

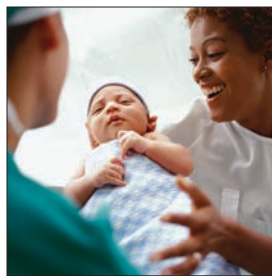
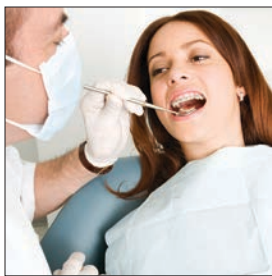
Better Choices. Better Health.

BE ENGAGED • FOCUSED • INSPIRED • TRANSFORMED

BE FIT!



2018 Benefits Reference Guide



THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Superintendent's Message

Dear District Employees,

We welcome you to view the benefits information included in this benefits reference guide. We've compiled all the information about benefits available to you as an employee of Palm Beach County School District into this handy guide.

► **MEDICAL** - The district provides subsidized medical insurance coverage to our full-time employees. Premiums start as low as \$50 per month for employee only coverage. You may also purchase coverage for your children, spouse or domestic partner. We offer many options and are confident you will find a plan that meets your needs and budget.

► **HEALTH REWARDS** - We also have an award-winning wellness program that will reward you with a \$600 discount from these premiums if you participate. Read the section titled Health Rewards for more information.

► **TERM LIFE** - Basic term life in the amount of \$20,000 is provided to you as a full-time employee.

► **DENTAL, VISION, LIFE & DISABILITY** - Dental, Vision, Disability and additional Term Life Insurance are optional benefits you may wish to review and decide if they are right for you.

► **FLEXIBLE SPENDING ACCOUNTS** - We offer FSAs for medical or dependent care. These tax-free programs allow you to put money aside from your paycheck and use those funds for medical or dependent care expenses. You save money because you never have to pay FICA or income tax on these monies.

► **RETIREMENT PLANS** - In addition to the Florida Retirement System (FRS) plans that you contribute 3% of your pay, you are eligible to enroll in a 403b or 457 plan. We offer both tax-deferred or ROTH accounts. If you start saving now, the funds will grow and you will be glad you participated at retirement time. Choose from a pre-selected list of vendors and enroll today. Plan B allows you to enroll while you are enrolling for your other benefits, and get started saving right away.

Sincerely,
Dr. Robert Avossa



ALEX® HELPS YOU PICK YOUR BENEFIT PLANS

The School District of Palm Beach County (PBCSD) is happy to provide you access to ALEX, an easy to use online tool, to help you with the 2018 benefit plan decision process. Before you make your enrollment decisions, be sure to spend a few minutes with ALEX to find the best-fit benefit plan for you and your family.

TOP 5 ALEX FACTS

1. ALEX is a PBCSD benefits expert who can help you pick the right plans and explain any terms or concepts you don't understand.
 2. ALEX is available online, so you can use the tool with your spouse and family members from any computer at any time.
 3. Using ALEX is easy! ALEX will ask you a few straightforward questions about your needs in order to form a custom recommendation that's right for you.
 4. For an expert on health insurance and employee benefits, ALEX is pretty funny. The experience is designed to be light, jargon-free, and helpful.
 5. ALEX does not create, receive, maintain, transmit, collect, or store any identifiable end-user information. Whatever you share with ALEX remains completely private.
- You can use ALEX to find or double-check your employee benefit options at www.myalex.com/pbcsd/2018 today.

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"CHAT" WITH ALEX

Before you make a benefits enrollment decision, be sure to talk to ALEX. ALEX can make sure you're in the right kind of plan for your needs, and that can save you and your family time and money.

FIND OUT WHICH PLAN IS BEST FOR YOU!

► WWW.MYALEX.COM/PBCSD/2018

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Employee Benefits Resource Directory

THE SCHOOL DISTRICT OF PALM BEACH COUNTY RISK & BENEFITS MANAGEMENT

561-434-8580

Fax 561-434-8103

<http://L.sdpbc.net/qmoi9>

COBRA MEDICAL, DENTAL, VISION BENEFIT OUTSOURCE, INC. (BOI)

5599 S. University Drive, Suite 201

Davie, FL 33328

888-877-2780

HEALTH CARE FSA

COBRA Information

WageWorks®

855-428-0446

DENTAL INSURANCE UNITEDHEALTHCARE DENTAL®

800-955-4137 Managed Care Plans

877-816-3596 PPO Plans

www.myuhc.com

UHC On-site Representative

Fulton Holland Building, A-103

561-434-8092 / 561-357-7564

MEDICAL & PHARMACY INSURANCE UNITEDHEALTHCARE®

www.myuhc.com

Member Services

888-380-0389

UHC On-site Representative

Fulton Holland Building, A-103

561-434-8092 / 561-357-7564

Nurse Liaison - Gail Diedrick, RN, BSN

561-434-7417

Telephone-based Coaching Program

800-478-1057

Diabetes Health Plan

866-944-9001

NurseLine

888-229-9322

Real Appeal

844-344-REAL(7325)

www.member.realappeal.com

FLEXIBLE SPENDING ACCOUNTS WAGEWORKS® CUSTOMER SERVICE

Mon - Fri, 8 a.m. - 8 p.m. ET

855-428-0446

FSA Debit Card Activation

24 hours a day

888-514-6845

www.wageworks.com

FBMC On-site Representative

Fulton Holland Building, A-103

561-434-7442

WAGEWORKS® FLEXIBLE SPENDING ACCOUNT CLAIMS

P.O. Box 14326

Lexington, KY 40512

855-428-0446

Toll-Free Claims Fax 1-855-291-0625

www.wageworks.com

DISABILITY INCOME PROTECTION PLAN METROPOLITAN LIFE INSURANCE COMPANY

(MetLife) 800-300-4296

www.MetLife.com/MyBenefits.com

TERM LIFE AND ACCIDENTAL DEATH & DISABILITY

Metropolitan Life Insurance Company

(MetLife) 800-638-6420

www.MetLife.com/MyBenefits.com

CRITICAL ILLNESS AND CRITICAL LIFE EVENTS UNIVERSAL LIFE INSURANCE ACCIDENT INSURANCE TRUSTMARK INSURANCE

866-636-5525

www.trustmarksolutions.com

email: pbsd@trustmarkins.com

HEALTH ADVOCATE HEALTH CARE NAVIGATION & EAP WORKLIFE ASSISTANCE

855-424-8400

[www.HealthAdvocate.com/
palmbeachschools](http://www.HealthAdvocate.com/palmbeachschools)

401(A) SPECIAL RETIREMENT PLAN ADMINISTRATOR BENCOR ADMINISTRATIVE SERVICES

888-258-3422

www.bencorplans.com

email: questions@bencorplans.com

403(B) PLAN ADMINISTRATOR TSA CONSULTING GROUP, INC.

Participant Transactions

28 Ferry Road SE

Fort Walton Beach, FL 32548

Phone: 888-796-3786

Fax: 866-741-0645

www.tsacg.com

VISION PLAN EYEMED VISION CARE

Provider Locator

866-299-1358

www.eyemed.com

Customer Service

866-723-0514

www.eyemed.com

Important Enrollment Information

ANNUAL OPEN ENROLLMENT

Existing employees are able to make changes to their benefits once per year during the Open Enrollment period. Please watch for the dates and make any required changes at that time.

OPEN ENROLLMENT IS USUALLY EVERY NOVEMBER

Employees who add dependents to plans	Documentation and Social Security information required (See page 15)
Those who want flexible spending accounts	These plans must be elected each year
All Employees	To review plan information, changes, cost and verify data

OPEN ENROLLMENT - WHO SHOULD PARTICIPATE? RETURNING FROM LEAVE OF ABSENCE

Returning to work can be exciting and stressful. Within 30 calendar days of your return from a leave of absence, it is critical that you contact Risk & Benefits Management to make elections. You will need to complete a paper enrollment form. At this time, elections due to a return from leave cannot be processed online. If you fail to complete a benefits change form within 30 calendar days of your return from leave, you will be enrolled in the default Low Option HMO medical plan with employee-only coverage. *(For additional information regarding your benefits while on leave, please refer to the leave information beginning on page 19 of this guide.)*



NEW HIRES: Be sure to enroll within 30 days of your hire date. Otherwise, you will default to Employee Only coverage in the Low Option HMO medical plan.

For online Open Enrollment, visit www.mysdpbc.org.

Enter your district Username and Password. Click on the [PeopleSoft icon](#), then click on [My Benefits/Benefits Enrollment](#) to make your selections.

PAPERLESS ENROLLMENT

This is a paperless enrollment, so you will enroll and confirm your benefits online. To access the district's online benefits enrollment system, visit www.mysdpbc.org. It is important for you to carefully review your elections prior to the close of your election period. Once you submit your elections and the enrollment period closes, your choices are irrevocable. We will process all submitted elections.

►TO ENROLL, GO TO WWW.MYSDPBC.ORG AND CLICK ON THE PEOPLESOFT ICON THEN CLICK ON [MY BENEFITS/THEN SELECT BENEFITS ENROLLMENT](#).

The system automatically defaults to the day you view the information. To see future benefits effective periods, such as new plan year information elected during Open Enrollment, change the date to 01/01/2018. New hire benefits become effective on the first day of the month after 30 days of employment. Therefore, new employees should enter the first day of the month in which benefits become effective.

HEALTH REWARDS - HOW TO KNOW IF YOU ARE RECEIVING THE HEALTH REWARDS CREDIT.

The name of our medical plan holds the key to this important information. If you are receiving the Health

Rewards credit, the medical plan name will end in "Health Rewards credit."

If you are not receiving the Health Rewards credit, only the medical plan name will be displayed.

This is what you need to know about your benefits:

- Benefit elections are irrevocable during the plan year, unless you experience a valid Change in Status (see page 17) and provide written documentation of the event. Approved pre-tax deductions will be made prospectively on the first day of the month after the benefits change form and supporting documentation showing that your request is consistent with, and on account of, the event.
- Waiving medical coverage requires that an election be made. Otherwise, default enrollment in the Low Option HMO single coverage will be processed.
- Waiving medical coverage is only an option for those who have medical coverage provided by another employer or an individual plan.
- Flexible Spending Accounts (FSAs) do not continue from one year to the next. You need to make an election each year to have an FSA in the new plan year. Please consult a tax expert for assistance with determining household maximums for FSAs.

Important Enrollment Information

- The Health Care FSA has an annual minimum of \$300 and an annual maximum of \$2,650.
- The Dependent Care FSA has an annual minimum of \$300 and an annual maximum of \$5,000.
- Review eligibility requirements (*see page 12*).
- Review employee responsibilities (*see page 9*).
- To enroll a newborn, you will need to provide proof of birth and/or a birth certificate within 60 days of birth.
- Review dependent audit requirements.
- You are responsible for reviewing your paycheck (available online) to make sure the proper plans and charges are reflected.
- Review your personal data such as mailing address and dates of birth for you and your covered dependents. You can update your personal information using the PeopleSoft My Benefits tool.
- Verify that complete and accurate information is properly reflected for your dependents.
- Review your plan election information, including any dependents you may have attached to a benefits plan to ensure accurate enrollment.
- Enrollment appeals are granted under very limited circumstances and generally are not permitted in the case of accidentally enrolling in a plan or adding/deleting a dependent in error. It is important that you confirm your elections and entries prior to the end of your enrollment period. *Please see page 7 for further information.*

It is important that you view your enrollment choices during this Open Enrollment period.

NAVIGATE FROM THE EMPLOYEES PORTAL PAGE THROUGH PEOPLESFT AND THEN FOLLOW THE PATH OF MY BENEFITS/BENEFIT SUMMARY

ENTER 01/01/2018 TO VIEW YOUR 2018 BENEFIT ELECTIONS

We will process the choices you have made. Anytime you want to view your confirmed elections, be sure to enter 01/01/2018 to view your 2018 benefit elections.

FLEXIBLE SPENDING ACCOUNT ENROLLMENT

You must re-enroll in Flexible Spending Accounts (FSAs) annually. FSA deductions begin the month in which the FSA becomes effective. **If you do not complete the enrollment process, your FSA benefits will NOT continue for the new 2018 plan year.**

►PRIOR TO THE LAST DAY OF THE ELECTION PERIOD BE SURE TO CONFIRM THAT YOUR BENEFIT CHOICES ARE CORRECT AND ACCURATE.

Elections made during the Open Enrollment period are irrevocable and should be reviewed carefully prior to the close of the election period. This is your one opportunity to make election choices.

While viewing your enrollment choices, please double-check each plan including the coverage level and payroll deduction.

PLAN TYPE: Which medical plan did you choose: Low Option HMO, High Option HMO or CDHP? Which dental plan did you choose: Managed Care or PPO?

COVERAGE LEVEL: Did you choose coverage for yourself only or did you include your dependent spouse and/or children?

DEPENDENT SECTION: Are all of the dependents you wish to cover listed? You should confirm that the date of birth and Social Security information has been entered and is correct.

FLEXIBLE SPENDING ACCOUNTS (FSAs): Verify which reimbursement FSA you are enrolled in. You cannot transfer funds between FSAs or switch from the Health Care FSA to the Dependent Care FSA.

HEALTH CARE FSA: Medical, dental and vision items for you and your eligible dependents (annual maximum: \$2,650).

DEPENDENT CARE FSA: Child day care and elder care expenses that enable you to work. You cannot use this FSA for your spouse or child's medical expenses.

PAYROLL DEDUCTION: Review your January check(s) to make sure that the payroll deductions match the plan and coverage level.

Enrollment Appeals

Enrollment appeals are granted under very narrow circumstances as provided by IRS guidance and consistent with district and insurer practices. It is important to note that failure to provide dependent verification information during enrollment, or accidentally electing or dropping a plan, adding or deleting a dependent in error are not errors that will be considered as an appeal and if submitted will be returned to you unprocessed.

IF YOU EXPERIENCE ONE OF THE FOLLOWING TYPES OF ENROLLMENT ERRORS FBMC WILL REVIEW AND CONSIDER YOUR REQUEST:

- Enrolling in a Dependent Care Flexible Spending Account and you do not have dependents who attend day care/elder care.
- Electing dependent coverage but you do not have eligible dependents (i.e. electing employee and spouse coverage, but you are not legally married).
- Other extenuating circumstances related to the enrollment process that would otherwise be deemed outside of your control by the plan or the IRS.

TO ENSURE YOUR APPEAL IS HANDLED PROMPTLY AND WITH DUE CONSIDERATION:

- Include the School District of Palm Beach County as your employer. Include your district Employee I.D. and your email address.
- Provide a detailed reason for the appeal.
- Include any additional supporting documents, information or comments you think may have a bearing on your appeal.

FBMC reviews and makes the final determination for all enrollment appeals based upon established guidelines. All appeal determinations made by FBMC are final.

You are provided an enrollment period to make your elections and during that same period you are expected to confirm that your elections are correct. You have until the last day of your election period to make any updates or corrections to your coverage, including adding or dropping dependents. **After the last day of your election period, the coverage you have elected will remain in place throughout the plan year unless you have a valid Change in Status.**

Appeals are granted under very narrow circumstances and generally are not permitted due to accidentally selecting a plan or adding or deleting a dependent.

With that understanding, you may submit written enrollment appeals within 30 days of your enrollment period close date to:

ENROLLMENT APPEALS:

FBMC Benefits Management
ATTN: Compliance & Risk Management
P.O. Box 1878
Tallahassee, FL 32302-1878

All enrollment appeals decisions are final.

FSA CLAIM APPEALS

WageWorks, the FSA claims administrator, reviews and makes the final determination for a denied Health Care FSA or Dependent Care FSA claim. You will need to provide a written letter that explains why you believe the claim should be approved. Employees must submit their appeal for a denied FSA claim within 30 calendar days of notification.

FSA APPEALS:

WageWorks Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

Or fax to:

Fax Number: 1-877-220-3248

Health Rewards Credit

PREPARE NOW AND EARN A \$50 PER MONTH MEDICAL PREMIUM CREDIT IN 2019

Earn a \$50 medical premium credit by actively participating in the Health Rewards program. Complete required activities between January 1 and August 31, 2018 to earn your credit beginning January 1, 2019.

Complete the required activities by December 31, 2018 and you will receive your credit beginning with the first premium due on or after June 1, 2019.

It is important for you and your covered spouse/partner to take full responsibility for tracking your progress. For those who use the Health Provider Screening form, please be aware that only the first form submitted will apply. You are responsible for faxing that form.

- Complete the confidential online health survey accessible through www.myuhc.com (you must log in).
- Complete a Biometric Screening (First submitted screening data will apply).
- Meet 4 of 5 Pre-established Biometric Markers.
- If two or more of your biometric measures do not fall within the established ranges, you can still earn reward percentages by participating in one of the alternative programs. These programs will help you get on the right track by providing education and coaching on positive health behaviors.

YOUR COVERED SPOUSE/PARTNER WILL ALSO NEED TO COMPLETE THE HEALTH REWARDS REQUIRED ACTIVITIES IN ORDER FOR THE \$50 PER MONTH HEALTH REWARDS CREDIT TO APPLY IN 2019.

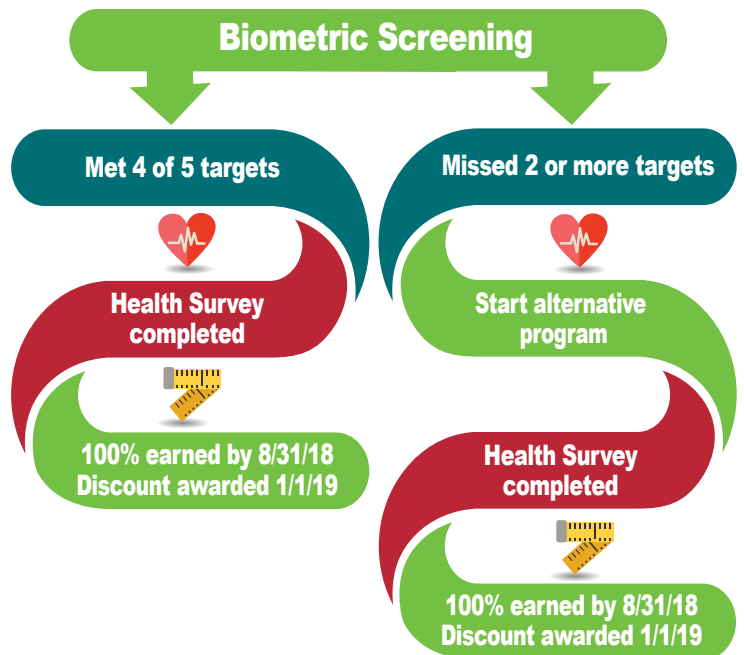
A \$50 per month tobacco surcharge will be added to the medical premium for employees who use tobacco products.*

Log in to: <http://L.sdpbc.net/v1hg7> for available resources to help you be tobacco-free and save.

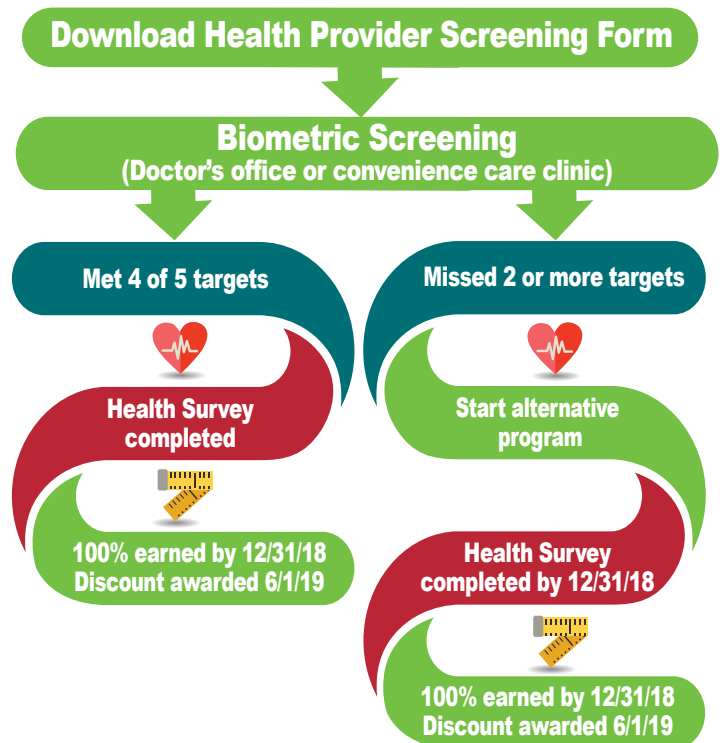
**Based upon self-reported information entered in PeopleSoft. Tobacco surcharge applies to tobacco users or employees who fail to enter a status on the Wellness and Surcharge page.*

Read more at: <http://L.sdpbc.net/oqa6a>

FOR FULL CREDIT



FOR PARTIAL CREDIT



Note: Participant is responsible for tracking progress and submission of Health Provider Screening form.

Employee Responsibilities

PAYROLL CONTRIBUTIONS WILL BEGIN IN THE EFFECTIVE MONTH OF COVERAGE.

EMPLOYEE RESPONSIBILITIES

- You are responsible for participating in and completing the online web enrollment process.
- You may do this on your own. Please carefully review your data to make sure that the information in the system is what you have elected.
- You are responsible for thoroughly reviewing your choices during the online enrollment and prior to submitting your elections.
- You are responsible for entering your enrollment data, including your dependents, your dependents' dates of birth and their Social Security information within the established enrollment time frames.
- You are responsible for maintaining your personal information such as your address.
- You are responsible for providing required documentation to satisfy the eligibility criteria for all enrolled dependents. Otherwise, dependent coverage will be canceled.
- You are responsible for reviewing your paycheck stub when your benefits become effective in order to verify your enrollment and the payroll contributions for the benefits you selected.
- You are responsible for notifying Risk & Benefits Management immediately (*within 30 calendar days of the effective date of your benefits*) if payroll deductions are taken for elections you have not made or if required contributions are not deducted from your pay.
- You are responsible for participating in the Open Enrollment process.
- You are responsible for notifying Risk & Benefits Management immediately (*no later than within 60 calendar days*) when a covered dependent no longer meets the eligibility requirements as defined on page 13.
- You are responsible for providing your tobacco status.



The text in this Benefits Reference Guide provides general information and does not contain all of the applicable terms and conditions of the various benefit plans referenced. Refer to the specific plan document for detailed plan benefits, exclusions and limitations. All updates and changes will be made to the online document as deemed necessary.

Find the most current information by logging in to:
<http://L.sdpbc.net/qmoi9> and selecting the **Benefits Reference Guide** link.

Contribution Overview

EMPLOYEE PAYROLL CONTRIBUTIONS

Your portion of the benefits cost will be deducted through payroll deductions over 22 or 24 pay periods, depending on your paycheck schedule. Changes to your paycheck schedule will impact your contribution amounts accordingly. Some plan premiums are based upon your age and/or earnings. Premiums for these plans are also subject to change.

Enrollment of any child(ren) and a domestic partner will be the equivalent of the family rate. The deductions will be reflected as the employee-only pretax rate and the balance of the deduction will be taken on an after-tax basis. Domestic partners must be covered in order for their children to be covered.

►IMPORTANT NOTE: Employees who receive 26 paychecks will have deductions taken only twice during the months when three checks are issued. Plan costs displayed in this guide may vary slightly from your actual payroll deductions due to rounding.

COVERAGE LEVELS

You will be able to purchase medical, dental and vision benefits at the following levels:

1. Employee only
2. Employee + child(ren)
3. Employee + spouse
4. Employee + family
5. Employee + domestic partner
6. Employee + domestic partner + children (partner's child(ren) and/or employee's child(ren))

This provides you with maximum flexibility to custom-build your benefits plan. You may select medical, dental and vision coverage separately. For example, you may need medical coverage for just you but dental coverage for you and your family.

OVERAGED ADULT CHILDREN

A separate application and contribution are required to enroll eligible adult children who meet the state's requirement and are between the ages of 26 and 30 years of age.

You are eligible to receive 401(a) Dollars if you waive medical coverage as an employee and are not enrolled as a dependent on a district medical plan.



PLAN	MONTHLY 401(a) DOLLARS	
	Full-Time	Part-Time
Waive Medical	\$100	\$50

401(a) DOLLARS

When an eligible employee waives medical coverage, the district will contribute the dollar amount specified in the table below into a 401(a) Special Retirement Plan in your name.

If you have medical coverage other than a district plan (i.e., under another employer's plan), you may waive the school district's medical coverage and receive 401(a) Dollars valued at \$100 per month (\$50 per month if you are a part-time eligible employee). However, once you become eligible for medical insurance as an employee, you are not eligible to be covered as a dependent on a district medical plan by another district employee or to waive medical coverage. *Please refer to page 63 for more detailed information and complete the required form.*

Enrollment Process

ONLINE BENEFITS ENROLLMENT – SECURE, PRIVATE AND NO APPOINTMENT NECESSARY!



- Secure, encrypted information
- Convenient – enroll 24/7
- Allows your spouse to participate with you
- Link to FAQs and providers
- Allows online benefits election verification

►HOW TO OBTAIN YOUR USER ID AND PASSWORD FOR THE PEOPLESOFT SYSTEM

(NOTE: If you already access PeopleSoft or district email, use your current user ID and password).

- Go to: **www.mysdpbc.org**
- Click on the Forgot/Change Password option
- Passwords must be a minimum of 8 characters made up of uppercase and lowercase letters and contain at least one numeric character and a symbol.
- Enter your username (*generally your Employee ID number*)
- If you need help, call 561-242-4100 (option 2)

►LOG IN TO PEOPLESOFT

- Click on My Benefits
- Then click on Benefits Enrollment

THE ENROLLMENT PROCESS

NEW HIRES/NEWLY ELIGIBLE: We are excited to provide our new hires and newly eligible employees with an online process to complete their benefits enrollment. Medical plan enrollment for a minimum of 18 months include: Low Option HMO, Consumer Driven Health Plan (High Deductible Plan), or waiving medical benefits (*if you are covered by a medical plan not offered by the district*). Enrollment in the High Option HMO plan will become a choice during the open enrollment period following your completion of a minimum of 18 months of continuous employment in a benefit eligible position.

OPEN ENROLLMENT

DURING OPEN ENROLLMENT YOU MAY ENROLL ONLINE INDEPENDENTLY: You may enroll in or change any benefit(s) during the Open Enrollment period. Thereafter, changes during the year are only allowed if you experience a valid Change in Status event (*see page 17 of this guide for more information on permitted mid-plan year election changes*). Change in Status events will be made effective on a prospective (future) basis only. This means when you make a timely request, the effective date will be the first day of the month after we have received all required documents to approve your eligible status change. The only exception to the prospective change rule will be in the event of changes made due to birth or adoption. The effective date will be the actual date of birth or placement/adoption as long as all required documents have been submitted within 60 days of the birth or placement/adoption.

PLAN AHEAD - FOR HEALTH REWARDS AND TRUSTMARK

You may schedule an appointment to meet with an FBMC Representative January 8, 2018 to February 9, 2018. It is vitally important that you meet with an FBMC Representative. They will help you with the following:

- Learn about the IRS regulated Form 1095-C
- Educate you on the 2018 Health Rewards Program
- Provide your 2018 Personal Health Rewards Planner
- Schedule your biometric screening appointment
- Tell you how Trustmark's Voluntary Benefits can protect your finances against life's ups and downs

RETURNING FROM LEAVE OF ABSENCE

Returning to work can be exciting and stressful. Within 30 calendar days of your return from a leave of absence, it is critical that you contact Risk & Benefits Management to make elections. You will need to complete a paper enrollment form. At this time, elections due to a return from leave cannot be processed online.

If you fail to complete a benefits change form within 30 calendar days of your return from leave, you will be enrolled in the default Low Option HMO medical plan with employee-only coverage. (*For additional information regarding your benefits while on leave, please refer to the leave information beginning on page 19.*)

Employee Eligibility Requirements

IN THIS SECTION:

- **ENROLLMENT ELIGIBILITY**
- **DEPENDENT ELIGIBILITY INFORMATION**
- **DEFAULT PLAN ENROLLMENT**

ENROLLMENT ELIGIBILITY REQUIREMENTS

We are excited to provide you with online access to complete your initial enrollment, which must be completed within 30 calendar days from your eligibility date. You are provided this time to review your benefits material. Instructions for accessing the online enrollment system can be found on page 11.

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

WHO IS ELIGIBLE?

As an employee of the district you may enroll in the dental and vision plans as an employee OR as an eligible dependent of another employee. You may not enroll in any plan as both an employee and a dependent. If you and another family member both work for the district, each of you cannot cover the other family member as a dependent under the medical or life insurance plans. 401(a) Dollars are contributed to a special retirement plan for any employee who waives medical coverage. In order to waive the district's medical coverage, your medical coverage cannot be a district-provided plan.

If you and your spouse/domestic partner both work for the district, only one of you may cover your eligible dependent children. District employees cannot be covered as a dependent in another district employee's medical plan. Each family member is required to enroll independently for the medical plan.

An eligible regular, full-time employee is defined as an employee who is in a paid status and works six or more hours per day (*7.5 hours per day for those in the CTA bargaining group*). Upon certain qualifying events, a covered employee, spouse and dependents may be eligible for group health plan continuation coverage under COBRA law. Refer to the COBRA section beginning on page 84.



An eligible regular, part-time employee is defined as an employee in a paid status and covered by the CTA bargaining unit working 3.75 hours per day; or, an employee who is in a paid status hired prior to December 31, 2011, and who remains in an active paid part-time status working four but less than six hours per day.

Any non-CTA employee is ineligible for benefits if hired or rehired into a part-time position or transfers from a full-time position into a part-time position.

Dependent Eligibility Requirements

If you are a newly-hired or rehired employee, your period of coverage begins on the first day of the month following 30 calendar days of continuous employment in a benefited position. For a minimum 18 months, your medical plan choices include the Low Option HMO, Consumer Driven Health Plan (CDHP) or Waive (opting out of coverage). Waiving your medical coverage is permitted as long as you are enrolled in medical plan offered outside of the District.

DEPENDENT AUDIT VERIFICATION

All employees adding any dependent(s) to coverage in the medical, dental and/or vision plans must provide documentation of their dependent's eligibility. (See page 15 for appropriate documentation.)

During Open Enrollment you should submit an original government certified document (sufficient to verify eligibility) to a benefits technician in Risk & Benefits Management. Office hours are Monday through Friday, 8 a.m. until 4:30 p.m. The document(s) will be reviewed and immediately returned. (Don't forget to actually enroll your dependent(s).)

New Hires: Use the online enrollment system to make your selections. Mail or bring in original required documents within 30 calendar days of your hire date to be eligible for dependent coverage.

Dependent verification is required to complete your request to add eligible dependents to a plan. You will be required to provide written documentation supporting your relationship and showing that your dependent(s) satisfy the dependent eligibility criteria as outlined below. **The supporting documentation will need to be mailed or brought to Risk & Benefits Management within 30 calendar days of your initial eligibility date.**

DEFAULT PLAN ENROLLMENT

Newly eligible employees who fail to make enrollment choices will be automatically processed as being enrolled with employee-only coverage in the Low Option HMO Medical plan and basic term life insurance. All other plan options will be waived for that plan year.

Subject to dependent verification, you may enroll eligible dependents in most plans that you elect to enroll in. However, if you and your eligible dependent are both employed and eligible for benefits through the district, keep in mind that you may only be enrolled in any given product as either an employee or a dependent; but not both. Domestic partner enrollment is limited to medical, dental and vision plans.

DEPENDENT ELIGIBILITY

Subject to dependent verification documentation, an eligible dependent includes your legal spouse, domestic partner (subject to additional eligibility criteria) or a dependent child. The term "child" is defined as a:

- child born to or legally adopted by you.
- stepchild.
- child of a covered domestic partner.
- child placed in your home pending adoption.
- child for whom legal guardianship/custody has been awarded to you or your spouse.
- grandchild added as a newborn up to a maximum of 18 months of age. Coverage continuation beyond 18 months of age is not available to grandchildren.

NOTE: If the grandchild's parent (your child) becomes ineligible, coverage for the grandchild and the grandchild's parent will terminate at the end of the month in which the eligibility criteria is not met.

The definition of eligible "child" is subject to the following conditions and limitations:

- Dependent child under the age of 26.
- Supporting documentation, such as a birth certificate, will be required for dependent verification.



DISTRICT EMPLOYEES ARE NOT ALLOWED TO COVER ANOTHER DISTRICT EMPLOYEE AS A DEPENDENT ON MEDICAL OR LIFE INSURANCE PLANS.

Dependent Eligibility Requirements

► HOW TO ENROLL ONLINE FOR DOMESTIC PARTNER BENEFITS

You should enroll in **employee-only** coverage under medical, dental and/or vision then scroll down to the **domestic partner** medical, dental and/or vision section to enroll your domestic partner and any children in the after-tax plans.

Remember to provide required documents to Risk & Benefits Management to finalize your elections.

COVERAGE FOR OVER AGED ADULT CHILDREN - PER F.S. 627.6562

(Unmarried 26 - 30 years of age)

A separate enrollment and contribution are required to enroll an unmarried, over aged adult child in the same medical plan you are enrolled in. The eligibility criteria is that the over aged adult child is:

- unmarried and has no dependents of his/her own.
- does not otherwise have other major medical health insurance available (cannot have another option of coverage available).
- lives in Florida or is a student in another state (proof required of residency or student status).
- has continuously been insured (certificate of creditable coverage required).

The application for this type of coverage is available at <http://L.sdpbc.net/59z0y>

COVERAGE FOR UNMARRIED CHILDREN WITH DISABILITIES

Coverage for an unmarried enrolled dependent child who is incapable of self-sustaining employment because of an intellectual disability or physical disability will be covered beyond the specified limiting age, provided that the child was disabled prior to attainment of the limiting age and the child is primarily dependent upon you for support and maintenance.



We require that you provide documentation from the Social Security Administration indicating your child has been deemed disabled. Proof must be provided 30 calendar days prior to when your child would no longer meet the eligibility age definition or at the initial time of enrollment.

Benefits technicians are available at the district office in A-103 to verify dependents you are adding to your plans. You - not the benefits technicians - are responsible for your enrollment data.

DID YOU READ ABOUT:

- WHO IS ELIGIBLE TO ENROLL?
- DOCUMENTATION REQUIREMENTS?
- DEPENDENT ELIGIBILITY?

Sample Dependent Audit Verification Guidelines

DOCUMENTS MUST BE PROVIDED BY THE CLOSE OF THE ENROLLMENT PERIOD.

We have listed the most commonly required supporting documentation for different types of dependent coverage. This list may not be all inclusive. The proof must substantiate the relationship.* Contact Risk & Benefits Management for unusual circumstances. *You must supply original documents to the benefits technician in Risk & Benefits Management.*

COVERED DEPENDENT	VERIFICATION DOCUMENTS
Legal spouse	Original government-issued marriage certificate
Domestic partner Palm Beach, Broward or Miami-Dade residents; non tri-county residents	<ul style="list-style-type: none"> • Proof of domestic partner registration (county) • Receipt for recording fee • Notarized domestic partner affidavit
Birth child Maximum age 25	<ul style="list-style-type: none"> • Original government-issued birth certificate (birth registration cards not accepted)
Adopted child Maximum age 25	Legal adoption documents naming employee (subscriber) as parent. If a spouse (not employee) is the adoptive parent, an original government-issued marriage certificate is also required
Stepchild Maximum age 25	<ul style="list-style-type: none"> • Original government-issued marriage certificate • Original government-issued birth certificate (birth registration cards not accepted)
Domestic partner's child Maximum age 25	<ul style="list-style-type: none"> • Original government-issued birth certificate (birth registration cards not accepted) Domestic partner must also be enrolled
Legal guardianship/ custody	<ul style="list-style-type: none"> • Original government-issued birth certificate (birth registration cards not accepted) • Court documents naming employee (subscriber) as legal guardian/custodian if spouse (not employee) is guardian/custodian • Original government-issued marriage certificate
Grandchild Birth to age 18 months maximum	<ul style="list-style-type: none"> • Original government-issued birth certificate (birth registration cards not accepted) of grandchild • Original government-issued birth certificate (birth registration cards not accepted) of covered dependent birth parent who is also enrolled in the plan
Disabled adult child Unmarried 26 years or older	<ul style="list-style-type: none"> • Original government-issued birth certificate (birth registration cards not accepted) • Original Social Security documents deeming the child disabled prior to turning 25 years old
Over aged adult children Unmarried 26 - 30 years	<ul style="list-style-type: none"> • Original government-issued birth certificate (birth registration cards not accepted) • Certificate of creditable coverage (request from prior insurance) • Application for over aged adult child • Copy of student schedule - if child does not reside in Florida <p>To be eligible for enrollment the adult child must:</p> <ul style="list-style-type: none"> • be unmarried • have no dependents • have no other major medical insurance coverage available • live in Florida OR live outside of Florida and be a student
<p>Be sure to enroll your eligible dependent using the online system and add him or her to each plan. You will need to enter the following required information:</p> <ul style="list-style-type: none"> • Dependent's legal name • Date of birth • Social Security number 	
<p><i>*Sometimes the documentation required to prove a dependent's eligibility for coverage can get complicated. EXAMPLE: Usually an original birth certificate is the only documentation needed for a biological child of an employee. This requirement applies when the employee is the biological mother and her maiden name at the time of the child's birth was Mary Jones and that is the name on the birth certificate. But if her name is now Mary Jackson because she changed it when she married Sam Jackson, we would need to see the child's original birth certificate to establish the relationship AND the employee's original marriage certificate to prove she is Mary Jones, the same person listed on the birth certificate.</i></p>	

Domestic Partnership

IN THIS SECTION:

- **DOMESTIC PARTNER ELIGIBILITY REQUIREMENTS**
- **HOW TO ENROLL ONLINE**
- **PAYROLL CONTRIBUTION/IMPUTED INCOME**

DOMESTIC PARTNERSHIP BENEFITS

The guidelines for the domestic partnership benefit can be found on this page and are posted on the Risk & Benefits Management page at <http://L.sdpbc.net/qmoi9>.

This is a post-tax benefit.

- Elections may only be made/changed during an Open Enrollment period.
- Residents of Palm Beach, Broward or Miami-Dade County are required to submit a completed domestic partner affidavit and proof of registration and recording as domestic partners through the county they reside in.

At the time of publication of this guide, information on how to register in Palm Beach County could be found at www.pbcountyclerk.com/courtservices/circuitcivil/domesticpartner.htm.

- Non-residents of the tri-county area are required to submit a completed domestic partner affidavit and supporting proof as outlined in the non-resident section of the affidavit.
- All documents must be sent to Risk & Benefits Management.
- Open Enrollment: The domestic partner affidavit and any other required documents must be sent by the close of enrollment.
- New Hires: The domestic partner affidavit and any other required documents must be sent within 30 calendar days of your date of hire.

DOMESTIC PARTNERSHIP ELIGIBILITY

All regular employees who are otherwise eligible for medical benefits are eligible to enroll their domestic partner in the medical, dental and/or vision plans. You may enroll as a new hire or during Open Enrollment only. Employees and their domestic partners must meet the following requirements in order to enroll in a medical plan:

- Must both be 18 years of age and mentally competent.
- Must not be related by blood in a manner that would bar marriage under the law of the State of Florida.
- Must be considered each other's sole domestic partner and not married to or partnered with any other spouse, spouse equivalent or domestic partner.

- Must have shared the same regular and permanent residence in a committed relationship for at least one year and intend to do so indefinitely.
- Both parties agree to be jointly responsible for each other's basic food, shelter and common necessities of life and welfare.
- Neither partner can have had another domestic partner at any time during the 12 months preceding this enrollment.

A signed affidavit attesting to the above will be required by both partners as well as proof that both are financially interdependent and living together. (See page 15 for the required documents.)

HOW TO ENROLL ONLINE FOR DOMESTIC PARTNER BENEFITS

You should enroll in employee-only coverage under medical, dental and/or vision, then scroll down to the domestic partner medical, dental and/or vision section to enroll your domestic partner and any children in the after-tax plans.

IMPUTED INCOME

The district subsidizes the actual plan costs, so you only pay the amounts beginning on page 33. However, due to IRS regulations, the amount paid by the district will be imputed income and you will be taxed on that amount.

► REMEMBER TO PROVIDE REQUIRED DOCUMENTS TO RISK & BENEFITS MANAGEMENT TO FINALIZE YOUR ELECTIONS.

It is mandatory to provide supporting documentation for enrolled dependents who are being added to the medical, dental and/or vision plans.

Failure to provide documentation will result in no coverage for those dependents.

Enrollment of any children and a domestic partner will be the equivalent of the family level. The deductions will be reflected as the employee-only pretax rate. The balance of the deduction will be taken on an after-tax basis.

Changing Your Coverage

IN THIS SECTION:

- **PROACTIVE ELECTIONS REQUIRED FOR PRE-TAX CHANGES**
- **CAN YOU MAKE A CHANGE**
- **HOW TO MAKE A CHANGE**
- **PERIODS OF COVERAGE**
- **IRS SPECIAL CONSISTENCY RULES**
- **ALLOWABLE CIS EVENTS**

AM I PERMITTED TO MAKE MID-PLAN YEAR ELECTION CHANGES?

Under some circumstances, the district's plan(s) and the IRS may permit you to make a mid-plan year election change on a prospective (future) basis, or vary a salary reduction amount, depending on the qualifying event and requested change. Making a change on a prospective basis means that the district will process all approved mid-year changes on the first day of the month after you make a Change in Status (CIS) election and submit all required documentation supporting your request.

HOW DO I MAKE A CHANGE?

Partial lists of permitted and not permitted qualifying events under the district's plan(s) appear on the following pages. Election changes must be consistent with and on account of the event. The district will, in its sole discretion, review on a uniform and consistent basis the facts and circumstances of each properly completed and timely submitted mid-plan year election change.

TO MAKE A CHANGE

Within **60 calendar days** of an event that is consistent with one of the events on the following pages, you must send a written request to your benefits technician. You must also provide written documentation supporting your change request. Your technician will review your request and documentation. If found to be a valid life event, an event will be created in PeopleSoft My Benefits to allow you to submit your changes.

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

required documentation. A full premium payment will be due for the period including that date. If your FSA election change request is denied, you will have 30 calendar days from the date you receive the denial to file a written appeal with FBMC. *For more information, refer to the "Appeals Process" section on page 7.*

WHAT IS MY PERIOD OF COVERAGE?

Your period of coverage for incurring expenses is your full plan year, unless you make a permitted mid-plan year election change.

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

However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Health Care FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within the School District of Palm Beach County's Health Care FSA plan and the IRS regulations governing the plan. Split periods of coverage do not apply to the Dependent Care FSA.

MID-PLAN YEAR CHANGE EXAMPLE

An employee is married on September 17 and notifies us on November 10. The notice falls within the 60 day guideline. The effective date of the change and pretax deduction for this change would begin on December 1 (*the first day of the month following written notification and receipt of required documentation*).

Generally, mid-plan year, pre-tax election changes including flexible spending accounts (FSAs) can only be made prospectively, the first day of the month after your election change request has been received by Risk & Benefits Management, unless otherwise provided by law. Retroactive pretax deductions are permitted for births and adoptions when the change and documentation are received within 60 days. Best practice is to notify Risk & Benefits Management, in writing, as soon as possible.

Changing Your Coverage



WHAT ARE THE IRS SPECIAL CONSISTENCY RULES GOVERNING CHANGES IN STATUS?

1. Loss of Dependent Eligibility – If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to your divorce, annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances. In most cases a change in plans is not allowed (e.g., HMO to CDHP).

2. Gain of Coverage Eligibility Under Another Employer's Plan – If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage or has coverage increased under the other employer's plan.

3. Dependent Care Expenses – You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRS§ (section) 129.

4. Group Term Life Insurance – For any valid CIS event, you may elect either to increase or decrease these types of coverage, as long as the request is consistent with the qualifying event (i.e., adding spouse life if the event is a marriage).

Visit our benefits website for additional information regarding eligible times to make changes to your elections.

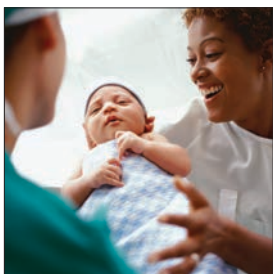
DID YOU READ ABOUT:

- IF YOU ARE ELIGIBLE TO MAKE A CHANGE?
- HOW TO MAKE A MID-PLAN YEAR CHANGE?
- YOUR PERIODS OF COVERAGE?
- THE IRS SPECIAL CONSISTENCY RULES?
- THE EXPLANATION OF ALLOWABLE CIS EVENTS?

Benefits While On Leave of Absence

IN THIS SECTION:

- **HOW A LEAVE OF ABSENCE AFFECTS YOUR BENEFITS**
- **RE-ENROLLMENT RULES WHEN YOU RETURN**
- **WHEN YOU SHOULD INITIATE A LEAVE OF ABSENCE REQUEST**



WHEN SHOULD YOU APPLY FOR A LEAVE OF ABSENCE?

To protect your benefits you should apply for a leave of absence whenever you will be in an unpaid status. While you are using sick and/or vacation time, you do not need to apply

for a leave of absence since you are still receiving pay from the district. However, if you miss work as a result of a work-related injury/illness, you should apply for a leave of absence even if you receive workers' compensation. Keep in mind that your benefits eligibility requires that you work the majority of your duty days. Therefore, anytime you are in an unpaid status, applying for a leave preserves your access to benefits. It's important for you to notify and keep your supervisor informed of all absences. Failure to report to work for the majority of your duty days could lead to a loss of benefits as well as job abandonment processing.

EMPLOYEES ON LEAVE

Your period of active coverage will end the last day of the month in which:

- A. you are physically at work.
- B. you are in a paid status using sick or annual days.
- C. your approved FMLA leave expires.
- D. payments are applied.

However, in most cases, your term life insurance ceases at the end of the month in which you stop being actively at work. Refer to your policy for detailed coverage rules, conversion rights and application deadlines. If you do not pay required contributions while on leave, your coverage will end and you will be required to re-satisfy eligibility requirements when you return to active status, except as otherwise provided by law. If you are on leave for other than your personal illness or maternity, you may not continue income protection.

Approved Medical Leave (FMLA) – You may continue your benefits while on approved FMLA status. The district

will make its contribution on your behalf for district paid benefits. You will be responsible for your regular contributions. Contact us at 561-434-7478 or 561-434-8668 if you do not receive a monthly billing statement. Coverage will be terminated for non-payment if premium payments are not received within 30 days of the due date.

Non-FMLA Leave - In order for your benefits to continue uninterrupted, you must physically return to work in a benefited position and have paid all required contributions prior to the last work day of the month in which your leave ends.

COBRA continuation would be extended once your FMLA status has been exhausted or once your benefits have been terminated due to being in an unpaid status for any reason including unpaid leave or in an unpaid status for more than 10 working days. You would be eligible to continue your medical, dental and/or vision benefits by electing and paying COBRA premiums. In some cases, you may also be eligible to continue your Health Care Flexible Spending Account (FSA) through COBRA as well. Please contact WageWorks directly for more information if your FSA is terminated.

Please also refer to the special rules concerning continuation of term life and/or income protection plans as it relates to leave status. *Please refer to page 20 for more information.*

LIFE/INCOME PROTECTION FOR PERSONAL ILLNESS

Employees who are enrolled in short-term and/or long-term disability plans and are on a leave of absence due to their own personal illness or maternity will be billed for those plans from the first day of the leave through the date that the disability benefits are expected to begin. The multiple elimination period for these plans are outlined in the disability section of this guide. Failure to pay premiums may result in disability claims being denied. Employees on leave of absence other than for their own illness or maternity are not eligible to continue the short-term or long-term disability plans once they are no longer receiving an income from the district. Premiums for these plans should not appear on any billing statements received.

YOU SHOULD CONTACT HUMAN RESOURCES WHEN YOU NEED TO TAKE TIME SPORADICALLY. YOU MAY BE ELIGIBLE FOR AN INTERMITTENT FMLA LEAVE.

Benefits While On Leave of Absence

The reason for your leave also impacts your life insurance coverage. If you were actively at work immediately before your leave of absence, your life benefits will continue through the last day of your approved FMLA leave as long as required premium payments are made.

If you are totally and permanently disabled, you may continue paying premiums for a maximum of 12 weeks from the date you were in a paid status. After 12 weeks, you must either convert to an individual policy or apply for Continued Protection (waiver of premium) directly with the life insurance provider. You must apply for a Continued Protection (waiver of premium) within nine months of the date of disability. During the waiver premium process, no premium payments will be due. You will be given the right to convert your policy if your Continued Protection (waiver of premium) request is denied. You will have **31 days** from the waiver of premium denial date to convert to an individual policy.

OTHER LEAVES – INELIGIBLE TO CONTINUE LIFE AND INCOME PROTECTION PLANS

Unfortunately, employees on leave for reasons other than personal illness or maternity are not eligible to continue group life plans beyond an approved FMLA leave. Coverage for these types of plans will end the later of the last day of the month you are actively at work or the last day of the month of an approved FMLA. Charges for life insurance, short-term and/or long-term disability should not be paid or appear on your billing statements.

APPROVED NON-PAID LEAVE

You can continue to receive coverage for certain benefits for the duration of your leave if you choose to elect COBRA continuation. Certain benefits, including short-term and long-term disability, life products and dependent care FSA cannot be continued while you are on an unpaid leave of absence. Life and disability benefits may only continue if the reason for your unpaid leave is due to your own illness/injury/maternity. You may contact Risk & Benefits Management representatives regarding premiums due for these benefits.

OTHER BENEFITS IMPACTED BY AN UNPAID LEAVE

We encourage you to contact the insurance providers/administrators if you are enrolled in any group life plans, MetLife plans, Trustmark plans, and/or a Health Care FSA.

They will be able to assist you with understanding how your leave of absence will impact your coverage in these plans. Please contact:

- Trustmark directly at 866-636-5525 for information regarding payment of premiums if you had a Trustmark Universal Life, Accident, Cancer Protector or Critical Illness policy.
- FBMC's On-site Representative directly at 561-434-7442 for information on continuation of your Health Care FSA on an after-tax basis.
- MetLife at 800-638-6420 for information about Continued Protection (waiver of premium) and/or 877-ASK-MET7 for discussions with a MetLife agent about converting your policy.

FLEXIBLE SPENDING ACCOUNTS (FSAs) WHILE ON LEAVE

Reimbursement for FSAs are only considered if expenses are incurred during the period you have made contributions. No reimbursement will be made for expenses during an unpaid leave if you fail to continue to make contributions. You may contact FBMC's On-site Representative at 561-434-7442 to arrange for the continuation of payment for your Health Care FSA. FSA leave of absence payments must be made directly to FBMC. You should continue your monthly contribution if you wish to request reimbursement for the period that you are on leave.

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

IF YOU FAIL TO CONTACT RISK & BENEFITS MANAGEMENT UPON YOUR RETURN FROM LEAVE, YOU WILL BE AUTOMATICALLY ENROLLED IN THE LOW OPTION HMO EMPLOYEE-ONLY MEDICAL PLAN AND BASIC LIFE INSURANCE. NO OTHER BENEFITS WILL BE AVAILABLE.

Benefits While On Leave of Absence

Employee-only medical plan and basic life insurance: Open Enrollment will only be processed for actively working employees. If you completed enrollment, but are not actively at work on the first working day of 2018, your election will not be processed.

CONTACT RISK & BENEFITS MANAGEMENT AT 561-434-7478 OR 561-434-8668
WITHIN 30 CALENDAR DAYS OF YOUR RETURN TO WORK.



STEPS TO CONTINUE YOUR HEALTH CARE FSA WHILE ON LEAVE:

1. Mail your check or money order to:
FBMC Benefits Management
ATTN: Benefits Administration
P. O. Box 1878
Tallahassee, FL 32302-1878

Make your check payable to "The School District of Palm Beach County." (FBMC is unable to accept online payments.)

Write your 16-digit FBMC Member number on your check or money order.
2. Include a note that indicates you are a School District of Palm Beach County employee on leave and you wish to continue contributing to your Health Care FSA.
3. If you have any questions about continuing your Health Care FSA while on leave, please contact FBMC's On-site Representative at 561-434-7442.

DISTRICT-PAID BENEFITS WHILE YOU ARE IN AN UNPAID STATUS

You should apply for an approved leave of absence in order to continue your benefits. Once you are unpaid for the majority of your duty days in any given month (even if you are not on leave) you are no longer eligible

for benefits. If you do not make sufficient payments to continue benefits, coverage will terminate at the end of the month in which you were eligible. District-paid benefits will begin again the first of the month after 30 calendar days of eligible paid employment.

UNPAID STATUS, NO APPROVED LEAVE

If you are not in a paid status, your benefits will end at the end of the month in which the unpaid status began. Should you fail to have payroll deductions taken for any period, coverage would be retroactively terminated at the end of the month for which premium payments were last received.

RE-ENROLLMENT UPON RETURN FROM LEAVE

Employees on approved leave during our Open Enrollment period may make changes to their medical, dental or vision plans and flexible spending accounts when they return to active duty. Remember, 401(a) Dollars are not available until the first day of the month after you return to a paid status plus any applicable waiting periods if you did not continue your benefits while on leave. Changes to any other benefits or continuation or reinstatement of any benefits may be made within 30 calendar days of your return to work.

If you do not contact Risk & Benefits Management to complete a benefits change form within 30 calendar days of your return to work, you will be enrolled in the default medical plan and other voluntary benefits may be dropped. Benefits that were canceled while on leave (short-term disability, long-term disability) will not automatically be reinstated. Please complete a benefits change form within 30 calendar days of your return to re-elect these types of plans.

DID YOU READ ABOUT:

- **WHEN TO APPLY FOR LEAVE OF ABSENCE?**
- **THE DIFFERENT TYPES OF LEAVE AND THEIR REQUIREMENTS?**

Health Care FSA While On Leave - FAQs

FREQUENTLY ASKED QUESTIONS

Q. Can I continue my Health Care FSA while on leave of absence (LOA)?

A. You may keep your account active or you may revoke your election while you are on leave. If you choose to keep your account active, you may continue to pay into your Health Care FSA (HCFSA) on a post-tax basis while on LOA. Although you lose the benefit of tax savings, this approach will keep your HCFSA period of coverage active and any eligible expenses you incur while on leave may be submitted and reimbursed while you are still on leave.

You may also keep your account active by making arrangements with the School District of Palm Beach County to adjust your contribution upon your return. Payroll will take the balance of your FSA pledge for the calendar year and divide it by your remaining pay dates, spreading the balance over the rest of your paychecks for the year. Again, any eligible expenses you incur while on leave will be paid. This approach gives you full tax advantage, but you must wait until you return from leave, and the School District of Palm Beach County notifies FBMC/WageWorks that you are active again, before you can be reimbursed for expenses incurred.

Q. What happens to my Health Care FSA while on leave?

A. Your payroll contribution will be discontinued. You may contact FBMC to continue contributions on a post-tax basis. Otherwise, you will have a break in coverage. Expenses incurred while on leave will not be eligible for reimbursement. If you return during the plan year, your FSA pledge will resume and the outstanding contribution balance will be deducted from the remaining paychecks.

Q. How do I continue my Health Care FSA while on LOA?

A. Once you go on leave, make your Health Care FSA contribution payments payable to “the School District of Palm Beach County” and mail your check or money order to:

FBMC Benefits Management, Inc.
ATTN: Benefits Administration
P. O. Box 1878
Tallahassee, FL 32302-1878
Phone: 561-434-7442
(Please do not send cash.)

Q. What if I don't want to continue my Health Care FSA when I return from LOA?

A. Because your FSA election is for the entire year, the district will resume taking payroll reductions until the end of the calendar year, **unless** you have a valid Change in Status event. However, you can always opt out of re-enrolling in an FSA during the next Open Enrollment period.

Q. Can I continue my Dependent Care FSA while on LOA?

A. No. The Dependent Care FSA is used to reimburse participants for work-related child and elder care expenses that enable them to work, look for work or attend school. While you are on leave you are considered “not actively at work,” and are thus ineligible to participate.

Q. When will my Dependent Care FSA terminate if I go on LOA?

A. It will terminate on the last day of the month in which your leave begins. Employees may re-enroll in the Dependent Care FSA within 30 days of returning from leave.

Coverage Termination

IN THIS SECTION:

- **WHEN BENEFITS TERMINATE**
- **WRITTEN NOTICE REQUIREMENTS**
- **CHANGE IN STATUS EVENTS**

EMPLOYEE COVERAGE

During the plan year, except as otherwise provided by law and in accordance with the School District of Palm Beach County's plan(s), terminating employees are covered as follows:

1. Through the last day of the month:
 - a. in which employment ends (all interim positions and 12-month employees are in this category).
 - b. in which a leave of absence without pay begins (refer to page 19–21 under the employees on leave section for more details).
 - c. in which suspension without pay begins.
 - d. in which you cease being in a benefits eligible position.
 - e. for which required employee contributions are made.
 - f. in which you do not work the majority of your duty days.
 - g. in which you are in an unpaid status without an approved leave.
2. Exceptions:
 - a. You qualify for the Family and Medical Leave Act (FMLA). In that case, coverage will end the last day of the month in which eligibility for FMLA ends, as long as required employee contributions are made.
 - b. You are a regular, but less than a 12-month employee, and you are in paid status through the last day of your contract period. In this case, coverage ends the last day of the month for which the required employee contributions are made. Exception: Term Life and/or income protection coverage may end as early as June 30 but will not continue beyond the period for which contributions are made.

CHANGE IN STATUS TERMINATION REQUESTS

You are permitted to make changes to your pre-tax benefit elections during the plan year only for legitimate Change in Status (CIS) events. The request may be granted if the life event is "on account of and corresponding with a valid CIS that affects eligibility for coverage." If you experience a qualifying CIS event, the election changes must be requested and submitted with proper documentation within 60 calendar days of the qualifying event and the change must be consistent with the type of event.



TERMINATION DUE TO CHANGE IN STATUS

Requests to terminate coverage for you and/or a dependent based upon an approved Change in Status (CIS) event will be effective the last day of the month after receipt of a completed Change in Status election and supporting documents.

Coverage Termination

RETIREMENT

Your benefits as an active employee end on the last day of the month in which you retire. However, for all employees (with the exception of 12-month employees) who retire at the end of a school year and work through their contract period, coverage will end on July 31 of that year. As a retiree of the School District of Palm Beach County, you are eligible to continue your health, dental and vision coverage if you pay the monthly premium in full.

PLEASE NOTE: Your retirement date must be in a month in which you are covered under the district's benefits plan in order to continue benefits as a retiree. If you are eligible for Medicare upon retirement, Medicare will become the primary payer on the first month following your retirement date, regardless of your coverage through the district. In order to be eligible to continue the health insurance benefits you have to be retired and receiving monthly payments from FRS. Enrollment in the FRS investment plan may limit your eligibility to continue health benefits upon retirement. Please refer to School Board Policy 6Gx503.79 for more information.

WITHIN 30 DAYS OF YOUR TERMINATION OF EMPLOYMENT, CONTACT:

- Risk & Benefits Management if you have not received information regarding COBRA options or retiree benefits, or to apply for a conversion policy for optional term life coverage.
- Trustmark directly for information regarding payment of premiums if you had a Trustmark Universal Life, Cancer Protector or Critical Illness policy.
- WageWorks customer service at 1-855-428-0446 to apply for COBRA continuation on an after-tax basis of your Health Care FSA.

Termination or Change to Non-Benefited Position

If you terminate employment or have a change in your employment status that results in you becoming ineligible for benefits, your coverage will remain in effect until the last day of that month in which the termination or Change in Status occurred.

Termination followed by rehire within 30 days

If you terminate employment and are rehired within 30 days or less after termination, we will by default re-enroll you into the benefit plans that were in place prior to the termination (including your Health Care FSA), unless otherwise provided by law. You will have access to the Health Care FSA balance up to the full annual limit for expenses incurred after you return (reduced by prior reimbursement). You may experience a break in coverage and will be subject to new waiting periods.

Termination followed by rehire after 30 days

If you terminate and are rehired 30 days or more after termination, you will be permitted to make a new election or enroll into the benefit plan(s) you had prior to termination. You will experience a break in coverage and will be subject to a new waiting periods and the plan choices offered during the initial 18 months of employment.

DEPENDENT COVERAGE

Your dependent's coverage will terminate on:

1. the last day of the month in which they meet the definition of eligible dependent. Maximum age for dependent coverage is 25 years of age. Coverage terminates on the last day of the calendar month in which they turn 26 years old.
2. the date you, the employee, lose coverage.
3. the date they are enrolled in coverage as a district employee.

EXCEPTIONS - If your child is disabled and you have provided documentation prior to termination of benefits or you have applied for coverage under the overaged adult child provision, or COBRA continuation is elected and premium payments are made.

Trustmark voluntary insurance termination provisions may vary by product. Please consult your policy.

DID YOU READ ABOUT:

- **HOW TERMINATION WILL AFFECT YOUR BENEFITS?**
- **YOUR RIGHTS AND RESPONSIBILITIES WHEN TERMINATED?**

Retiring From The District

IN THIS SECTION:

- **HOW BEING ELIGIBLE FOR MEDICARE PART B AFFECTS YOU**
- **HOW RETIRING AFFECTS BENEFITS**
- **YOUR RESPONSIBILITIES WHEN RETIRING**
- **HOW ENROLLING IN COBRA MAY AFFECT YOU**
- **CHECK OUT ALL OF YOUR OPTIONS**

Leaving the district can occur for many reasons, such as finding a new job, relocating to a different state, losing a position, reducing hours or deciding to retire. In any case, you will be offered a way to continue the district's benefits.

Keep in mind that you may have to make decisions regarding what is best for your individual needs as they relate to health insurance.

The cost of continuing coverage will definitely increase and some choices may be affected by your eligibility and enrollment in other types of plans, such as Medicare Part B, or your enrollment for benefits as part of your COBRA rights.

Just be aware that once you leave the district, payment of claims may be affected by coordination rules. We suggest that before you make decisions on how you will continue to be insured, you check out all of your options. Being eligible for Medicare may significantly change how claims are reimbursed by this plan.

In the same manner, claim payments under this plan may be different if you are eligible for Medicare and elect to continue coverage through COBRA.

We suggest that before you decide to continue the district medical plans, you take the time to read the Medicare information on "Who Pays First" and the specific coordination of benefits section of the medical plan document.

For your convenience, you can find out important Medicare information at www.medicare.gov. Your medical plan documents can be found on the Risk & Benefits web page under employee benefits.

If you are eligible for Medicare upon retirement, Medicare will become the primary payer on the first of the month following your retirement date, regardless of your coverage through the district.

RETIRING EMPLOYEES

Some plans are portable, which means you can continue the same plan at the same premium rates. Other plans may be converted to an individual policy, which may result in plan design changes and an increase in premium rates. Your benefits as an active employee end on the last day of the month in which you retire. However, for all employees (with the exception of 12-month employees) who retire at the end of a school year and work through their contract period – coverage will end on July 31 of that year.

As a retiree of the School District of Palm Beach County, you are eligible to continue your health, dental and vision coverage if you pay the full monthly cost. You should make an appointment to meet with the retiree benefits technician by calling 561-434-8673 to review your options and obtain premium information about one month prior to retirement.

PLEASE NOTE: Your retirement date must be in a month in which you are covered under the district's benefits plan in order to continue benefits as a retiree. For example, for 12-month employees, benefits are provided for active employees until the end of the month in which you retire, provided you have actually worked during that month. For less than 12-month employees, the same rules apply with the exception that at the end of the school year, if you complete your contract, most benefits will remain in place through the end of July. If you do not physically return to work in August, your benefits ended in July, so your retirement date must be in July. Continuing with this example, if you choose an August retirement date, you will not be eligible to continue benefits as a retiree. For more information regarding your retiree benefit options, visit <http://L.sdpbc.net/f6z3L>.

Please refer to the Coverage Termination section for further information.

DID YOU READ ABOUT:

- **HOW RETIREMENT WILL AFFECT YOUR BENEFITS?**
- **YOUR RESPONSIBILITIES WHEN YOU RETIRE?**
- **HOW MEDICARE ELIGIBILITY MAY AFFECT YOUR COVERAGE UNDER THIS PLAN?**
- **HOW COBRA AND/OR DISTRICT RETIREE BENEFITS COORDINATE WITH MEDICARE?**

Medical Plans Introduction

IN THIS SECTION:

- **MEDICAL COMPARISON CHARTS**
- **MONEY SAVING PHARMACY BENEFIT**
- **BENEFIT EXTRAS**
- **ONLINE TOOLS AND SERVICES**

WELCOME - WE'RE GLAD YOU'RE HERE

While no one can predict the future, you can prepare for it. Your UnitedHealthcare benefits provide you with access to people, resources and tools to help you when you aren't feeling your best. We have also created unique programs to help you improve your health and wellness. We believe knowledge is the heart of your health care, so we want to give you resources to help you:

- Be active with your health care
- Make healthy choices
- Find answers
- Save money
- Take charge of your health

BEFORE YOU ENROLL

Your doctor is likely already in our network. Whether you are at home, traveling or you have a covered child going to school out-of-state, a network doctor or hospital is likely close by. In addition, there are no referrals. You can see the specialist you want. Emergencies are covered anywhere in the world, and you usually don't have to worry about claim paperwork for network care.

THE UNITEDHEALTHCARE NETWORK:



Find a network doctor or hospital.
Search by facility, location, gender, and languages spoken.

1. www.myUHC.com
2. Click on "Find Physician, Laboratory or Facility".
3. Choose "Find a Physician."

YOUR ID CARD - YOUR KEY TO ACCESSING CARE WHEN YOU NEED IT

Your benefit plan is an important part of your daily life, even if you don't need services every day. It protects you and helps you better manage your health. Right now is the perfect time to find out all you can about your coverage before you need it, especially how it works and where to go for care.



ALWAYS CARRY YOUR ID CARD

Your ID card has key information about you and your coverage. Put your card in your wallet or your pocketbook so you won't forget it. When you're at doctors' offices, drugstores and hospitals, show it to make sure you are not billed unnecessarily. You may also be asked to show a picture ID, such as your driver's license or another government ID card with a picture on it, so be sure to bring this with you, too. Add the Health4me app to your smart phone and carry your virtual ID card with you all the time.

THESE EXTRAS ARE PART OF EVERY PLAN

When you enroll in a UnitedHealthcare health plan, you'll not only have the freedom to use any doctor or hospital in our nationwide network, including specialists, but you'll also be able to take advantage of many valuable programs and services to make your health care experience easier. And, they are available at no additional cost.

24-hour nurse services lets you speak with a registered nurse by phone anytime. Nurses can even help schedule doctor appointments.

Healthy Pregnancy Program can help soon-to-be-mothers through every stage of pregnancy and delivery.

Health Coaches offer telephonic and online support to help lose weight, stop smoking, manage diabetes and more.

Health and wellness programs can help you eat right, stop smoking and relax. You can participate online, in the comfort of your own home.

Other helpful tools include:

- Health care cost estimator
- Physician match
- Hospital comparison

Medical Plan Comparison Charts

Benefits-at-a-Glance • UnitedHealthcare

LOW OPTION HMO

This plan gives you the freedom to see any doctor or other health care professional from our national network, including specialists, without a referral. In addition, you do not have to worry about any claim forms or bills.

MEMBER PAYMENTS	IN-NETWORK ONLY
In-Patient Hospital Coinsurance	20% of eligible expenses after deductible
Annual Out-of-Pocket Maximum	\$6,000 for individual, \$12,000 for family
Annual Medical Expense Deductible	\$500 for individual, \$1,000 for family
Coinsurance Rate	20% of eligible expenses after deductible
Primary Care Doctor Check United's provider directory before making your decision regarding your health care provider	Choose any doctor from the United open access directory. You may access any participating specialist without a referral.
Preventive Care	No charge
Office Visit (Primary Care)	\$30 copayment for UHC Premium Tier 1 Primary/\$40 copay non-Tier 1 Deductible does not apply
Specialist Office Visit	\$55 copayment for UnitedHealth Premium Tier 1 provider/\$60 copayment non-Tier 1 Deductible does not apply No referral needed
Outpatient Hospital and Surgical Services X-ray Other diagnostic services (MRI, CT scan, laboratory test, etc.)	20% of eligible expenses after deductible
Outpatient Rehabilitation Therapy	\$35 copayment per visit ¹ Deductible does not apply
Approved Durable Medical Equipment	20% of eligible expenses after deductible
Emergency Ambulance Trip	\$150 copayment per trip
Hospital Pre-Admission Requirement	Your doctor will take care of all pre-notification requirements.
Emergency Room Care	\$250 copayment (waived if admitted)
Urgent Care Copay	\$75 copayment Deductible does not apply
Convenience Care Clinic - NCH HealthSpot Station - Virtual Office Visits	\$40 copayment - Deductible does not apply \$15 copayment - Deductible does not apply \$25 copayment - Deductible does not apply
Outpatient Mental Health & Substance Abuse Services	\$35 individual, \$25 group Deductible does not apply
Prescription Drugs • 30-day supply per prescription at participating pharmacists • Mail order for a 90-day supply of formulary maintenance medication per prescription	Annual Rx deductible \$100 individual (retail) / \$200 family (retail) Tier 1/\$10 • Tier 2/\$30 • Tier 3/\$60 • Tier 4/\$100 No deductible for mail order – Tier 1/\$25 • Tier 2/\$75 • Tier 3/\$150 • Tier 4/\$250

Network www.myUHC.com. Network name "UnitedHealthcare Choice." This network is for both the Low/High Option HMO.

¹ 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type; 36 visits per year for cardiac therapy

Medical Plan Comparison Charts

Benefits-at-a-Glance • UnitedHealthcare

HIGH OPTION HMO

This plan gives you the freedom to see any doctor or other health care professional from our national network, including specialists, without a referral. In addition, you do not have to worry about any claim forms or bills.

MEMBER PAYMENTS	IN-NETWORK ONLY
Inpatient Hospital Coinsurance	10% of eligible expenses after deductible
Annual Out-of-Pocket Maximum	\$3,000 for individual, \$6,000 for family
Annual Medical Expense Deductible	\$350 for individual - \$700 for family
Coinsurance Rate	10% of eligible expenses after deductible
Primary Care Doctor Check United's provider directory before making your decision regarding your health care provider	Choose any doctor from the United Open Access directory. You may access any participating specialist without a referral.
Preventive Care	No charge
Office Visit (Primary Care)	\$25 copayment for UHC Premium Tier 1 Primary/ \$35 copayment for non-Tier 1 Deductible does not apply
Specialist Office Visit	\$35 copayment for UHC Premium Tier 1 Specialist/ \$45 copayment for non-Tier 1 Specialist Deductible does not apply No referral needed
Outpatient Hospital and Surgical Services X-ray - Other diagnostic services (MRI, CT scan, lab test, etc.)	10% of eligible expenses after deductible
Outpatient Rehabilitation Therapy	\$20 copayment per visit ¹ Deductible does not apply
Approved Durable Medical Equipment	10% of eligible expenses after deductible
Emergency Ambulance Trip	10% of eligible expenses after deductible
Hospital Pre-Admission Requirement	Your doctor will take care of all pre-notification requirements
Emergency Room Care	\$150 copayment (waived if admitted)
Urgent Care Copay	\$50 copayment Deductible does not apply
Convenience Care Clinic - NCH HealthSpot Station - Virtual Office Visits	\$25 copayment - Deductible does not apply \$15 copayment - Deductible does not apply \$25 copayment - Deductible does not apply
Outpatient Mental Health & Substance Abuse Services	\$20 individual, \$15 group Deductible does not apply
Prescription Drugs • 30-day supply per prescription at participating pharmacists • Mail order for a 90-day supply of formulary maintenance medication per prescription	Annual Rx deductible \$100 individual (retail) / \$200 family (retail) Tier 1/\$10 • Tier 2/\$30 • Tier 3/\$60 • Tier 4/\$100 No deductible for mail order – Tier 1/\$25 • Tier 2/\$75 • Tier 3/\$150 • Tier 4/\$250

Network www.myUHC.com. Network name "UnitedHealthcare Choice." This network is for both the Low/High Option HMO.

¹ 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type; 36 visits per year for cardiac therapy.

Medical Plan Comparison Charts

Benefits-at-a-Glance • UnitedHealthcare

CDHP WITH AN HSA*

The Consumer Driven Health Plan (CDHP) with a Health Savings Account puts you in control of your medical spending and gives you the ability to save money in your HSA for future health care needs. The School District of Palm Beach County will fund monthly the following amounts into your HSA account: \$60 for Employee Only, \$90 for Employee + Child(ren), \$90 for Employee + Spouse, and \$120 for Employee + Family. This plan gives you the freedom to see any doctor or other health professional from our national network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network doctor, facility or other health care professional. You may also choose to seek care outside the network without a referral. However, you should know that care received from a non-network doctor, facility or other health care professional means a higher deductible and copayment.

MEMBER PAYMENTS	IN-NETWORK ONLY	OUT-OF-NETWORK
In-Patient Hospital Coinsurance	30% of contracted fee after deductible	40% of eligible expenses after deductible
Annual Out-of-Pocket Maximum	\$6,350 for individual and \$12,700 for family	\$10,000 for individual \$20,000 for family
Annual Medical Expense Deductible	\$3,000 for individual and \$6,000 for family	\$4,500 for individual \$9,000 for family
Consurance Rate	30% of contracted fee	40% of eligible expenses
Primary Care Doctor	Choose any doctor from the United network "UnitedHealthcare Choice Plus." You may access any participating specialist without a referral.	Choose any licensed doctor
Preventive Care - Office visit - Routine mammogram**	No charge No charge	40% of eligible expenses after deductible 40% of eligible expenses after deductible
Office Visit (Primary Care)	30% of contracted fee after deductible	40% of eligible expenses after deductible
Specialist Office Visit	30% of contracted fee after deductible	40% of eligible expenses after deductible
Outpatient Hospital and Surgical Services - X-Ray, Other diagnostic services (MRI, CT scan, laboratory test, etc.)	30% of contracted fee after deductible	40% of eligible expenses after deductible
Out-Patient Rehabilitation Therapy ¹	30% of contracted fee after deductible	40% of eligible expenses after deductible
Approved Durable Medical Equipment	30% of contracted fee after deductible	40% of eligible expenses after deductible
Emergency Ambulance Trip	30% of contracted fee after deductible	40% of eligible expenses after deductible
Hospital Pre-Admission Requirement	Your doctor will take care of pre-notification	It is your responsibility to see that your doctor takes care of pre-notification
Emergency Room Care	30% of contracted fee after deductible	40% of eligible expenses after deductible
Urgent Care Copay	30% of contracted fee after deductible	40% of eligible expenses after deductible
Convenience Care Clinic - NCH HealthSpot Station	30% of contracted fee after deductible \$60 copayment; deductible applies then \$15 after deductible	40% of eligible expenses after deductible N/A
- Virtual Office Visits	\$40 then 30% of contracted fee after deductible	N/A
Outpatient Mental Health & Substance Abuse Services	30% of contracted fee after deductible	40% of eligible expenses after deductible
<div> <div>Prescription Drugs</div> <div> <div>• 31-day supply per prescription at participating pharmacists</div> <div>• Mail order for a 90-day supply of formulary maintenance medication per prescription</div> </div> <div> <div>In-Network</div> <div> <div>Tier 1/\$10 copay after deductible • Tier 2/ Retail: \$30 copay after deductible Tier 3/Retail: \$60 copay after deductible • Tier 4/Retail: \$100 copay after deductible</div> <div>Mail-Order</div> <div> <div>Tier 1/\$25 copay after deductible • Tier 2/\$75 copay after deductible Tier 3/\$150 copay after deductible • Tier 4/\$250 copay after deductible</div> </div> </div> </div> </div>		

Network www.myUHC.com. Network name "UnitedHealthcare Choice Plus."

* Special eligibility requirements apply for HSA enrollment

¹ 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type; 36 visits per year for cardiac therapy

Health Savings Account (HSA)

WHAT ELSE DO YOU NEED TO KNOW ABOUT AN HSA?

Start a Savings Plan for Your Health

Congratulations. By enrolling in your company's high-deductible health plan you may be eligible to open and save in a health savings account (HSA) from Optum BankSM, Member FDIC. Here is some information about how an HSA works and directions for getting started.

What Is an HSA?

Think of an HSA as a savings plan for health care you'll need today, tomorrow and into the future. It works like a regular bank account, but you don't pay federal income tax on the money you deposit. When you use your HSA money to pay for qualified medical expenses, you won't pay income taxes on the money, either. You even build your savings into a nest egg for retirement.

Unlike a flexible spending account (FSA), your savings grow from year to year. There's no "use it or lose it" rule. The money is there when you need it. And it's yours to keep.

Why Have an HSA?

An HSA simply helps you plan, save and pay for health care.

You own it.

The money belongs to you, even deposits made by others, such as an employer or family member. You keep it, even if you change jobs or health plans.

It has triple tax benefits.

- Money deposited is federal income tax-free.
- Savings grow tax-free.
- Withdrawals made for qualified expenses are also income tax-free.

Anyone can contribute.

You, your employer or a loved one. There are no restrictions on who can put money into your account.

It's not just for doctor visits.

You can use your HSA to pay for medical needs such as eyeglasses, hearing aids and qualified prescriptions. You can even use your savings to pay for other kinds of health insurance, such as COBRA, long-term care and any health plan coverage you have while receiving unemployment compensation. When you turn 65, you can use HSA savings to pay for any tax-deductible health insurance (except for Medicare supplemental insurance).

You can invest it.

Once your balance reaches the investment threshold,* you can begin investing in mutual funds. If you earn money on your investments, you don't pay income tax on that money, either.

You can save for the future.

By saving in an HSA, you can be ready for expenses due to illness or accident. And, after you turn 65 or become entitled to Medicare benefits, you may withdraw money from your HSA for expenses that are not qualified medical expenses which are subject to standard income taxes, without penalty. Save as much as you can now, and you could possibly have a nest egg when you retire.

With an HSA you can:



DEPOSIT

Deposit your health care dollars.



GROW

Grow your savings.



SAVE

Save on taxes.



PAY

Pay for health care now or later.

*Investments are not FDIC insured, not guaranteed by Optum BankSM, and may lose value.

Health Savings Account (HSA)

When should I establish my HSA?

Open your HSA as soon as you are eligible to do so. That way, you can use your HSA to pay or reimburse yourself for qualified medical expenses. You cannot use your HSA to reimburse yourself for medical expenses you had before you established your account.

What Else Do You Need to Know About an HSA?

Eligibility rules apply.

To deposit money into an HSA, you must be enrolled in an HSA-eligible health plan. You are eligible if:

- You are covered under an eligible high-deductible health plan (HDHP).
- You are covered by no other health coverage, unless it is permissible coverage like vision or dental.
- You are not enrolled in Medicare.
- You cannot be claimed as a dependent on someone else's tax return.

Some other restrictions apply. Please consult your tax, benefits or financial advisor.

If you switch to a health plan that makes you ineligible to continue depositing money in an HSA, you may continue to use the money in your account for qualified medical expenses, but you can no longer make deposits.

Contribution limits are determined every year by the IRS.

In 2018, the contribution limits increase to \$3,450 for individual coverage and \$6,900 for family coverage. The IRS also allows you to make an extra catch-up deposit of \$1,000 if you are 55 or older.

You can make contributions all the way up to the

tax-filing deadline (usually April 15) and still get tax credit for the previous year.

It's different from a flexible spending account (FSA).

You may have had a health care FSA in the past. With an FSA, all the money you chose to contribute was available to help pay for eligible expenses on the first day of your plan year.

An HSA works differently. Money grows in your HSA as you (and maybe your employer) deposit money into it. You can use your debit card or online bill pay for qualified expenses only if you have enough money in the account to cover the cost.

While you are growing your HSA savings, you may pay for a qualified medical expense out of your pocket. You can reimburse yourself from your HSA later, after you have enough money in your account. Remember, though, that you can only reimburse yourself for qualified expenses you had after you establish your HSA.

Keep your receipts.

Save all your receipts for qualified medical expenses! If the IRS asks, you must be able to prove that you used your HSA money only to pay or reimburse yourself for qualified medical expenses.

Paying with your HSA is easy.

- Use your debit card to pay at the pharmacy, doctor's office or elsewhere. You can also order extra cards for covered family members.
- Pay your bills for qualified medical expenses online at myuhc.com.
- Pay out of pocket and reimburse yourself. You can do that online or by withdrawing money with your debit card from any ATM with the MasterCard® logo.
- Order Optum Bank checks (\$10 for 25).

Health Savings Account (HSA)

Getting Started

1. Enroll online.

Sign up through your employer or enroll at welcometouhc.com. You can also open your HSA at optumbank.com. Check with your supervisor or benefits specialist to learn about your company's application process.

2. Start saving.

There are several ways to contribute to your account.

- Payroll deduction: If your employer allows, pre-tax dollars are taken out of your paycheck and deposited into your HSA. It's the easiest way to build your savings.
- Electronic deposits: Log in to your account and make a deposit by transferring money from another bank account.
- Check: Mail a check along with a contribution form, available online.
- Transfer or roll over funds: If you already have an HSA, you can roll over or transfer funds from that account into your Optum Bank account. Some restrictions apply. Find more information and a rollover/transfer form on our website.

3. Be on the lookout.

If you enroll online you may be able to choose to receive your welcome kit electronically. If you sign up through your employer you will receive your welcome kit in the mail. Within seven to 10 days your HSA Debit MasterCard® will arrive by mail in an unmarked envelope.

Customer Service Is Here to Help

Visit myuhc.com.

Manage your account, pay bills, download forms and find other helpful HSA information. Be sure to log on monthly to check your statement.

Call us toll-free at (800) 791-9361.

Friendly, knowledgeable customer care professionals are available from 8 a.m. to 8 p.m. Eastern time, Monday through Friday. Assistance for most foreign-language speakers is also available.

Health savings accounts (HSAs) are individual accounts offered by Optum BankSM, Member FDIC, and are subject to eligibility and restrictions, including but not limited to restrictions on distributions for qualified medical expenses set forth in section 213(d) of the Internal Revenue Code. State taxes may apply. This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment and restrictions. Federal and state laws and regulations are subject to change.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc., or their affiliates.



Medical* Plan Cost

2018 EMPLOYEE PER-PAY-PERIOD MEDICAL CONTRIBUTIONS

***RATE DOES NOT REFLECT HEALTH REWARDS DISCOUNT OR TOBACCO SURCHARGE**

In order to enroll in any plan listed below, your per pay salary must support the deduction.

MEDICAL PLAN	FULL-TIME				PART-TIME**			
	24 Deductions		22 Deductions		24 Deductions		22 Deductions	
EE = Employee	District Contribution	Employee Deductions	District Contribution	Employee Deductions	District Contribution	Employee Deductions	District Contribution	Employee Deductions
Low Option HMO								
EE only	\$225.00	\$25.00	\$245.43	\$27.27	\$225.00	\$25.00	\$245.43	\$27.27
EE + child(ren)	\$380.00	\$68.00	\$414.50	\$74.18	\$365.00	\$83.00	\$398.14	\$90.54
EE + spouse	\$392.50	\$89.00	\$428.14	\$97.09	\$377.50	\$104.00	\$411.78	\$113.45
EE + family	\$475.50	\$151.00	\$518.68	\$164.72	\$460.50	\$166.00	\$502.31	\$181.09
High Option HMO								
EE only	\$262.50	\$45.00	\$286.34	\$49.09	\$212.50	\$95.00	\$231.80	\$103.63
EE + child(ren)	\$405.00	\$135.00	\$441.77	\$147.27	\$340.00	\$200.00	\$370.87	\$218.18
EE + spouse	\$415.00	\$160.00	\$452.68	\$174.54	\$350.00	\$225.00	\$381.78	\$245.45
EE + family	\$540.00	\$230.00	\$589.03	\$250.91	\$475.00	\$295.00	\$518.13	\$321.81
CDHP MEDICAL								
EE only	\$185.00	\$30.00	\$201.80	\$32.73	\$185.00	\$30.00	\$201.80	\$32.73
EE + child(ren)	\$315.00	\$78.00	\$343.60	\$85.09	\$300.00	\$93.00	\$327.24	\$101.45
EE + spouse	\$335.00	\$99.00	\$365.42	\$108.00	\$320.00	\$114.00	\$349.06	\$124.36
EE + family	\$405.00	\$166.00	\$441.77	\$181.09	\$390.00	\$181.00	\$425.41	\$197.45
401(A) DOLLARS	FULL-TIME				PART-TIME			
	District Contribution		District Contribution		District Contribution		District Contribution	
Waive Health	\$50.00		\$54.54		\$25.00		\$27.27	

**NOTE: Amounts reflected on paychecks may vary slightly due to rounding. Rates above do not include Health Rewards discount or tobacco surcharge rates.*

Enrollment of any children and a domestic partner will be the equivalent of the above rates. The deductions will be reflected as the employee-only pre-tax rate and the balance of the deduction will be taken on an after-tax basis.

***Applies to CTA Bargaining units or those in part-time status as of 12/31/2011.*

Unless otherwise noted, all benefits listed are valid only for health services received through participating providers or with plan approval. Notification of services may be required.

This summary information is subject to change. This summary is not to be solely relied upon by members or applicants. If there is a discrepancy between this summary and the summary plan description (SPD) the information found in the summary plan description would supersede.

Health Care Benefits Doctors



TIPS TO MAKE YOUR DOCTOR'S VISIT WORTHWHILE

BEFORE YOUR APPOINTMENT:

1. Make a list of all questions you have for your doctor, nurse or pharmacist.
2. Write down medications you are currently taking, including prescriptions, over-the-counter medicines and herbal supplements.
3. Plan to bring a family member or friend to your visit if you have a hard time remembering what your doctor tells you.

DURING YOUR APPOINTMENT:

1. Tell your doctor if a family member has been diagnosed with a serious disease or condition. Also mention if you have or will be traveling outside the country.
2. Ask your doctor at every visit to send any laboratory test to a network facility.
3. Before you leave, make sure you can read and/or understand your doctor's or pharmacist's instructions. If you don't understand, it's okay to ask them to explain until you understand.

UNITEDHEALTH PREMIUM® TIER 1

Find Recognized Doctors and Hospitals in the Network With the UnitedHealth Premium designation program*, we help you:

- Find doctors and hospitals in your area that meet quality and cost-efficiency criteria
- Find doctors you can call directly, without prior approval
- Find names quickly online
- Get access to 27 specialties, including primary care, cardiology and orthopedics, as well as facilities in six specialties, including:
 - congenital heart disease
 - cardiac care
 - neonatology
 - infertility
 - total joint replacement
 - spine surgery

**UnitedHealth Premium Tier 1 is not available in all geographic locations. For a complete description of the UnitedHealth Premium® Tier 1 designation program, including details on the methodology used, geographic availability and program limitation, please visit myuhc.com®.*

Criteria for designation comes from nationally recognized quality standards and market-based cost efficiency standards. For our members with special medical concerns, we also provide information from the National Committee for Quality Assurance (NCQA) Doctor Recognition Program.

FINDING A UNITEDHEALTH PREMIUM TIER 1 DOCTOR



Visit your member website, myuhc.com®, to search the directory and look for this blue TIER 1 symbol next to your results.

**CONSULT THE BENEFIT REFERENCE GUIDE
THROUGHOUT THE YEAR AND REFER TO IT
FOR IMPORTANT INFORMATION**

<http://L.sdpbc.net/gdo9u>

Using Pharmacy Benefits



The right medications for you

Make informed decisions

UnitedHealthcare Prescription Drug List (PDL)

The PDL includes most brand and generic prescription medications approved by the FDA. Medications are placed on different “tiers” based on our evaluation about their overall value. Tier 1 is the lowest-cost tier option. When selecting a medication, you and your doctor should consult the PDL.



Log on to myuhc.com to look for potential lower-cost alternatives and helpful resources.



Call the OptumRx™ Specialty Pharmacy at 888-739-5820.



Specialty medications

Specialty medications for most plans are managed through our specialty pharmacy program. Take advantage of personalized support designed to help you get the most out of your treatment plan. Our specialty pharmacy program also offers on-call pharmacists available 24 hours a day, information about lower-cost medication options and additional resources. Call the OptumRx Specialty Pharmacy at 888-739-5820 to learn more.

Want to learn more about specific medications?

- Log on to myuhc.com and click “Pharmacies and Prescriptions” or “Manage My Prescriptions” to access drug information.

Save money

Look for potential lower-cost alternatives

Log on to myuhc.com to look for your lowest-cost options. Ask your doctor if a lower-cost alternative medication may be right for you.

Generic options

Approximately 75% of brand medications have generic equivalents available. Generics contain the same active ingredients (the chemicals that make a medication work) as brand medications. Generic medications must meet the same FDA brand medication standards.

myuhc.com

Dental Benefits Introduction

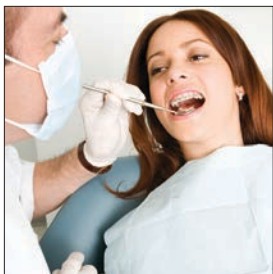
IN THIS SECTION:

DENTAL PLAN OPTIONS

ORTHODONTICS

PRENATAL DENTAL CARE PROGRAM

PLAN COMPARISONS



UNITEDHEALTHCARE DENTAL®

We've given you a reason to smile with a selection of four flexible dental plans, paid through a voluntary, pre-tax benefit. With all of these options, we are sure you will find a

plan that meets your dental needs. You may select UnitedHealthcare dental coverage separately from your medical plan.

PRENATAL DENTAL CARE PROGRAM

Taking care of your teeth and gums during pregnancy is an important part of a woman's and her unborn child's overall good health and well-being. Experts say that disease related to the gums and tooth-support structures (periodontal disease) during pregnancy is linked to an increased risk of pre-term delivery.

That's why we've created a dental program which provides additional in-network preventive dental care coverage for expectant mothers. If you are in your second or third trimester of pregnancy, you are eligible for this program's benefits as part of your benefit plan. On your next visit, tell your dentist that you are pregnant. Provide the stage of your pregnancy and due date, and also make sure the dentist notes your attending doctor's or obstetrician's name (this must be included on the claim form). All fees and expenses for cleanings, deep scaling (cleaning the teeth deeper down the tooth), debridement (removing dead or infected tissues) and periodontal maintenance will be waived, if your dentist determines you require these procedures.

THE FOUR OPTIONS OFFERED ARE: MANAGED CARE PLANS

Option 1 (Plan S500PB) is a pre-paid plan. This plan offers a savings of 30 percent to 60 percent on all basic and major dental services. What you will pay the dentist on your visit is listed in your schedule of benefits. With this plan there are no hidden charges. Additionally, you will receive the following features:

- No waiting periods
- No claim forms to submit
- No primary dentist selection required
- Self-referral to specialist dentist for a 25 percent discount
- Defined costs on 293 procedure codes
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included
- Implant rider coverage
- 25 percent discount on all procedure codes not listed

Option 2 (Plan S700PB) is a pre-paid plan. This plan offers a guaranteed savings of 25 percent to 50 percent on basic and major dental services. What you will pay the dentist on your visit is listed in your schedule of benefits. With this plan there are no hidden charges. Additionally, you will receive the following features:

- No waiting periods
- No claim forms to submit
- No primary dentist selection required
- Self-referral to specialist dentist for a 25 percent discount
- Defined costs on 293 procedure codes
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included
- Implant rider coverage
- 25 percent discount on all procedure codes not listed

Specialty Services for Managed Care Plan (S500PB and S700PB)

- The fees within this overview of services apply when such services are performed by a participating general dentist, unless otherwise authorized by UnitedHealthcare Dental.*
- If services are not listed within the schedule of benefits and are performed by a participating general dentist, fees will be charged at the dentist's usual and customary fee less 25 percent.
- The participating general dentist you select may not perform all outlined procedures. The copayments shown apply to general dentists who perform these procedures. Therefore, you are encouraged to secure availability of the scheduled services with your participating general dentist.
- Should the services of a specialist (oral surgeon, endodontist, orthodontist, periodontist, prosthodontist or pedodontist) be necessary, you may receive this care in one of two ways: (1) you may go directly to a participating specialist with no referral and receive a 25 percent reduction off the provider's usual and customary fee; or (2) you may obtain prior written

Dental Benefits

authorization by UnitedHealthcare Dental* and receive specialty treatment by an approved participating specialist at the listed copayments. Please refer to the specialty care referral policy in your member ID packet.

* UnitedHealthcare Dental plans are administered by Dental Benefit Providers, Inc.

Managed Care Plans (\$500PB and \$700PB) Features: Florida Only Network

About fillings

The aforementioned UnitedHealthcare Dental Managed Care programs provide coverage for the following fillings benefits:

Amalgam (silver fillings) \$500PB and \$700PB

- No copayments - covered 100 percent.
- Verify that your treating dentist provides amalgam fillings. If your dentist does not offer amalgam fillings, you will receive a resin (white filling).

Composite resin (white fillings) \$500PB

- Anterior Teeth – No copayment
- Posterior Teeth – No copayment

\$700PB

- Anterior Teeth – No copayment
- Posterior Teeth – No copayment

Please discuss your treatment plan with your dentist prior to the initiation of treatment. If the dentist you selected does not cover the treatment you desire, please check with another dentist within our network. With this plan, you have the ability to select any dentist within the network at any time.

USING A PEDODONTIST

With both Managed Care Plans, Options 1 and 2, you have the choice to select the participating dentist that best satisfies the needs of each individual. Pedodontists are available to children age 16 and under. Pedodontists only treat children, so you have the option to select a pedodontist for your child or you may choose to have your child see a general dentist. The choice is yours, and UnitedHealthcare Dental allows you to make the best choice for you and your family.

ORTHODONTICS

Both the above managed care plans - \$700PB and \$500PB-cover orthodontia. These managed care plans allow coverage for both adults and children. Copayments under \$700PB are set at \$2,200 for children, \$2,250 for adolescents and \$2,350 for adults. Copayments under \$500PB are set at \$1,600 for children and adolescents; \$1,950 for adults. These prices are based on 24 months of orthodontic treatment. Cases that require more than 24 months are subject to additional charges.

PPO PLANS

Option 3 (PPO Plan P5215) is a High Option PPO plan that allows you and each covered family member to use the provider of your choice; however, you'll receive a higher level of coverage when you choose a participating network provider. There is a deductible of \$50 per person (\$150 per family). There is no deductible for preventive and diagnostic services. This plan has an annual maximum benefit of \$1,000 and covers orthodontia for

TYPICAL ANNUAL COST	OPTION 1-\$500PB	OPTION 2-\$700PB	OPTION 3-P5215***	OPTION 4-P5105***
	What You Pay In-Network Only	What You Pay In-Network	What You Pay** In-Net/Out-of-Network	What You Pay** In-Net/Out-of-
Network				
Office visit	No charge	No charge	0% / 10%	0% / 20%
Oral exam (every 6 months)	No charge	No charge	0% / 10%	0% / 20%
Tooth extraction (simple)	\$10	\$20	20% / 30%	50% / 60%
Silver fillings	No charge	No charge	20% / 30%	50% / 60%
Prophylaxis (cleaning - every 6 months)	No charge	No charge	0% / 10%	0% / 20%
Composite resin filling****	No charge	No charge	20% / 30%	50% / 60%
Crown*	\$240*	\$245*	50% / 60%	50% / 60%
Molar root canal	\$225	\$245	20% / 30%	50% / 60%
Bridge - porcelain, base metal, per tooth*	\$240*	\$245*	50% / 60%	50% / 60%

* See exclusion and limitations.

** Member is responsible for the difference between the allowed amount and what the provider charges.

*** Deductible applies except for preventive and diagnostic services.

**** Up to three per calendar year -- thereafter discounted rates apply.

Dental Plan Cost

children up to the age of 19. The lifetime orthodontic maximum benefit is \$2,000. There is a 12-month waiting period for major services and orthodontic services for new members.**

Option 4 (PPO Plan P5105) is a Low Option PPO plan that allows you and each covered family member to use the provider of your choice; however, you'll receive a higher level of coverage when you choose a participating network provider. There is a deductible of \$50 per person (\$150 per family). There is no deductible for preventive and diagnostic services. This plan has an annual maximum benefit of \$1,000 but **DOES NOT** cover orthodontic services. There is a 12-month waiting period for major services for new members.**

***Waiting periods will apply for new enrolling members and late entrants.*

ORAL CANCER SCREENING

Coverage for light contrast technology, the latest in oral cancer detection, is available on all our insured PPO plans. Should light contrast detect abnormalities, we also cover the next line of defense, brush biopsy.

CONSUMER MAXMULTIPLIERSM

Consumer MaxMultiplier is a feature included in your UnitedHealthcare Dental PPO plan* that puts dental care decisions and potential additional funding for claims that exceed the plan maximum in the form of an award balance directly in your hands.

HOW AWARDS ARE EARNED:

- Consumer MaxMultiplier is administered at the member level. This means each member is eligible to earn his or her own awards.
- Members must use their dental benefit at least once per year.
- If the total of all submitted claims paid for a particular member does not exceed the established \$500 threshold amount, an award balance** is established.
- Members may qualify for an additional \$100 bonus award, if all claims during the year are paid to network providers.
- An award balance is the amount accumulated throughout the benefit period, tracked electronically and correlated with the member's record. (P5215 & P5105)

USING YOUR AWARDS:

The award balance can be used to fund additional claims for dental services when the member exceeds the original benefit period maximum.** Once a new benefit period

maximum begins, the award account balance, if any, is carried over to the new benefit period and available for use should the member exceed the plan maximum.

- Award balances cannot be used for orthodontic services.
- Claims for services to be covered or partially covered by an award balance should be submitted as any other dental claim.
- The award balance may be used for non-network claims.

*** Funds are not physical. They cannot be accessed or withdrawn by the member. Funds are automatically distributed by UnitedHealthcare Dental when the member utilizes the plan and exceeds the benefit period plan maximum.*

YOUR DENTAL RATES

Per pay period pre-tax deductions are as follows:

	24 Deductions	22
Deductions		
MANAGED CARE PLANS (FL ONLY NETWORK)		
DENTAL OPTION 1 - PLAN S500PB WITH ORTHODONTIA		
Employee only	\$7.86	\$ 8.57
Employee & child(ren)	\$16.68	\$18.19
*Employee & spouse	\$13.74	\$14.99
*Employee & family	\$21.59	\$23.55
DENTAL OPTION 2 - PLAN S700PB WITH ORTHODONTIA		
Employee only	\$6.08	\$6.63
Employee & child(ren)	\$13.00	\$14.18
*Employee & spouse	\$10.57	\$11.53
*Employee & family	\$16.65	\$18.16
PPO PLANS (NATIONAL NETWORKS)		
DENTAL OPTION 3 - PPO DENTAL HIGH PLAN P5215 WITH ORTHODONTIA		
Employee only	\$17.76	\$19.37
Employee & child(ren)	\$48.83	\$53.26
*Employee & spouse	\$43.51	\$47.56
*Employee & family	\$65.71	\$71.67
DENTAL OPTION 4 - PPO DENTAL LOW PLAN P5105 (NO ORTHODONTIA)		
Employee only	\$14.00	\$15.27
Employee & child(ren)	\$38.50	\$42.00
*Employee & spouse	\$34.30	\$37.41
*Employee & family	\$51.81	\$56.51

** NOTE: Domestic partner rates will be the equivalent of the above rates. The deduction will be reflected as the employee-only pretax rate and the balance of the deduction will be taken on an after-tax basis. Amounts reflected on paychecks may vary slightly due to rounding.*

Dental Benefits | Covered Procedures

COMMONLY COVERED PROCEDURES - PPO PLANS (P5215 AND P5105).

Sample procedure codes, see full schedule for complete listing at
<http://L.sdpbc.net/d8bi3>

BENEFIT	Option 3 - High PPO Plan P5215		Option 4 - Low PPO Plan P5105	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLE (MAXIMUM 3 PER FAMILY) <i>Calendar year is January 1 - December 31</i>				
Class I	None	None	None	None
Class II, III, IV	\$50 per year, individual	\$50 per year, individual	\$50 per year, individual	\$50 per year, individual
CALENDAR YEAR MAXIMUM	\$1,000	\$1,000	\$1,000	\$1,000
LIFETIME ORTHODONTIC MAXIMUM	\$2,000	\$2,000	Not covered	Not covered
WAITING PERIOD				
Class I and II	None	None	None	None
Class III	12 months	12 months	12 months	12 months
Class IV	12 months	12 months	N/A	N/A
BENEFIT	In-Network	Out-of-Network*	In-Network	Out-of-Network*
CLASS I - PREVENTIVE & DIAGNOSTIC				
Oral evaluation (diagnostic)	100%	90%	100%	80%
X-Rays (diagnostic)	100%	90%	100%	80%
Lab and other diagnostic tests	100%	90%	100%	80%
Prophylaxis (preventive)	100%	90%	100%	80%
Fluoride treatment (preventive)	100%	90%	100%	80%
Sealants	100%	90%	100%	80%
Space maintainers	100%	90%	100%	80%
CLASS II - BASIC SERVICES				
Restoration (amalgams and resin-based only)	80%	70%	50%	40%
General services (emergency treatment and anesthesia)	80%	70%	50%	40%
Simple extractions	80%	70%	50%	40%
Oral surgery (includes surgical extractions)	80%	70%	50%	40%
Periodontics	80%	70%	50%	40%
Endodontics				
CLASS III - MAJOR SERVICES				
Inlays/onlays/crowns and bridges	50%	40%	50%	40%
Dentures and other removable prosthetics	50%	40%	50%	40%
Fixed prosthetics	50%	40%	50%	40%
Implants (limited to one time per consecutive 60 months)	50%	40%	50%	40%
CLASS IV - ORTHODONTIC SERVICES				
Orthodontia (child up to age 19)	50%	50%	Not covered	Not covered

*Out-of-network percentage is based upon allowable charges.

Please refer to your Certificate of Coverage booklet for a complete list of benefits, frequencies, limitations and exclusions for all plans.

The UnitedHealthcare Dental PPO Plans are administered by Dental Benefit Providers, Inc. and underwritten by UnitedHealthcare Insurance Company.

The Solstice Dental Plans are offered by Dental Benefit Providers, Inc. and underwritten by Solstice Benefits, Inc., a licensed prepaid limited health service organization, under F.S. 636.

Dental Benefits | Covered Procedures

COMMONLY COVERED PROCEDURES - MANAGED CARE PLANS (\$500PB & \$700PB)

Sample procedure codes, see full schedule for complete listing at
<http://L.sdpbc.net/d8bi3>

BENEFIT (Florida Only Network)	Option 1 Plan \$500PB	Option 2 Plan \$700PB
DEDUCTIBLE		
Yearly deductible	None	None
Calendar year maximum	None	None
Claim forms	None	None
Rosters	None	None
Primary dentist required	None	None
DIAGNOSTIC/PREVENTIVE	YOU PAY	YOU PAY
Office visit	No charge	No charge
Routine exams	No charge (2 per 12 months)	No charge (2 per 12 months)
Prophylaxis (cleaning) - basic	No charge (2 per 12 months)	No charge (2 per 12 months)
Emergency treatment (palliative)	No charge	No charge
X-ray and complete series including bite wings	No charge (1 per 60 months)	No charge (1 per 60 months)
Fluoride application	No charge (1 per 12 months)	No charge (1 per 12 months)
BASIC/RESTORATIVE PROCEDURES***		
Simple extractions	\$10	\$20
Amalgam fillings - 1 surface permanent	No charge	No charge
Root canals (1 canal)	\$100	\$110
Root canal (3 canals)	\$225	\$245
Composite resin fillings (up to 3 per calendar year)****	No charge	No charge
Sealants (age limit applies)**	No charge	No charge
MAJOR PROCEDURES		
Crowns - porcelain, base metal**	\$240	\$245
Dentures - upper/lower**	\$260 each	\$325 each
Bridges - porcelain base metal**	\$240	\$245
PERIODONTICS	YOU PAY	YOU PAY
Scaling and root planing per year	\$45 per quadrant (limit 2 per year)**	\$50 per quadrant (limit 2 per year)**
ORTHODONTICS	YOU PAY	YOU PAY
Pre-orthodontic treatment visit	\$0	\$35
Comprehensive treatment of transitional dentition	\$1,600	\$2,200
Comprehensive treatment of adolescent transitional dentition	\$1,600	\$2,250
Comprehensive treatment of adult dentition	\$1,950	\$2,350

**See exclusions and limitations.

***Surgical removal of impacted tooth provided at a 25% reduction off specialist's usual and customary fee when pathology does not exist. When pathology exists your copay will apply with approved referral.

**** Up to three per calendar year – thereafter discounted rates apply.

DID YOU READ ABOUT:

- DENTAL PLAN OPTIONS?
- PLAN COMPARISONS?
- ORTHODONTICS?

Vision Benefits Introduction

IN THIS SECTION:

- **VISION PLAN DESCRIPTION**
- **LENS OPTIONS**
- **HOW TO LOCATE A PROVIDER**
- **MAIL-ORDER CONTACT LENSES**

PLAN PROVIDER: EYEMED VISION CARE

An eye examination means more than getting a prescription; it evaluates your eye health and is critical in the early detection of several vision and health-related conditions, including:



- glaucoma
- diabetes
- cataracts
- hypertension

Since early detection is key for treatment, periodic eye examinations play a vital role in ensuring the health of your eyes. This is why EyeMed providers are dedicated to preserving your vision by making it convenient for you to receive quality eye care.

Eye examinations are also important for the health and safety of children. The American Optometric Association recommends that children receive their first eye examination from an eye care professional as early as six months of age. Afterward, your provider will advise you when to schedule your child's next eye examination. EyeMed's thousands of provider locations allow you to begin receiving substantial savings on your eye care and eyewear needs at one of many locations nationwide.

PLAN FEATURES

You may choose independent ophthalmologists, optometrists, opticians or the convenience of a retail facility including LensCrafters®, most Pearle Vision locations, Sears Optical and Target Optical locations in your area or throughout the country for:

- eye examinations
- contact lenses
- glasses
- Rx sunglasses
- lens options and accessories or
- LASIK and PRK laser vision correction discounts.

EYEMED SAVINGS VS. OTHER VISION CARE PLANS

You will find that your vision care plan delivers greater savings at more provider locations than a coupon or special offer. You may also use your benefit when it's convenient to you, without having to worry about coupon expiration dates or limited time offers.

PLEASE NOTE: Your benefit cannot be combined with any other discounts or promotional offers.

CLAIM FORMS

You do not need to obtain a claim form for the in-network services. Simply inform your provider that you are an EyeMed member when you make your appointment or visit a participating provider location. If you receive an EyeMed Vision Care ID card, you should present this card to identify yourself as an EyeMed member.

Today, with EyeMed, your explanation of benefits (EOB) is provided online. To access your EOB, visit **www.eyemed.com**. If you prefer to continue to receive a paper copy of your EOB, simply log in to the member website to set up your preferences. You may also call the customer care center at **866-723-0514** to update your preferences.

LENS OPTIONS

You can choose from many different lenses and lens options for your frames at participating EyeMed provider locations. Here are just a few of the lens options you may find at participating provider locations:

- **Ultra Violet (UV) protection** – UV rays can be generated from the sun or other light sources. With enough exposure to these light rays, there could be an increased risk of cataracts and macular degeneration. UV protection helps to prevent these rays from harming the eye.
- **Anti-reflective (AR) coating** – This coating reduces the amount of light that reflects off the lenses. These lenses can be particularly helpful for driving at night, when reflections on your lenses may be greater than daylight driving conditions. AR coating also enables people to see your eyes more clearly as opposed to seeing the reflection off your lenses.
- **Scratch-resistant coating** – When scratches are present on your lenses, they may distort or interfere with your vision. This protective coating is added to the lens surface to protect it from normal scratches as a result of everyday mishaps. It's a great way to extend the life of your eyewear.

Vision Plan Cost

VISION CARE PREMIUMS

Per pay period pretax payroll deductions are as follows:

FULL-TIME OR PART-TIME

Deductions	24	22
	Deductions	Deductions
	EyeMed VISION	CARE OPTION
Employee only	\$2.73	\$2.97
Employee & family	\$7.00	\$7.64

Amounts reflected on paychecks may vary slightly due to rounding.

ADDITIONAL PURCHASES AND OUT-OF-POCKET DISCOUNT

You will receive a 20 percent discount on items not covered by the plan at participating providers, which may not be combined with any other discounts or promotional offer; additionally, the discount does not apply to EyeMed's providers' professional services or disposable contact lenses.

Benefits are not provided for services or materials arising from: orthoptic or vision training; subnormal vision aids and any associated supplemental testing; aniseikonic lenses; medical and/or surgical treatment of the eyes; corrective eyewear required by an employer as a condition of employment, and safety eyewear; services provided as a result of workers' compensation law; plano non-prescription lenses and non-prescription sunglasses (except for the 20 percent EyeMed discount); two pairs of glasses in lieu of bifocals; services or materials provided by any other group benefit providing for vision care. Benefit allowances provide no remaining balance for future use within the same benefit period. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period.

Continued eyewear savings - Your EyeMed benefit also provides for continued savings through our continued eyewear savings plan. After your initial benefits have been utilized, you may receive ongoing discounts on additional eyewear purchases at EyeMed provider locations, which result in discounts up to 40 percent off the retail price of complete pair eyeglass purchases, 20 percent off partial pair purchases, and 15 percent off conventional contact lenses. See your EyeMed provider for details.

TO LOCATE AN EYEMED PROVIDER NEAR YOU:

Visit the EyeMed website at www.eyemed.com and choose "Select" network and enter your ZIP code to find a provider.

Enrollment of any children and a domestic partner will be the equivalent of the above rates. The deductions will be reflected as the employee-only pre-tax rate and the balance of the deduction will be taken on an after-tax basis.

Customer service representatives are available to answer your questions seven days a week, including evenings. EyeMed offers easy-to-use benefits, with no claim forms to complete for in-network services.

Call EyeMed customer call center at **1-866-723-0514** and choose the "provider locator" automated option or speak to a customer service representative during normal operating hours:

Monday-Friday, 7:30 a.m. - 11 p.m.
Sunday, 11 a.m. - 7 p.m. EST

**VISIT THE EYEMED WEBSITE AT WWW.EYEMED.COM
AND CHOOSE "SELECT" NETWORK AND ENTER YOUR ZIP CODE TO FIND A PROVIDER.**

**FOR THE MOST UPDATED LISTING, ONCE YOU ARE A MEMBER VISIT OUR WEBSITE AT
WWW.EYEMED.COM OR CALL 1-866-723-0514.**

Vision Benefits | Plan Services



EYEMED PLAN SERVICES	In-Network Member Cost	Out-of-Network Maximum Reimbursement
EXAM WITH DILATION AS NECESSARY	\$10 copayment	Up to \$35
RETINAL IMAGING BENEFIT	Up to \$39	N/A
EXAM OPTIONS		
Standard contact lens fit and follow-up*	Up to \$40	N/A
Premium contact lens fit and follow-up**	10% of retail	N/A
FRAMES:	\$0 copay; \$120 allowance; 20% of balance over \$120	\$60
STANDARD PLASTIC LENSES:		
Single vision	\$15 copayment	\$25
Bifocal	\$15 copayment	\$40
Trifocal	\$15 copayment	\$55
Standard progressive	\$60 copayment	\$55
Premium progressive	\$60, 80% of charge less \$120 allowance	\$55
LENS OPTIONS (PAID BY THE MEMBER AND ADDED TO THE BASE PRICE OF THE LENS):		
UV Coating	\$12	\$2
Tint (solid and gradient)	\$12	\$2
Standard scratch-coating	\$15	N/A
Standard polycarbonate - adult	\$35	\$3
Standard polycarbonate - children under 19	\$35	\$3
Standard anti-reflective	\$45	N/A
Polarized	20% off retail price	N/A
Other add-ons and services	20% off retail price	N/A
CONTACT LENSES (INCLUDES MATERIALS ONLY; IN LIEU OF LENSES):		
Conventional	\$0 copayment; \$125 allowance plus 15% off balance over \$125	\$100 \$100
Disposables	\$0 copayment; \$125 allowance plus balance over \$125	\$200
Medically necessary	\$0 copayment, paid in full	
LASIK AND PRK VISION CORRECTION PROCEDURES†	15% off retail price OR 5% off promotional pricing	N/A
FREQUENCY:		
Exams	Once every 12 months	
Frames	Once every 24 months	
Standard plastic lenses or contact lenses	Once every 12 months	

* Standard contact lens fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

** Premium contact lens fitting - all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)

† LASIK and PRK correction procedures are provided by the U.S. laser network, owned by LCA-Vision. You must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount.

Vision Benefits | Plan Services

LENSCRAFTERS



EyeMed
VISION CARE®

Sears
Optical

PEARLE VISION

EYEMED VISION CARE HAS MANY UNIQUE ONLINE CAPABILITIES, INCLUDING THE FOLLOWING:

- Locate the provider nearest you by going to **www.eyemed.com** and click on “Select” network.
- View your benefits, including service eligibility and the next date of service.
- Printable replacement ID cards.
- Online claims status.
- Ability to “go paperless” and receive explanation of benefits electronically.
- Learn more about the importance of vision care through Vision Wellness content.
- Access the mobile website to locate a provider, view ID cards, benefits and contact EyeMed.
- EyeMed mobile app available for iPhone, iPad and most Android touch users.

CONTACTSDIRECT.COM IS AN ONLINE IN-NETWORK BENEFIT



HOW DOES THE PROGRAM WORK? THREE EASY STEPS

Use your contact lens allowance online by using your in-network benefits. Simply go to **www.contactsdirect.com**. Select your

lenses from a wide selection of top selling brands. In-network benefits instantly apply to your purchase, and contact lenses will ship as soon as the prescription is verified—most ship the same day.

1. Click on register in the top navigation
2. Fill out the registration form
3. Check the box to apply your vision insurance
4. **www.contactsdirect.com** will find your plan and apply your vision insurance online, right in the cart. EyeMed Vision Care offers replacement contact lenses by mail. This service option is available to all EyeMed Vision Care members!

**Some states do not require the provider to release the prescription.*

Employee Wellness

IN THIS SECTION:

- **WELLNESS MISSION**
- **WELLNESS ESSENTIALS**
- **AVAILABLE PROGRAMS**
- **HEALTH ADVOCATE ASSISTANCE**

EMPLOYEE WELLNESS

The School District of Palm Beach County is committed to helping employees adopt a healthy lifestyle and improve their quality of life.

It has been proven that people who are healthy are more productive, more motivated and more satisfied at home and at work. While our focus is to promote the health and well-being of school district staff through education, behavior modification, guidance and support, Employee Wellness also produces good role models for students while supporting high student achievement.

The Health Rewards Program seeks to establish a workplace that encourages and supports a healthy lifestyle by integrating health promotion activities and resources that help to enhance health and well-being.

Our goal is to keep people healthy, reduce the risk factors among at-risk members and improve the health of those who already have chronic conditions by encouraging them to make lifestyle changes. To do this we give employees easy access to the resources needed to make well-informed decisions about their health and health care.



KEY COMPONENTS OF EMPLOYEE WELLNESS:

Our health promotion efforts are comprised of awareness, educational activities, behavior or lifestyle change programs, and the creation of supportive environments. The following highlights some of our numerous efforts to give employees the opportunities and information they need to be proactive and address their health & wellness:

- Wellness newsletter & tip sheets
- Health & wellness seminars
- On-site health screenings, mammography & immunizations
- Disease & care management
- Online health information & resources
- Healthy Pregnancy Program
- Health & fitness discounts
- Confidential health survey
- Online & telephonic health coaching
- On-site weight management & smoking cessation programs
- Employee Assistance Program
- Advocacy health care help
- Preventive care campaigns
- Clinical program engagement
- HealthyLiving-Lessons for Life Nurseline
- Wellness Champion Program
- Health Rewards
- Stress management strategies
- Community fitness events
- Accessible physical activity & healthy eating options
- Staff sports program
- Real Appeal weight loss program
- Nicklaus Children's Hospital kiosk
- Virtual visits
- Diabetes prevention programs
- Apps - Health4Me



**FOR MORE INFORMATION, MONTHLY HEALTH TIPS
AND UPCOMING WELLNESS EVENTS, PLEASE VISIT**
<http://L.sdpbc.net/1aex7>

Health Rewards

HEALTH REWARDS

UnitedHealthcare Health Rewards sponsored by the School District of Palm Beach County is an innovative incentive program designed to help you adopt healthy behaviors as a way of life. This reward is a premium credit that is paid by the district and applies only while you are actively working for the district and enrolled in a district medical plan. An employee with single coverage will need to earn 100% by August 31, 2018, to earn the full \$600 dollar discount for the plan year 2019.

The Health Rewards program allows you to track your points and progress at www.myuhc.com. You'll be able to know where you stand and what required activities still need to be completed to reap the Health Rewards.

TOOLS TO HELP YOU REAP HEALTHY REWARDS IN 2018

Each person (employee and covered spouse or domestic partner) is eligible to participate.

HEALTH REWARDS - ACHIEVE 4 OUT OF 5 BIOMETRIC MEASUREMENTS*		
Biometric Screening (First submission applies)	Targeted Measurements (Achieve 4 out of 5)	Reasonable Alternative Options <i>*Complete one designated reasonable alternative program, if two or more targeted measurements are missed.</i>
Total Cholesterol	Less than 200 mg/dl	Rally Missions (4 weeks) Complete 3 Rally Missions at www.myuhc.com
Fasting Glucose (Blood Sugar)	Less than 100 mg/dl	Telephone-Based Coaching For hearing impaired, dial TTY 711 before calling one of the toll-free telephone numbers Complete one coaching program (8 - 12 weeks) Call 800-478-1057 for telephonic coaching registration
Blood Pressure	Less than or equal to 140/90 mm/HG	Real Appeal Complete program (up to 16 weeks) Call 844-344-REAL (7325) for more information
Body Mass Index (BMI)	27.5 or less or (2 point improvement from previous year)	YMCA - Diabetes Prevention Program (DPP) Complete program (16 weeks) Call 561-300-3227 for more information
LDL Cholesterol	Less than 130 mg/dl	

FOR OFFICIAL RULES VISIT
<http://L.sdpbc.net/v1hg7>

TRACK YOUR PROGRESS ON MYUHC.COM.

**100% COMPLETION IS THE GOAL
TO EARN THE DISCOUNT!**

Health Rewards with Outcomes



THE KEY TO WELLNESS IS YOU!

We firmly believe that any significant reduction in health care costs will depend ultimately on a commitment by our members to make healthier, more educated lifestyle choices, manage their

illnesses better and become more knowledgeable about which health care services most cost-effectively serve their individual needs. By implementing our Health Rewards Program, the school district is taking steps to ensure that resources are maximized to provide a strong, healthy and productive workforce. By encouraging staff members to pursue a healthy lifestyle, this, in turn contributes to improved health status, improved morale and a greater personal commitment to a healthier school environment.

HEALTH REWARDS

Employees enrolled in a medical plan can save on their medical premium contributions by participating in the Health Rewards program. Participants who fulfill the Wellness requirements by the deadline will receive the Health Rewards discount of \$50 per month in 2019. If a spouse/domestic partner is covered on a participant's medical plan, that spouse/domestic partner must also meet the Health Rewards requirements in order for the employee to qualify for the discount. Your results are protected by Federal Law and will remain confidential. The district will only be notified of your participation if you have completed all required actions within the program. Each participant must earn 100 percent to complete the requirements.

PARTICIPANT ELIGIBILITY

Who can participate in 2018? An employee enrolled in a medical plan offered by Palm Beach County School District (PBCSD) must earn 100 percent. A covered spouse or domestic partner who completes the program requirements while enrolled in a medical plan offered by PBCSD must also earn 100 percent.

Participation Rules, Guidelines and Actions:

1. **Earn 33 percent** by completing and submitting a confidential online **Health Survey** at www.myuhc.com. (See Participation Resources #1)
2. **Earn 33 percent** for a **Biometric Screening** which includes Total Cholesterol, LDL, Fasting Glucose, Blood Pressure, and Body Mass Index (BMI) criteria. Participate in On-site Biometric Screenings OR download a personalized Health Provider Screening Form (MD Form) for completion by your in-network doctor or Convenience Care Clinic (not an Urgent Care Clinic) doctor. (See Participation Resources #2) Only your first biometric screening will count towards this program.
3. **Earn 34 percent by achieving Biometric Measurements from the chart or** completing a reasonable alternative program if two or more targets are not met. (See Participation Resources #3 and #4)
4. **Participants are responsible for completing all actions while covered by a medical plan offered by the school district and tracking their percentage during the program period.** Participants are responsible for working with service providers and UnitedHealthcare to ensure percentages are properly awarded and recognized. Percentages can take 30 to 45 days to display; plan accordingly.
5. **This program is voluntary.** Failure to participate does not render you ineligible for medical plan coverage. You will simply pay the standard employee premium contribution.

HEALTH REWARDS COMPLETION TIMEFRAME

January 1, 2018 – December 31, 2018

FULL HEALTH REWARDS CREDIT

All Health Rewards steps completed between January 1, 2018 and August 31, 2018 will receive the discount beginning with the first payroll deduction on or after January 1, 2019.

Special Note: Completion of one reasonable alternative program is subject to the Health Rewards program deadlines.

PARTIAL HEALTH REWARDS CREDIT

Complete all actions by December 31, 2018

All Health Rewards steps completed by December 31, 2018 will receive the discount beginning with the first payroll deduction on or after June 1, 2019.

Special Note: Completion of one reasonable alternative program is subject to the Health Rewards program deadlines.

Health Rewards with Outcomes

PARTICIPATION RESOURCES

- Each participant will need to complete a **Biometric Screening** worth 33 percent.
- You can fulfill this requirement in one of two ways: by participating in an On-site Biometric Screening; or by having your in-network doctor or a Convenience Care Clinic (not an Urgent Care Clinic) provider conduct your screening. If you do not participate in an On-site Biometric Screening, your doctor must complete a Health Provider Screening Form (MD Form). If your doctor draws your blood or gives you a prescription, your lab work must be processed at a LabCorp facility. An email confirmation of receipt of the MD Forms will be sent if an email address was provided at the time of registration for the screening. You may call **1-877-818-5826** if a confirmation is not provided within 30 days.

Biometric Screening	Targeted Measurements (Achieve 4 out of 5)
Total Cholesterol	Less than 200 mg/dl
Fasting Glucose (Blood Sugar)	Less than 100 mg/dl
Blood Pressure	Less than or equal to 140/90
Body Mass Index (BMI)	Less than or equal to 27.5 or a 2 point improvement from 2017 measurement
LDL (Cholesterol Value)	Less than 130/mg/dl

To find an On-site Biometric Screening location or to download your personalized MD Form, visit <http://L.sdpbc.net/v1hg7> and click on the **Health Provider Screening Form** link under *Benefits & Important Information*.

- Meet 4 out of 5 targeted measurements** in the following categories to earn 34 percent for meeting the biometric measurements. If you visit a convenience care clinic or participate in an On-site Biometric Screening event, a finger prick is all you will need. Otherwise,

network providers will perform a blood draw that needs to be processed through LabCorp while you are covered under a medical plan offered by the district in order to be eligible for the Health Rewards credit.

- To complete your **Health Survey**, log in to **www.myuhc.com®**. Click the “Go to Rally” link under the Health & Wellness Tab. Begin your Health Survey. Follow the directions listed and confirm that your survey has been submitted. This step takes approximately 15 minutes to complete. You will receive 33 percent once your survey has been submitted.

- If two or more of your biometric measurements do not fall within the established ranges, you can still earn rewards by participating in one of the designated reasonable alternative programs. These programs will educate you with health goal tracking to help you better understand your overall risk profile, encouraging you to take a proactive and long-lasting approach to health and wellness. All screenings, the online health survey, MD Form submission and the designated reasonable alternative program must be **completed prior** to the program deadline to be eligible for that period’s health rewards credit. A list of designated reasonable alternatives programs are listed on the next page. For more information, please visit our Wellness website at <http://L.sdpbc.net/v1hg7>.

Your health plan is committed to helping you achieve your best health status. Please submit general Health Rewards questions to **Staffwellness@palmbeachschools.org**. For specific questions that include personal health information (PHI), you may contact our On-site UHC representative Gaby Perez (561-434-8092) or Matthew Jarsen (561-357-7564).

Examples		
Completed Actions	Participant A	Participant B
Online Health Survey	33%	33%
On-site Biometric Screening or Health Screening Form Submitted	33%	33%
Achieved 4 of 5 Targeted Measurements	4 targets met – 34%	2 or more missed targets – 0% earned

Designated Reasonable Alternative Options



ALTERNATIVE OPTION #1: TELEPHONE-BASED COACHING

Complete a telephone-based coaching course. You may choose any of the following topics that interest you.

- Exercise
- Heart Healthy Lifestyle
- Stress Management
- Weight Management
- Nutrition Management
- Diabetes Lifestyle
- Tobacco Cessation

Once you have completed your coaching sessions and your Health Provider Screening form with the missed biometric measurements has been processed, your coach will submit information to indicate that you have completed the coaching program.

ALTERNATIVE OPTION #2: REAL APPEAL

realappeal[®] Participate in Real Appeal, a yearlong, highly motivating, online weight loss program. Meet with a coach on a computer or smartphone, and be on your way to losing weight for good! (Completion of a minimum of 16 weekly coaching sessions is required in order for Real Appeal to qualify as an alternative option.

**COMPLETE ONE ALTERNATIVE ACTION
IF YOU HAVE 2 OR MORE MISSED MARKERS**

ALTERNATIVE OPTION #3: DIABETES PREVENTION PROGRAM (DPP)

If you like face-to-face help this may be the option for you if you are at risk of diabetes. Everyone needs a push, a pat on the back, a helping hand sometimes. A little encouragement goes a long way when you're making big changes. In the YMCA's Diabetes Prevention Program you'll spend a year surrounded by a group of supportive people with common goals who care about your well-being.

As a participant, you'll enjoy:

- A safe space where you can feel comfortable sharing and learning in private.
- Making new friends. You will support each other as you all trade old habits for healthier new ones.
- Working as a group. You don't have to figure this out alone.
- The new energy and confidence that comes with losing weight and reducing your risk for diabetes.

IMPROVE YOUR HEALTH, BOOST YOUR ENERGY

To help reduce your risk for diabetes, your goal in the YMCA's Diabetes Prevention Program is to reduce your body weight by 7 percent and increase your physical activity by at least 150 minutes per week within the first half of the program.

ALTERNATIVE OPTION #4: RALLY MISSIONS

A mission is a customized digital action plan designed to help you improve your life. Mission recommendations are made just for you under four categories: Move, Eat, Feel and Care. Each mission is designed to be simple, action-focused and attainable. Missions meet you where you are and help you take small steps toward better health.

To join a mission, select the MISSIONS tab at the top of any page in Rally, and click on BROWSE ALL. You'll see the missions RECOMMENDED FOR YOU at the top. In addition to the personal recommendations, you can view all available missions in the missions gallery. Most missions can be completed in about 4 weeks.

Rally Online Health & Wellness Experience

THE FIRST STEP - LOG ON TO MYUHC.COM®

Go to www.myuhc.com®. If you are already registered, log in with your username and password and click on the “Visit Rally Health & Wellness” icon.



If you have never registered on myuhc.com® click “Register Now” and follow the prompts, then proceed to the Health & Wellness tab as described above.

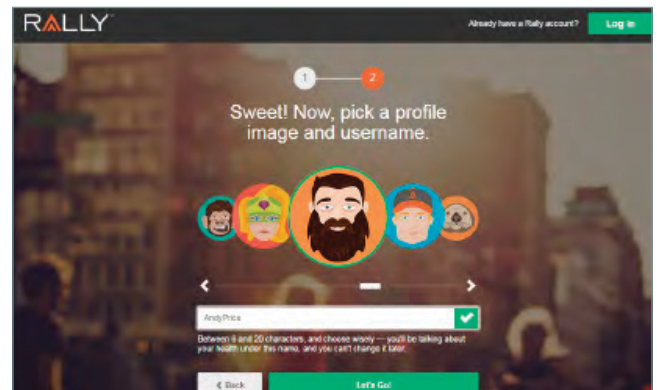
REGISTRATION

Registration may be required if this is your first time visiting the site. Follow the screen prompts.

LET’S GET STARTED WITH RALLY

You are now on the RALLY registration page. Register by following the 3 simple on-screen steps. You will choose an Avatar to participate in online communities or other activities. Your username should be fun and memorable but NOT your real name.

RALLY™ With RALLY it takes just a few minutes to answer some simple questions and get immediate and confidential results. You will be provided with specific health suggestions for you to consider and follow-up actions that are designed to work with you and your daily behaviors. This information may help you better understand your healthy behaviors to help you live a healthier lifestyle.



Wellness Services

WELLNESS SERVICES TO HELP YOU MEET YOUR PERSONAL HEALTH GOALS

Current members: You can access our wellness services today. Just log in to **myuhc.com®** and click on “Health & Wellness,” or call the Customer Care number on the back of your health plan ID card.

FIND SUPPORT BY WORKING WITH A PERSONAL HEALTH COACH

If you have health risks, our health coaches may call you to offer their support. They can set up a personal plan to help provide health tips and coaching support, or you can call them for help in finding ways to improve your health.



GET HELP TO STOP SMOKING OR QUIT USING TOBACCO

We know it's not easy to quit, but we'll give you the support you need. You'll receive tips on how to quit, set a “quit date” and begin a step-by-step program with access to online tools that can help you stay on track by:

- Identifying common obstacles to quitting
- Understanding nicotine replacement therapy options
- Dealing with temptations and preventing relapse.

LEARN HOW WE CAN HELP YOU LOSE WEIGHT

There are real advantages to losing weight. Being overweight can lead to diseases, such as heart disease,

diabetes, high blood pressure and high cholesterol. Our online health coaches will guide you through a staged approach to learning about proper nutrition and how to plan healthy meals.

- Learn different ways to lose weight.
- Plan more nutritional meals.
- Manage your exercise and track your progress.
- Avoid temptations.

TOBACCO USE COMES WITH A SURCHARGE - QUIT TO SAVE YOUR HEALTH, AND SAVE DOLLARS IN THE FUTURE

AVOID PREMIUM SURCHARGES!

You know that tobacco is bad for you. So, why not quit? It's hurting your health, draining your wallet and leaving you behind in a world that's becoming tobacco-free. We encourage you to take steps to quit and save on premium dollars in the future. Also, think of the added saving you will have when you no longer spend money to buy tobacco products. The potential savings are waiting for you.

HOW DOES IT WORK?

The School District of Palm Beach County asked that each employee log in to PeopleSoft and click on the My Benefits tile. Click the Wellness Rewards and Surcharge option to review or update your tobacco status. You only need to provide this information once, unless you have a change in your tobacco status while at the district.

Tobacco users (or those who fail to indicate their tobacco status) will have a \$50 per month surcharge added to their medical premium. We encourage you to take steps to quit and save in the future. If you are not a tobacco user, you will not have monthly tobacco charges added to your insurance premium payroll deduction. If you start using tobacco products, you must notify Risk & Benefits Management for a classification change.

Flexible Spending Accounts (FSAs)

WHAT IS A FLEXIBLE SPENDING ACCOUNT (FSA)?

An FSA is an IRS tax-favored account that helps you to stretch your health care and dependent care dollars.

FSAs feature:

- IRS-approved reimbursement of eligible expenses tax-free
- Per-pay-period deposits from your pre-tax salary
- Savings on income and Social Security taxes
- Security of paying anticipated expenses with your FSA

IS AN FSA RIGHT FOR ME?

If you spend any money on recurring eligible expenses during your plan year, you may save money by paying for them with an FSA. A portion of your salary is deposited into your FSA each pay period.

- Decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- Save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a tax savings analysis by visiting the “tax calculators” link at www.wageworks.com/myhcfsa and www.wageworks.com/mydcfsa.

WHAT TYPES OF FSAs ARE AVAILABLE?

The School District of Palm Beach County offers you a Health Care FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

HEALTH CARE FSA

Medical expenses not covered by your insurance plan may be eligible for reimbursement using your Health Care FSA, including:

- prescription drugs
- eyeglasses
- orthodontia

DEPENDENT CARE FSA (DAY CARE/ELDER CARE)

Dependent care expenses, whether for a child or an elder, include any expense that allows you to work, such as:

- day care services
- in-home care
- nursery and preschool
- summer day camps

Refer to the Health Care FSA and Dependent Care FSA sections of this reference guide for specifics on each type of FSA.

RECEIVING REIMBURSEMENT

Your reimbursement will be processed within five business days from the time your properly completed and signed claim form is received. To avoid delays, follow the instructions for submitting FSA Claims.

DIRECT DEPOSIT

Enroll in direct deposit to expedite the time of your reimbursement.

- FSA reimbursement funds are automatically deposited into your checking or savings account within 48 hours of your claim approval.
- There is no fee for this service.
- You don't have to wait for postal service delivery of your reimbursement (however, you will receive notification that the claim has been processed).



To apply, visit www.wageworks.com or call WageWorks Customer Service, Mon - Fri, 8 a.m. - 8 p.m. ET at 1-855-428-0446. **PLEASE**

NOTE that processing your FSA direct deposit enrollment may take between four and six weeks.

FSA GRACE PERIOD

An IRS Revenue Notice permits a “**grace period**” of two months and 15 days following the end of your 2018 plan year (December 31, 2018) for an FSA. This grace period ends on March 15, 2019. **During the grace period, you may incur expenses and submit claims for these expenses.** Funds will be automatically deducted from any remaining dollars in your 2018 Health Care FSA or Dependent Care FSA.

You should not confuse the grace period with the plan's “**run-out period**”. The run-out period extends until March 31, 2019. This is a period for filing claims incurred anytime during the 2018 plan year, as well as claims incurred during the grace period mentioned above.

Claims will be processed in the order in which they are received, and your accounts will be debited accordingly. This is true for both paper claims and WageWorks® Healthcare Card transactions. If you have funds remaining in an account for the prior plan year, these funds will be used first until exhausted. Then subsequent claims will be debited from your new plan year account balance.

Flexible Spending Accounts (FSAs)

WHERE CAN I GET INFORMATION ABOUT FSAS?

If you have specific questions about FSAs, contact the Customer Service department. Visit www.wageworks.com or call WageWorks Customer Service Mon - Fri, 8 a.m. - 8 p.m. ET at 855-428-0446. **PLEASE NOTE** that your account information will not be discussed with others without your verbal or written authorization.

FSA GUIDELINES:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Health Care FSA or vice versa.
3. You have a 90-day run-out period (until March 31, 2019) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage and any applicable grace period within the 2018 plan year.
4. You may not receive insurance benefits or any other compensation for expenses that are reimbursed through your FSAs.
5. You cannot deduct reimbursed expenses for income tax purposes.
6. You may not be reimbursed for a service that you have not yet received.
7. You may only be reimbursed for expenses incurred while you are actively enrolled and making contributions.
8. Be conservative when estimating your medical and/or dependent care expenses for the 2018 plan year. IRS regulations state that any unused funds that remain

FSA SAVINGS EXAMPLE*

(With FSA)		(Without FSA)
\$31,000	Annual gross income	\$31,000
- 2,650	FSA deposit for recurring expenses	- 0
\$28,350	Taxable gross income	\$31,000
\$6,421.28	Federal, Social Security taxes	- 7,021.50
\$21,928.72	Annual net income	\$23,978.50
- 0	Cost of recurring expenses	- 2,650
\$21,928.72	Spendable income	\$21,328.50

By using an FSA to pay for anticipated recurring expenses, you convert the money you save in taxes to additional spendable income. That's a potential annual savings of **\$600.22!**

**Based upon a 22.65 percent tax rate (15 percent federal and 6.2 percent Social Security and 1.45 percent Medicare) calculated on a calendar year.*

in your FSA after a plan year and any applicable grace period ends, and all reimbursable requests have been submitted and processed, cannot be returned to you or carried forward to the next plan year.

9. When enrolling in either or both FSAs, written notice of agreement with the following will be required:
 - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for my IRS-eligible dependents and myself.
 - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s), before seeking reimbursement from my FSA.
 - I will not seek reimbursement through any additional source.
 - I will collect and maintain sufficient documentation to validate the foregoing.

WHAT DOCUMENTATION OF EXPENSES DO I NEED TO KEEP?

The IRS requires FSA customers to maintain complete documentation, including keeping copies of statements, invoices or bills for reimbursed expenses, for a minimum of one year. This also applies to WageWorks® Healthcare Card transactions as well.

HOW DO I GET THE FORMS I NEED?

Log in to www.wageworks.com to obtain:

- Claim forms
- A letter of medical need
- Direct deposit form

For more information, refer to the getting answers section of this Reference Guide or call WageWorks Customer Service at 855-428-0446 for further assistance.

WILL CONTRIBUTIONS AFFECT MY INCOME TAXES?

Salary reductions made under a cafeteria plan, including contributions to one or both FSAs, will lower your taxable income and taxes. These reductions are one of the money-saving aspects of starting an FSA. Depending on the state, additional state income tax savings or credits may also be available. Your salary reductions will reduce earned income for purposes of the federal Earned Income Tax Credit (EITC). *To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information.*

DID YOU READ ABOUT:

- **HOW AN FSA WORKS?**
- **DIRECT DEPOSIT?**
- **THE GRACE PERIOD?**

Health Care FSA

IN THIS SECTION:

- WHOSE EXPENSES ARE ELIGIBLE
- OVER-THE-COUNTER REIMBURSEMENT
- ELIGIBLE EXPENSES
- HOW TO RECEIVE REIMBURSEMENT

WHAT IS A HEALTH CARE FSA?

A Health Care FSA is an IRS tax-favored account you can use to pay for your eligible medical expenses not covered by your insurance or any other plan. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on page 56.

WHOSE EXPENSES ARE ELIGIBLE?

Your Health Care FSA may be used to reimburse eligible expenses incurred by:

- yourself
- your spouse
- your qualifying children
- your qualifying relative

An individual is a **qualifying child** if he or she is not someone else's qualifying child and:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada;
- has a specified family-type relationship to you;
- lives in your household more than half of the taxable year;
- is 18 years old or younger (25 years, if a full-time student) at the end of the taxable year; and,
- has not provided more than one-half of their own support during the taxable year.

An individual is a **qualifying relative** if he or she is a U.S. citizen, national or a resident of the U.S., Mexico or Canada and:

- has a specified family-type relationship to you, is not someone else's qualifying child and receives more than one-half of his or her support from you during the taxable year; or,
- if no specified family-type relationship to you exists, is a member of and lives in your household (without violating local law) for the entire taxable year and receives more than one-half of his or her support from you during the taxable year.

NOTE: There is no age requirement for a qualifying child if he or she is physically and/or mentally incapable of self-care. An eligible child of divorced parents is treated as a dependent of both, so either or both parents can establish a Health Care FSA.

CAN TRAVEL EXPENSES FOR MEDICAL CARE BE REIMBURSED?

Travel expenses primarily for, and essential to, receiving medical care, including healthcare provider and pharmacy visits, may be reimbursable through your Health Care FSA. With proper substantiation, eligible expenses can include:

- actual round-trip mileage
- parking fees
- transportation to another city
- tolls

ARE PRESCRIPTIONS ELIGIBLE FOR REIMBURSEMENT?

Yes, most filled prescriptions are eligible for Health Care FSA reimbursement, as long as you properly substantiate the expense. Proper submission of the reimbursement request is needed to ensure that the drug is eligible for reimbursement. The IRS requires that the complete name of all medicines and drugs be obtained and documented on pharmacy invoices (including prescription number, date(s) of service and total dollar amount). This information must be included when submitting your request for reimbursement.

OVER-THE-COUNTER REIMBURSEMENT RULES

Under the Patient Protection and Affordable Care Act (PPACA) Over-the-Counter (OTC) drugs and medicines require a prescription from a doctor to qualify for reimbursement. For example, this includes such items as digestive aids, allergy and sinus drugs, pain relief, cold medicines, cough medicines, laxatives, motion sickness and stomach remedies, sleep aids, cold sore, anti-diarrheal and anti-gas meds, anti-itch items, baby rash creams, insect bite treatments, respiratory treatments and anti-infective medications.

Be sure to review your enrollment materials carefully and check www.wageworks.com regularly for updates.

VISIT WWW.WAGeworks.COM FOR A LIST OF FREQUENTLY ASKED QUESTIONS (FAQs).
YOU MUST KEEP YOUR DOCUMENTATION FOR A MINIMUM OF ONE YEAR AND SUBMIT IT UPON REQUEST.

MINIMUM ANNUAL DEPOSIT: \$300
MAXIMUM ANNUAL DEPOSIT: \$2,650

IS ORTHODONTIC TREATMENT REIMBURSABLE?

Orthodontic treatment designed to treat a specific medical condition is reimbursable through your Health Care FSA if the proper documentation is provided:

- a written statement, bill or invoice from the treating dentist/orthodontist showing the type and date the service was incurred, the name of the eligible individual receiving the service, the cost for the service and
- a copy of the patient's contract with the dentist/orthodontist for the orthodontia treatment (only required if a participant requests reimbursement for the total program cost spread over a period of time).

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under the School District of Palm Beach County's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call WageWorks Customer Service at 855-428-0446.

WHEN ARE MY FUNDS AVAILABLE?

Once you sign up for a Health Care FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage. Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

SHOULD I CLAIM MY EXPENSES ON IRS FORM 1040?

With a Health Care FSA, the money you set aside for health care expenses is deducted from your salary before taxes. It is always tax-free, regardless of the amount. By enrolling in a Health Care FSA, you guarantee your savings.

Itemizing your health care expenses on your IRS form 1040 may give you a different tax advantage, depending on their percentage of your adjusted gross income. You should consult a tax professional to determine the avenue that is right for you.

ARE SOME EXPENSES INELIGIBLE?

Expenses not eligible for reimbursement through your Health Care FSA include:

- insurance premiums;
- vision warranties and service contracts; and,
- cosmetic surgery not deemed medically necessary to alleviate, mitigate or prevent a medical condition. Limitation and exclusions apply for over-the-counter medications.

WHEN DO I REQUEST REIMBURSEMENT?

You may use your Health Care FSA to reimburse eligible expenses after you have sought (and exhausted) all means of reimbursement provided by the School District of Palm Beach County and any other appropriate resource. Also keep in mind that some eligible expenses are reimbursable on the date available, not the date ordered.

HOW DO I REQUEST REIMBURSEMENT?

Requesting reimbursement from your Health Care FSA is easy. Simply fax or mail a correctly completed claim form along with the following:

- an invoice or bill from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided or
- an explanation of benefits (EOB)* from your health insurance provider that shows the specific type of service you received, the date and cost of the service and any uninsured portion of the cost; and
- a written statement from your health care provider indicating the service was medically necessary if those services could be deemed cosmetic in nature, accompanied by the invoice or bill for the service.

PLEASE NOTE that canceled checks or credit card receipts (or copies) listing the cost of eligible expenses are **not** valid documentation for Health Care FSA reimbursement.

Fax TOLL-FREE to: 1-855-291-0625

Mail to: WageWorks
Claims Administrator
P.O. Box 14326
Lexington, KY 40512

**EOBs are not required if your coverage is through an HMO.*

Health Care FSA

EZ RECEIPTS

Managing your FSA benefits is easier than ever with WageWorks. Wherever life takes you – whether it's commuting to work, taking care of your family's health or managing a child's or dependent's day care – you know you can count on WageWorks to make it more affordable.

Now, with our enhanced EZ Receipts® mobile application, we've made it faster and more convenient. EZ Receipts enables you to submit health care claims and to upload receipts for WageWorks Healthcare Card transactions right from your smartphone, access help features right at your fingertips and get immediate email confirmations for claims.

No more filling out forms and mailing them in – easily submit claims and receipts online. Just pick up your smartphone to manage your WageWorks Healthcare FSA or Dependent Care FSA account with the EZ Receipts Mobile App. EZ Receipts is compatible with iPhone, Android and Blackberry.

WITH EZ RECEIPTS YOU CAN:

- File a Claim or Submit a Receipt and get reimbursed fast.
- Use the Shortcut Buttons to speed your way through the process.
- Get easy access to transactions.
- Check your current Health Care FSA and Dependent Care FSA account balance.
- Submit WageWorks Healthcare FSA (Debit) Card receipt.
- Have your day care provider sign directly in the App.

HERE'S HOW IT WORKS:

1. Use your WageWorks® Healthcare FSA Debit Card for eligible purchases. Keep a copy of your receipt.
2. Snap a picture of your receipt on your mobile phone with the EZ Receipts mobile application.
3. EZ Receipts will automatically submit your receipt to WageWorks for reimbursement. You can use the EZ Receipts mobile App with any FSA account. That's it! EZ Receipts does the rest!

To download the App and learn more, go to www.wageworks.com/aboutmobile.

PARTIAL LIST OF MEDICALLY NECESSARY ELIGIBLE EXPENSES*

Acupuncture
Ambulance service
Birth control pills and devices
Chiropractic care
Contact lenses (corrective)
Dental fees
Diagnostic tests/health screening
Doctor fees
Drug addiction/alcoholism treatment
Drugs
Experimental medical treatment
Eyeglasses
Guide dogs
Hearing aids and exams
In vitro fertilization
Injections and vaccinations
Nursing services
Optometrist fees
Orthodontic treatment
Prescription drugs to alleviate nicotine withdrawal symptoms
Smoking cessation programs/treatments
Surgery
Transportation for medical care
Weight-loss programs/meetings
Wheelchairs
X-rays

NOTE: Budget conservatively. No reimbursement or refund of Health Care FSA funds is available for services that do not occur within your plan year and grace period.

**IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply and will be supplied to you following enrollment.*

DID YOU READ ABOUT:

- **WHO IS ELIGIBLE TO PARTICIPATE?**
- **ELIGIBLE MEDICAL EXPENSES?**
- **HOW TO REQUEST REIMBURSEMENT?**

WageWorks® Healthcare Card

IN THIS SECTION:

- **HOW WAGEWORKS® HEALTHCARE CARD WORKS**
- **WHEN TO SUBMIT DOCUMENTATION**
- **WAGEWORKS® HEALTHCARE CARD ADVANTAGES**

WHAT IS THE WAGEWORKS® HEALTHCARE CARD?



The WageWorks® Healthcare Card is a stored-value card. It is a convenient medical expense FSA reimbursement option that

allows electronic reimbursement of eligible expenses under the School District of Palm Beach County's plan and IRS guidelines. Your annual Health Care FSA contribution is available to you at the beginning of your plan year.

When you use the WageWorks® Healthcare Card to pay for eligible expenses, funds are electronically deducted from your Health Care FSA. The WageWorks® Healthcare Card is a convenient way to access your Health Care FSA funds; however, the IRS still requires substantiation of service. Please keep this in mind as you seek services and use the WageWorks® Healthcare Card. Always request that your service provider give you a detailed statement of service. You will be notified of any reimbursement requiring that you submit a claim and documentation to satisfy the IRS requirement.

WHEN DO I SEND IN DOCUMENTATION FOR A WAGEWORKS® HEALTHCARE CARD EXPENSE?

You must send in documentation for certain WageWorks® Healthcare Card transactions, such as those that are not a known office visit or prescription copayments (as outlined in your health plan's schedule of benefits). When requested, you must send in documentation for these transactions. Documentation for a WageWorks® Healthcare Card expense is a statement or bill showing:

- name of the patient
- name of the service provider
- date of service
- type of service (including prescription name) and
- total amount of service.

NOTE: This documentation must be sent with a properly completed claim form and cannot be processed without it. Like all other FSA documentation, you must keep the

WageWorks® Healthcare Card expense documentation for a minimum of one year and submit it when requested.

WHAT AGREEMENT AM I MAKING WHEN I USE THE WAGEWORKS® HEALTHCARE CARD?

By using the WageWorks® Healthcare Card, you are agreeing to the "FSA Guidelines" portion of this Reference Guide on page 53.

WHAT ARE THE WAGEWORKS® HEALTHCARE CARD ADVANTAGES?

- Instant **reimbursements** for health care expenses, including prescriptions, copayments and mail-order prescription services;
- Instant **approval of some** medical, vision and dental expenses (others require documentation);
- No out-of-pocket expense; and,
- Easy access to your Health Care FSA funds.

NOTE: You cannot use the WageWorks® Healthcare Card for cosmetic dental expenses or eyeglass warranties.

HOW DO I GET A WAGEWORKS® HEALTHCARE CARD?

You will automatically receive the WageWorks® Healthcare Card. One card will be sent to you in the mail. You may visit www.wageworks.com to order a card for your spouse or eligible dependent. You should keep your card to use each plan year until its expiration date. You will have to activate your card. There are no fees for using the card!

HOW DO I USE THE WAGEWORKS® HEALTHCARE CARD?

For eligible expenses, simply swipe the WageWorks® Healthcare Card like you would with any other credit card at your health care provider or at an IIAS certified merchant. Whether at your health care provider or drugstore, the amount of your eligible expenses will be automatically deducted from your Health Care FSA. To locate an IIAS certified merchant near you, see the **IIAS FAQs** at www.wageworks.com.

WHAT HAPPENS IF I HAVE MONEY LEFT IN MY ACCOUNT AT THE END OF THE PLAN YEAR?

As long as you submit a paper claim form, the funds left in our account from the prior plan year will be used first until the account has been exhausted – through March 15, 2019, which is the grace period allowed by the IRS. Then subsequent claims will be debited from your new plan year account balance. *For more information on the grace period, see page 52.*

WageWorks® Healthcare Card

Download a claim form at
www.wageworks.com

I USED THE WAGEWORKS® HEALTHCARE CARD AT THE DOCTOR'S OFFICE.

NOW WHAT? No documentation is required if you only paid an established copayment. For all other expenses, be prepared to submit a legible copy of a statement, bill or invoice which must be included with your online claim with the following information:

- the date service(s) was received
- the name of the person(s) for whom the service(s) was provided
- the type of service(s) rendered
- the name and address of the provider and the cost of the service(s).

We've made it easy for you to send in confirmation for WageWorks® Healthcare Card purchases. Simply complete the online claim form at www.wageworks.com with your detailed invoice. You can check the status of your WageWorks® Healthcare Card transactions online. Visit www.wageworks.com and log in to view all of your account information.

HEALTH CARE FSA REIMBURSEMENT COMPARISON - PLASTIC VS. PAPER!

WageWorks® Healthcare Card	Paper Reimbursement
<ul style="list-style-type: none"> • Service must occur during benefit period: 01/01/18 to 12/31/18 • Deadline for services is 01/01/18 to 12/31/18 • Use it or lose it rule applies 12/31/18 	<ul style="list-style-type: none"> • Service must occur during benefit period: 01/01/18 to 12/31/18 • Deadline for services is 12/31/18* • Use it or lose it rule applies
<ul style="list-style-type: none"> • Card can be used for eligible dental, medical and vision services Insurance is not required, but if you have insurance coverage card may be used after insurance has been utilized. • Dependent expenses are eligible. 	<ul style="list-style-type: none"> • Account can be used for eligible dental, medical and vision services. Insurance is not required. If you have insurance coverage, request reimbursement for out-of-pocket expenses after insurance has been utilized. • Dependent expenses are eligible.
<ul style="list-style-type: none"> • Claim form and documentation must be submitted when using the card (except for certain copays). • Copays for known medical office visit and prescription services no longer require documentation to be submitted for substantiation. • All documentation should be kept by the employee for up to one year as the IRS requires documentation to be submitted upon their request. • Documentation must be submitted by 03/31/19. 	<ul style="list-style-type: none"> • In order to receive reimbursement, a bill, statement or invoice <u>must always</u> accompany your claim form. • Documentation must be submitted by 03/31/19.
A card can be suspended when documentation is not received or is incomplete, when card transaction is deemed ineligible, or when transaction is highlighted on your monthly statement.	Documentation can be accumulated and sent periodically or all at the same time, provided it is all sent by the deadline mentioned above and it is for the current plan year only.
Documentation must include: patient name, type of service, date, provider and total amount (who, what, when, where and how much).	Documentation must include: patient name, type of service, date, provider and total amount (who, what, when, where and how much).
Claim forms must be submitted with documentation. Visit www.wageworks.com to download a claim form.	Claim forms must be submitted in order to receive reimbursement. Visit www.wageworks.com to download.
Card resets 12/31 each year and reloads 01/01 of each year with your new annualized amount. (FSAs require annual re-enrollment).	Account terminates 12/31 of each year and with new enrollment renews 01/01 of each year.
If your card is suspended due to outstanding card transactions, you will experience reclassification of the unverified card transaction.	Reimbursement request is rejected if proper documentation is not provided.
Tax-free savings PLUS no out-of-pocket funds spent, no reimbursement wait time and no money spent on postage.	Tax-free savings.
<ul style="list-style-type: none"> • Example of an eligible payment card expense that <u>does not</u> require documentation: \$25 copay for medical office visit. • Example of an eligible payment card expense that <u>does</u> require documentation: purchase eyeglasses from Lens Crafters. 	Example of eligible reimbursable expense: 10% coinsurance for outpatient surgery.

*excludes surgery- see page 55

Dependent Care FSA

IN THIS SECTION:

- **ELIGIBLE DEPENDENT CARE EXPENSES**
- **MAXIMUM ANNUAL DEPOSIT**
- **INELIGIBLE EXPENSES**
- **HOW TO REQUEST REIMBURSEMENT**

WHAT IS A DEPENDENT CARE FSA?

A Dependent Care FSA is an IRS tax-favored account you can use to pay for your eligible dependent day care expenses to ensure your dependents (child or elder) are taken care of while you and your spouse (if married) are working. These funds are set aside from your salary before taxes are deducted, allowing you to pay your eligible expenses tax-free. A partial list of these eligible expenses can be found on the next page.

WHOSE EXPENSES ARE ELIGIBLE?

You may use your Dependent Care FSA to receive reimbursement for eligible dependent day care expenses for qualifying individuals.

A qualifying individual includes a **qualifying child**, if he or she:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- has a specified family-type relationship to you
- lives in your household for more than half of the taxable year.
- is 12 years old or younger and
- has not provided more than one-half of his or her own support during the taxable year.

A qualifying individual includes your **spouse**, if he or she:

- is physically and/or mentally incapable of self-care
- lives in your household for more than half of the taxable year.
- spends at least eight hours per day in your home.

A qualifying individual includes your **qualifying relative**, if he or she:

- is a U.S. citizen, national or a resident of the U.S., Mexico or Canada
- is physically and/or mentally incapable of self-care
- is not someone else's qualifying child
- lives in your household for more than half of the taxable year
- spends at least eight hours per day in your home and
- receives more than one-half of his or her support from you during the taxable year.

NOTE: Only the custodial parent of divorced or legally-separated parents can be reimbursed using the Dependent Care FSA.

WHAT IS MY MAXIMUM ANNUAL DEPOSIT?

- If you are married and filing separately, your maximum annual deposit is \$2,500.
- If you are single and head of household, your maximum annual deposit is \$5,000.
- If you are married and filing jointly, your maximum annual deposit is \$5,000.
- If either you or your spouse earn less than \$5,000 a year, your maximum annual deposit is equal to the lower of the two incomes.
- If your spouse is a full-time student or incapable of self-care, your maximum annual deposit is \$3,000 a year for one dependent and \$5,000 a year for two or more dependents.

WHEN ARE MY FUNDS AVAILABLE?

Once you sign up for a Dependent Care FSA and decide how much to contribute, the funds available to you depend on the actual funds in your account. Unlike a Health Care FSA, the entire maximum annual amount is not available during the plan year, but rather after your payroll deductions are received.

SHOULD I CLAIM TAX CREDITS OR EXCLUSIONS?

Since money set aside in your Dependent Care FSA is always tax-free, you guarantee savings by paying for your eligible expenses through your IRS tax-favored account. Depending on the amount of income taxes you are required to pay, participation in a Dependent Care FSA may produce a greater tax benefit than claiming tax credits or exclusions alone.

Remember, you cannot use the dependent care tax credit if you are married and filing separately. Further, any dependent care expenses reimbursed through your Dependent Care FSA cannot be filed for the dependent care tax credit, and vice versa.

MINIMUM ANNUAL DEPOSIT: \$300

MAXIMUM ANNUAL DEPOSIT: THE MAXIMUM CONTRIBUTION DEPENDS ON YOUR TAX FILING STATUS AS THE LIST ON THIS PAGE INDICATES.

Dependent Care FSA

PARTIAL LIST OF ELIGIBLE EXPENSES*

Before/after school care
Baby-sitting fees
Day care services (childcare/elder care)
Elder care services
In-home care/au pair services
Nursery and preschool
Summer day camps

**Budget conservatively. No reimbursement or refund of Dependent Care FSA funds is available for services that do not occur within your plan year. IRS-qualified expenses are subject to federal regulatory change at any time during a tax year. Certain other substantiation requirements and restrictions may apply and will be supplied to you following enrollment.*

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information. You may also visit www.wageworks.com/myhcfsa and www.wageworks.com/mydcfsa to complete a tax savings analysis.

ARE SOME EXPENSES INELIGIBLE?

Expenses not eligible for reimbursement through your Dependent Care FSA include:

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

WILL I NEED TO KEEP ANY ADDITIONAL DOCUMENTATION?

To claim the income exclusion for dependent care expenses on IRS form 2441 (child and dependent care expenses), you must be able to identify your dependent care provider. If your dependent care is provided by an individual, you will need their Social Security number for identification, unless he or she is a resident or non-resident alien who does not have a Social Security number. If your dependent care is provided by an establishment, you will need its Taxpayer Identification Number (TIN).

If you are unable to obtain a dependent care provider's information, you must compose a written statement that explains the circumstances and states that you made a serious and earnest effort to get the information. This statement must accompany your IRS form 2441.

WHEN DO I REQUEST REIMBURSEMENT?

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

HOW DO I REQUEST REIMBURSEMENT?

Requesting reimbursement from your Dependent Care FSA is easy. Simply fax or mail a correctly completed claim form along with documentation showing the following:

- the name, age and grade of the dependent receiving the service;
- the cost of the service
- the name and address of the provider and
- the beginning and ending dates of the service.

Be certain you obtain and submit the above information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement. Canceled checks or credit card receipts (or copies) listing the cost of eligible expenses are not valid documentation for Dependent Care FSA reimbursement.

Fax toll-free to: 1-855-291-0625

Mail to: WageWorks

Claims Administrator

P.O. Box 14326, Lexington, KY 40512

NOTE: If you elect to participate in the Dependent Care FSA or if you file for the Dependent Care Tax Credit, you must attach IRS form 2441, reflecting the information above, to your 1040 income tax return. Failure to do this may result in the IRS denying your pre-tax exclusion.

Be certain you obtain and submit all needed information when requesting reimbursement from your Dependent Care FSA. This information is required with each request for reimbursement.

A properly completed request will help speed along the process of your reimbursement, allowing you to receive your check or direct deposit promptly.

DID YOU READ ABOUT:

- **WHO IS ELIGIBLE TO PARTICIPATE?**
- **ELIGIBLE MEDICAL EXPENSES?**
- **HOW TO REQUEST REIMBURSEMENT?**

FSA Worksheets

To figure out how much to deposit in your FSA, refer to the following worksheets. Calculate the amount you expect to pay during the plan year for eligible, uninsured out-of-pocket medical and/or dependent care expenses. This calculated amount cannot exceed established IRS

and plan limits. (Refer to the individual FSA descriptions in this Reference Guide for limits.)

Be conservative in your estimates, since any money remaining in your accounts cannot be returned to you or carried forward to the next plan year.

HEALTH CARE FSA WORKSHEET

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

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	\$ _____
Coinsurance or copayments	\$ _____
Virtual office visits copayments	\$ _____
Vision care	\$ _____
Dental care	\$ _____
Prescription drugs	\$ _____
Travel costs for medical care	\$ _____
Other eligible expenses (including OTCs)	\$ _____

TOTAL (cannot exceed \$2,650) \$ _____

DIVIDE by the number of scheduled deductions remaining in the plan year after your benefits effective date.* \$ _____

This is your pay period contribution. \$ _____

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

DEPENDENT CARE FSA WORKSHEET

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

CHILD CARE EXPENSES

Day care services	\$ _____
In-home care/au pair services	\$ _____
Nursery and preschool	\$ _____
After school care	\$ _____
Summer day camps	\$ _____

ELDER CARE SERVICES

Day care center	\$ _____
In-home care	\$ _____

TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year. \$ _____

DIVIDE by the number of scheduled deductions remaining in the plan year after your benefit effective date.* \$ _____

This is your pay period contribution. \$ _____

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

AT YOUR REQUEST, YOUR FSA REIMBURSEMENT CHECKS MAY BE DEPOSITED INTO YOUR CHECKING OR SAVINGS ACCOUNT BY ENROLLING IN DIRECT DEPOSIT.

Accessing Your Benefits

Customer Care offers you a variety of resources to make inquiries on your benefits and Flexible Spending Accounts (FSAs), including information from the WageWorks website and Customer Care.

PERSONAL IDENTIFICATION NUMBER (PIN)

The last four digits of your SSN will be your Wageworks ID. Your PIN is needed to register.
Future logins will require username and password.

If you forget your PIN, call the WageWorks Customer Service Center at 1-855-428-0446.

RECORD YOUR PIN HERE:

ON THE WEB

Go to **www.wageworks.com** to begin. Your first step is to register, using your name, mailing ZIP code, email address and one of the following: Participant ID (NOT your seven-digit Employee ID) or Social Security number (current users will continue to use your existing login credentials).

Fill out the registration form, enter the random image string into the text box, read the user acceptance agreement and then click the "I agree. Complete my registration" button. You will receive an email shortly to finalize the registration. Follow the instructions within the email.

If you previously registered an email address and password on WageWorks' website, you may continue using this information. If you haven't registered, log in to the site as a first-time user. Follow the link on the login page and register through the WageWorks Login.



MANAGING YOUR ACCOUNT

You can manage and check your account online. The "Claims and Activity" page details your account activity and will even alert you if any card transactions are in need of verification.

For the latest information, visit **www.WageWorks.com** and link to your account information 24/7. In addition to reviewing your most recent FSA activity, you can:

- Update your account preferences and personal information.
- View your transactions and account history for current and past plan years.
- Download applicable forms.
- Schedule payments to health care and dependent care providers.
- Check the complete list of eligible expenses for FSA programs.
- Order additional WageWorks® Healthcare Cards for your family.
- Manage your account while on the go via the mobile website.
- Download the EZ Receipts® app so that you are able to file claims and take care of card use paperwork from your smartphone.

Special Retirement Plan

IN THIS SECTION:

- **SPECIAL RETIREMENT PLAN DESCRIPTION**
- **HOW IT WORKS**
- **HOW MUCH YOU CAN CONTRIBUTE**



WHAT IS THE SPECIAL RETIREMENT PLAN?

This Special Retirement Plan is for those employees who are eligible for medical insurance through the district, but because they have other medical insurance, waive their medical coverage. Instead these employees receive 401(a) dollars which are deposited into the BENCOR special retirement plan. This plan is a tax-deferred retirement plan, in which you may direct where funds are deposited by choosing from investment options. The BENCOR 401(a) Special Retirement Plan is tax-qualified under Internal Revenue Code Section 401(a). BENCOR Administrative Services provides a full range of administrative services to the BENCOR 401(a) Special Retirement Plan and its participants.

PLAN PROVIDER: BENCOR

A 401(a) Special Retirement Plan is a benefit option you have as you create your benefits package. Only 401(a) Dollars can be deposited into this account. See page 10 for information on 401(a) Dollars.

HOW MUCH MONEY CAN I CONTRIBUTE?

The district will contribute 100 percent of the value of your 401(a) Dollars into this plan. Unfortunately, no other dollars can be used to fund this 401(a) Special Retirement Plan.

AM I ELIGIBLE FOR 401(A) DOLLARS AND MEDICAL COVERAGE AS A DEPENDENT?

If you have medical coverage other than a district plan (i.e., under another employer's plan or a retirement plan), you may waive the school district's coverage and receive \$100 401(a) Dollars per month (\$50 per month if you are a part-time eligible employee). However, you are not eligible for the 401(a) Dollars if you are covered as a dependent by another district employee.

HOW DOES IT WORK? If you elected to participate in this tax-advantaged plan, the district will make monthly contributions on your behalf. All contributions to the BENCOR Plan are made on a pre-tax basis. You will never pay Social Security or Medicare taxes on plan contributions. Income taxes are deferred until withdrawals are made.

Contributions are allocated to an individual account in your name and initially deposited in a guaranteed or fixed account. You will be able to direct how the money is invested from a menu of 17 different funds with a wide range of investment objectives. You also have the ability to change the investment choices. You may change your investment options online at www.bencorplans.com.

When you retire or otherwise terminate employment with the district, your accumulated account balance may remain in the plan or be distributed to you in a lump sum cash payment or transferred to an IRA or another retirement plan. You pay income taxes only when you receive a cash distribution. No taxes are imposed when the contributions are made or until earnings are actually paid to you. Thus, the BENCOR Special Retirement Plan offers you an excellent tax deferral opportunity.

Special Retirement Plan

HOW DO I ACCESS MY ACCOUNT?

Go to **www.bencorplans.com**, click on Participant Log On, then select the Get Started box and follow the prompts to create your personalized user ID and password.

Be sure to designate your beneficiary and select your investment options online at **www.bencorplans.com**.

WHEN DO I RECEIVE STATEMENTS?

Statements are sent semi-annually. You may enroll in e-statements online to save time, paper and ink.

HOW CAN I GET MORE INFORMATION?

Contact Bencor Administrative Services at 1-888-258-3422, Option 1 or email **questions@bencor.com**.

FEATURES OF THE PARTICIPANT WEBSITE

- | | |
|----------------------------------|---------------------------------|
| • Unit Values | • Investment Fund Objectives |
| • Account Balance | • Fund Performance |
| • Account Balance, by Fund | • Address Changes |
| • Fund Transfers | • Investment Allocation Changes |
| • Online Beneficiary Designation | • Transaction History |
| • Download Forms | • Plan Overview |

DID YOU READ ABOUT:

- THE SPECIAL RETIREMENT PLAN?
- HOW THE PLAN WORKS?
- HOW MUCH YOU CAN CONTRIBUTE?

Disability Income Protection

IN THIS SECTION:

- **ELIGIBILITY**
- **PLAN PROVISIONS**
- **SHORT- AND LONG-TERM OPTIONS**
- **ADDITIONAL BENEFITS**

PLAN PROVIDER: METROPOLITAN LIFE INSURANCE COMPANY (METLIFE)



Your greatest asset is your ability to earn a living. What if you lost your ability to work? You may be eligible to replace a portion of your income if you become disabled due to a covered accident or illness.

You may select the Short-Term Disability Plan (STD) or Long-Term Disability Plan (LTD), or both. These benefits work in conjunction with, and not in addition to, sick leave. Premiums are based on your age and salary and will be updated as these may change.

ABOUT THE PLAN PROVIDER

MetLife underwrites the Short-Term and Long-Term Disability Plans. If you have any questions regarding these plans or need to file a claim, then please call MetLife at 1-800-300-4296 between 8 a.m. and 11 p.m. ET, Monday through Friday.

The Disability Certificate issued by MetLife is available at <http://L.sdpbc.net/6jrf6>.

ELIGIBILITY

The Voluntary Disability Program is available to employees who:

- are actively at work
- work full time or at least 40 hours per week for all regular employees or 18.75 hours per week for those in the CTA bargaining group
- meet the eligibility requirements of the school district.

You may elect this coverage during the Open Enrollment period or within the first 30 days of your employment date.

EARNING/SALARY DEFINITION

For the purpose of disability premiums and benefit determinations, earnings or salary includes most year-round supplements such as:

- Degree supplements
- Complexity level supplements
- Shift differentials
- Supervisory supplements and certifications
- Other salary included in the district's multiple components of pay

Please refer to the certificate issued by MetLife for further information.

PROVISIONS AFFECTING THE STD AND LTD PLANS

Elimination Period – The time between the start of the disability and the date the benefit payments begin. This will vary for each person in the STD Plan based on the plan that you choose.

Waiver of Premium – You do not pay premiums while disability benefits are payable. Premiums are waived beginning with the next premium due date following the completion of the elimination period (or when you are notified by MetLife's Claims Department).

Maternity Benefits – Disability caused by pregnancy is covered the same as sickness, and as with other sicknesses, is subject to both the pre-existing exclusion clause as well as the 7-day, 14-day, or 60-day elimination period during which no benefits are payable (Short-Term Disability only).

INTEGRATION – The benefits will be reduced by other sources of income the employee receives. Examples of other sources of income include: retirement benefits, Social Security and workers' compensation. A more detailed explanation is available in the certificate issued to all participants.

Benefits for mental illness, alcoholism, or drug abuse – Benefits are payable for a limited period. See your certificate for details.

Please refer to the disability certificate issued by MetLife for further information.

Disability Income Protection, Short-Term

SHORT-TERM DISABILITY PLAN

The Short-Term Disability (STD) Plan is designed to offer temporary income protection. You have three options from which to choose. Each plan provides coverage for up to 26 weeks (unless otherwise stated in the disability certificate issued by MetLife). Commencement of benefit and benefit amount depends on which option you choose. Refer to the chart in this section to determine which option best fits your needs. The maximum benefit under this plan is \$2,500 per week. An employee cannot collect sick pay and STD benefits at the same time.

DEFINITION OF DISABILITY

Disabled or disability means that, due to sickness or as a direct result of accidental injury:

You are receiving appropriate care and treatment and complying with the requirements of such treatment; and

You are unable to earn more than 80 percent of your pre-disability earnings at your own occupation for any employer; and unable to perform each of the material duties of your own occupation.

If your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute disability.

WHAT'S NOT COVERED

A BENEFIT WILL NOT BE PAID FOR ANY DISABILITY CAUSED OR CONTRIBUTED TO BY:

- War, whether declared or undeclared, or act of war, insurrection, rebellion, or terrorist act;
- Active participation in a riot;
- Intentionally self-inflicted injury;
- Attempted suicide;
- Commission of or attempt to commit a felony;
- Any injury or illness for which the employee is eligible to receive benefits under workers' compensation or a similar law.

OPTION	DISABILITY		
	% of Weekly Income	ACCIDENT	SICKNESS
A	66 $\frac{2}{3}$ %	1st day*	8th day*
B	60%	15th day*	15th day*
C	60%	61st day*	61st day*
*Except as otherwise stated in the disability certificate issued by MetLife.			

A BENEFIT WILL NOT BE PAID FOR ANY DISABILITY CAUSED OR CONTRIBUTED TO BY ELECTIVE TREATMENT OR PROCEDURES SUCH AS:

- Cosmetic surgery or treatment primarily to change appearance;
- Sex-change surgery;
- Reversal of sterilization;
- Liposuction;
- Visual correction surgery;
- In-vitro fertilization, embryo transfer procedure, or artificial insemination.

NOTE: Pregnancies and complications from any of these procedures will be treated as a sickness.

WHEN COVERAGE ENDS

Coverage ends on the earliest:

- Date group policy ends;
- Date insurance ends for employee's class;
- End of period for which premium has been paid;
- Date employee ceases to be eligible;
- Date employment ends;
- Date employee retires.

IMPORTANT: Your premium and any benefit will be based on your salary, which includes: (1) degree supplements; (2) other supplements; (3) complexity level supplements, etc. Your salary is annualized then divided by 52 to determine your weekly salary.

PRE-EXISTING CONDITION

The STD Plan contains a pre-existing condition limitation which will pay benefits for any disability that results from, or is caused or contributed to by, a pre-existing condition for four weeks, unless at the time you became disabled:

- you have not received medical care for the condition for six months while insured under the plan or
- you have been continuously insured under the plan for 12 months.

PRE-EXISTING CONDITION MEANS A SICKNESS OR ACCIDENTAL INJURY FOR WHICH YOU:

- received medical treatment, consultation, care, or services;
- took prescription medication or had medications prescribed; or
- had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment; in the six months before your insurance under this certificate takes effect.

Disability Income Protection, Short- and Long-Term Plans

WHEN TO SUBMIT A SHORT-TERM DISABILITY CLAIM

You should file your claim with MetLife if you anticipate being disabled or are disabled and will be unable to work for a period of time that exceeds the elimination period you selected during enrollment.

HOW TO SUBMIT A SHORT-TERM DISABILITY CLAIM

You may initiate your claim by calling MetLife's toll-free telephonic claim intake number at 1-800-300-4296 and report your claim. You will not need to submit a paper claim form as MetLife's clinical intake specialist will take your information by phone. However, it will be your responsibility to provide an authorization form to your doctor to be signed/dated and faxed or mailed to MetLife. This allows MetLife to access your medical information in order to process your claim.

LONG-TERM DISABILITY PLAN

The Long-Term Disability (LTD) Plan is designed to offer financial security for you and your family. Features include:

- a benefit amount of up to 60 percent of your pre-disability monthly Salary;
- a 180-day elimination period;
- a minimum monthly benefit of the greater of \$100 or 10 percent of the benefit based on monthly income loss before the deduction of other income benefits; and,
- a maximum monthly benefit amount of \$12,500.

WHAT IS THE DEFINITION OF DISABILITY?

Disabled or disability means that, due to sickness or as a direct result accidental injury:

- You are receiving appropriate care and treatment and complying with the requirements of such treatment; and
- You are, during the elimination period and the next 60 months of sickness or accidental Injury:
- unable to earn more than 80 percent of your pre-disability earnings at your own occupation for any employer in your local economy; and,
- unable to perform each of the material duties of your own occupation; and

You are, after such period:

- unable to earn more than 60 percent of your pre-disability earnings at any gainful occupation for any employer in your local economy; and,

- unable to perform the duties of any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.

If your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute disability."

WHAT'S NOT COVERED

A benefit will not be paid for any disability caused or contributed to by:

- War, whether declared or undeclared, or act of war, insurrection, rebellion, or terrorist act;
- Active participation in a riot;
- Intentionally self-inflicted injury;
- Attempted suicide;
- Commission of or attempt to commit a felony.

WHEN COVERAGE ENDS

Coverage ends on the earliest of:

- Date Group Policy Ends;
- Date insurance ends for employee's class;
- End of period for which premium has been paid;
- Date employee ceases to be eligible;
- Date employment ends;
- Date employee retires.

PRE-EXISTING CONDITION

The LTD Plan contains a pre-existing disability condition limitation which will not pay benefits, or any increase in benefits, for any disability that results from, or is caused or contributed to by, a pre-existing condition, unless at the time you became disabled:

- you have not received medical care for the condition for six months while insured under the plan; or,
- you have been continuously insured under the plan for 12 months.

PRE-EXISTING CONDITION DEFINITION

Pre-Existing condition means a sickness or accidental injury for which you:

- received medical treatment, consultation, care, or services;
- took prescribed medication or had medications prescribed; or
- had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment; in the six months before your insurance under this certificate takes effect.

Disability Income Protection, Long-Term Plans

RECURRENT DISABILITY

A recurrent disability is a disability that is related to, or due to, the same cause or causes of a prior disability for which a monthly benefit was paid. A recurrent disability will be treated as part of the prior disability and you will not have to complete another elimination period if, after receiving disability benefits under the plan, an employee returns to work on a full-time basis for less than six months and performs all of the duties of the employee's own occupation. Benefit payments will be subject to the terms of the plan for the prior disability.



WHEN TO SUBMIT A LONG-TERM DISABILITY CLAIM

If you are enrolled for STD, the transition process to LTD is automated – you do not need to file a separate claim form.

If you are not enrolled in the STD Plan and have enrolled in the LTD Plan only, you should file your claim with MetLife halfway through your LTD elimination period (on or around the 90th day).

HOW TO SUBMIT A LONG-TERM DISABILITY CLAIM

If you are enrolled in the STD Plan, the transition process to LTD is automated by MetLife's claim system. A separate LTD claim form is not needed. However, completion of a claimant questionnaire is required that requests information about other income/offset information, past work experience/education and medical providers. MetLife may also obtain additional information from the School District of Palm Beach County.

If you did not enroll in the Short-Term Disability plan and have enrolled in the Long-Term Disability plan only, you may file a claim telephonically by calling MetLife at 800-300-4296.

WHAT BENEFITS ARE INCLUDED IN LONG-TERM DISABILITY?

If you become disabled, the following benefits can help until you get back to full-time work.

Work Incentive Benefit – 100 percent income replacement allowed for the first 24 months from the date benefits begin; thereafter, reduced by 50 percent of the amount you earn from working while disabled. No offset for earnings or Family Care Expense income received while working. Subject to 100 percent of your pre disability earnings.

Rehabilitation and Return to Work Assistance – MetLife vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help you return to productive, independent lifestyles. Monthly benefit is increased by 10 percent while participating in a MetLife approved rehabilitation program.

Moving Expense Incentive – Reimburses claimants for expenses associated with moving to a new residence if recommended as part of an approved MetLife rehabilitation – no dollar maximum or minimum distance requirement.

Worksite Modification Benefit – Assists the School District of Palm Beach County with the cost of making job modifications/accommodations and supports compliance with the American with Disabilities Act (ADA). The job modifications/accommodations have no stated dollar maximum or number of occurrences limit.

Family Care Credit Benefit – Up to \$400 per month per eligible family member for 24 months (no aggregate dollar or family number maximums) while employee is participating in approved MetLife Rehabilitation Program. Cannot be paid after the maximum benefit period ends.

Disability Income Protection, Long-Term Plans

Survivor Benefit – If you were receiving a monthly disability benefit at the time of your death, we will pay a survivor income benefit, when we receive proof satisfactory to us:

1. of your death; and
2. that the person claiming the benefit is entitled to it.

Surviving Children – We must receive the satisfactory proof for survivor income benefits within one year of the date of your death.

The survivor income benefit will only be paid:

1. to your surviving spouse; or
2. if no surviving spouse, in equal shares to your surviving children. If there is no surviving spouse or surviving children, then no benefit will be paid.

However, we will first apply the survivor income benefit to any overpayment which may exist on your claim.

NOTE: These product descriptions do not constitute an insurance certificate or policy. The information provided is intended only to assist in the selection of benefits. Final determination of benefits, exact terms and exclusion of coverage for each benefit plan are contained in certificates of insurance issued by the participating insurance companies.

Certificate(s) of coverage for your insurance benefits are available to you online throughout the year. A hard copy of these certificates will not be mailed to you automatically. Your Certificate(s) of coverage are document(s) issued by the insurance company for benefits registered with the state of Florida. These documents are available for the benefits you selected during Open Enrollment or as a new employee.

To view or print a copy of a certificate of coverage, visit <http://L.sdpbc.net/6jrf6>.

PRIOR TO AGE 63	TO NORMAL RETIREMENT AGE (NRA) OR 42 MONTHS IF GREATER
63	NRA or 36 months if greater
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 & over	21 months

Disability Income Protection Rates

24 PAYROLL DEDUCTIONS PER YEAR FOR EMPLOYEES RECEIVING 26 PAY CHECKS PER YEAR

DISABILITY INCOME PROTECTION PROGRAM

HOW TO ESTIMATE PAYROLL DEDUCTION – BASED ON 24 PAYROLL DEDUCTIONS PER YEAR

	Short-Term Disability	Long-Term Disability
A. Enter Annual Salary	\$ _____	\$ _____
B. Divide by 100	\$ _____	\$ _____
C. Multiply by your appropriate rate below	\$ _____	\$ _____
D. Divide by 24 (number of payroll deductions/yr)	\$ _____	\$ _____

Example

	Short-Term Disability	Long-Term Disability
A. Enter Annual Salary	\$20,000.00	\$20,000.00
B. Divide by 100	\$200.00	\$200.00
C. Multiply by your appropriate rate below (\$.77 for STD / \$.91 for LTD)	\$154.00	\$182.00
D. Divide by 24	\$6.42	\$7.58

SHORT-TERM DISABILITY MONTHLY RATES

Employee's Age	Rates per \$100 of Covered Payroll		
	OPTION A	OPTION B	OPTION C
54 & Under	\$0.77	\$0.53	\$0.42
55 - 59	\$1.01	\$0.69	\$0.55
60 - 64	\$1.16	\$0.79	\$0.63
65 & Over	\$1.41	\$0.97	\$0.77

LONG-TERM DISABILITY MONTHLY RATES

Employee's Age	Rates per \$100 of Covered Payroll
24 & Under	\$0.09
25 - 29	\$0.11
30 - 34	\$0.18
35 - 39	\$0.29
40 - 44	\$0.40
45 - 49	\$0.54
50 - 54	\$0.75
55 - 59	\$0.88
60 & Over	\$0.91

Disability Income Protection Rates

22 PAYROLL DEDUCTIONS PER YEAR FOR EMPLOYEES RECEIVING 22 PAY CHECKS PER YEAR

DISABILITY INCOME PROTECTION PROGRAM

HOW TO ESTIMATE PAYROLL DEDUCTION – BASED ON 22 PAYROLL DEDUCTIONS PER YEAR

- Enter Annual Salary
- Divide by 100
- Multiply by your appropriate rate below
- Divide by 22 (number of payroll deductions/yr)

Short-Term Disability	Long-Term Disability
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____
\$ _____	\$ _____

EXAMPLE:

- Enter Annual Salary
- Divide by 100
- Multiply by your appropriate rate below
(\$.77 for STD / \$1.08 for LTD)
- Divide by 22

Short-Term Disability	Long-Term Disability
\$20,000.00	\$20,000.00
\$200.00	\$200.00
\$154.00	\$216.00
\$7.00	\$9.82

SHORT-TERM DISABILITY MONTHLY RATES

Employee's Age	Rates per \$100 of Covered Payroll		
	OPTION A	OPTION B	OPTION C
54 & Under	\$0.77	\$0.53	\$0.42
55 - 59	\$1.01	\$0.69	\$0.55
60 - 64	\$1.16	\$0.79	\$0.63
65 & Over	\$1.41	\$0.97	\$0.77

LONG-TERM DISABILITY MONTHLY RATES

Employee's Age	Rates per \$100 of Covered Payroll
24 & Under	\$0.10
25 - 29	\$0.13
30 - 34	\$0.21
35 - 39	\$0.34
40 - 44	\$0.47
45 - 49	\$0.64
50 - 54	\$0.89
55 - 59	\$1.03
60 & Over	\$1.08

DID YOU READ ABOUT:

- HOW THE PLAN WORKS?
- COVERAGE LEVELS?
- SHORT- AND LONG-TERM OPTIONS?

IN THIS SECTION:

- **BASIC LIFE INSURANCE**
- **PERSONAL ACCIDENT INSURANCE**
- **OPTIONAL LIFE INSURANCE**

POST-TAX BENEFITS

Plan Provider: Underwritten by Metropolitan Life Insurance Company (MetLife).

The School District of Palm Beach County is always looking for ways to improve your benefits plan and wants you to have the opportunity to apply for the life insurance you need at a price you can afford. Getting the income protection needed to guard against life's uncertainties should not be difficult or expensive. That's why the School District of Palm Beach County is offering you a life benefits plan from MetLife. This coverage is designed to help provide your family with a financial foundation that you can build upon. You have the opportunity to benefit from all that MetLife offers, including:

- Basic Life Insurance and Personal Accident Insurance (employer paid);
- Optional Life Insurance and Optional Accident Insurance (employee paid);
- Spouse Life Insurance and Optional (Spouse) Accident Insurance (employee paid);
- Child Life Insurance (employee paid).

BASIC LIFE INSURANCE

Protecting your family's future is no doubt one of your highest priorities. One way to help achieve this goal is through life insurance. The School District of Palm Beach County provides you with a valuable basic life insurance plan at no cost to you.

WHAT ARE MY BASIC LIFE INSURANCE BENEFITS?

The School District of Palm Beach County provides you with basic life insurance in the amount of \$20,000 for full-time employees and \$10,000 for part-time employees.

WHAT ARE THE BASIC LIFE INSURANCE FEATURES?

- Accelerated Benefits Option
- Conversion
- Continued Protection (waiver of premium)
- Extended Death Benefit



For more information regarding these features, please refer to the product features section on page 74-75.

EXCLUSION - THIS PLAN WILL NOT PAY BENEFITS IF LOSS OF LIFE IS THE RESULT OF SUICIDE THAT OCCURS WITHIN THE FIRST TWO YEARS OF COVERAGE.

DEPENDENT CHILDREN

Coverage available: Life Insurance only

Amount of coverage available: For dependent child(ren) from age six months up to 26 years of age.

PERSONAL ACCIDENT INSURANCE

MetLife insurance products are designed to provide full-time protection against accidental death or injuries – 24 hours a day, 365 days a year.

You must submit a completed Statement of Health form directly to MetLife by mail or fax no later than **December 19, 2017**. Submission of an incomplete application will not extend the deadline. To download the Statement of Health form go to:
<http://L.sdpbc.net/59z0y>

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069

Phone: 800-638-6420, Option 1
FAX: 1-859-225-7909

Group Term Life

WHAT BENEFITS ARE AVAILABLE?



When enrolled in Basic Life Insurance you automatically receive Personal Accident Insurance in an amount equal to your Basic Life Insurance. Provided alongside your Basic Life Insurance, this coverage is designed to help safeguard

you and your family from a financial loss due to an unexpected accidental death or injury.

MetLife and the School District of Palm Beach County know that you are the best judge of your life insurance needs.

OPTIONAL LIFE INSURANCE WHAT BENEFITS ARE AVAILABLE?

In addition to your Basic Life Insurance, the School District of Palm Beach County is offering the opportunity to purchase additional life insurance protection through MetLife's Optional Life Insurance program. This benefit is designed to help provide financial security for you and your family. Since this coverage is an employee-paid benefit, premiums will be conveniently deducted from your paycheck post-tax.

WHAT ARE MY OPTIONS? WHAT ARE THE MAXIMUM AMOUNTS I CAN APPLY FOR?

After carefully considering your lifestyle and utilizing the tools provided, you can decide just how much financial protection is right for you.

LIFE INSURANCE REDUCTION

At age 70, providing you are still employed, your Optional Life coverage will decrease as follows: 65 percent reduction at age 70; 45 percent reduction at age 75; 30 percent reduction at age 80. Premiums and coverage for your spouse will end at age 70; at that time your spouse may choose to convert this coverage to an individual Life Insurance policy.

You must submit your application to continue coverage within 31 days of termination and pay your premium. See the Life Insurance Certificate issued by MetLife for more details. It is the sole responsibility of the employee to apply for this benefit.

NOTE: If you are covered as an employee, you cannot also be covered as a spouse or dependent child. No person may be eligible for insurance under this policy as both an employee and a spouse at the same time.

Your dependent child(ren) may be enrolled for Optional Child Life Insurance under one insured employee's plan of benefits. You may either be enrolled as an employee or a dependent but not covered and enrolled under both classifications.

POST-TAX BENEFITS GUARANTEED ISSUE: NEW HIRES

At the time of hire and during the benefit selection process, a new hire employee may select up to five (5) times their basic annual salary in \$20,000 increments, not to exceed \$500,000, with a minimum selection amount of \$20,000. A Statement of Health (SOH) form is required for coverage exceeding \$100,000. To download the Statement of Health form go to: <http://L.sdpbc.net/4vdbh>.

For Optional Spouse Life Insurance, an employee may select coverage in \$10,000 increments, not to exceed 50 percent of the employee's Optional Life Insurance coverage with a minimum amount of \$10,000 and a maximum amount of \$250,000. A Statement of Health (SOH) form for the spouse is required for coverage exceeding \$50,000. Go to <http://L.sdpbc.net/4vdbh> to download the Statement of Health form.

For Optional Child Life Insurance, an employee may select coverage of \$5,000 or \$10,000. A Statement of Health form is NOT required for either election as both are guaranteed issue. The following age limit payout and eligibility applies:

- Live birth to six months: \$1,500; and
- Six months to 25 years: \$5,000 or \$10,000

DURING OPEN ENROLLMENT

You may enroll for an additional \$20,000 of Optional Life Insurance for yourself without providing evidence of good health, as long as you are currently enrolled for Optional Life Insurance and carry less than five times your annual salary or \$100,000 (whichever is less).

You may also apply for additional coverage for yourself, your spouse or dependent child(ren) at Open Enrollment. A MetLife Statement of Health form may be required. Coverage maybe subject to Underwriting Approval.

Group Term Life

WHAT ARE THE OPTIONAL LIFE INSURANCE FEATURES?

- Accelerated Benefits Option
- Will Preparation Services
- Conversion
- Continued Protection (waiver of premium)

For more information regarding these features, please refer to the product features section on page 75.

Optional Life coverage is provided under a group insurance policy, issued in Florida to the School District of Palm Beach County by MetLife. Optional Life Insurance under the School District of Palm Beach County's plan ends the earliest of:

- date insurance ends for employees' class;
- end of the period for which the last premium has been paid for employee;
- date employee ceases to be in eligible class;
- end of the month in which employment ends; or
- end of the month the employee retires in accordance with the policyholder's retirement plan. Only applicable if retirees are NOT covered.

Benefits end on the last day of the month following the event.

POST-TAX BENEFITS OPTIONAL ACCIDENT INSURANCE

Provided alongside your Optional Life Insurance, Optional Accident Insurance offers a matching amount of Optional Accident Insurance benefits in addition to the Personal Accident Insurance that the School District of Palm Beach County has made available to you.

WHAT BENEFITS ARE AVAILABLE?

When you enroll in Optional Life Insurance, you are automatically enrolled in Optional Accident Insurance. The benefit amount for Optional Accident Insurance is equal to the benefit amount for Optional Life Insurance. Since this coverage is an employee-paid coverage, post-tax premiums will be conveniently deducted from your paycheck.

WHAT ARE THE OPTIONAL ACCIDENT INSURANCE FEATURES?

For Wearing a Seat Belt and Protection by an Airbag - Death benefits will be increased by 10 percent, but not more than \$25,000, if the insured person dies as a direct

result of injuries in a covered automobile accident while wearing a properly fastened seat belt. We will increase the death benefit by an additional 5 percent, but not more than \$10,000, if the insured was in a seat protected by a properly functioning and deployed airbag.

For Child Care Expense - MetLife will pay a benefit for a surviving child under 13 who is enrolled in a licensed child care center at the time of the accident or within 90 days afterward. This benefit is three percent of the benefit amount, to a maximum of \$3,000 a year for four straight years or until the child turns 13, whichever occurs first.

For Home Alteration and Vehicle Modification - If you or your insured spouse requires home alteration or vehicle modification within one year of a covered accident, we will pay 10 percent of your benefit amount, to a maximum of \$25,000, for alterations or modifications that are doctor-certified as necessary for an independent lifestyle.

For Rehabilitation - If you or your insured spouse incurs rehabilitative expenses within two years of a covered loss, we will pay an additional 5 percent of the benefit amount, up to \$10,000, for each covered accident.

For Furthering Child Education - If you die in a covered accident, for each child who qualifies for this benefit, we will pay an amount equal to the tuition charges incurred for a period of up to four consecutive academic years, not to exceed:

- an academic year maximum of \$10,000; and
- an overall maximum of 20 percent of the full amount of the benefit.

We may require proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed.

TWO CHILD LIFE OPTIONS ARE AVAILABLE:

LIFE INSURANCE ONLY

OPTION ONE \$5,000* at a monthly rate of \$.35 for all children

OPTION TWO \$10,000* at a monthly rate of \$.69 for all children

** For dependent child(ren) from live birth to six months, the benefit is \$1,500. There is no matching amount of Accident Insurance for children.*

Group Term Life

For Training for Your Spouse - If you die in a covered accident and your insured spouse is enrolled in an accredited school or enrolls within one year of your death:

- \$5,000 per year for one year
- Minimum = \$1,000
- Maximum = 5 percent of Full Amount

For Hospital Confinement - If confinement occurs within 12 months of an accidental injury:

- 1 percent of full amount up to \$2,500 max per month
- Beginning on the fifth day of confinement
- Maximum = 12 months

HOW MUCH COVERAGE CAN I BUY?

You – You will automatically receive an amount equal to your Optional Life Insurance.

Your spouse – The spouse is allowed to receive half of your Optional Spouse Life Insurance.

You may need to request changes to your existing coverage if, in the future, you no longer have dependents who qualify for coverage. We will refund premium if you do not notify us of this and it is determined at the time of a claim that premium has been overpaid.

POST-TAX BENEFITS

WHAT IS NOT COVERED?

- Sickness, disease, physical or mental or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning.);
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Infection, other than infection occurring in an external accidental wound, not including accidental food poisoning;
- Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training.

Reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the National Guard of any other country.

Any incident related to travel in an aircraft or device:

- As a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
- For parachuting or otherwise exiting from the aircraft while the aircraft is in flight except for the purpose of self-preservation;
- For testing or experimental purposes;
- By or for any military authority;
- For travel or designed for travel beyond the earth's atmosphere;
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot;
- If the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred;
- If the injured party is committing or attempting to commit a felony;
- Voluntary intake or use by any means of any drug, medication or sedative, unless it is:
 - a. taken or used as prescribed by a doctor, or;
 - b. an "over the counter" drug, medication or sedative taken as directed;
- Alcohol in combination with any drug, medication, or sedative; or,
- Poison, gas, or fumes.

PRODUCT FEATURES

Accelerated Benefit Option: Terminal Illness Benefit –

MetLife will pay a Terminal Illness Benefit if we determine you or your spouse are terminally ill. The amount of this benefit is 80 percent of the life insurance benefit in effect for you or your spouse on the date we determine you are terminally ill up to the max. Benefit amount is shown in your Schedule of Benefits for this option. The Terminal Illness Benefit is payable only once in an insured's lifetime.

Will Preparation and Estate Resolution Services –

Will preparation is offered by Hyatt Legal Plans, a MetLife company, and provides eligible employees and their spouses with face-to-face access to attorneys participating in Hyatt Legal Plan's network for preparing or updating a will, living will and power of attorney. When you choose a participating Hyatt Legal Plan's attorney, the attorney's fees are fully covered and there are no claim forms to

Group Term Life

RATES (MONTHLY)

Optional Life Insurance & Optional Accident Insurance

Employee only	\$.159 per \$1,000 of coverage per month
Employee & Spouse	\$.676 per \$1,000 of coverage per month

file. You also have the flexibility of using a non-network attorney and being reimbursed for covered services according to a set fee schedule. **www.WillsCenter.com** is also available and provides online interactive tools to assist with the creation of a will and other legal documents on your own, at your own pace, 24 hours a day, 7 days a week. The site also provides access to other valuable financial educational materials. Face-to-Face Estate Resolution Services provides beneficiaries and executors/administrators access to face-to-face legal representation for probating your and your spouse's estates.

Conversion – If your coverage is reduced or ends due to age, disability or termination of employment, you can obtain an individual life insurance policy without proof of good health. To convert coverage, you must apply for the individual policy and pay the first premium payment within 31 days after your group coverage ends. Eligible insured dependents may convert their coverage as well. Converted policies are subject to additional restrictions if you convert because of termination or amendment of the group policy.

Continued Protection (waiver of premium) and Extended Death Benefit – To make sure you can keep the life insurance protection you need during a difficult period of your life, the life insurance plan provides

continued protection (waiver of premium). If you are totally disabled prior to age 60 and satisfy a 9 month waiting period, your life insurance will continue and you won't need to pay premiums while you are disabled. Once approved, continued protection (waiver of premium) can remain in force until age 65.

HOW IT WORKS: If you are totally and permanently disabled prior to age 60, you may continue paying premiums for a maximum of 12 weeks from the date you were in a paid status. After 12 weeks, you will be given both the option to convert to an individual policy and an option to apply for a continued protection (waiver of premium) directly with the life insurance provider. You must apply for a continued protection (waiver of premium) within 9 months of the date of disability.

During the wait period for continued protection (waiver of premium), a loss would be covered under the plan's extended death benefit if you were totally and permanently disabled at the time of loss. Any conversion policy in place would be surrendered at this time and premiums paid for the conversion policy would be refunded.

A loss during the continued protection (waiver of premium) wait period where you are not deemed to have been disabled at time of loss would require a conversion policy to be in place for a claim to be payable.

Online Plan Description – you will be able to review any of the Life and Accident Insurance provisions in more detail through the School District of Palm Beach County's website at <http://L.sdpbc.net/0m9kw>.

DID YOU READ ABOUT:

- **BASIC LIFE INSURANCE?**
- **OPTIONAL LIFE INSURANCE FEATURES?**
- **DEPENDENT LIFE INSURANCE OPTIONS?**

Group Term Life

Travel Assistance with Identity Theft Solutions –

To complement your MetLife Insurance coverage, you have access to Travel Assistance, a special travel service administered by AXA Assistance USA, Inc. (AXA) through a marketing arrangement with MetLife. Travel Assistance offers you and your dependents worldwide medical, travel, concierge and legal and financial assistance services, 24 hours a day, 365 days a year.

- Travel Assistance Coverage

While traveling internationally or domestically, two participants have access to medical assistance if faced with an emergency. With one simple phone call, you and your dependents will have access to:

- Over 600,000 pre-qualified providers worldwide;
- Air and ground ambulance service;
- Trained multilingual personnel who can advise and assist you quickly and professionally in a travel emergency.

- General Travel Information

Before you travel, you can visit the AXA Assistance website to obtain information about your visa, passport, inoculation requirements and local customs as well as 24-hour pre-departure information on weather, currency and much more.

- Identity Theft Solutions

You and your dependents also have access to Identity Theft Solutions, a benefit accessible while you are home or traveling. This service provides:

- Education & Protection: An identity theft risk and prevention toolkit and resolution guide;
- Personal Guidance: Assistance with filing and obtaining police and credit reports, contacting creditor fraud departments, taking inventory of lost or stolen items and more.
- Concierge Services: Also included are concierge services designed to fulfill various travel and entertainment requests as well as arrangements for business-related services such as flight, hotel and dining reservations, general destination and transportation information, city guides and much more.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between Metropolitan Life Insurance Company and the School District of Palm Beach County. Specific details regarding these provisions can be found in the life and accident insurance certificate issued by MetLife. If you have additional questions regarding your life or accident insurance, please contact your benefits administrator.

Coverage is underwritten by: Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.

A certificate of coverage for your Group Life Insurance Plan is available online at <http://L.sdpbc.net/qt8gL> or can be accessed by contacting Risk & Benefits Management.

403(b) Traditional, Roth & 457(b) Deferred Plans

WANT TO START SAVING, BUT NOT SURE WHERE TO INVEST? Get started with PLAN B, a quick enrollment plan that allows you to start saving and makes it easy for you to switch to an approved investment plan later.

Call 1-866-752-6286 for more information.

QUICK ENROLL PLAN B

Quick Enroll Plan(b) is a simplified voluntary retirement savings plan. You do not have to make an investment decision immediately and your contribution for this plan is deposited into a Guaranteed Income Fund (GIF), which has a guarantee of principle and interest crediting. The earlier you start saving for your retirement the better!

TRADITIONAL PRE-TAX

The School District of Palm Beach County provides the opportunity for eligible employees to make tax-sheltered investments through payroll deductions in accordance with Internal Revenue Code 403(b) & 403(b)(7). You will not have to pay federal income tax on the money you invest until the money is withdrawn. This is a smart way to save money for retirement.

ROTH POST-TAX

Roth plans allow you to invest funds from your salary on a post-tax basis. Your investments will grow tax-free and you will not have to pay any income tax on the investments or profits when the funds are withdrawn after you retire or otherwise qualify. Most of the vendors on this page also administer the Roth plans.

Please visit: www.tsacg.com/individual/plan-sponsor/florida/school-district-of-palm-beach-county for a complete listing of what program each vendor offers. Contact the Agent/Broker of Record for the company of your choice listed to the right for investment options and to schedule an appointment with a company representative.

All employees receiving a W-2 each year are eligible to participate in any of the voluntary retirement plans. Visit our website at <http://L.sdpbc.net/im1yL> for important information. You may also click <http://L.sdpbc.net/msk9m> to view our plan document.

Employees are able to use the “My Benefits” section of PeopleSoft to enroll in these benefits. An account must first be established with a participating vendor before payroll deductions can begin.

“My Benefits” can also be used to increase or decrease your existing contributions by simply logging in to **My Benefits/Retirement Savings Plan** and then clicking on the “EDIT” button of your existing savings plan.

American Century Services*

(No Agent of Record) - 800-345-3533

AXA Equitable Life Assurance Co.*

Mario Basilone - 561-961-9343

Buttelman & Associates Financial Services (GWN)**

Michael Buttelman - 561-965-1000, ext. 1237

Fidelity Retirement Services

(No Agent of Record) - 800-343-0860

Great American Life Insurance Co.

Mike Mracna - 561-649-9200

Horace Mann

Theresa Goulet - 561-743-1669

The Legend Group, Lincoln Investment

Jessica Kovachik - 888-883-6710

Lincoln Investment Planning

Mike Mracna - 561-649-9200

MetLife

Ken Suchy 561-746-6652

National Life Group a.k.a LSW

Lewis Smith - 800-579-2878

Plan Member Services*

Richard Rush - 800-874-6910 ext. 2332

PFS Investments

R. Ken Sloan - 561-635-0947**

Quick Enroll Plan B - 1-866-752-6286

TIAA CREF

(No Agent of Record) - 800-842-2888

VALIC (Variable Annuity Life)*

David Allen - 561-688-6301 or 954-946-1765
800-448-2542

Voya Financial

Scott Satalino - 866-865-2660

Voya Reliastar

Scott Satalino - 877-882-5050

**Member of the IBC. The Independent Benefits Consortium (IBC) is a not-for-profit corporation made up by a coalition of The Florida Education Association, The Florida School Board Association, The Florida Association of District School Superintendents and The Florida Association of School Administrators. They developed the IBC 403(b) Model Plan. The companies selected by the IBC have agreed to offer favorable rates to all districts. Ask your company to match the fees of the Model Plan. For more info: www.theModelPlan.com.*

*** 457(b) Service not offered*

Trustmark Critical LifeEvents® Insurance

**YOU MAY ONLY ENROLL IN TRUSTMARK BENEFITS DURING
THE JANUARY VOLUNTARY BENEFITS ENROLLMENT PERIOD**

Trustmark's Critical LifeEvents® was designed to focus on the many ways critical illness touches your life. Benefits are payable for early identification as well as for later-stage diagnosis. Earlier benefits help provide funds as quickly as possible to help ensure that treatment or preventive measures may stave off late-stage illness. A replenishing annual benefit helps you deal with a new or recurring covered condition. You can use the benefit any way you wish, whether it's for treatment, changes to your home or someone to watch your kids.

HOW DOES CRITICAL LIFEEVENTS WORK?

Critical LifeEvents is designed to help manage critical illness the way it is experienced by those closest to it. Early diagnosis of a major illness can be a lifesaver, yet successful treatment may be expensive, and a critical illness can sometimes come back again. Critical LifeEvents protection provides continual assistance when covered critical illnesses come into your life:

- Your benefit replenishes each calendar year to help you deal with a new or recurring covered condition.
- Benefits are payable for early identification of a condition as well as for later-stage diagnosis. These can help with early treatment that may stave off serious late-stage illness.
- The policy focuses on the conditions that are most likely to occur. This helps keep coverage affordable.
- Events that trigger a benefit are simple and easy to understand.
- Benefits can be used to pay for whatever you and/or your family need most.
- Choose a personalized benefit amount at time of enrollment: your maximum available for benefit payouts each calendar year.

HOW ARE BENEFITS PAID?

Critical LifeEvents pays a benefit when there's a new diagnosis of a covered critical illness. Depending on the diagnosis you receive, your benefit payment may be 100%, 50% or 10% of your selected benefit amount. The following conditions are covered with no lifetime maximum on the number of payouts:

- Cancer
- Coronary Artery Disease/Heart Attack
- Cerebral Vascular Disease/Stroke

You are not alone when you have Trustmark protection. Life goes on. And so does your Trustmark Critical LifeEvents Insurance.

FEATURES THAT WORK FOR YOU

Healthy Living Rider – Provides coverage annually for one \$50 routine service for early detection and prevention. Also pays for certain follow-up diagnostic tests; your policy will contain complete details.

Specified Illness Rider – Provides a benefit at 10%, 50%, or 100%, once per lifetime per condition, for additional covered conditions, including: permanent blindness, occupational HIV, paralysis due to sickness, renal or other organ failure, stem cell/bone marrow transplant, central nervous conditions, or complications of diabetes.

A 30-day waiting period may apply before benefits are payable. Please consult your policy/ group certificate for specific covered illnesses and details.

BENEFITS YOU'LL APPRECIATE

- Access to medical experts – Receive one-on-one support through Best Doctors®, a leader in connecting you to medical information you may need for a wide range of medical conditions.
- Guaranteed renewable – Guaranteed active coverage for life, as long as premiums are paid. Your premium may change if the premium for all policies in your class changes.
- Level premiums & coverage – Rates will not increase and benefits will not decrease due to age.
- Family coverage – Apply for your spouse, children, and dependent grandchildren.
- Portability – Take your coverage with you and pay the same premium even if you change jobs or retire.
- Convenient payroll deduction – No checks to write. A direct bill option is available, if you change jobs or retire.

Pre-Existing Condition Limitation: No benefit will be paid for any condition caused by or resulting from a pre-existing condition.

PLAN PROVIDER

Trustmark
Voluntary Benefit Solutions®

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" Excellent.

This information is being provided to employees by School District of Palm Beach County in advance of more complete information from the insurer. (Coverage election is limited to the Voluntary Benefits Enrollment period.)

Trustmark Critical Illness

CURRENT PARTICIPANTS ONLY

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

The plan provides an immediate pre-selected lump sum cash benefit upon first diagnosis of a covered critical illness or cancer after the plan's effective date. Your benefit is paid in full regardless of whether you have started treatment and allows you to decide how to use your benefit money.

WHO IS ELIGIBLE?

Employees who have active critical illness coverage through Trustmark may apply for an increase up to a total of \$100,000 of coverage. The \$100,000 is a combination of current critical illness and cancer and/or critical illness coverage (including the EZ Value Plan) and new critical illness coverage.

Employees with existing Cancer Protector coverage through Trustmark may continue their current plans. No new policies will be issued to replace current plans.

PLAN FEATURES

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

**Maximum issue age is 60.*

ISSUE AGES

- Employees (18 through 70)
- Spouse (18 through 70)
- Children (15 days through 25)

WHAT PAYROLL DEDUCTION PREMIUMS WILL I PAY FOR THIS PLAN?

You select the coverage and premium that best fits your budget and family needs. Premiums are based on age, coverage selected and tobacco use. As a School District of Palm Beach County employee, you may receive a high insurance value at an affordable cost. Speak with your FBMC Representative for more information.

CAN I CONTINUE MY COVERAGE IF I TERMINATE EMPLOYMENT OR RETIRE?

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

HOW DO I MAKE CHANGES TO MY ELECTION?

You may elect to change your policy after it goes into effect by calling the Trustmark Service Center at 866-636-5525. Changes are forwarded to your employer and should be reflected in your paycheck within two to four weeks.

WHAT IF I HAVE QUESTIONS ABOUT MY CERTIFICATE?

After you enroll, you can get answers about your certificate by calling 866-636-5525.

OPTIONAL HEALTH SCREENING BENEFIT

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

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

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

POLICY INCREASES MAY BE MADE DURING THE JANUARY VOLUNTARY BENEFITS ENROLLMENT PERIOD.

Trustmark Universal LifeEvents®

YOU MAY ONLY ENROLL IN TRUSTMARK BENEFITS DURING THE JANUARY VOLUNTARY BENEFITS ENROLLMENT PERIOD.

PLAN PROVIDER

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

WHAT IS UNIVERSAL LIFEEVENTS?

Wouldn't you like to have life insurance you can take with you whenever you leave the school district – a plan that features portable coverage and may accumulate cash values?

Thanks to the School District of Palm Beach County, you have the opportunity to apply for this plan without a medical examination.

WHO IS ELIGIBLE?

The following employees are eligible and may apply for coverage during the January voluntary benefits enrollment period.

- Full-time or regular part-time employees
- Employees between the ages of 18 and 64
- Employees actively working at the time of application and the first deduction date

CAN I APPLY FOR MY DEPENDENTS?

Yes. Your spouse, children or grandchildren might also qualify for coverage. In fact, you don't have to get coverage for yourself to cover family members. There may be additional eligibility requirements to include your grandchildren.

WHAT DOES THE PLAN OFFER?

This plan offers more than just the peace of mind that your family will be taken care of if something happens to you. It also offers you and your family flexible benefits that include:

Accelerated Death Benefit – If a physician determines that you have 24 months or less to live, an advance death benefit pays up to 75 percent of the base certificate death benefit (up to \$225,000). The Accelerated Death Benefit is subject to review by the insurer and reduces the final death benefit.



Interest-earning Cash Value – Interest is credited to your plan. Current tax law allows the cash value in this life insurance plan to accumulate on a tax-deferred basis (within guidelines).

Home Health, Adult Day Care and Long-Term Care Rider – If you are confined in a qualified long-term care facility, assisted living facility or require medically necessary home health or adult day care, this pays you a monthly benefit of 4 percent of your policy for up to 25 months. Benefits are paid as advance death benefits.

Optional Accidental Death Benefit – If you should die by accidental means before your 75th birthday, your death benefit will double. Available to ages 15 - 70.

Optional EZ Value Plan – This plan also offers the EZ Value Plan Option, an inflation-fighting option which automatically increases coverage annually on each of the first five or ten policy anniversaries. For employees and their spouses under 65, the amount of the Death Benefit Increase is equal to the amount of protection an additional \$1 per week deduction (or \$2 per week for employees only) would purchase on the first five anniversaries. An increase of \$1 per week on each of the first 10 anniversaries is available to employees and spouses up to age 60.

Trustmark Universal LifeEvents®

YOU MAY ONLY ENROLL IN TRUSTMARK BENEFITS DURING THE JANUARY VOLUNTARY BENEFITS ENROLLMENT PERIOD.

Death Benefit Restoration Rider – Automatically increases the Death Benefit to restore the advanced death benefits for home health care, adult day care or long-term care confinement in a nursing home.

EXAMPLE: An insured party has a \$50,000 death benefit with the Home Health and Long-Term Care rider and dies after 10 months of long-term care confinement.

WITH RIDER	
Total Benefits Paid	\$70,000
Death Benefit	\$50,000
Living LTC Benefit	\$20,000

WAIVER OF PREMIUM (OPTIONAL)

Premiums for base coverage and added riders and benefits may be waived if the primary insured is totally disabled as defined in the rider prior to the policy anniversary date nearest his or her 60th birthday.

HOW DO I APPLY?

You may apply for coverage during the January voluntary benefits enrollment period. Follow the instructions in your open enrollment letter to schedule an appointment to meet with an FBMC Representative.

CAN I CONTINUE MY UNIVERSAL LIFE COVERAGE IF I TERMINATE EMPLOYMENT OR RETIRE?

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

WHAT IF I HAVE QUESTIONS ABOUT MY CERTIFICATE?

After you enroll, you can get answers about your certificate by calling the dedicated Trustmark Customer Service line at 1-866-636-5525.

ISSUE AGES:

- Employees 18 to 64
- Spouses 18 to 64
- Children 0 to 23*
- Grandchildren 0 to 18*

**Children and grandchildren are eligible the day after they leave the hospital.*

PLAN PROVIDER

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" Excellent.

Universal LifeEvents Insurance is available on a post-tax basis, and a separate application is required. This employer-provided information is in advance of more complete information from the insurer.

Plan Form GUL.205/IUL.205 is underwritten by Trustmark Insurance Company, Lake Forest, Illinois.

Trustmark Accident Insurance

YOU MAY ONLY ENROLL IN TRUSTMARK BENEFITS DURING THE JANUARY VOLUNTARY BENEFITS ENROLLMENT PERIOD.

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

WHO IS ELIGIBLE?

- Employees – Ages 17 to 80, actively working full-time
- Spouses – Ages 17 to 80, who are not disabled
- Children – Birth to age 26, who are unmarried and dependent

PLAN FEATURES

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

WELLNESS BENEFIT

Promotes good health among employees and their families by providing them a \$50 benefit to offset the cost of going to the doctor for routine physicals, immunizations and health screening tests, regardless of other coverage. The benefit provides a maximum of two visits per person, annually. Eligible tests include:

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

ACCIDENTAL DEATH BENEFIT

Provides a lump-sum benefit for an accidental death that occurs within 90 days of a covered accident.

- \$100,000 | \$50,000 | 25,000
- The benefit doubles if the accidental death is due to a common carrier.

CATASTROPHIC ACCIDENT BENEFIT

Helps families during the transitional period following a catastrophic loss:

- Provides a lump-sum benefit for catastrophic loss after fulfilling a 90-day elimination period.
- \$150,000 | \$75,000 | \$75,000
- A catastrophic loss is the loss of use of sight, hearing, speech, arms, or legs.

DEFINITIONS

Covered Accident - An accident causing injury, which:

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

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

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

Maximum Benefit Period - The longest period of time for which hospital benefits will be paid.

Waiting Period - There is a 60 day period of time following the effective date of the certificate during which wellness benefits are not payable. (Coverage election is limited to the January voluntary benefits enrollment period.)

PLAN PROVIDER

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" Excellent.

This information is being provided to employees by the School District of Palm Beach County in advance of more complete information from the insurer.

COBRA Notification

IMPORTANT CONTINUATION COVERAGE INFORMATION

WHAT IS CONTINUATION COVERAGE?

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

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be downloaded from www.tsacg.com/individual/plan-sponsor/florida/school-district-of-palm-beach-county.

HOW LONG WILL CONTINUATION COVERAGE LAST?

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

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

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

If you have questions about your employer-funded Health Care FSA, call Wageworks at 855-428-0446.

A notice form is provided for your use and can be found on the district's website at <http://L.sdpbc.net/59z0y>. You may also obtain the notice form by writing to Benefit Outsource, Inc. (BOI), 5599 S. University Drive, Suite 201, Davie, FL 33328 or calling 1-888-877-2780. Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid on time, or
- a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, or
- if a covered employee enrolls in Medicare, or
- if the employer ceases to provide any group health plan for its employees.

HOW CAN YOU EXTEND THE LENGTH OF CONTINUATION COVERAGE?

FOR GROUP HEALTH PLANS (EXCEPT HEALTH CARE FSAs): If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify BOI of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep your employer and Wageworks/FBMC informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and Wageworks/FBMC.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, U.S. Department of Labor.

DISABILITY: An 11-month extension of coverage may be available if any of the qualified beneficiaries are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify BOI of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All qualified beneficiaries who have elected continuation coverage and qualify will be entitled to the 11-month disability extension. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify BOI of that fact within 30 days of SSA's determination.

SECOND QUALIFYING EVENT

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage, resulting in a maximum amount of continuation coverage of 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the plan. You must notify BOI within 60 days after a second qualifying event occurs.

HOW CAN YOU ELECT CONTINUATION COVERAGE?

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

You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

COBRA Notification

IMPORTANT CONTINUATION COVERAGE INFORMATION

The Health Insurance Marketplace is an available alternative Health Care coverage option for you and your dependent(s).

Beginning with open enrollment in 2018, for an effective date of January 1, 2018, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that right away lowers your monthly premiums. You can see what the premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, if you request enrollment within 30 days, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouses' plan), even if the plan generally does not accept late enrollees.

HOW MUCH DOES CONTINUATION COVERAGE COST?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. This amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). For Health Care FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

WHEN AND HOW MUST PAYMENTS FOR CONTINUATION COVERAGE BE MADE?

FIRST PAYMENT FOR CONTINUATION COVERAGE: If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA election form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the election notice is postmarked, if mailed). If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the plan.

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

Your first payment for continuation coverage should be sent to:
Benefit Outsource, Inc. (BOI)
5599 S. University Drive, Suite 201
Davie, FL 33328

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the plan, these periodic payments for continuation coverage are due on the first day of each month. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA election notice form. BOI will send coupons for use in making periodic payments.

Periodic payments for continuation coverage should be sent to:
Benefit Outsource, Inc. (BOI)
5599 S. University Drive, Suite 201
Davie, FL 33328

GRACE PERIODS FOR PERIODIC PAYMENTS

Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the plan will be suspended as of the due date and

then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the plan.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS INTRODUCTION

You are receiving this notice because you have recently become covered under a group health plan sponsored by the School District of Palm Beach County (the plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the plan and under federal law, you should either review the plan's summary plan description or get a copy of the plan document from the School District of Palm Beach County (Risk & Benefits Management).

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct. If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because any of the following qualifying events happens:
 1. Your spouse dies;
 2. Your spouse's hours of employment are reduced;
 3. Your spouse's employment ends for any reason other than his or her gross misconduct;
 4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
 5. You become divorced or legally separated from your spouse. Your dependent children will become qualified beneficiaries if they will lose coverage under the plan because any of the following qualifying events happens:
 - a. The parent-employee dies;
 - b. The parent-employee's hours of employment are reduced;
 - c. The parent-employee's employment ends for any reason other than his or her gross misconduct;
 - d. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
 - e. The parents become divorced or legally separated; or
 - f. The child stops being eligible for coverage under the plan as a "dependent child."

COBRA Notification

IMPORTANT CONTINUATION COVERAGE INFORMATION

Sometimes filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the School District of Palm Beach County, and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.

The plan will offer COBRA continuation coverage to qualified beneficiaries only after BOI has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or enrollment of the employee in Medicare (Part A, Part B or both), BOI will offer COBRA continuation coverage to each qualified beneficiary.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify BOI. The plan requires you to notify BOI within 60 days by completing the required notice form, which is available on the district's website (see page 17) after the qualifying event occurs. Benefit Outsource, Inc. (BOI), 5599 S. University Drive, Suite 201, Davie, FL 33328.

Once BOI receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify BOI in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that BOI is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

This notice should be sent to:

Benefit Outsource, Inc. (BOI)
5599 S. University Drive, Suite 201 Davie, FL 33328

You must attach a copy of the SSA Determination Letter to the notice.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the plan as a dependent child. In all of these cases, you must make sure that BOI is notified of the second qualifying event within 60 days of the second qualifying event.

This notice must be sent to:

Benefit Outsource, Inc. (BOI)
5599 S. University Drive, Suite 201
Davie, FL 33328

You must attach a copy of the applicable supporting documentation to the notice (i.e., the divorce decree, death certificate).

RETIREE Q&A - WHAT SHOULD I DO WHEN I RETIRE?

During the 90 days prior to your anticipated retirement date, contact Risk & Benefits Management, Retiree Technician, at **561-434-8673** to schedule an appointment for retirement and continuation of group health/life plans and flexible benefits.

SPECIAL CONSIDERATION FOR TERM LIFE INSURANCE

Refer to the Conversion Provision on the Group Term Life pages as well as your policy certificate for timelines and application requirements.

WHEN I RETIRE, TO WHOM DO I SEND PAYMENTS?

Retirees continuing their eligible group health, dental, vision and/or term life (\$1,000) insurance may elect to pay their full premium payments through deductions from the Florida Retirement System or provide authorization for the district to take automatic deductions (ACH) from your bank account. Until FRS or ACH deductions begin, payment by personal check or money order is required.

FOR MORE INFORMATION

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

Beyond Your Benefits

SOCIAL SECURITY

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

However, the tax savings realized through the Flexible Benefits Plan generally outweighs the Social Security reduction. Call FBMC Customer Care at 1-855-5MYFBMC (1-855-569-3262) for an approximation.

ITEMIZED DEDUCTIONS

The portion of your salary set aside for before-tax benefit premiums and flexible spending accounts through the School District of Palm Beach County's plans will not be included in the taxable salary or reported to the IRS on your W-2 form. However, your annualized Dependent Care FSA contributions will appear on your W-2 form as a non-taxable item. You will not have to claim these payments as deductions at the end of the calendar year. Your before-tax deductions cannot be used as itemized deductions for income tax purposes at the end of the calendar year.

SPECIAL ENROLLMENT RIGHTS PERTAINING TO MEDICAL BENEFITS

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health plan insurance coverage, you may in the future be able to enroll yourself or your dependent in the School District of Palm Beach County's plan provided that you request enrollment within 60 days after the other coverage ends.

DISCLAIMER - HEALTH INSURANCE BENEFITS PROVIDED UNDER HEALTH INSURANCE PLAN(S)

Health Insurance benefits will be provided, not by the School District of Palm Beach County's Flexible Benefits Plan, but by the Health Insurance Plan(s) Certificates of Coverage. The types and amounts of health insurance benefits available under the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s) Certificates of Coverage. All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) Certificates of Coverage.

NOTICE OF ADMINISTRATOR'S CAPACITY

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

1. **Contract Administrator-FBMC Benefits Management (FBMC)** has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.
2. **Policyholder-This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.**
3. **Insurer-The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.**

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

FBMC PRIVACY STATEMENT

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

FBMC'S PRIVACY STATEMENT IS AS FOLLOWS:

- I. **We collect only the customer information necessary to consistently deliver responsive services.**
FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally vary depending on the products or services you request and may include:
 - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.
 - Responses from you and others such as information relating to your employment and insurance coverage.
 - Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
 - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.
- II. **Under Federal Law you have certain rights with respect to your protected health information.** You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.
- III. **We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information.** We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.
- IV. **We limit how, and with whom, we share customer information.** We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Medicare Part D Certificate of Creditable Coverage

IMPORTANT NOTICE FROM THE SCHOOL DISTRICT OF PALM BEACH COUNTY ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

PLEASE READ THIS NOTICE CAREFULLY AND KEEP IT WHERE YOU CAN FIND IT. THIS NOTICE HAS INFORMATION ABOUT YOUR CURRENT PRESCRIPTION DRUG COVERAGE WITH THE SCHOOL DISTRICT OF PALM BEACH COUNTY AND PRESCRIPTION DRUG COVERAGE AVAILABLE FOR PEOPLE WITH MEDICARE.

It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

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 through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage.

All Medicare prescription 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. The School District of Palm Beach County has determined that the prescription drug coverage offered by UnitedHealthcare is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered creditable coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan each year from October 15th through December 7th and when they first become eligible for Medicare. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month special enrollment period (SEP) to join a Medicare drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your UnitedHealthcare prescription drug coverage, be aware that you will not be able to get this coverage back. Prescription drug coverage is a part of the total health insurance plan offered by UnitedHealthcare and cannot be purchased separately.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

If you drop your coverage with the School District of Palm Beach County and enroll in a Medicare prescription drug plan, you will not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with the School District of Palm Beach County and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage: contact our office at 1-561-434-8580.

NOTE: You will receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, or if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

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

- Visit www.medicare.gov.
- Call your state health insurance assistance program for personalized help (see your copy of the "Medicare & You" handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this notice. If you enroll in one of the new plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: October 1, 2017
Name of Entity: School District of Palm Beach County
Contact: Benefits Technician
Address: 3370 Forest Hill Boulevard, Suite A-103
West Palm Beach, FL 33406-5870
Phone: 561-434-8673

PeopleSoft “My Homepage”

MY HOMEPAGE TILES

Keeping your data updated and close at hand just got a lot easier. The **PeopleSoft My Homepage Tiles** provides you with 24/7 access to your personal data. By taking advantage of the “My Homepage” feature of PeopleSoft, you can:

- view your personal data, including your benefit enrollment and dependent information and
- modify beneficiary information at your convenience.

Q: What am I able to view or change using “My Homepage”?

A: You can:

- update your address and emergency contact information
- view and print your paycheck and W-2 information
- update/change your life insurance beneficiary information; including the percentage
- view which plans you and your dependents are enrolled in
- verify your payroll deductions
- enroll/ increase/decrease your 403(b)
- verify/update your tobacco status
- view your benefit enrollment information
- provide online consent for 1095 Form
- enroll in eLearning
- view payable time
- and much more

Q: I cannot seem to log in to PeopleSoft to complete my benefits enrollment; who should I contact?

A: Make sure you have reviewed the instructions on how to obtain or reset your password. If you still need help, contact the IT Help Desk at PX 44100 or 561-242- 4100 for further assistance. Remember your enrollment is time sensitive, so do not delay completing your enrollment by the enrollment deadline.

Q: How much time do I have to complete my online enrollment?

A: You have up to 30 calendar days from your employment start date (or transfer to a benefited position) to complete your online benefits enrollment and tobacco affidavit. During Open Enrollment time, you have until 4:30 p.m. on the published deadline date.

Q: Will more time be granted to me if there is a holiday, system outage or if I have problems with my password?

A: In most cases, no additional time will be granted. Since you have 30 days to complete your enrollment, it is expected that you will act promptly and resolve any unexpected issues well before the final date to enroll.

Q: When should I be able to access the online enrollment system?

A: Within 48 to 72 hours of your start date, you should be able to create a password and then have immediate access to complete your enrollment.

Q: How do I create a password?

A: Follow the step-by-step enrollment instructions which explains how to create a password. It also includes information on how to get help if you have forgotten your password.



CONTRACT ADMINISTRATOR
FBMC Benefits Management, Inc.
PO Box 1878 • Tallahassee, FL 32302-1878
www.fbmc.com

*Information contained herein does not constitute an insurance certificate or policy.
Certificates will be provided to participants following the start of the plan year, if applicable.*