will not roll over into the HSA Plan (rollovers to HSA plans are not allowed by the IRS). Please consider any anticipated unspent HRA funds prior to making your final medical plan selection. You may visit www.myuhc.com for HRA balance information or contact UHC customer service at the number listed on your medical card.
3. Medical Gap or Bridge Plans, through Colonial Life Insurance Co., will be offered at affordable pricing to provide a benefit to offset exposures to high out-of-pocket cost for hospitalizations, surgeries, diagnostics exams, etc. See your Enrollment Guide or Enrollment Counselor for details (Pre-Existing Condition Limitations do apply).
4. Many voluntary benefit plans offered last year will now require Evidence of Insurability (EOI). See your Enrollment Guide or Enrollment Counselor for details.

Must Reads: IMPORTANT INFORMATION

1. Enrollment in one of the District's Flexible Spending Accounts (Medical or Dependent Care FSA) or the Health Savings Account (HSA) is **MANDATORY EACH YEAR!** This means that if you wish to continue in one of these accounts, you **MUST** sign up for participation during this Open Enrollment period, as your existing deduction(s) cancels at the end of each Plan Year.
2. An enrollment specialist will be visiting your work location on the date(s) shown on the Enrollment Schedule enclosed. For employees that miss your work location enrollment, enrollment counselors will be available at the Hall Center Break Room, for the entire enrollment period and we will also have a TOLL FREE CALL CENTER for the entire Open Enrollment with extended hours. You will also be able to SELF-ENROLL ON-LINE at www.myFBMC.com. Requests for changes after Open Enrollment will not be honored unless they qualify under the "IRS Change of Status Rules".
3. You will be receiving an updated comprehensive benefits guide for the new Plan Year. Please contact your front office (schools) or departmental secretary (Hall Center, Warehouse and McDaniel's Bldg. departments) if you have not received your new guide. The new guide will have information on all health/dental plans and rates through the end of **December 31, 2013** to assist employees in benefit selection comparisons. This guide will also be available on the District's Risk Management Web Site on the Employee Portal.

Checklist

Bring the following information to your enrollment meeting when you see an Enrollment Counselor.

- A "sample" enrollment form is attached to assist you in completing your medical plan selections prior to enrolling. This is not the actual enrollment form, only a sample that you may bring with you for your enroller.
- Social Security Numbers for your dependents.
- Dates of Birth for both your dependents and beneficiaries.
- Addresses for both your dependents and beneficiaries for voluntary products.
- New Dependent Verification: If you choose to add a dependent to any benefit, you must provide a document verifying the dependent is eligible. You do not need to verify current dependents added in previous years. If adding a new dependent, please bring a birth certificate, adoption decree or marriage certificate to enable dependent verification. Dependents cannot be added without document verification.
- For New Employees: Please bring a copy of your most current enrollment form from the Risk Management and Employee Benefit's Dept. as you may not be populated in the enroller's laptop. This will assist in identifying what Plans you are "currently" enrolled in.

QUESTIONS AND ANSWERS:

1. Do I have to come to Open Enrollment if I do not wish to make any changes or purchase any additional products? We always encourage employees to visit with an enroller to explore the benefits offered by the District. Also, if you wish to participate in one of the District's Flexible Spending Accounts (Medical or Dependent Care FSA), or Health Spending Account (HSA), you must sign up for participation each year.

2. If I currently participate in a Medical or Dependent Care FSA or HSA with the District, do I have to re-enroll during open enrollment for the new plan year? Yes, you must re-enroll each year to participate in a Medical or Dependent Care FSA, or HSA account starting January 1, 2013. You may also continue using only your Medical Expense FSA during the Grace Period, which is two months and 15 days after the end of the plan year. The IRS does not allow the District to roll-over or continue FSA amounts beyond a 12-month period, which ends on December 31 each year; however, you do have a 90-day run-out period (through March 30 of the following year) at the end of the plan year for reimbursement of eligible FSA expenses incurred during the 2012 plan year (including the Grace Period). HSA's are owned by the employee, so these balances remain without any risk of forfeiture.

3. What should I elect for my Medical Expense FSA per-pay-period amount? You should estimate and enroll in an amount per-pay-period that will cover out-of-pocket expenses that you anticipate incurring during the twelve (12) month period from January 1-December 31, 2013. The Grace Period will allow you additional time to incur claims if you have not previously incurred sufficient eligible out-of-pocket expenses prior to December 31, 2013. This will help reduce the chances of an employee forfeiting amounts deposited into their Medical Expense FSA.

4. What is an HRA (Health Reimbursement Account)? A HRA is a traditional major medical plan that may have additional HRA funds deposited by the employer to offset expenses charged toward your deductible. This HRA reimbursement arrangement either pays or reimburses employees for qualified medical care expenses incurred by the employee or the employee's spouse or tax qualified dependents.

5. What expenses are covered by the Health Reimbursement Account? Any HRA funds in your account will be used first to cover out-of-pocket medical expenses other than co-pays. After the HRA funds are exhausted, regular coverage provisions apply based on a schedule of benefits.

6. Can I still have an FSA account and select the HRA? Yes, you may still have an FSA account and choose the HRA for your coverage selection.

7. Can I use the HRA account for my perscriptions? No, the HRA can only be used for your medical (Doctor, Hospital, Labs, etc.) expenses.

8. Can the balances in the HRA account just be used for the employee? No, the HRA funds may be used for medical expenses that are incurred by anyone covered under your plan (yourself, spouse, child, etc.).

9. What Doctors/Centers can I use? You can use the same Doctors/Centers that are currently covered by the UHC network.

10. What if I have unused contributions left in the HRA account at the end of the year? Any employee that maintains the same HRA Plan (HRA-Base or the Choice \$500 HRA) will have immediate access to the use of any remaining HRA balances for the 2012 plan year. If you elect to change your current HRA plan but still remain in an existing HRA plan, remaining balances may be delayed to allow for claim run-out periods from 2012, of approximately 2-3 months.

QUESTIONS AND ANSWERS (Continued):

11. What is the **HSA plan** and is it right for me? The HSA plan is a qualified **HDHP** (high deductible health plan) that provides major health coverage only after an annual deductible is satisfied. Both medical services (doctor, urgent care, emergency, room, hospitalization, etc...) and pharmacy benefits (prescription drugs) go toward offsetting the annual deductible and the HSA plan starts covering all medical and pharmacy benefits at 80% after the annual deductible is satisfied. Once an out-of-pocket limit is reached, the plan picks up the cost of these services at 100% for the remainder of the plan year. **The HSA plan may be the perfect fit for employees (or families) in good health that are looking for a lower premium option. (NETWORK DISCOUNTS ARE APPLIED FOR EXPENSES INCURRED DURING THE DEDUCTIBLE PERIOD)**

12. How do the **HSA plan** deductibles and out-of-pocket amounts work? The HSA plan is the only plan where the deductible also goes toward or erodes the plan out-of-pocket maximum. Plus the HSA is the only plan where your prescription cost also erodes both of these annual amounts. An employee selecting single coverage has to satisfy the individual deductible/out-of-pocket amounts, and someone with a dependent(s) will have to satisfy the family deductible/out-of-pocket amount.

13. What is the **HSA Account** and how does it work? The HSA plan offers the ability for an employee to set up a pre-tax payroll distribution for paying qualified out-of-pocket medical expenses.... very similar to a medical flexible spending account. This account is considered a tax-exempt individual savings account. The HSA account contributions are not taxed as income so employees can pay for out-of-pocket medical expenses on a pre-tax basis using a credit card supplied by UHC. This account is owned by the employee so all pre-tax funds deposited in the account are yours even after you leave employment or retire. These funds can be used to pay for qualified medical expenses as long as a balance exists.

14. Who can have an **HSA Account**? Anyone that enrolls in the HSA plan is eligible as long as you are NOT: 1) covered by another medical plan that is not a high-deductible health plan, 2) entitled to Medicare benefits, 3) claimed as a dependent on another person's tax return.

15. What are the maximum annual contribution amounts for an **HSA**? For 2013, amounts allowed are \$3,250 for an individuals and \$6,450 for families.

16. Can my unspent **HRA** funds be transferred into my **HSA** account? **NO**, the IRS does NOT allow for **HRA** to **HSA** transfers.

17. Can I still have an **HSA** account and select the **FSA** also? No, you will deposit pre-tax payroll contributions directly in your new **HSA** account instead and you will use this account for out-of-pocket medical expenses subject to the **HSA** balance in the account at the time of use.

18. *How can I enroll this year?* You will have three ways to enroll this year....1) schedule an appointment to see an enroller at your work location, 2) self-enroll on line 24 hr/day 7 days/week during the open enrollment period at www.myfbmc.com or 3) use the telephone call center to speak with an enroller even with extended hours.

19. If I am interested in purchasing a voluntary benefit product such as a Medical Gap Plan, Universal Life Policy, Critical Illness Policy, Short-Term Disability, Long-Term Disability, Vision, Additional Term Life, etc.... *How can I enroll this year?* You may self-enroll in the Vision Plan but you will need to either schedule an appointment with the on-site enroller or speak with an enroller via the toll-free call center to enroll in the Medical Gap Plan, Universal Life Policy, Critical Illness Policy, Short-Term Disability, Long-Term Disability, and Additional Term Life products. Some of these voluntary products may offer limited underwriting or guarantee issue during this year's enrollment **ONLY**. In addition, Pre-Existing Limitation may apply, so please review your employee benefits guide or ask the enroller for details.

Changes to Your Benefit Plan Selections (Change of Status Issues)

Am I permitted to make mid-plan year election changes other than at Open Enrollment?

Under some circumstances, the School District's Plan(s) and the IRS may permit you to make a mid-year election change, known as a "special enrollment period". A rule of thumb is that any deductions for insurance benefits (Health, Dental, Vision Care, Medical FSA, Dependent Care FSA, Cancer and Intensive Care) that are included under the District's Cafeteria Plan that are deducted on a "**PRE-TAX**" basis cannot be changed other than at Open Enrollment each year. The **ONLY** exception to this rule is if you have a qualifying "Change in Status" as defined by the IRS and the change is allowed under the District's Plan(s). This Change in Status Event may qualify you for a "special enrollment period" as long as you notify and make an application for the change to the District within **30 DAYS** of the effective date of the change (**CHANGE HAS TO BE DOCUMENTED** for the election changes to be considered). Notifications received after the 30-day period will not be allowed and you will be responsible for continuing to make premium payments even though certain ineligible dependents may no longer be eligible for coverage other than through a COBRA enrollment. See your Benefits Guide for additional details concerning "Changing Your Coverage". The Risk Management Department has a cutoff date of the 15th of each month to make changes effective the first of the following month.

Eligibility and Dependent Information

You are eligible for benefits as an active employee if you are a permanent, full-time employee of the School District and work at least 20 hours/week. See additional details concerning employee eligibility in the Employee Benefits Guide.

Dependent Eligibility (Who can be covered)

You can cover eligible dependents under every benefit that shows a premium amount for dependent coverage (refer to the rate charts that appear with each benefit description) provided you participate in the same benefit. Eligible dependents may include (documentation may be required):

- your legal spouse
- your own unmarried children
- children for whom you have been appointed legal guardian (through the courts) and
- stepchildren and legally adopted children (provided they reside in your household and primarily depend on you for support).

For all of the benefits below, unmarried insured children who are physically or mentally handicapped, and fully incapable of self-care, will be covered until disablement becomes other than total. Proof of disability must be submitted to the Risk Management Department following the child's 19th birthday. Please refer to specific dependent eligibility information on the following benefit information pages of this Reference Guide.

Dependent Eligibility (For Dental, Life and Vision Plans)

Until the following conditions are reached, eligible dependents will be covered from birth, adoption or time of guardianship. Your dependent children are eligible for coverage under the Dental, Life and Vision Plans to age 19. Eligible dependents include your spouse and unmarried children (by birth, marriage, adoption or legal custody) who are living with you and dependent on you for more than half of their support, if they are:

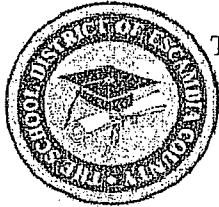
- under age 19
- age 19 to 25, enrolled as a full-time student in an approved school (verification required on a semester/quarterly basis to the Risk Management Department)
- age 25 or older, and incapable of self-support or
- children for whom you are required to provide health or dental coverage, as mandated by court order, judgment or decree.

Dependent Eligibility – (Health Coverage Only)

Until the following conditions are reached, eligible dependents will be covered from birth, adoption or time of guardianship. Your dependent children are eligible for coverage under the Medical Plan to the end of the calendar year in which the child reaches the age of 26. Eligible children include your children (by birth, marriage, adoption or legal custody) if they are:

- under age 26
- age 26 or older, and incapable of self-support (as documented with UnitedHealthcare before age 26) or
- children for whom you are required to provide health coverage, as mandated by court order, judgment or decree.

Any employee found with ineligible dependents WILL BE required to pay back ALL benefits paid where dependent coverage was not allowed. Verification of Dependent status may be requested at any time by the Risk Management Dept.



THE SCHOOL DISTRICT OF ESCAMBIA COUNTY, FLORIDA
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MALCOLM THOMAS, SUPERINTENDENT

Risk Management and
Benefits Department
(850) 469-6267

Checklist for Benefits Enrollment:

Bring the following information to your enrollment meeting when you see a Benefit Specialist:

1. Social Security Numbers for your dependents.
2. Dates of Birth for both your dependents and beneficiaries.
3. Addresses for both your dependents and beneficiaries.
4. New Dependent Verification: If you choose to add a dependent to any benefit, you must provide a document verifying the dependent is eligible. Please bring a birth certificate, adoption decree, court-ordered guardianship agreement, college verification of full-time status (children 19 and older) for dental and vision coverage, or marriage certificate to enable dependent verification. For a step-child, please provide a copy of the divorce decree showing insurance coverage requirements. New dependents cannot be added without document verification.

REQUIRED DOCUMENTATION FOR ECSD DEPENDENT ELIGIBILITY AND ENROLLMENT

The Trustees of the Escambia County School District's Employee Benefit Trust Fund are required to ensure that only employees, retirees, and their eligible dependents are receiving health care benefits paid from the Trust Fund. As a result, the District must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, children, "over-age" children, and disabled dependents) must submit documentation per the details below.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex to whom you are legally married.	<ul style="list-style-type: none"> • A photocopy of the Marriage Certificate, and • A photocopy of the front page of the employee/retiree's most recently filed federal tax return* (Form 1040) that includes the spouse.
CHILDREN Under Age 26	<p>Your children under age 26.</p> <p>Stepchildren, foster children, legally adopted children, and children placed for adoption are also eligible provided they are under the age of 26.</p>	<ul style="list-style-type: none"> • Natural Child – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. • Step Child – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse as a parent and the same documentation listed above, which is required for a spouse. • Legal Guardian, Adoption, or Foster Child(ren) – Photocopies of Affidavits of Dependency, Final Court Orders with the presiding judge's signature and seal, or Adoption Final Decree with the presiding judge's signature and seal.
CHILDREN Age 26 & Higher	<p>The State of Florida allows children up to the age of 30 to be considered dependents for the purposes of health insurance eligibility and access, provided that the child:</p> <ul style="list-style-type: none"> • Is unmarried and does not have a dependent of his/her own, and • Is a resident of Florida or student, and • Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any 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. 	<ul style="list-style-type: none"> • You must provide the same documentation listed above, which is required for children under the age of 26, and • A completed Overage Dependent Affidavit, and • A photocopy of the front page of the employee/retiree's most recently filed federal tax return* (Form 1040) that includes the dependent, or a photocopy of the front page of the dependent's most recently filed federal tax return* (Form 1040) if the dependent files his/her own return.
DISABLED	An unmarried child age 30 or over who is or becomes disabled and dependent upon you.	<ul style="list-style-type: none"> • You must provide the same documentation listed above, which is required for children under the age of 26, and • Proof of disability (you do not need to provide this documentation if previously provided to the Risk Management Department)

**Note: For tax forms and other documents, you may black out all financial information and all but the last 4 digits of any Social Security numbers.*