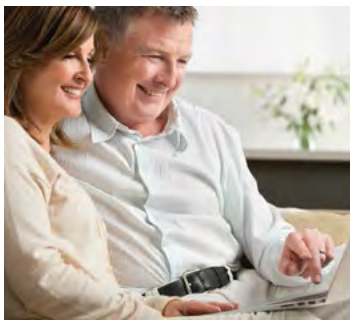
2014 PLAN YEAR

FLEXIBLE BENEFITS PLAN
REFERENCE GUIDE

Cultivating Wellness and Celebrating Our Successes



The School District of Palm Beach County

Employee Benefits Resource Directory

Risk & Benefits Management
561-434-8580
Fax 561-434-8103
www.palmbeachschools.org/riskmgmt

COBRA
Medical, Dental, Vision
Benefit Outsource, Inc. (BOI)
5599 S. University Drive, Suite 201
Davie, FL 33328
1-888-877-2780

Health Care FSA COBRA Information
WageWorks®
1-855-428-0446

Dental Insurance
UnitedHealthcare Dental®
1-877-816-3596 PPO Plans
1-800-955-4137 Managed Care Plans
www.myuhcdental.com

UHC on-site representative
Fulton Holland Building, A-103
561-434-8092 / 561-357-7564

Health Advocate
Healthcare Navigation &
EAP WorkLife Assistance
1-855-424-8400
www.healthadvocate.com/members

Flexible Spending Accounts
FBMC Benefits Management, Inc.
WageWorks Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
1-855-428-0446

FSA Card activation line; 24 hours a day
1-888-514-6845
www.myfbmc.com

FBMC Onsite Representative
Fulton Holland Building, A-103
561-434-7442

WageWorks®
Flexible Spending Account Claims
P.O. Box 14326
Lexington, KY 40512
1-855-428-0446

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

Medical Insurance
UnitedHealthcare®
www.myuhc.com

Member Services & Pharmacy Benefits
1-888-380-0389

UHC Onsite Representative
Fulton Holland Building, A-103
561-434-8092/561-357-7564

Nurse Liaison - Gail Diedrick, RN, BSN
561-434-7417

Wellness Coaching Program
1-800-478-1057

Diabetes Health Plan
1-866-944-9001

Healthy Living Lessons for Life - NurseLine
1-888-229-9322

Disability Income Protection Plan
Hartford Life and Accident Insurance
Company (The Hartford)
1-800-741-4306
www.thehartfordatwork.com

Term Life and Accident
Life Insurance Company of North
America, a CIGNA company
1-800-423-1282
www.cigna.com

Identity Theft Hotline
1-888-226-4567
www.cigna.com/idtheft

Critical Illness
Universal Life Insurance
Trustmark Insurance
1-866-636-5525
www.trustmarkinsurance.com
e-mail: pbsd@trustmarkins.com

401(a) Special Retirement Plan Administrator
BENCOR Administrative Services
1-888-258-3422
www.bencorplans.com
e-mail: questions@bencor.com

403(b) Plan Administrator
TSA Consulting Group, Inc.
Participant Transactions
28 Ferry Road SE
Fort Walton Beach, FL 32548
Phone: 1-888-796-3786
Fax: 1-866-741-0645
www.tsacg.com/

Vision Plan
EyeMed Vision Care
Provider Locator
1-866-299-1358
www.eyemedvisioncare.com

Customer Service
1-866-723-0514
www.eyemedvisioncare.com

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School District of Palm Beach County

What's NEW for 2014?

IN THIS SECTION...

- Enrollment information
- New Medical Plan Offering
- Plan changes
- Wellness Rewards
- Important reminders
- Open Enrollment and plan year dates
- Online Open Enrollment

You are encouraged to read this guide, which provides the information necessary to help you decide the benefits that are right for you. **The Low Option HMO or Waive Option will be the medical plan options for rehired employees and those who are newly eligible for benefits.**

BENEFIT ENHANCEMENTS:

MEDICAL

High and Low Option HMO plans

- Deductibles and co-pays (excluding prescriptions) now apply towards Annual Out of Pocket Maximums
- No annual dollar limitations on covered services
- No change in plan cost

New Consumer Driven Health Plan (CDHP) to replace the PPO plan

- CDHP rates that are much lower than the existing PPO medical plan
- This is a high deductible health plan that provides freedom and flexibility
- Nationwide Network - UnitedHealthcare Choice Plus
- Preventive Services are covered In-Network at 100%
- Annual deductible - $4,500 Individual; $9,000 Family
- Annual Out of Pocket Maximum: $6,350 Individual; $12,700 Family
- Out of Network benefits are available (Same Annual Out of Pocket maximum as the current PPO plan)
- **NEW -** Health Savings Account (HSA) is available to CDHP enrollees with an employer contribution
  - Allows members to use HSA contributions on a pre-tax basis for qualified medical expenses
  - IRS guidelines apply for member eligibility and qualified medical expenses for HSAs
- Current PPO plan participants will be defaulted to the CDHP if you do not re-enroll

DENTAL

Managed Care DHMO Plans

- S500PB - slight rate decrease
- S700 - name change to S700PB; no change to plan rates
- S700PB - all participants to receive new I.D. cards
- Both plans are enhanced to include up to three composite resin (white) fillings at zero co-pay
- Rider added for implant coverage

PPO Plans

- Rate increase applies to both PPO dental plans (High Option 5215 & Low Option 5105)
- Coverage for Implants

VISION

- Slight rate increase

FLEXIBLE SPENDING ACCOUNTS (HEALTH AND DEPENDENT CARE)

- Transition to new claims platform (FBMC partners with WageWorks)
- New Health Care FSA cards will be issued with WageWorks logo effective 1/1/2014
- Hold period December 13 through December 31, 2013; transactions (card or paper claims) will not be processed during this period.

WELLNESS REWARDS

- Plan requirements remain the same for 2014. Visit www.palmbeachschools.org/riskmgmt/wellness2 for official rules.
- Plan requirements will change beginning in 2015. More information will be provided in the future.

OPEN ENROLLMENT DATES:

November 4, 2013 - November 22, 2013

Prepare now and save $50 per month in medical premiums in 2015

You can save $50 per month in medical premiums beginning January 1, 2015, if you do the following between January 1 and July 31, 2014. If you cannot get all of the steps completed until December 31, 2014, you can still receive $50 per month partial Wellness Rewards beginning with the first eligible premium deduction on or after June 1, 2015.

The program has been expanded to give you and your covered spouse/partner more flexibility to meet the preventive service requirement as well as partial credit. The deadline for completing these actions is December 2014.

1. Complete the confidential online health assessment accessible through **www.myuhc.com** (you must log in).

2. Complete biometric screenings, which must be processed through Lab Corporation of America (LabCorp) measuring your fasting blood sugar and cholesterol levels (fasting HDL& LDL results).

3. Complete ONE of the following doctor recommended preventive actions:

a) Preventive physical or
b) Mammogram (age/gender specific) or
c) Colonoscopy (age specific) or
d) Cervical cancer screening/PAP (age/gender specific or
e) Participate in online or telephonic health coaching **(programs may take up to nine weeks to complete)** such as:
   i) Healthy pregnancy
   ii) Stress management
   iii) Weight loss
   iv) Asthma
   v) Heart healthy lifestyle
   vi) Diabetes
   vii) Blood pressure

Your covered spouse/partner will also need to complete the Wellness Reward steps in order for the $50 per month discount to apply in 2015.

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

Log in to:
www.palmbeachschools.org/riskmgmt/wellness2
for available resources to help you be tobacco free and save in 2015.

* Based upon self reported information
* Tobacco surcharge applies to tobacco users or employees who fail to provide their tobacco status by the program deadline.

Make sure we have your most current address information in our records. Use the **Self Service** tool to confirm or update your address information.

Be sure to get familiar with the new look and feel of the Health & Wellness page on www.myuhc.com.

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

Click on the **Employees** tab and **Self Service** link on the right;
then click on **Self Service/Benefits/Benefits Enrollment** to make your selections.

Important Information

- Benefit elections are irrevocable during the plan year, unless you experience a valid Change in Status (see page 19) 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 FSA accounts.
- The FSA health account has an annual minimum of $300 and an annual maximum of $2,500.
- The FSA dependent care account has an annual minimum of $300 and an annual maximium of $5,000 .
- Review eligibility requirements (see page 13).
- Review employee responsibilities (see page 9). Newborns WILL NOT automatically be added to your plan. To enroll a newborn, you will need to make a written request by completing a benefits change form and providing an original birth certification 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 **Self Service** 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 32 for further information.

Enrollment Information and Deadlines

Wellness Rewards - Know if You Are Receiving the Premium Discount.

The name of our medical plan holds the key to this important information. If you are receiving the Wellness Rewards discount, the medical plan name will end in "Wellness."

If you are not receiving the discount, only the medical plan name will be displayed.

Important Dates to Remember

Your Open Enrollment period of election dates are:

November 4, 2013 - November 22, 2013

Your period of coverage dates are:
January 1, 2014 - December 31, 2014

Paperless Enrollment

This is a paperless enrollment, and you will enroll and confirm your benefits online. 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.

Log onto **www.palmbeachschools.org** and click on the **Employees** tab. Click on **Self Service** under **Services** on the right of the web page. Select **Benefits/Benefits Summary.**

The system automatically defaults to the day you view the information. To see future benefit effective periods, such as new plan year information elected during Open Enrollment, change the date to 1/1/2014. New hire benefits become effective on the first day of the month after 30 days of employment. Therefore, new employees should enter the 1st day of the month in which benefits become effective.

WageWorks, the FSA 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. New employees must also declare their tobacco status online through the Self Service/Benefits/Wellness Rewards and Surcharge page.

Newly eligible employees must enroll online within 30 calendar days of their hire or rehire date. Medical plan options are limited to electing coverage in the Low Option HMO plan for a minimum of 12 months **OR** to waiving medical plan coverage.

If elections are not made within 30 calendar days, enrollment will default to the Low Option HMO single medical plan and basic life insurance. All other coverage options will be waived. These defaulted elections will remain in place for the plan year unless you notify us of a qualified Change in Status event.

Appeals

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

Fringe Benefits Management Company (FBMC)
P.O. Box 1878
Tallahassee, FL 32302-1878

DID YOU READ ABOUT...

- The plan and benefit changes?
- The important reminders?
- The Open Enrollment and plan year dates?
- The appeals process and deadline?

Online Enrollment

This is a paperless enrollment.
Prior to the last day of the election period be sure to confirm that your benefit choices are correct and accurate.

Navigate from the Employees tab found on the district's main web page to the Benefits Summary found at: Self Service/Benefits/BenefitSummary.

Enter 1/1/2014 to view your 2014 benefit elections.

We will process the choices you have made. Anytime you want to view your confirmed elections, be sure to enter 1/1/2014 to view your 2014 benefit elections.

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 the 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: High Option HMO, Low 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: $2,500).
- Dependent Care FSA: Child day care and elder day care expenses that enable you to work. You **cannot** use this FSA for your spouse or child's medical expenses.
- Payroll deduction: In January check to make sure that the payroll deduction matches the plan and coverage level.

Employee Responsibilities

IN THIS SECTION...

- **Your enrollment process responsibilities**
- **Payroll contribution information**
- **401(a) Dollars overview**
- **Outline of coverage levels**

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.
- Your 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 15.
- 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 on to **www.palmbeachschools.org/riskmgmt/EnrollmentQuickLinks2013.asp** and selecting the **Flexible 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 pre-tax 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.

Over-Aged 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.

401(a) Dollars

When an eligible employee waives medical coverage, the district will make a deposit of these 401(a) Dollars 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 86 for more detailed information and complete the required form.

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

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.

DID YOU READ ABOUT...

- Your responsibilities?
- The contribution information?
- The 401(a) Dollar overview?
- The coverage level outline?

Enrollment Process

IN THIS SECTION...

- Enrollment process for current employees, new hires and employees returning from leave of absence
- How to obtain your user ID and password for online enrollment
- Who should enroll during Open Enrollment
- Your FSA 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 is limited to electing Low Option HMO plan coverage or waiving medical benefits. Enrollment in the Low Option HMO plan requires a minimum of 12 months enrollment.

Online Benefits Enrollment – secure, private and no appointment necessary! Visit **www.palmbeachschools.org**. Click on the **Employees** tab; under **Services**, click on the **Self-Service** link (you will need your user ID and password in order to enroll).

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

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 19 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.

How to Obtain Your User ID and Password for the PeopleSoft E-Benefits Enrollment System

(**NOTE:** If you already access PeopleSoft or district email, you can use your current user ID and password to access the PeopleSoft benefits enrollment system).

- Go to the district's homepage at: **www.palmbeachschools.org**.
- Click on the password reset information link on the right-hand side of the homepage under Services.
- Complete the requested information. You will be provided your user ID (for new employees, this is also your employee ID) and a temporary password.
- You will be asked to choose another password the first time you log in to PeopleSoft. Be sure you have a pen and paper available to record it for future reference.

To access the online employee Self Service system:

- Click on **Benefits**
- Then click on **Benefits Enrollment**

Enrollment Process

Open Enrollment - Who Should Participate?

Employees who add dependents to plans	Documentation and Social Security information required*
Those wanting 2014 flexible spending accounts	These plans must be elected each year
All employees	To review plan information and changes, cost and verify data

*Refer to 2014 Benefit Reference Guide for specific requirements

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 2014 plan year.

Returning from Leave of Absence

Returning to work can be exciting and stressful. Within 30 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 page 24 of this guide).

DID YOU READ ABOUT...

- The enrollment process for your specific employment status?
- How you can obtain your user ID and password to enroll online?
- Whether you should enroll during Open Enrollment?

Employee Eligibility Requirements

IN THIS SECTION...

- Who is eligible to enroll
- Dependent eligibility information
- Default plan enrollment
- Rules to waive medical coverage

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 8.

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 programs as an employee **OR** as an eligible dependent of another employee. You may not enroll in any program 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 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 118.

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 or life insurance plans.

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. Your medical plan election will be limited to the Low Option HMO/Waive option for a minimum of 12 months.

Dependent Eligibility

Dependent Audit Verification

All employees adding any dependent 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, 8:00 a.m. until 4:30 p.m. The document(s) will be reviewed and immediately returned. **(Don't forget to actually enroll your dependent.)**

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.*

* You may only enroll your registered domestic partner in medical, dental and vision plans - **not** term life insurance.

District employees are not allowed to cover another district employee as a dependent on the medical or life insurance plans.

Dependent Eligibility Requirements

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.
- a stepchild.
- a child of a covered domestic partner.
- a child placed in your home pending adoption.
- a child for whom legal guardianship/custody has been awarded to you or your spouse.
- a 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.

Coverage for Over Aged Adult Children (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 www.palmbeachschools.org/riskmgmt/Benefits/BenefitForms.asp.

Coverage for Unmarried Handicapped Children

Coverage for an unmarried enrolled dependent child who is incapable of self-sustaining employment because of mental retardation or physical handicap will be covered beyond the specified limiting age, provided that the child was incapacitated 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 that 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	• Proof of domestic partner registration (county). • Receipt for recording fee. • Notarized domestic partner affidavit.
Birth child *Maximum age 25*	• 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*	• Original government-issued **marriage certificate.** • Original government-issued **birth certificate** (birth registration cards **not** accepted).
Domestic partner's child (*Maximum age 25*)	• Original government-issued **birth certificate** (birth registration cards not accepted). *Domestic partner must also be enrolled.*
Legal guardianship/custody	• 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*	• 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)*	• 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 yrs)*	• Original government-issued **birth certificate** (birth registration cards not accepted). • **Certificate of creditable coverage** (sample attached – request from prior insurance). • **Application for over aged adult child.** • Copy of student schedule - if child does not reside in Florida. **To be eligible for enrollment the adult child must:** • 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.

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:

- **Dependent's legal name**
- **Date of birth**
- **Social Security number**

*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.

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 **www.palmbeachschools.org/riskmgmt**.

- 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 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.

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 pre-tax rate. The balance of the deduction will be taken on an after-tax basis.

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.

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 17 for the required documents.)

Imputed Income

The district subsidizes the actual plan costs, so you only pay the amounts listed on page 38. However, due to IRS regulations, the amount paid by the district will be imputed income and you will be taxed on that amount.

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.

PALM BEACH COUNTY SCHOOL DISTRICT DOMESTIC PARTNERSHIP ENROLLMENT GUIDELINES

For employees who **are** residents of Palm Beach, Broward or Miami-Dade County

In order to enroll your domestic partner and your domestic partner's eligible children in the health, dental and/or vision plans, you must provide the documents from Item 1 and Item 2 below to Risk & Benefits Management at 3370 Forest Hill Blvd., A-103, West Palm Beach, Florida 33406. For the forms and requirements of registration and recording, visit the Palm Beach County Government website at www.pbcountyclerk.com/courtservices/circuitcivil/domesticpartner.htm. (This was correct at the time of publication).

Item 1. Complete, sign and have notarized a domestic partner affidavit that may be downloaded from the benefits forms web page.

Item 2. Provide proof of registration and recording as domestic partners through the county in which you reside.

For employees who reside **outside** of Palm Beach, Broward or Miami-Dade County

In order to enroll your domestic partner and your domestic partner's eligible children in the health, dental and/or vision plans, you must complete and send items 1 and 2 plus the additional requirements for group insurance benefits to Risk & Benefits Management at 3370 Forest Hill Blvd., A-103, West Palm Beach, FL 33406.

Item 1. Complete and sign a domestic partner affidavit in the presence of a notary. Non tri-county residents must also provide required proof as outlined in the non-resident portion of this affidavit.

Item 2. Provide proof that you and your domestic partner live together and are financially interdependent by submitting a copy of at least one item from each of the lists below.

LIST A	LIST B
Drivers' licenses showing the same address.	Statement(s) from a joint checking account.
Passports showing the same address.	Credit card(s) with the same account number for both names.
Mortgage, lease or deed showing both names.	Designations of each person as authorized signatories for a safe deposit box or joint wills.
Utility bills showing both names.	

Requirements and Information for Group Insurance Benefits:

1. Eligible employees are those employees who are eligible for benefits.
2. You may enroll during Open Enrollment or within 30 calendar days of your hire date by completing the online enrollment and providing the required documentation.
3. The domestic partner must be your "sole spousal equivalent." You both must live together in an exclusive committed relationship and assume responsibility for each others basic living expenses.
4. You must meet all requirements of the affidavit on page 16.
5. The non-employee domestic partner and his/her dependents do not have rights to continue coverage under federal or state laws.

Please list individuals to be enrolled in the insurance program. Please fill in all requested information listed below.

Name (First/Last)	Date of Birth	Relationship DP/CH/ DPC*	Social Security Number	Enrolled in M/D/V**

*Domestic Partner (DP) Employee's Child (CH) Domestic Partner's Child (DPC) **Plan Type: (M)edical, (D)ental, (V)ision
Coverage is subject to satisfying eligibility requirements. Documentation is required for all requests to enroll a dependent.

This form must be received by Risk & Benefits Management by the close of Open Enrollment. New employees have 30 calendar days from their hire date to provide this form and any other required supporting documentation to Risk & Benefits Management.

Mail the requested information to:
Palm Beach County School District
Risk & Benefits Management
3370 Forest Hill Boulevard, A-103
West Palm Beach, FL 33406

Affidavit of Domestic Partnership

- ☐ I am a resident of Palm Beach, Broward or Miami-Dade County
- ☐ I am NOT a resident in the Florida tri-county area

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

- ☐ We are each eighteen years of age or older and mentally competent.
- ☐ We are not related by blood in a manner that would bar marriage under the laws of the State of Florida.
- ☐ We have a close and committed personal relationship, and we are each other's sole domestic partner not married to or partnered with any other spouse, spouse equivalent or domestic partner.
- ☐ For at least one year we have shared the same regular and permanent residence in a committed relationship and intend to do so indefinitely.
- ☐ Neither of us has had another domestic partner at anytime during the 12 months preceding this enrollment.
- ☐ We have provided true and accurate required documentation of our relationship.
- ☐ Each of us understands and agrees that in the event any of the statements set forth herein are not true, the insurance or health care coverage for which this affidavit is being submitted may be rescinded and/or each of us shall jointly and severally be liable for any expenses incurred by the employer, insurer or health care entity.
- ☐ Each of us understands and agrees that election changes are only permitted during the Open Enrollment period.
- ☐ Each of us understands that should our relationship dissolve, it is our responsibility to notify the District and to terminate the Domestic Partner coverage.
- ☐ We further understand that continuation of benefits will not be extended to my partner and/or my partner's children.

_____ _____

Employee (Please Print) Domestic Partner (Please Print)

_____ _____

Employee (Signature) Domestic Partner (Signature)

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

_____

NOTARY PUBLIC

NOTARY SEAL

Type of identification produced _____

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 have completed a benefits change form and 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 form.

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 complete and submit a benefits change form to Risk & Benefits Management.

You may download the benefits change form directly at **www.palmbeachschools.org/riskmgmt**. Documentation supporting your election change request is required. Once your request has been reviewed, approved and processed, your existing elections and contribution amount will change (as appropriate). Approved changes will become effective on the first of the month following receipt of the benefits change form and all required documentation. 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 31.

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 your employer'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 pre-tax 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 pre-tax 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.

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 IRC § 129.

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

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?

Changing Your Coverage

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
I. CHANGE IN STATUS					
A. Change in Employee's Legal Marital Status					
1. Gain Spouse (Marriage)	Employee may enroll or increase election for newly eligible spouse and dependent children as well as pre-existing dependents; employee may also revoke or decrease own or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan. HIPAA special enrollment rights may also apply.		Employee may enroll or increase election for newly eligible spouse and dependents; employee may also decrease election if employee or dependents become eligible under new spouse's health plan.	Employee may enroll or increase election for newly eligible spouse and dependents; employee may also decrease election if employee or dependents become eligible under new spouse's Dependent Care FSA plan; or, employee may cease coverage if new spouse is not employed or makes a Dependent Care FSA coverage election under spouse's plan.	Employee may enroll in coverage when eligibility is affected.
2. Lose Spouse • Divorce, legal separation, annulment, or death of spouse	Employee may revoke election only for spouse; employee may also elect coverage for self or dependents who lose eligibility under spouse's plan if such individual loses eligibility; employee may also enroll new and pre-existing dependents so long as at least one dependent has lost coverage under the spouse's plan. HIPAA special enrollment rights may also apply.		Employee may decrease election to reflect loss of spouse's eligibility; employee may also enroll or increase election where coverage is lost under spouse's health plan.	Employee may enroll or increase election to accommodate newly eligible dependents (e.g., due to death of spouse); employee may also cease coverage if eligibility is lost (e.g., because dependent now resides with ex-spouse).	Employee may cease coverage when eligibility is affected.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
B. Change in the Number of Employee's Dependents					
1. Gain Dependent (Birth, adoption)	Employee may enroll or increase election for newly eligible dependents and/or enroll any pre-existing dependents; employee may also revoke or decrease own or dependent's coverage if employee or dependent become eligible under spouse's plan. HIPAA special enrollment rights may also apply.			Employee may enroll or increase election to accommodate newly eligible dependents and any other non-covered dependents.	Employee may increase coverage when eligibility is affected.
1. Lose Dependent (Death)	Employee may drop coverage only for the dependent who loses eligibility.			Employee may decrease election for dependent who lost eligibility.	Employee may decrease or cease coverage even when eligibility is not affected.
C. Change in Employment Status of Employee, Spouse, or Dependent That Affects Eligibility					
1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) That Triggers Eligibility					
a. Commencement of employment by employee or other change in employment status (e.g., PT to FT, hourly to salaried, etc.) Triggering eligibility under component plan	Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents.				(e.g., PT to FT, hourly to salaried, etc.) No change permitted.
b. Commencement of employment by spouse or dependent or other employment event triggering eligibility under their employer's plan	Employee may revoke or decrease election under employee's, spouse's, or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's coverage.		Employee may decrease or cease election if he or she gains eligibility for health coverage under spouse's or dependent's plan.	Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work); employee may also revoke election for dependent's coverage if dependent is added to spouse's plan.	No change permitted.

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Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
2. Termination of Employment by Employee, Spouse or Dependent (or Other Change in Employment Status) That Causes Loss of Eligibility					
a. Termination of employee's employment or other change in employment status (e.g., unpaid leave, FT to PT, strike, salaried to hourly, etc.) resulting in a loss of eligibility	Employee may revoke or decrease election for employee, spouse or dependent who loses eligibility under the plan.		Employee may revoke election to reflect loss of eligibility (note that under most health FSAs, employee loses coverage automatically).	Employee may revoke or decrease election to reflect loss of eligibility.	Employee may revoke or decrease election to reflect loss of eligibility.
i. Termination and rehire within 30 days	Prior elections at termination are reinstated unless another event has occurred that allows a change (as an alternative, employer may prohibit participation until next plan year).				
ii. Termination and rehire after 30 days	Employee may make new elections.				
b. Termination of spouse's or dependent's employment (or other change in employment status resulting in a loss of eligibility under their employer's plan)	Employee may enroll or increase election for employee, spouse or dependent who loses eligibility under spouse's or dependent's employer's plan; employee may also enroll previously eligible dependents. HIPAA special enrollment rights may also apply.		Employee may enroll or increase election to reflect loss of eligibility for health coverage.	Employee may enroll or increase election if spouse or dependent loses eligibility for Dependent Care FSA; employee may also decrease or cease election to reflect loss of eligibility for coverage (e.g., if spouse stops working).	No change permitted.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
D. Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements (See also discussion of gain/loss of eligibility under dependent or spouse's employer's plan)					
1. **Event by which dependent satisfies eligibility requirements under employer's plan** (attaining a specified age, becoming single, becoming a student, etc.)	Employee may enroll or increase election for affected dependent; employee may also add previously eligible but not enrolled dependents.		Employee may increase election or enroll only if dependent gains eligibility under health FSA.	Employee may increase election or enroll to take into account expenses of affected dependent.	No change permitted.
2. **Event by which dependent ceases to satisfy eligibility requirements under employer's plan** (attaining a specified age, getting married, ceasing to be a student, etc.)	Employee may decrease or revoke election only for affected dependent.		Employee may decrease or revoke election to take into account ineligibility of expense of affected dependent, but only if eligibility is lost. If dependent remains a tax dependent and the health FSA provides that the dependent's expenses remain eligible for reimbursement, then the employee could increase health FSA election.	Employee may decrease or drop election to take into account expenses of affected dependent.	No change permitted.
E. Change in Place of Residence of Employee, Spouse, or Dependent					
1. **Move triggers eligibility**	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.			N/A. Dependent Care FSA eligibility is not generally affected by place of residence (but see change in coverage below).	No change permitted.
2. **Move causes loss of eligibility** (e.g., employee or dependent moves outside HMO service area)	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of an HMO service area.			N/A. Dependent Care FSA eligibility is not generally affected by place of residence (but see change in coverage below).	No change permitted.

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Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
II. Change in Coverage Under Other Employer Cafeteria Plan or Qualified Benefits Plan					
1. Other Employer Plan Increases Coverage	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under another employer plan.	No change permitted.		No change permitted.	
2. Other Employer's Plan Decreases or Ceases Coverage	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer plan. Other previously eligible dependents may be enrolled.	Corresponding changes can be made under employer's plan.	No change permitted.	No change permitted.	
3. Open Enrollment Under Other Employer Plan / Different Plan Year	Corresponding changes can be made under employer's plan permitted.		No change permitted.	No change permitted.	
III. Loss of Group Health Coverage Sponsored by Governmental or Educational Institution	Employee may enroll or increase election for employee, spouse, or dependent if employee, spouse, or dependent loses group health coverage sponsored by governmental or educational institution. If employee loses individual coverage, he or she may add coverage for family members as well.		No change permitted.		

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
IV. MEDICARE OR MEDICAL					
A. Employee, spouse, or dependent enrolled in employer's accident or health plan becomes entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines)	Employee may cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Employee may cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Employee may decrease or revoke election under employer plan.	No change permitted.	No change permitted.
B. **Employee, spouse, or dependent loses eligibility for Medicare or MediCaid** (other than coverage solely for pediatric vaccines)	Employee may elect to commence or increase coverage for employee, spouse, or dependent, as applicable and add previously eligible (but not yet enrolled) dependents.	Employee may cancel or reduce coverage for employee, spouse, or dependent, as applicable.	Employee may commence or increase election under employer plan.	No change permitted.	No change permitted.

Event	Major Medical	Dental and Vision	Health FSA	Dependent Care FSA	Employee Group Term Life & AD&D
V. FMLA LEAVES OF ABSENCE					
A. Employee's commencement of FMLA leave	Employee can make same election changes as employee on non-FMLA leave. Employer must allow employee on unpaid FMLA leave either to revoke coverage or to continue coverage but allow employee to discontinue payment of his or her share of the contribution during the leave. The employer may recover the employee's share of contributions when the employee returns to work. FMLA also allows an employer to require that employees on paid FMLA leave continue coverage if employees on non-FMLA paid leave are required to continue coverage.		Same as previous column. Upon return, employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) or at a level reduced pro rata for the missed contributions.	Employee may make a new election if coverage terminated while on FMLA leave. Employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from non-FMLA leave are required to be reinstated in their elections.	

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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.

You should contact human resources when you need to take time sporadically. You may be eligible for an intermittent FMLA leave.

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.

Within 30 calendar days of beginning an approved unpaid leave of absence, contact:

- Risk & Benefits Management to obtain and submit a benefits change form to make a change to your existing pre-tax elections (except your Health Care FSA), and to arrange to continue certain benefits by paying your contribution amount on an after-tax basis.

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 FMLA 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 flexible spending health account through COBRA as well. Please contact WageWorks directly for more information if your FSA is terminated.

Non-CTA part time employees will not be eligible for benefits upon return from leave.

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 25 for more information.

Benefits While on Leave of Absence

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 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.

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 a waiver of premium directly with the life insurance provider. You must apply for a 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 waiver of premium request is denied. You will have 31 days from the waiver of premium denial date to convert to an individual 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 WageWorks customer service at 1-855-426-0446 to arrange for the continuation of payment for your Health Care FSA account. You should continue your monthly contribution if you wish to request reimbursement for the period that you are on leave.

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

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 or 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 FSAs 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: CIGNA plans, Trustmark plans, and/or a flexible spending health account. **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 1-866-636-5525 for information regarding payment of premiums if you had a Trustmark Universal Life, Cancer Protector or Critical Illness policy.
- WageWorks Customer Service at 1-855-426-0446 to apply for continuation of your Health Care FSA on an after-tax basis.
- NEBCO at 1-800-423-1282 for life insurance conversion and/or waiver of premium information and applications.

FSA Leave of Absence (LOA)

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 (HFSA) on a post-tax basis while on LOA. Although you lose the benefit of tax savings, this approach will keep your HFSA 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 your employer 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 your employer notifies Fringe Benefits Management Company, a division of WageWorks, that you are active again before you can be reimbursed for expenses incurred.

Q. What happens if I revoke my Health Care FSA while on leave?

A. If you choose to revoke your election while on leave, you will have a break in coverage. Expenses incurred while on leave are not eligible for reimbursement. When you return from leave your account will be reactivated using the same per payroll contribution amount as prior to taking leave, and your annual pledge will be reduced by the missed payrolls.

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

A. Participants should contact WageWorks customer service at 1-855-426-0446 to set up a personal payment plan for their HFSA. Once you go on leave, make your Health Care FSA contribution payments payable to "The School District of Palm Beach County" and mail to:

WageWorks
(Flexible Spending Accounts)
CLAIMS ADMINISTRATOR-FBWW
P.O. Box 14326
Lexington, KY 40512
TOLL FREE Fax: 1-855-291-0625
(Please do not send cash.)

Q. What if I don't want to continue my medical expense 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 a 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.

Benefits While on Leave of Absence

Ineligible for district-paid benefits – You are not eligible for district-paid benefits when 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.

Non-CTA part time employees who have a break in coverage are not eligible to re-enroll in benefits upon return to active status.

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 **2014,** 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.

If you fail to contact Risk & Benefits Management upon your return from leave, you will be limited to the Low Option HMO employee only medical plan and basic life insurance.

DID YOU READ ABOUT...

- **When to apply for leave of absence?**
- **The different types of leave and their requirements?**

Leave of Absence - Summer Benefits

IN THIS SECTION...

- **Duty Day codes and required workdays**

It is your responsibility to notify Risk & Benefits Management within one week of your return to work. Your return from leave date may impact our ability to make deductions from your summer paychecks. If we are unable to take the deductions because of summer payroll processing deadlines, you will receive a billing statement.

All employees, other than 12-month employees or 216(R), must be in a paid status or on approved FMLA leave for the majority of their duty days in May and June to be eligible for the normal school district contributions toward their June and July insurance benefits. Therefore, if your contract's last workday is **June 6, 2014,** you must be in a paid or FMLA status through **May 20, 2014** (14 work days).

If you are not in an FMLA and/or paid status for the majority of your duty days in May and June, you will not receive district-paid insurance benefits until October 1 (provided that you return to work on the first duty day in a benefited position in August). The waiting period will apply and your benefits are reinstated the first of the month following 30 days of active employment.

Twelve month employees are required to pay the full premium for any month in which they are not in a paid or FMLA status on the first of that month. If you have any questions, please feel free to contact Risk & Benefits Management at 561-434-8668 (PX 48668) or 561-434-7478 (PX 47478).

Duty Day codes and the required workdays:

Duty Day Groups	Be in a Paid Status through	Return to Work by or FMLA Status by		Combined May/ June Duty Days
180, 182(NT) 188(T)	6/05/2014	5/16/2015	5/19/2014	14
187NT	6/06/2014	5/19/2014	5/20/2014	14
190,193,196,206(TI), 235	6/06/2014	5/19/2014	5/20/2014	14
193, 195	6/06/2014	5/19/2014	5/20/2014	14
206(NT), 216(TI)	6/12/2014	5/21/2014	5/22/2014	16
226(E) NT	6/26/2014	5/28/2014	5/29/2014	20
226(T&I, 216(NT)	6/19/2014	5/23/2014	5/24/2014	18

In order for benefits to continue in the summer when reinstated as of June 1, you must be in a paid status as of June 1.

DID YOU READ ABOUT...

- **The required workdays to continue benefits during the summer?**

Coverage Termination

IN THIS SECTION...

- **How termination affects benefits**
- **Your responsibilities when terminated**

Employee Coverage

During the plan year, except as otherwise provided by law and in accordance with your employer'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 24 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 terminated effective the last day of the month after receipt of a completed Change in Status form and supporting documents have been received.

NOTE: Change forms received during the summer months will be processed with an effective date of August 31.

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. It 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.

Coverage Termination

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 1-855-426-0446 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 re-hire within 30 days – If you terminate employment and are re-hired 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 re-hire after 30 days – If you terminate and are re-hired 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, except that you will be limited to the low option HMO medical plan. You will experience a break in coverage and will be subject to new waiting periods.

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 over-aged adult child provision, or COBRA continuation is elected and premium payments are made.

Trustmark Cancer Protector and PremierSelect℠ Critical Illness will cease at the end of the calendar year in which they turn 19 (or age 23) if a full-time student in an accredited school, college or university, and provided they are unmarried and dependent on the participant for support.

DID YOU READ ABOUT...

- How termination will affect your benefits?
- Your rights and responsibilities when terminated?

Benefits When You Leave 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 **www.palmbeachschools.org/riskmgmt/benefits/retireebenefits2012.asp**.

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?

Appeals

IN THIS SECTION...

- How to initiate an appeal
- Appeal rules and requirements

Appeals Process Information & Deadlines

It is our goal to process your elections correctly. We need your help to make sure we do so. That is why we ask that you pay careful attention to plan details and dependent information as you enroll.

You have until the close of business on November 22, 2013, to review and confirm your benefit elections online and make any adjustments that may be needed. You should pay close attention and confirm that you are enrolled in the correct plans and that the correct dependents, if applicable, are attached to those benefits.

Enrollment Appeals

After the start of the plan year, 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 Flexible Spending Account and you do not have dependents who attend daycare/eldercare.
- 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 assure 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 description of the reason for the appeal
- Include any additional supporting documents, information or comments you think may have a bearing on your appeal
- Submit your appeal as soon as the discrepancy is known to you as many decisions are based upon the number of days that have elapsed since the start of the plan year.

Generally, within 30 business days, FBMC will notify you if additional information is needed and will provide the final determination.

All enrollment appeal decisions are final.

Direct Enrollment Appeals to:
FBMC Benefits Management
Attn: Compliance & Risk Management
P.O. Box 1878
Tallahassee, FL 32302-1878
Fax: 850-514-5805

FSA Appeals

To Appeal a Denied Medical FSA or Dependent Care FSA Claim

If you feel your claim was denied in error, you have the right to file an appeal by writing a letter that explains why you believe the claim should be approved. Your appeal may be submitted in writing and mailed to:

WageWorks Claims Appeal Board
P.O. Box 991
Mequon, WI 53092-0991
Fax Number: 1-877-220-3248

- Your appeal must be received within 180 days of the date you receive notice that your claim was denied.

DID YOU READ ABOUT...

- How to file an appeal?
- Your rights and responsibilities when filing an appeal?

Healthcare Benefits 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.

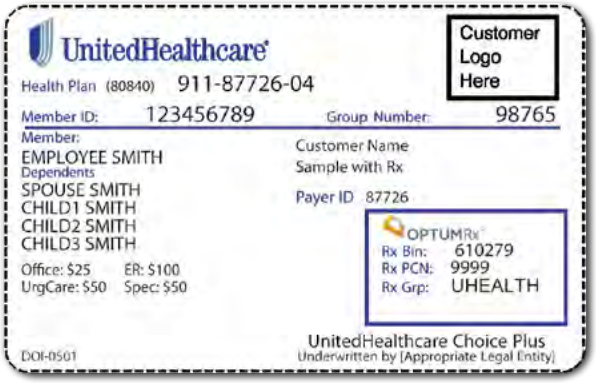
1. **www.myUHC.com/**
2. Click on "Physicians & Facilities."
3. Choose "Find a Physician."

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.



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:

- Healthcare cost estimator
- Physician match
- Hospital comparison

Healthcare Terms I Need To Know

What Does that Word Mean?

- **Copay:** this is the fixed dollar amount that you will be asked to pay directly to the provider at the time of service for a doctors visit, prescription fill, urgent care trip, etc. For example, the contract for a certain network of doctors may require that patients pay a $30 copay.
- **Deductible:** the amount you need to pay each year before your insurance begins paying coinsurance. Certain benefit design options make you responsible for a percentage of your medical costs after you've reached your "deductible" for the year.
- **Coinsurance:** A percentage of the eligible expenses you are required to pay out-of-pocket (the remaining percentage of eligible expenses are paid by the medical plan).
- **Out-of-pocket Maximum (OOPM):** the maximum dollar amount on the portion of covered medical expense that you must pay during a benefit period (often a calendar year). When the out-of-pocket maximum is met, you will not have to pay further deductibles, copayments or coinsurance for that plan year.
- **In-network:** coverage for treatment obtained from a contracted or network doctor or hospital and typically provides discounted charges for services.
- **Out-of-network:** coverage for treatment obtained from a non-contracted doctor or hospital and typically requires higher payments.

Understanding the Deductible…

The deductible is the amount you need to pay each year before your insurance begins paying coinsurance. Certain benefit design options make you responsible for a percentage of your medical costs after you've reached your "deductible" for the year.

Remember:

- Some network benefits have an office visit co-pay while other benefits will be subject to the deductible. If there is a copay, meeting the deductible is not required.
- The deductible will apply to all major services such as inpatient hospitalization, outpatient surgery, outpatient diagnostic therapeutic services, ambulance (Please refer to the next slides for more details)
- The in-network and out-of-network deductible and coinsurance are completely separate.
- Deductible and coinsurance accumulate separately by calendar year from January 1st to December 31st

Here's How the Deductible Works…

- The in-network deductible is $500, co-insurance is 20% and the out-of-pocket maximum (OOPM) is **$6,000**.
- How they work together:
  - Inpatient Hospitalization (network facility): $25,000
  - Patient deductible: **$500**, = balance of $24,500
  - Co-insurance of 20% billed until OOPM of $6,000
- 20% X $24,500 = **$4,900**; however, OOPM = $6,000

  therefore member responsibility = **$4,900** + (ded.)
  - Plan pays 80% of the bill until the out-of-pocket max is met, then 100%

Medical Plan Comparison Charts

UnitedHealthcare Benefits-at-a-Glance	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**
In-Patient Hospital Co-Insurance	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
Co-Insurance 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.
Office Visit (Primary Care)	$25 co-payment Deductible does not apply
Specialist Office Visit Allergy shots in doctor's office	$35 co-payment Deductible does not apply • No referral needed
Preventive Care	No charge
Outpatient Hospital and Surgical Services X-ray Other diagnostic services (MRI, CT scan, laboratory test, etc.)	10% of eligible expenses after deductible
Out-Patient Rehabilitation Therapy	$20 co-payment 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 co-payment (waived if admitted)
Urgent Care Co-pay	$50 co-payment Deductible does not apply
Convenience Care Clinic	$25 co-payment 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) $10 tier 1, $30 tier 2, $60 tier 3, $100 tier 4 No deductible for mail order – $25 tier 1, $75 tier 2, $150 tier 3, $250 tier 4
Network www.myUHC.com. Network name "UnitedHealthcare Choice." This network is for both the High/Low 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

UnitedHealthcare

Benefits-at-a-Glance

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. The premiums are less than the High Option HMO plan. However, the out-of-pocket expenses are slightly higher than the High Option HMO plan.

Member Payments	In-Network Only
In-Patient Hospital Co-Insurance	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
Co-Insurance 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.
Office Visit (Primary Care)	$40 co-payment Deductible does not apply
Specialist Office Visit Allergy shots in doctor's office	$60 co-payment Deductible does not apply • No referral needed
Preventive Care	No charge
Outpatient Hospital and Surgical Services X-ray Other diagnostic services (MRI, CT scan, laboratory test, etc.)	20% of eligible expenses after deductible
Out-Patient Rehabilitation Therapy	$35 co-payment per visit[1] Deductible does not apply
Approved Durable Medical Equipment	20% of eligible expenses after deductible
Emergency Ambulance Trip	$150 co-payment per trip
Hospital Pre-Admission Requirement	Your doctor will take care of all pre-notification requirements.
Emergency Room Care	$250 co-payment (waived if admitted)
Urgent Care Co-pay	$75 co-payment Deductible does not apply
Convenience Care Clinic	$40 co-payment 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) $10 tier 1, $30 tier 2, $60 tier 3, $100 tier 4 No deductible for mail order – $25 tier 1, $75 tier 2, $150 tier 3, $250 tier 4
Network **www.myUHC.com**. Network name "UnitedHealthcare Choice." This network is for both the High/Low 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

UnitedHealthcare

Benefits-at-a-Glance

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 co-payment.

Member Payments	In-Network Only	Out-of-Network
In-Patient Hospital Co-Insurance	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 and $20,000 for family
Annual Medical Expense Deductible	$4,500 for individual and $9,000 for family	$4,500 for individual and $9,000 for family
Co-Insurance Rate	30% of contracted fee	40% of eligible expenses
Primary Care Doctor	Choose any physician from the United network "UnitedHealthcare Choice Plus." You may access any participating specialist without a referral.	Choose any licensed doctor
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
Preventive Care Office visit Routine mammogram*	 No charge No charge	 40% of eligible expenses 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 30% of contracted fee after deductible	 40% of eligible expenses after deductible 40% of eligible expenses after deductible
Out-Patient Rehabilitation Therapy	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 Co-pay	30% of contracted fee after deductible	40% of eligible expenses after deductible
Convenience Care Clinic	30% of contracted fee after deductible	40% of eligible expenses after deductible
Outpatient Mental Health & Substance Abuse Services	30% of contracted fee after deductible	40% of eligible expenses after deductible
Prescription Drugs 30-day supply per prescription at participating pharmacists Mail order for a 90-day supply of formulary maintenance-medication per prescription	 30% of contracted fee after deductible 30% of contracted fee after deductible	 40% of eligible expenses after deductible 40% of eligible expenses after deductible
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) $10 tier 1, $30 tier 2, $60 tier 3, $100 tier 4 No deductible for mail order – $25 tier 1, $75 tier 2, $150 tier 3, $250 tier 4	40% of eligible expenses after deductible Not covered

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

[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 Contribution***

2014 Employee Per-Pay-Period Medical Contributions

*Rate does not reflect Wellness 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**			
EE = Employee	District Contribution	24 Employee Deductions	District Contribution	22 Employee Deductions	District Contribution	24 Employee Deductions	District Contribution	22 Employee Deductions
Low Option HMO								
EE only	$215.00	$25.00	$234.52	$27.27	$215.00	$25.00	$234.52	$27.27
EE + child(ren)	$365.00	$68.00	$398.14	$74.18	$350.00	$83.00	$381.78	$90.54
EE + spouse	$381.50	$89.00	$416.14	$97.09	$366.50	$104.00	$399.78	$113.45
EE + family	$465.50	$151.00	$507.77	$164.72	$450.50	$166.00	$491.41	$181.09
High Option HMO								
EE only	$237.50	$45.00	$259.07	$49.09	$187.50	$95.00	$204.53	$103.63
EE + child(ren)	$380.00	$135.00	$414.50	$147.27	$315.00	$200.00	$243.60	$218.18
EE + spouse	$390.00	$160.00	$425.41	$174.54	$325.00	$225.00	$354.51	$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 Wellness 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.

**Part time status applies CTA Bargaining units or those in grand fathered 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.

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 Bank℠, 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 Bank℠ and may lose value.

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), such as the District's Consumer Driven Health Plan (CDHP).
- You are covered by no other health coverage, unless it is permissible coverage like vision or dental.
- You are not enrolled in Medicare. (Any Medicare Enrollment makes you ineligible.)
- You cannot be claimed as a dependent on someone else's tax return
- You are ineligible to enroll in an FSA plan with the District.

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.

For 2014, the maximum deposit limit (employer and employee) is $3,300 if you have individual coverage and $6,550 if you have a family policy. The IRS also allows you to make an extra catch-up deposit of $1,000 in 201

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).

Getting Started

1. Enroll online.

Sign up through your employer or enroll at welcometouhc.com or myuhc.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® and your debit card personal identification number (PIN) will arrive by mail in separate unmarked envelopes for your safety and security.

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 Bank℠, 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.

OPTUM™

UnitedHealthcare®

Your award-winning road map to health.

Health4Me

UnitedHealthcare's Health4Me mobile app was selected as the Appy Award winner for 2013 in the Healthcare and Fitness category.

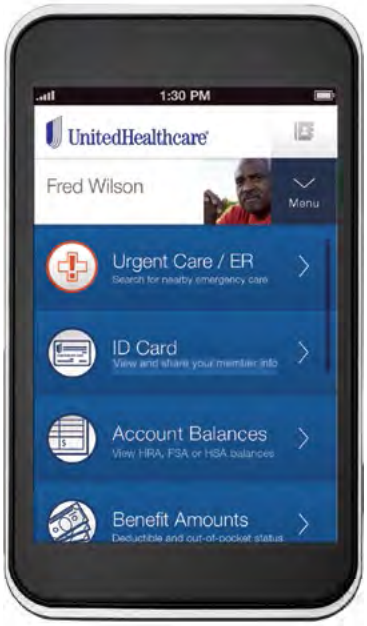
AppyAwards
BEST HEALTHCARE & FITNESS APP
2013

Key features include*

- Search for physicians or facilities by location or specialty
- Store favorite physicians and facilities
- View claims
- Have an Easy Connect representative contact you to answer any questions
- View and share health plan ID card information
- Access and update your Personal Health Record
- Check status of deductible and out-of-pocket spending
- Locate nearby convenience clinics, urgent care facilities and emergency rooms
- Complete confidentiality
- Personalize with notes and reminders

The UnitedHealthcare Health4Me™ mobile app makes it easier for members to take greater control of their health by providing millions of UnitedHealthcare members with 24/7 access to a registered nurse and their personal health benefits information, as well as the ability to locate a nearby physician, hospital or other medical facility that participates in the UnitedHealthcare care provider network.

Within the app, members can access myHealthcare Cost Estimator to comparison shop for the most common treatments and procedures based on both quality and cost. The estimates are based on the actual contracted rates with physicians, hospitals, clinics and other health care providers to provide estimated pricing.



Available on the App Store

Android available in Google play

UnitedHealthcare®

Produced by MediaPost Communications, a media, advertising and marketing news and events publishing company based in New York, the annual Appy Awards' aim is to acknowledge extraordinary Applications, whether they be mobile, social, or Web-based. The Appys don't discriminate by format, platform or device; instead, they focus on simply honoring the best Apps in all imaginable categories: http://appyawards.net/.

*Some features may not be available for all employer plans.

All UnitedHealthcare members can access a cost estimator online tool at myuhc.com.® Depending on your specific benefit plan and the ZIP code that is entered, either the myHealthcare Cost Estimator or the Treatment Cost Estimator will be available. A mobile version of myHealthcare Cost Estimator is available in the Health4Me mobile app, and additional ZIP codes and procedures will be added soon. This tool is not intended to be a guarantee of your costs or benefits. Your actual costs and/or benefits may vary. When accessing the tool, please refer to the Terms and Conditions of Use and Why Your Costs May Vary sections for further information regarding cost estimates. Refer to your health plan coverage document for information regarding your specific benefits.

App Store is a service mark of Apple, Inc. Android is a registered trademark of Google, Inc.

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

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

Criteria for designation come 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 doctor

Visit your member website, myuhc.com, to search the directory and look for these symbols next to your results:

★★ UnitedHealth Premium quality and cost efficiency doctor

★ UnitedHealth Premium quality doctor

NCQA/ADA Diabetes Doctor Recognition Program (DPRP)

NCQA/AHA/ASA Heart/Stroke Recognition Program (HSRP)

Consult the benefit reference guide throughout the year and refer to it for important information.

www.palmbeachschools.org/riskmgmt

Where Should I Go for Care?

Helping you choose the right care center

Care Center	Why would I use this care center?	What type of care would they provide*?	What are the cost and time considerations?**
Doctor's Office	**You need routine care or treatment for a current health issue.** Your primary doctor knows you and your health history. Your doctor can access your medical records, provide preventive and routine care, manage your medications and refer you to a specialist, if necessary.	• Routine checkups • Immunizations • Preventive services • Manage your general health	Requires a co-payment. Normally requires an appointment. Little wait time with scheduled appointment.
Convenience Care Clinic	**You can't get to your doctor's office, but your condition is not urgent or an emergency.** Convenience care clinics are often located in malls or retail stores offering services for minor health conditions. Staffed by nurse practitioners and physician assistants.	• Common infections (e.g., strep throat) • Minor skin conditions (e.g., poison ivy) • Flu shots • Pregnancy tests • Minor cuts • Earaches	Requires a co-payment similar to office visit. Walk-in patients welcome with no appointments necessary, but wait times can vary.
Urgent Care Center	**You may need care quickly, but it is not an emergency, and your primary physician may not be available.** Urgent care centers offer treatment for non-life threatening injuries or illnesses. Staffed by qualified doctors.	• Sprains • Strains • Minor broken bones (e.g., finger) • Minor infections • High fever • Minor burns	Requires a co-payment higher than an office visit. Walk in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first.
Emergency Room	**You need immediate treatment of a very serious or critical condition.** The ER is for the treatment of life-threatening or very serious conditions that require immediate medical attention. Do not ignore an emergency. If a situation seems life threatening, take action. Call 911 or your local emergency number right away.	• Heavy bleeding • Large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Major burns • Spinal injuries • Severe head injury • Difficulty breathing • Major broken bones	Often requires a much higher co-payment. Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

If you have questions or need more information, you can speak with a registered nurse at anytime by calling the number on the back of your UnitedHealthcare member ID card.

*This is a sample list of services and may not be all-inclusive.

**Costs and time information represents averages only and is not tied to a specific condition or treatment. Your out-of-pocket costs will vary based on plan design.

TAKE CHARGE. KNOW MORE.

4P
PROCEDURE
PROVIDER
PRICE
PLACE

myHealthcare Cost Estimator is your personalized online tool that will empower you to make more informed health care decisions.

myHealthcare Cost Estimator is available to UnitedHealthcare members at no additional cost. When you are able to get information based on your individual plan, you'll have the knowledge to better understand your choices and be in greater control of your health care.

More personalized data.
More validated data.

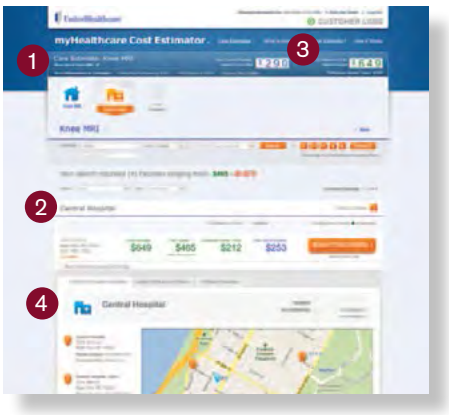
myHealthcare Cost Estimator is changing the way you access personalized information, for the better. This online tool provides more validated data than any other estimator of its kind. That's because the estimates used are based on UnitedHealthcare's claims database, which includes 250+ million claims over the last five quarter's, validated against fees. Plus, it's fully integrated with customer service and clinical support so you can get the answers you need.

Scan the code to view
a demo of **myHealthcare Cost Estimator.**

Log on to myuhc.com® to get started.

UnitedHealthcare®

Be in the **know.**



Know the 4 Ps

1. **Know your procedure.**
   Become educated on your procedure and learn about alternative treatment options that may be more cost-effective.
2. **Know your provider.**
   Where available, select a quality provider through our UnitedHealth Premium® program, which rates doctors based on national industry quality standards and local market cost-efficiency benchmarks.
3. **Know your price.**
   Access personalized resources to easily estimate out-of-pocket costs for your procedure based on your specific health plan.
4. **Know the place.**
   Find a provider based on your geographic search criteria, view maps and print directions.

Take charge of your care with a Care Path.

A **Care Path** is a planned treatment program that may consist of one or more health services that may span any length of time depending on the health condition being treated. Once you establish a **Care Path** on **myHealthcare Cost Estimator,** you can track your progress from the first consult to the last follow-up.

The choice is yours.

We provide the cost and, where available, quality information on physicians in the specialty you need. But ultimately the choice is yours when it comes to selecting the provider and procedure you think will deliver the quality of care you demand.

Get started in three easy steps.

Start using **myHealthcare Cost Estimator** today. It's currently available in over 45 markets, featuring in-depth information on over 100 procedures. More cities and procedures will be added soon. After all, when you take charge, you'll know more about how to make the most of your health plan.

1. Register with your member health plan ID number at **myuhc.com.**
2. Set up an email, username and password.
3. Take full advantage of all the value-added benefits this online tool has to offer.

Visit **myuhc.com** today to access **myHealthcare Cost Estimator.**

UnitedHealthcare®

100-11307 04/12 Consumer

The right medications for you

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

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

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.

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.

Try the OptumRx™ Mail Service Pharmacy – you may save money, and it's convenient

With the OptumRx Mail Service Pharmacy you'll get:

The opportunity to save money and time

- Depending on your benefit plan, you may save money by having your doctor prescribe a 3-month supply of medication. Your medications are mailed to you with standard shipping at no cost to you.

Advanced quality checks

- Your prescription claim history on file is reviewed by a pharmacist to look for drug combinations that may not be appropriate to be taken together.

24/7 access to pharmacists

- Call **1-800-788-4863** and speak with a pharmacist

Follow these simple steps

Step 1 – Talk to your doctor

Get the right prescription

Request up to a 3-month supply, with refills for up to one year (if appropriate).

Step 2 – Pass your information to the mail service pharmacy

By fax or electronically:

- **Your doctor can call 1-800-788-4863 for instructions to fax prescription(s) directly to OptumRx Mail Service Pharmacy (NOTE: Faxed prescriptions can only be accepted from your doctor's office)**
- Ask your doctor to send immediately by using ePrescribe

Online:

- Log on to myuhc.com
- Click on "Manage my Prescriptions"
- Select "Transfer Prescriptions" and select the medications you would like to transfer to mail service.

By mail:

- Ask your doctor for a new prescription for up to a 3-month supply, plus refills for up to one year (if appropriate)
- Go to myuhc.com and download an order form
- Mail the new prescription and order form[2] to the address provided.

Note: Most prescriptions arrive within 7days from the date your completed order is received. If you need your medication right away, ask your doctor to write a prescription for a 1-month supply that can be immediately filled at a participating retail pharmacy.

2. The information you supply on the order form is kept confidential in accordance with applicable laws, and the health and allergy information you provide helps the pharmacist check for possible problems with some medications.

myuhc.com

Preventive Care Services

UnitedHealthcare is dedicated to helping people live healthier lives, and we encourage our members to receive age and gender appropriate preventive health services.

We encourage you to obtain preventive care services and health screenings, as appropriate for your age, to help maintain or improve your health and achieve your health and wellness goals. Regular preventive care visits and health screenings may help to identify potential health risks for early diagnosis and treatment, helping you live a healthier life.

UnitedHealthcare plans typically cover preventive services, as specified in the health care reform law,[1] at 100% without charging a copayment, coinsurance or deductible, as long as they are received in the health plan's network. UnitedHealthcare also covers other routine services, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage.

Talk to your doctor

Consult your doctor for your specific preventive health recommendations, as he or she is your most important source of information about your health.

Summary of preventive care services benefit

UnitedHealthcare is committed to advancing prevention and early detection of disease. The following is a high-level summary of the services covered under the preventive care services benefit shown by age/gender groups:

All members

- Preventive medicine for adults[2]; all standard immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).

All members at an appropriate age and/or risk status

Screening for:

- Obesity
- Cholesterol level and lipids
- Colorectal cancer[2] for ages 50+
- Certain sexually transmitted diseases including HIV
- Cardiovascular Disease aspirin use counseling for ages 45+
- High blood pressure
- Diabetes for certain populations
- Tobacco use
- Diet and nutrition
- Alcohol abuse
- Depression

Women's health services effective as of 9-23-2010:

- Screening mammography (film and digital) for all adult women[2]
- Cervical cancer screening including Pap smears
- Genetic counseling for the BRCA breast cancer gene
- Counseling for cancer prevention strategies for women at high risk for breast cancer
- Screening for certain sexually transmitted diseases including HIV for certain populations
- Osteoporosis for certain populations[2]

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Women's health continued

- Pregnant women for:
  - Iron-deficiency anemia
  - Bacteria in urine
  - Hepatitis B virus
  - Rh incompatibility
  - Counseling to promote and aid with breast feeding

The follow guidelines reflect the expanded Women's preventive health care services provided under the health reform law.

- Yearly well-women visits
- Sexually transmitted infections counseling
- Contraception methods and counseling
- Domestic violence screening
- Gestational diabetes screening
- HIV screening and counseling
- Human papillomavirus testing (beginning at age 30, and for every 3 years thereafter)
- Breast-feeding support, supplies, including renting or purchase of specified breast feeding equipment from an approved vendor and counseling

Men's health

Screening:

- Human Papillomavirus for males age 9-26 years
- Abdominal aortic aneurysm for men 65 – 75 years old who have ever smoked

Children:

Services at each of these preventive visits will vary based on age, but will include some of the following:

- Measurement of your child's head size
- Measurement of length/height and weight
- Screening blood tests, if appropriate
- Providing age appropriate immunizations
- Vision screening
- Hearing screening
- Counseling on oral health
- Psychological and behavioral development assessment
- Counseling on the harmful effects of smoking and illicit use of drugs (for older children and adolescents)
- Counseling for children and their parents on nutrition and exercise
- Screening certain children at high risk for high cholesterol, sexually transmitted diseases, lead poisoning, tuberculosis and more.

As outlined above, many women's preventive health care services, including mammograms, screenings for cervical cancer, and immunizations, are covered with no cost sharing by UnitedHealthcare for certain health plans.

Please talk with your doctor and make the health care decisions that may be right for you in managing your own health today.

To learn more about the preventive care services that may be right for you visit www.uhcpreventivecare.com.

Note that the above screenings are provided with no cost sharing. Medications prescribed to treat a condition are not covered without cost-share under the preventive services benefit.[1]

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1 Preventive services that are covered with no cost share are those services described in the United States Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the CDC, and HRSA Guidelines for women, as well as children, including the American Academy of Pediatrics Bright Futures periodicity guidelines.

2 Certain preventive care services are not currently required to be covered by the health reform law; however, various additional services are covered under UnitedHealthcare's preventive care services benefit.

Dental

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 dental plans with exciting new enhancements. UnitedHealthcare Dental is a leading dental provider in Florida, and we are proud to have been selected as your dental carrier. We offer 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% to 60% 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% discount.
- Defined costs on 293 procedure codes.
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included.
- Implant rider coverage.
- 25% discount on all procedure codes not listed.

Option 2 (Plan S700PB) is a pre-paid plan. This plan offers a guaranteed savings of 25% to 50% 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% discount.
- Defined costs on 293 procedure codes.
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included.
- Implant rider coverage.
- 25% 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%.
- The participating general dentist you select may not perform all outlined procedures. The co-payments 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% reduction off the provider's usual and customary fee; or (2) you may obtain prior written authorization by UnitedHealthcare Dental* and receive specialty treatment by an approved participating specialist at the listed co-payments. 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 (S500PB and S700PB) Features:

About fillings

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

Amalgam (silver fillings) (S500PB and S700PB)

- No co-payments - covered 100%
- 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)

S500PB

- Anterior Teeth – No co-payment
- Posterior Teeth – No co-payment

S700PB

- Anterior Teeth – No co-payment
- Posterior Teeth – No co-payment

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.

Typical Annual Cost	***OPTION I-S500PB*** What You Pay In-Network Only	***OPTION 2-S700PB*** What You Pay In-Network	***OPTION 3-P5215**** What You Pay** In-Network/Out-of-Network	***OPTION 4-P5105**** What You Pay** In-Network/ Out-of-Network
Office visit	No charge	No charge	0% / 10%	0% / 20%
Oral examination (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.

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-S700PB and S500PB-cover orthodontia. These managed care plans allow coverage for both adults and children. Co-payments under S700PB are set at $2,200 for children, $2,250 for adolescents and $2,350 for adults. Co-payments under S500PB 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 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.**

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

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.

Your Dental Rates

Per pay period pre-tax deductions are as follows:

	24 Deductions	22 Deductions
Managed Care Plans		
Dental Option I - 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		
Dental Option 3 - PPO Dental High Plan P5215 with orthodontia		
Employee only	$16.67	$18.18
Employee & child(ren)	$45.84	$50.00
*Employee & spouse	$40.84	$44.55
*Employee & family	$61.68	$67.28
Dental Option 4 - PPO Dental Low Plan P5105 (no orthodontia)		
Employee only	$12.50	$12.50
Employee & child(ren)	$34.38	$34.38
*Employee & spouse	$30.64	$30.64
*Employee & family	$46.27	$46.27

*NOTE: Domestic partner rates will be the equivalent of the above rates. The deduction will be reflected as the employee-only pre-tax 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.

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 MaxMultiplier℠

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.

PPO Plan Design Changes for 2014

- Implant coverage included.

Commonly Covered Procedures - Managed Care Plans (S500PB & S700PB)

BENEFIT	Option 1 Plan S500PB	Option 2 Plan S700PB
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 Routine exams Prophylaxis (cleaning) - basic Emergency treatment (palliative) X-ray and complete series including bitewings Fluoride application	No charge No charge (2 per 12 months) No charge (2 per 12 months) No charge No charge (1 per 60 months) No charge (1 per 12 months)	No charge No charge (2 per 12 months) No charge (2 per 12 months) No charge No charge (1 per 60 months) No charge (1 per 12 months)
BASIC/RESTORATIVE PROCEDURES*** Simple extractions Amalgam fillings - 1 surface permanent Root canals (1 canal) Root canal (3 canals) Composite resin fillings (up to 3 per calendar year)****** Sealants (age limit applies)**	 $10 No charge $100 $225 No charge No charge	 $20 No charge $110 $245 No charge No charge
MAJOR PROCEDURES Crowns - porcelain, base metal** Dentures - upper/lower** Bridges - porcelain base metal**	 $240 $260 each $240	 $245 $325 each $245
Periodontics		
Scaling and root planing per year	$45 per quadrant (limit 2 per year)**	$50 per quadrant (limit 2 per year)**
Orthodontics		
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 co-pay will apply with approved referral.

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

PPO Plans (P5215 and P5105)

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) (Calendar year is January 1 - December 31) Class I Class II, III, IV	 None $50 per year, individual	 None $50 per year, individual	 None $50 per year, individual	 None $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 Class III Class IV	 None 12 months 12 months	 None 12 months 12 months	 None 12 months N/A	 None 12 months N/A
BENEFIT	**In-Network**	**Out of Network***	**In-Network**	**Out of Network***
CLASS I - PREVENTIVE & DIAGNOSTIC Oral evaluation (diagnostic) X-Rays (diagnostic) Lab and other diagnostic tests Prophylaxis (preventive) Fluoride treatment (preventive) Sealants Space maintainers	 100% 100% 100% 100% 100% 100% 100%	 90% 90% 90% 90% 90% 90% 90%	 100% 100% 100% 100% 100% 100% 100%	 80% 80% 80% 80% 80% 80% 80%
CLASS II - BASIC SERVICES Restoration (amalgams and resin-based only) General services (emergency treatment and anesthesia) Simple extractions Oral surgery (includes surgical extractions) Periodontics Endodontics	 80% 80% 80% 80% 80% 80%	 70% 70% 70% 70% 70% 70%	 50% 50% 50% 50% 50% 50%	 40% 40% 40% 40% 40% 40%
CLASS III - MAJOR SERVICES Inlays/onlays/crowns and bridges Dentures and other removable prosthetics Fixed prosthetics Implants (limited to one time per consective 60 months)	 50% 50% 50% 50%	 40% 40% 40% 40%	 50% 50% 50% 50%	 40% 40% 40% 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.

DID YOU READ ABOUT...

- Dental plan options?
- Plan comparisons?
- Orthodontics?

Vision

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®, Pearle Vision, 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.eyemedvisioncare.com. If you prefer to continue to receive a paper copy of your EOB, simply log in to the member web to set up your preferences. You may also call the customer care center to update your preferences.

EyeMed Vision Care has many unique online capabilities, including the following:

- Locate the provider nearest you by going to eyemedvisioncare.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.

LensCrafters®

Pearle Vision

Sears Optical

Target Optical

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

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.

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.

VISION CARE PREMIUMS

Per pay period pre-tax payroll deductions are as follows:

FULL TIME OR PART TIME

	24 Deductions	22 Deductions
EyeMed VISION CARE OPTION		
Employee only	$2.67	$2.91
Employee & family	$6.86	$7.48

Amounts reflected on paychecks may vary slightly due to rounding.

To Locate an EyeMed Provider Near You:

Visit the EyeMed website at www.eyemedvisioncare.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. - 8 p.m. EST).

Replacement Contact Lens by Mail Service

EyeMed

How Does the Program Work?

Three easy steps

EyeMed Vision Care offers replacement contact lenses by mail. This service option is available to all EyeMed Vision Care members!

All EyeMed members have the option to purchase replacement contact lenses for great prices over the Internet, and have them mailed directly to your home!

If you are in need of replacement contact lenses and wish to utilize the convenience of having the lenses mailed to your home, it's as easy as 1,2,3 . . .

1. Log on to **www.eyemedcontacts.com** to order replacement lenses. You must have a valid contact lens prescription to order lenses from the site.
2. Enter the name of your vision care provider, type and quantity of lenses you wish to purchase, as well as the requested billing and shipping information. As this service is not part of your core benefit, expenses from the service are not a covered benefit and are not reimbursable.
3. Eyemedcontacts.com will request the specific prescription from your eye care provider. Upon approval from your provider, your lenses will be mailed directly to your home.

Because quality of care is our first priority, this program is for replacement lenses only.

If you have a contact lens allowance with your core benefit, it is not applicable to the replacement lens service. You should always receive a comprehensive contact lens exam and your initial pair of lenses from your EyeMed professional provider to ensure proper fit and follow-up care.

Once you have enrolled in the vision plan, for more details about the program, please visit eyemedvisioncare.com or call **our customer care center at 1-866-723-0514.**

Can I Submit Expenses from this Service as an Out-of-Network Claim?

Yes. For instance, if you are new to the plan, already have a valid and current contact lens prescription and have an out-of-network contact lens benefit, it may be applied to this service. The member should follow the normal out-of-network claim process to be reimbursed.

OUT-OF-NETWORK BENEFIT

VISION SERVICES	MEMBER REIMBURSEMENT**
Examination with dilation as necessary	Up to $35
Frame:	Up to $60
Lenses (one pair)	
Single vision	Up to $25
Bifocal	Up to $40
Trifocal	Up to $55
Standard progressive	Up to $55
Premium progressive	Up to $55
Contact lenses (includes materials; only in lieu of lenses)	
Conventional	Up to $100
Disposable	Up to $100
Medically necessary	Up to $200

No coverage for lens options, or laser vision procedures outside the U.S. laser network.

** Co-payment does not apply

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

For the most updated listing, after you are a member visit our website at **www.eyemedvisioncare.com** or call **1-866-723-0514**.

DID YOU READ ABOUT...

- **Vision plan details?**
- **Mail-order contact lenses?**
- **How to locate a provider?**

*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 Employee Wellness 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 & wellbeing.

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 highlight is 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 assessments
- Online & telephonic health coaching
- On site Weight Management & Smoking Cessation Programs
- Employee Assistance Program
- Preventive care campaigns
- Clinical program engagement
- HealthyLiving-Lessons for Life Nurseline
- Wellness Champion Program
- Wellness Rewards
- Stress management strategies
- Community fitness events
- Accessible physical activity & healthy eating options

For more information, monthly health tips and upcoming wellness events, please visit: **www.palmbeachschools.org/riskmgmt/Wellness2**.

Employee Wellness

I AM
I DO
I GET

Earn up to $600 in rewards for healthy behaviors

WELLNESS 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 discount on your premium that will be 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 **300 points** by July 31, 2014, to earn the full $600 dollar discount for the plan year 2015.

The Wellness 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 steps still need to be taken to reap Wellness Rewards for 2015. **It's as easy as 1-2-3! If you and/or a covered spouse/partner complete all three requirements between January 1, 2014 and December 31, 2014, you will save maximum premium dollars in 2015! Completing the program by December 31, 2014 results in discounts beginning June 1, 2015.**

Each person (employee and covered spouse or domestic partner) is eligible to participate in this voluntary program to receive full point values by July 31, 2014.

2014 - 2015

(Wellness Rewards does not apply to covered children)		POINT VALUE	POINTS COMPLETED
	Complete Biometric Health Screening (LabCorp)	100	0
	Complete health assessment	100	0
	Choose ONE additional Wellness Action (see items at right)*	100	0
Total Individual Points Required		**300**	

Points system and program requirements are subject to change each year.
Points tracked at **www.myuhc.com, on the Health & Wellness tab.**
Complete actions by December 31, 2014, for partial credit.

* A Wellness Action can include ONE of the following preventive screenings:

a) Preventive physical or
b) Mammogram (age/gender specific) or
c) Colonoscopy (age specific) or
d) Cervical cancer screening/PAP (age/gender specific) or
e) Participate in online or telephonic health coaching (programs are a minimum of six weeks), such as:
   i) Healthy pregnancy
   ii) Stress management
   iii) Weight management
   iv) Asthma
   v) Heart healthy lifestyle
   vi) Diabetes
   vii) Blood pressure
   viii) Tobacco cessation
   ix) Nutrition
   x) Exercise

www.palmbeachschools.org/riskmgmt/wellness2

Employee Wellness

The Key to Wellness is You!

We firmly believe that any significant reduction in healthcare 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 healthcare services most cost-effectively serve their individual needs. By implementing our Employee Wellness 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. To view some of the numerous efforts to give employees the opportunities and information they need to be proactive and to address their health and wellness needs, please visit the **employee wellness website at www.palmbeachschools.org/riskmgmt/wellness2/.**

Wellness Rewards

Wellness Rewards allows employees and spouses/domestic partners the option to select which health actions they would like to take in order to achieve your 300 points. It's really pretty simple.

Beginning January 1, 2014, the entire calendar year will be the window for employees and their covered spouses/domestic partners to complete the wellness rewards point requirements for the discount ($50 off the monthly contribution) to apply at a specified point in calendar year 2015.

- If the 300/600 points are met by July 31, 2014, the discount will start with the payroll deduction effective on or after January 1, 2015.
- If the 300/600 points are met by December 31, 2014, the discount will start with the payroll deduction effective on or after June 1, 2015.

It's that simple. You have an entire year to take action and either save a little or save a lot!

Take Action Early

To participate in the Wellness Rewards program, the following **CONFIDENTIAL** activities must be completed by July 31, 2014 to receive a full year of discounts in 2015. If you complete the activities by December 31, 2014, then you will receive the discount for half of the 2015 plan year.

Your participation will remain confidential and reviewed only by healthcare professionals. The school district will be notified only that you have completed the following steps:

- Online health assessment (at www.myuhc.com)
- Biometric health screenings (at LabCorp)
- Doctor recommended Wellness Action of your choice (select one)
  - Preventive physical (i.e. well woman exam, annual wellness physical)
  - Mammogram (age specific)
  - Colonoscopy (age specific)
  - Cervical cancer screening or PAP smear
  - Participate in one of the 6-9 week online health coaching or telephonic wellness coaching program

Health Assessment

The Health Assessment is an online interactive tool that allows you to assess your lifestyle habits that are directly linked to health status and health care costs. These lifestyle habits include: activity/exercise, alcohol use, back care, driving, eating, exams, self-care, smoking, stress, weight control, and well-being. The results and recommendations from the health assessment provide immediate feedback to help you improve or maintain your health.

It also assesses your risk for some key diseases like heart attack, diabetes, and cancer. Most importantly, your results are completely confidential and created especially for you, based on your answers to basic questions about your health habits. Once you receive the results of your assessment and set personalized wellness goals, you can begin achieving those goals. You'll feel better about yourself and enjoy the reward of making healthy choices.

How to Complete a Health Assessment

To complete the health assessment, go to **www.myuhc.com**.

Log in (if not registered click "register now" and enter requested information to create your username and password). Click on "health & wellness." Click on "take the health assessment."

Employee Wellness

HealthyLiving-Lessons for Life Wellness Rewards

Biometric Health Screenings

One of the first steps toward better health is to know your key measures. Biometric screenings include: BMI (Body Mass Index or Height/Weight), fasting total, HDL and LDL cholesterol, fasting blood sugar/glucose, and blood pressure. By knowing your key numbers you can assess your current health status and determine if you are at risk for health problems like heart disease and diabetes. Reviewing results with your doctor can provide personalized follow-up with recommended treatment and wellness tools to improve your health. Please keep in mind that your doctor may request that other recommended tests be done. These tests will be subject to plan level co-pay and deductibles.

How to Complete a Biometric Screening

As part of an annual wellness visit at your doctor's office, the doctor will measure your height/weight and blood pressure and will send you to a lab for blood work if not taken in their office. (Your biometric screening is part of your preventive care benefits, which are covered at 100%. All blood work must be done through a Lab Corporation of America (LabCorp) in order to count toward the Wellness Rewards program.

If you do not have a primary care doctor, go to www.myuhc.com. Click on "find physician, laboratory or facility." Select "UnitedHealthcare Choice" for providers accepting the High Option HMO and/or Low Option HMO plans. Select "UnitedHealthcare Choice Plus" for the DCHP plan.

Wellness Action (select one)

- **Mammogram** – annually for women starting at age 40, or recommendation
- **Colonoscopy** – every 10 years starting at age 50, recommendation
- **Annual physical/preventive care exam** – includes height, weight, blood pressure
- **Cervical Cancer Screening** – annually for women who are 18 year of age or older
- **Participate in one** of the 6-9 week **online health coaching or telephonic wellness coaching programs**

For more information about preventive care services that might be right for you visit **www.uhcpreventivecare.com**.

Annual Physical/Preventive Wellness Exam

Seeing your doctor each year to have a wellness check up makes good sense. This is also a requirement to satisfy the requirements of Wellness Rewards. An annual physical/preventive wellness exam also includes an annual well woman exam.

How to Complete the Annual Physical

Schedule an appointment with an in-network doctor. You can find an in-network doctor by visiting **www.myuhc.com** and logging in with your UHC user name and password. This is not your district log in. A basic annual check up is all that is required at this time. Again, preventive service should be at no co-payment.

Keep a Good Thing Going! Make a Healthy Change

For general information on understanding the results of your biometric screenings or to find additional support in making health changes, please call HealthyLiving-Lessons for Life NurseLine at 1-888-229-9322 or visit **www.myuhc.com**.

Small investments in supporting a healthier lifestyle can make a tremendous difference!

For more information or questions please visit:
www.palmbeachschools.org/riskmgmt/Wellness2/

How Can I View My Activities and Rewards?

1. Go to myuhc.com® and enter your username and password (if you do not have a username and password, registration is easy). Click on the Health & Wellness tab on the homepage.
2. Once on the Health & Wellness tab you will see "I AM, I DO, I GET" tabs. Review each of these tabs to familiarize yourself with the wellness portal. Under "I Get," you will see a tab for "My Rewards." Clicking on the link will bring you to your specific rewards page.

PLEASE NOTE that both you and your covered spouse or domestic partner must complete the events to receive the full credit. The reward period is from 1/1/2014 – 7/31/14 for full credit or 1/1/2014 - 12/31/14 for partial credit.

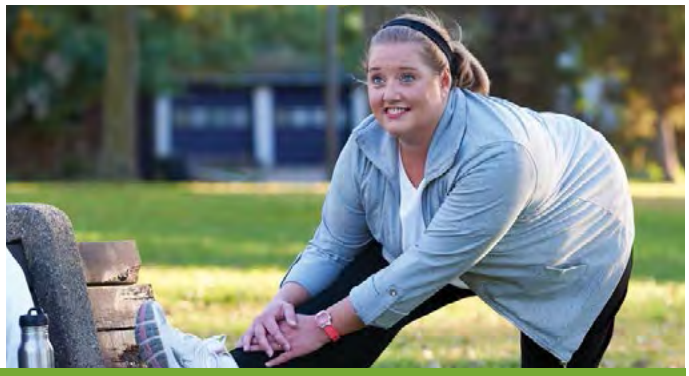
What if I still have questions?

In addition to reviewing your incentive information online, you can call our toll free incentive support line at 1-866-868-5484 with questions about your incentives.

Healthcare Benefits - Wellness Services

Wellness services to help you meet your personal health goals

Current members: You can access our wellness services today. Just login 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 and
- 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.

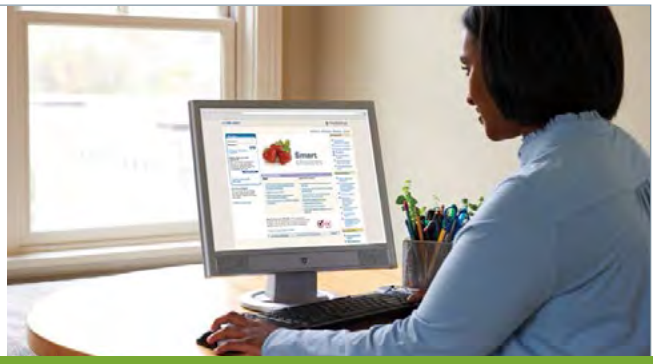
Tobacco Use Comes with a Surcharge - Quit to Save Your Health, and $ave Dollars in the Future

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 provide us with their tobacco status as of October 1, 2014. The status provided at that time will be used to determine if a surcharge will apply for the entire 2015 plan year. The tobacco status will remain on file. Only those who have a Change in Status will need to update their status throughout the year. Every calendar year you'll be able to update your tobacco status. 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.



Nurse-at-Work

Your nurse liaison works to promote the utilization of clinical programs, disease management, Diabetes Health Plan and care management. This is your worksite connection to clinical resources and information to help you improve your health through education, motivation and assistance.

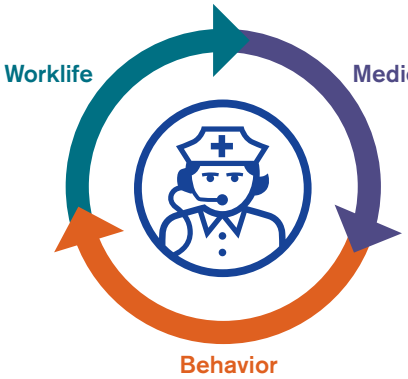
- Identify and recommend medical condition-specific programs.
- Educate and help manage your specific health needs.
- Help you choose appropriate medical care.
- Enroll in clinical and Disease Management programs, as well learn to manage diabetes related conditions

Education helping you identify and learn about health behaviors that help you meet your health and wellness goals

Motivation inspiring you to adopt a healthier lifestyle that will bring optimal health and well-being

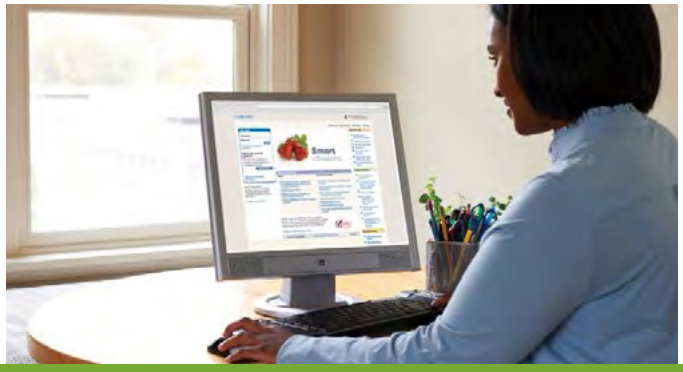
Assistance helping you manage chronic illnesses by encouraging you to participate in one of our many care or disease management programs

Nurse Liaison Connects symptoms with health history



Please keep in mind:
All information shared with Gail is strictly confidential and will not be shared with the School District. This resource is not a replacement for your primary doctor. UnitedHealthcare has included this worksite resource as part of our healthcare package and was approved by the District. Risk & Benefits Management is very excited to offer this worksite resource for you.

You can reach call Gail at:
561-434-7417 office
561-294-4539 cell
gail_a_diedrick@uhc.com
Monday - Friday
8 am– 4:30 pm



Check out these online services to help you meet your unique needs

Source4Women.com

Women typically make most of the health care decisions for themselves and their families. That's why we introduced **Source4Women.com**. You'll find information and resources to help you manage your own health, through every stage of life, and manage the health of your family. Plus, you can:

- Read blogs from nationally respected health care professionals
- Watch Health and wellness videos from Dr. Mehmet Oz of the popular "The Dr. Oz Show"
- Participate in online seminars
- Connect with other women in private online communities

Storytellers: health care success stories told by the people who lived them

We've traveled the country to record health care success stories told by actual UnitedHealthcare members. Through their personal and moving accounts, we continue to be inspired by their courage and humbled by their UnitedHealthcare experience. We are honored to be able to share their stories with you. See their stories and more at uhc.com/storytellers.

Visit Health Care Lane® healthcarelane.com/PBCSD

Whether you're enrolling in a new plan or just exploring the options, the more you know, the better. You'll meet a lot of friendly people who will help you make sense of health coverage and get the most from your plan. And don't forget to check out Wellness Days. Wellness Days is a fun-filled festival of good health and wellness. You will be entertained and educated on the benefits of having a UnitedHealthcare plan.

Healthy Mind Healthy Body® e-newsletter

Sign up to receive a newsletter made just for you. You choose the topics that are of interest to you, and we email the newsletter to your personal email account each month. Topic choices include:

- Healthy living
- Fitness, nutrition and weight management
- Family and child health
- Women's and men's health
- Diabetes
- Asthma and more

Visit **www.uhc.com/myhealthnews** to sign up today.

Employee Wellness

HealthyLiving-Lessons for Life Health Kiosk

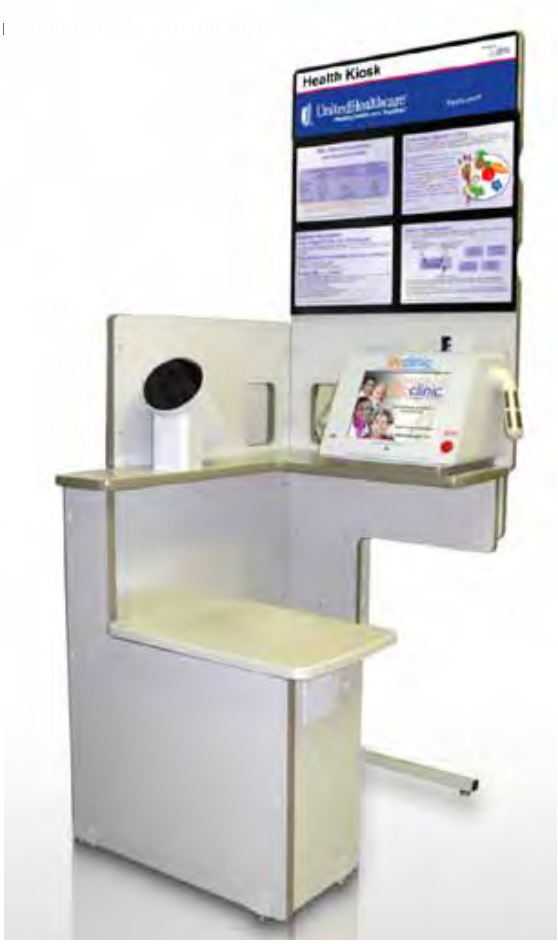
Health Kiosk - Helping you monitor your health and "Know your Numbers"

A convenient and visible onsite solution that helps motivate employees to make healthy behavior changes:

- Provides easy access to members key biometric data
- Tracks progress toward their health goals
- Gives the School District ability to assess overall health status of employees with de-identified data

The Health Kiosk will make it easy for you to track, measure and store the followi

- Weight
- Body Mass Index (BMI)
- Body fat percentage
- Blood pressure (systolic and diastolic)
- Pulse
- Blood oxygen level
- Glucose (uploaded from USB-enabled glucose meter)



Your confidential health information uploads to myuhc.com® Personal Health Record if a UnitedHealthcare member; Lifeclinic.com Personal Health Record if not a member.

Visit www.palmbeachschools.org/riskmgmt/wellness2 to find out the location of the health kiosk and get to know your numbers!

Exclusively for The School District of Palm Beach County

HealthAdvocate™

Your Lifeline for Healthcare Help

Top Reasons to Call Us... 855.424.8400

Health Advocacy

Find the right doctors

We'll also locate the right hospitals, dentists and other leading healthcare providers anywhere in the country.

Schedule appointments

We can help expedite the earliest appointments with providers including hard-to-reach specialists and arrange treatments and tests.

Get cost estimates

You'll receive estimates of common medical procedures in your area to help you make informed decisions.

Help resolve insurance claims

Our experts get to the bottom of your issue to assist with negotiating billing and payment arrangements.

EAP+Work/Life

Licensed experts available

Receive assistance for marital relationships, family/parenting issues, work conflicts, stress or anxiety.

Address drug and alcohol abuse

A professional counselor can make a referral for in-depth, long-term help.

Eldercare and Childcare

We can find resources including in-home care, assisted living and nursing homes; daycare and summer programs.

Financial, Legal, Identity Theft

We locate experts to assist with budgeting, debt management, estate planning and fraud recovery.

...and much more

Help is Only a Phone Call Away

Your Health Advocate benefit is paid by The School District of Palm Beach County and covers benefit-eligible employees, their spouses/domestic partners, dependent children, parents and parents-in-law.

24/7 Support

855.424.8400

HealthAdvocate.com/palmbeachschools

HealthAdvocate™

Always at your side

Independent. Confidential. Convenient. Health Advocate is not affiliated with any insurance or third party provider. Health Advocate does not replace health insurance coverage, provide medical care or recommend treatment.

 HA-CEM-1208022-3FLY

Flexible Spending Accounts

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 and
- 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.

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You 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?

Your employer 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 FSAs

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

- breast pumps
- eyeglasses
- orthodontia

Dependent Care FSAs (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.

FSA Grace Period

An IRS Revenue Notice permits a "**grace period**" of two months and 15 days following the end of your 2014 plan year (December 31, 2014) for an FSA. This grace period ends on March 15, 2015. **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 2014 health care 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, 2015. This is a period for filing claims incurred anytime during the 2015 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® Health Care 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.

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 your requests located in the FSA materials you will receive following enrollment.

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.

Flexible Spending Accounts

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
  1-855-428-0446

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 healthcare FSA or vice versa.
3. You have a 90-day run-out period (until March 31, 2015) 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 2014 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 2014 plan year. IRS regulations state that any unused funds that remain 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.
   - And, I will collect and maintain sufficient documentation to validate the foregoing.

FSA Savings Example*

(With FSA)		*(Without FSA)*
$31,000	Annual gross income	$31,000
- 2,500	FSA deposit for recurring expenses	- 0
$28,500	Taxable gross income	$31,000
$6,455.25	Federal, Social Security taxes	- 7,021.50
$22,044.75	Annual net income	$23,978.50
- 0	Cost of recurring expenses	-2,500
$22,044.75	Spendable income	$21,478.50

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

$566.25!

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

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® Health Care Card transactions as well.

How Do I Get the Forms I Need?

Log on 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 -855-426-0446 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 the next page.

Whose expenses are eligible?

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

- Yourself
- Your spouse
- Your qualifying child
- 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 for 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 healthcare FSA.

Minimum annual deposit: $300
Maximum annual deposit: $2,500*

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.

Can Travel Expenses for Medical Care Be Reimbursed?

Travel expenses primarily for, and essential to, receiving medical care, including health care 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
- tolls
- transportation to another city

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.

Partial List of Medically Necessary Eligible Expenses*

Acupuncture

Ambulance service

Birth control pills and devices

Breast pumps

Chiropractic care

Contact lenses (corrective)

Dental fees

Diagnostic tests/health screening

Doctor fees

Drug addiction/alcoholism treatment

Drugs

Experimental medical treatment

Eyeglasses

Guide dogs

Hearing aids and exams

In vitro fertilization

Injections and vaccinations

Nursing services

Optometrist fees

Orthodontic treatment

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.

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 your employer'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 1-855-426-0446.

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 your employer 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-FBWW
P.O. Box 14326
Lexington, KY 40512

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

DID YOU READ ABOUT...

- **Who is eligible to participate?**
- **Eligible medical expenses?**
- **How to request reimbursement?**

WageWorks® Health Care Card

IN THIS SECTION...

- How the WageWorks® Health Care Card works
- When to submit documentation
- WageWorks® Health Care Card advantages

What Is the WageWorks® Health Care Card?

The WageWorks® Health Care Card is a stored-value card. It is a convenient medical expense FSA reimbursement option that allows electronic reimbursement of eligible expenses under your employer'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® Health Care Card to pay for eligible expenses, funds are electronically deducted from your Health Care FSA. The WageWorks® Health Care Card is a convenient way to access your health FSA funds; however, the IRS still requires substantiation of service. Please keep this in mind as you seek services and use the WageWorks® Health Care 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® Health Care Card Expense?

You must send in documentation for certain WageWorks® Health Care Card transactions, such as those that are **not** a known office visit or prescription co-payments (as outlined in your health plan's schedule of benefits). When requested, you must send in documentation for these transactions. Documentation for an WageWorks® Health Care 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® Health Care Card expense documentation for a minimum of one year and submit it when requested.

What Agreement Am I Making When I Use the WageWorks® Health Care Card?

By using the WageWorks® Health Care Card, you are agreeing to the "FSA Guidelines" portion of this Reference Guide on page 71.

What Are the WageWorks® Health Care Card Advantages?

- instant **reimbursements** for health care expenses, including prescriptions, co-payments 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® Health Care Card for cosmetic dental expenses or eyeglass warranties.

How Do I Get a WageWorks® Health Care Card?

You will automatically receive the WageWorks® Health Care Card. Two cards will be sent to you in the mail: one for you, and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date. You will have to activate your card. There are no fees for using the card!

How Do I Use the WageWorks® Health Care Card?

For eligible expenses, simply swipe the WageWorks® Health Care 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 your account from the prior plan year will be used first until the account has been exhausted — through March 15, 2015, 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 71.

WageWorks® Health Care Card

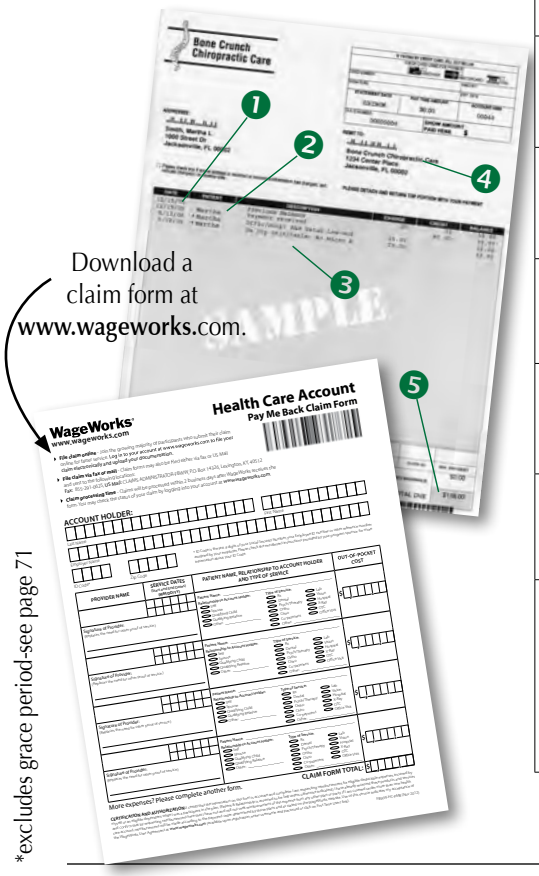
I Used the WageWorks® Health Care Card at the Doctor's Office. Now What?

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

1. the date service(s) was received
2. the name of the person(s) for whom the service(s) was provided
3. the type of service(s) rendered
4. the name and address of the provider and
5. the cost of the service(s).

We've made it easy for you to send in confirmation for your WageWorks® Health Care Card purchases. Simply complete the online claim form at **www.wageworks.com** with your detailed invoice. You can check the status of your WageWorks® Health Care Card transactions online.

Visit **www.wageworks.**com and log on to view all of your account information.



Download a claim form at **www.wageworks.**com.

Heath Care FSA Reimbursement Comparison - Plastic vs. Paper!

WageWorks® Health Care Card	Paper Reimbursement
• Service must occur during benefit period: 01/01/14 to 12/31/14 • Deadline for services is 12/31/14* • Use it or lose it rule applies	• Service must occur during benefit period: 01/01/14 to 12/31/14 • Deadline for services is 12/31/14* • Use it or lose it rule applies
• 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.	• 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.
• Claim form and documentation must be submitted when using the card (except for certain co-pays). • Co-pays 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 03/31/15.	• In order to receive reimbursement, a bill, statement or invoice **must always** accompany your claim form. • Documentation must be submitted by 03/31/15.
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 a copy.
Card expires 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 a payback deduction through your payroll.	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.**
• Example of an eligible payment card expense that does not require documentation: $25 co-pay for medical office visit. • Example of an eligible payment card expense that does require documentation: purchase eye glasses from Lens Crafters.	Example of eligible reimbursable expense: 10% co-insurance for outpatient surgery.

*excludes grace period-see page 71

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 and
- 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.

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.

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.

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.myFBMC.com** 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.

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.

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-FBWW
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.

DID YOU READ ABOUT...

- Whose expenses are eligible?
- The maximum annual deposit?
- 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	$ _____
Co-insurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses (including OTCs)	$ _____
TOTAL (amount cannot exceed $2,500)	$ _____
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 FBMC website and Customer Care.

On the Web

Go to **myFBMC.com** to begin. Your first step is to register, using your name, mailing zip code, e-mail address and one of the following: FBMC 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 e-mail shortly to finalize the registration. Follow the instructions within the e-mail.

If you previously registered an e-mail address and password on FBMC's 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 FBMC Premier 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.myFBMC.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® Health Care 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.

Personal Identification Number (PIN)

The last four digits of your SSN will be your first PIN. After your initial login, you will be asked to register and select your own confidential PIN to access this system in the future. Your new PIN cannot be the last four digits of your SSN, cannot be longer than eight digits and must be greater than zero.

Record your PIN here.
Remember, this will be your PIN.

If you forget your PIN, call Customer Care at **1-855-5MYFBMC (1-855-569-3262)**.

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 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 Plan offers you an excellent tax deferral opportunity.

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.

Special Retirement Plan

How Do I Access My Account?

Go to www.benecorplans.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
- Account Balance
- Account Balance, by Fund
- Fund Transfers
- Online Beneficiary Designation
- Download Forms
- Investment Fund Objectives
- Fund Performance
- Address Changes
- Investment Allocation Changes
- Transaction History
- Plan Overview

DID YOU READ ABOUT...

- **The special retirement plan?**
- **How the plan works?**
- **How much you can contribute?**

Disability Income Protection

Post-tax Benefits

IN THIS SECTION...

- Eligibility
- Plan provisions
- Short and long-term options
- Additional benefits

Plan Provider: Hartford Life and Accident Insurance Company

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 your salary changes.

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 disability plan document for further information.

Provisions Affecting Both 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 short-term income protection plan based on the plan that you choose.

Waiver of Premium – You do not pay premiums while 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 Hartford Life and Accident Insurance Company's Claims Department).

Maternity Benefits – Disability caused by pregnancy is covered as any other 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(s) of coverage for details.

Disability Income Protection

Plan Provider: Hartford Life and Accident Insurance Company

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 your salary changes.

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.

	Benefit Amount	Benefit Begins	
OPTION	% OF WEEKLY INCOME	ACCIDENT	SICKNESS
A	66 2/3%	1st day*	8th day*
B	60%	15th day*	15th day*
C	60%	61st day*	61st day*

*Except as otherwise stated in your policy.

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 disability plan document for further information.

Provisions Affecting Both 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 short-term income protection plan based on the plan that you choose.

Waiver of Premium – You do not pay premiums while 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 Hartford Life and Accident Insurance Company's Claims Department).

Maternity Benefits – Disability caused by pregnancy is covered as any other 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(s) of coverage for details.

About the Plan Provider

Hartford Life and Accident Insurance Company underwrites the Short-Term and Long-Term Disability plans. If you have any questions regarding these plans, please call Hartford Life and Accident Insurance Company at 1-800-741-4306 between 8:00 am and 8:00 pm ET, Monday through Friday.

A certificate of coverage for your Disability Income Protection Plan is available at **www.palmbeachschools.org/riskmgmt.**

Disability Income Protection

Short-Term Disability Plan

The Short-Term Disability 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 your policy). 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 per employee. An employee cannot collect sick pay and short-term disability benefits at the same time.

What's Not Covered

The policy does not cover and no benefit will be paid for any disability:

- unless you are under the regular care of a doctor
- that is caused or contributed to by war or act of war, whether declared or not
- caused by your commission of or attempt to commit a felony
- caused or contributed to by an intentionally self-inflicted injury
- for which workers' compensation benefits are paid or may be paid if claimed
- sustained as a result of doing any work for pay or profit for another employer or
- if you are receiving or are eligible for benefits for a disability under a prior disability plan that was sponsored by your employer and was terminated before the effective date of the policy.

When Coverage Ends

Coverage ends on the earliest of:

- The last day of the month during which the policy terminates
- The last day of the month during which the policy no longer insures your class
- The last day of the month during which the premium payment is due but not paid
- The last day of the period for which you make any required premium payment
- The last day of the month during which your employer terminates your employment
- The last day of the month during which you cease to be an active employee in an eligible class for any reason unless continued in accordance with any of the continuation provisions.

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 Limitation – The Short-Term Disability 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 6 months while insured under the policy or
- You have been continuously insured under the policy for 12 months.

Pre-existing condition means any injury, sickness, mental illness, pregnancy or episode of substance abuse for which you received medical care including consultation, medical advice, recommendation or prescriptions or treatment during the 6 month period prior to your effective date of coverage or change in coverage.

How Long are Benefits Payable?

AGE AT DISABILITY	BENEFIT DURATION
Prior to Age 63	To Normal Retirement Age (NRA) or 42 months if greater
63	To NRA or 36 months if greater
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 & over	12 months

When to Submit a Short-Term Disability Claim

You should file your claim with The Hartford 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 The Hartford's toll-free telephonic claim intake number at 1-800-741-4306 and report your claim. You will not need to submit a paper claim form as The Hartford clinical intake specialist will take your information by phone. However, it will be your responsibility to provide an authorization form to your physician to be signed/dated and faxed or mailed to The Hartford. This allows The Hartford to access your medical information in order to process your claim.

Long-Term Disability Plan

The Long-Term Disability 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% 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?

Disability or Disabled means you are prevented from performing one or more of the essential duties of your occupation during the elimination period and your occupation for the 5 year period following the elimination period, and as a result, your current monthly earnings are less than 80% of your indexed pre-disability earnings. After the 5 year period, disability means you are prevented from performing one or more of the essential duties of any occupation for which you are qualified by education, training or experience and that has an earnings potential greater than the lesser of the product of your indexed pre-disability earnings and the benefit percentage or the maximum monthly benefit.

If at the end of your elimination period, you are prevented from performing one or more of the essential duties of your occupation, but your current monthly earnings are greater than 80% of your pre-disability earnings, your elimination period will be extended for a total period of 12 months from the original date of disability, or until such time as your current monthly earnings are less than 80% of your pre-disability earnings, whichever occurs first.

What's Not Covered

The policy does not cover and no benefit will be paid for any disability:

- unless you are under the regular care of a physician
- that is caused or contributed to by war or act of war, whether declared or not
- caused by your commission of or attempt to commit a felony
- caused or contributed to by your being engaged in an illegal occupation
- caused or contributed to by an intentionally self inflicted injury or
- if you are receiving or are eligible for benefits for a disability under a prior disability plan that was sponsored by your employer and was terminated before the effective date of the policy.

When Coverage Ends

Coverage ends on the earliest of:

- The last day of the month during which the policy terminates
- The last day of the month during which the policy no longer insures your class
- The last day of the month during which the premium payment is due but not paid
- The last day of the period for which you make any required premium payment
- The last day of the month during which your employer terminates your employment
- The last day of the month during which you cease to be an active employee in an eligible class for any reason unless continued in accordance with any of the continuation provisions.

Pre-existing condition – The Long-Term Disability 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 6 months while insured under the policy or
- you have been continuously insured under the policy for 12 months.

Pre-existing condition means any injury, sickness, mental illness, pregnancy or episode of substance abuse for which you received medical care including consultation, medical advice, recommendation or prescriptions or treatment during the 6 month period prior to your effective date of coverage or change in coverage.

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 have enrolled for short –term disability, the transition process to long-term disability is automated – you do not need to file a separate long-term disability claim form.

If you have not enrolled in the short-term disability plan and have enrolled in the long-term disability plan only, you should file your claim with The Hartford halfway through your LTD elimination period.

How to Submit a Long-Term Disability Claim

If you have enrolled for short-term disability, the transition process to long-term disability is automated by The Hartford's claim system. A separate long-term disability claim form is not needed. However, a claimant questionnaire is sent to you that requests information about other income/offset information, past work experience/education and medical providers. The Hartford may also obtain additional information from the employer.

If you did not enroll in the Short-Term Disability plan and have enrolled in the Long-Term Disability plan only, a paper claim will need to be filed with The Hartford for consideration for LTD benefits. You can obtain the application for long-term disability income benefits form via your employer's website. The application gives instructions on the submission process.

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 – This benefit offers an effective incentive if you are disabled and return to work. You may receive your full disability benefit during the first 12 months after returning, as long as your benefit and earnings are not more than 100 percent of pre-disability earnings.

Rehabilitation and Return to Work Assistance – The Hartford vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help you return to productive, independent lifestyles.

Worksite Modification Benefit – The Hartford helps your employer make the worksite accommodations necessary to enable employees to return to work. This benefit reimburses your employer up to the amount equal to the amount of the maximum monthly benefit for worksite modifications for each employee.

Family Care Credit Benefit – When you are disabled and incurring child care expenses for your dependent child(ren) and participating continuously in the Rehabilitation and Return to Work Assistance program, The Hartford will, for the purpose of calculating your benefit, deduct the cost of family care from earnings received from work as part of a program of rehabilitation, subject to limitations. The reimbursement payment will begin immediately after you start the Rehabilitation and Return to Work Program. The child must be under 13 years of age or incapable of providing their own care on a daily basis due to their own physical handicap or mental retardation.

Survivor Income Benefit – If you were receiving a monthly disability benefit at the time of your death, The Hartford will pay your eligible survivor a lump sum benefit equal to three months of your gross disability payment.

Ability Assist – Ability Assist helps you deal with life's challenges after a disability. The services available include:

- Easy access to professionals – toll-free, 24/7
- Up to five face-to-face sessions per year
- Financial and legal consultation
- Trusted online resources and tools

The Hartford offers the professional support of Ability Assist to you at no additional cost if you have enrolled in the Long-Term Disability Plan. You and your family, including spouse and dependents, can use these services for up to two years after The Hartford has approved your LTD claim. You will be notified how to access these services at the time your LTD claim is approved.

Additional Benefits Included with the LTD Plan

Employee Travel Assistance Program – Just one phone call gives employees and their families 24-hour access to a network of emergency medical and legal resources any time they travel more than 100 miles from home. The toll-free number to access these services is 1-800-243-6108.

The Hartford's Travel Assistance Program is provided by Europe Assistance, the world's leading assistance network. The program provides three kinds of services for your business or vacation travel - Pre Trip Information, Emergency Medical Assistance, and Emergency Personal Services subject to terms and conditions of the policy. All the travel services are easy to take advantage of from start to finish.

Pre-trip planning includes:

- Visa, passport, inoculation and immunization requirements
- International "hot spots"
- Travel advisories
- Foreign exchange rates
- Embassy and consular referrals

Emergency medical assistance includes:

- Medical referrals, medical monitoring, and medical evacuation
- Repatriation
- Traveling companion and dependent children assistance
- Emergency medical payments
- Return of mortal remains
- Replacement of medication and eyeglasses

Emergency personal services include:

- Sending and receiving emergency messages
- Emergency travel arrangements
- Emergency cash
- Locating lost items
- Legal assistance
- Bail advancement
- Translation

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, log on to **www.palmbeachschools.org/riskmgmt**.

Disability Income Protection

24 Payroll Deductions Per Year
For Employees Receiving 26 Pay Checks Per Year

SHORT-TERM DISABILITY															
Sample Payroll Deductions & Benefits - 2014 Rates															
Based on Bi-Monthly Payroll with 24 Payroll Deductions Per Year															
	PLAN A					PLAN B					PLAN C				
Annual Salary	Weekly Benefit Amount	EMPLOYEE'S AGE				Weekly Benefit Amount	EMPLOYEE'S AGE				Weekly Benefit Amount	EMPLOYEE'S AGE			
		54 & Under	55 - 59	60 - 64	65 & Over		54 & Under	55 - 59	60 - 64	65 & Over		54 & Under	55 - 59	60 - 64	65 & Over
$20,000	$256	$7.42	$9.75	$11.17	$13.58	$231	$5.08	$6.67	$7.58	$9.33	$231	$4.00	$5.33	$6.08	$7.42
25,000	321	$9.27	$12.19	$13.96	$16.98	289	$6.35	$8.33	$9.48	$11.67	289	$5.00	$6.67	$7.60	$9.27
30,000	385	$11.13	$14.63	$16.75	$20.38	346	$7.63	$10.00	$11.38	$14.00	346	$6.00	$8.00	$9.13	$11.13
35,000	449	$12.98	$17.06	$19.54	$23.77	404	$8.90	$11.67	$13.27	$16.33	404	$7.00	$9.33	$10.65	$12.98
40,000	513	$14.83	$19.50	$22.33	$27.17	462	$10.17	$13.33	$15.17	$18.67	462	$8.00	$10.67	$12.17	$14.83
45,000	577	$16.69	$21.94	$25.13	$30.56	519	$11.44	$15.00	$17.06	$21.00	519	$9.00	$12.00	$13.69	$16.69
50,000	641	$18.54	$24.38	$27.92	$33.96	577	$12.71	$16.67	$18.96	$23.33	577	$10.00	$13.33	$15.21	$18.54
55,000	705	$20.40	$26.81	$30.71	$37.35	635	$13.98	$18.33	$20.85	$25.67	635	$11.00	$14.67	$16.73	$20.40
60,000	769	$22.25	$29.25	$33.50	$40.75	692	$15.25	$20.00	$22.75	$28.00	692	$12.00	$16.00	$18.25	$22.25
65,000	833	$24.10	$31.69	$36.29	$44.15	750	$16.52	$21.67	$24.65	$30.33	750	$13.00	$17.33	$19.77	$24.10
70,000	897	$25.96	$34.13	$39.08	$47.54	808	$17.79	$23.33	$26.54	$32.67	808	$14.00	$18.67	$21.29	$25.96
75,000	962	$27.81	$36.56	$41.88	$50.94	865	$19.06	$25.00	$28.44	$35.00	865	$15.00	$20.00	$22.81	$27.81
80,000	1,026	$29.67	$39.00	$44.67	$54.33	923	$20.33	$26.67	$30.33	$37.33	923	$16.00	$21.33	$24.33	$29.67

LONG-TERM DISABILITY										
Sample Payroll Deductions & Benefits - 2014 Rates										
Based on Bi-Monthly Payroll with 24 Payroll Deductions Per Year										
Annual Salary	Monthly Benefit Amount	EMPLOYEE'S AGE								
		24 & Under	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 & Over
$20,000	$1,000	$0.67	$0.92	$1.42	$2.25	$3.17	$4.25	$5.83	$6.83	$7.17
25,000	1,250	$0.83	$1.15	$1.77	$2.81	$3.96	$5.31	$7.29	$8.54	$8.96
30,000	1,500	$1.00	$1.38	$2.13	$3.38	$4.75	$6.38	$8.75	$10.25	$10.75
35,000	1,750	$1.17	$1.60	$2.48	$3.94	$5.54	$7.44	$10.21	$11.96	$12.54
40,000	2,000	$1.33	$1.83	$2.83	$4.50	$6.33	$8.50	$11.67	$13.67	$14.33
45,000	2,250	$1.50	$2.06	$3.19	$5.06	$7.13	$9.56	$13.13	$15.38	$16.13
50,000	2,500	$1.67	$2.29	$3.54	$5.63	$7.92	$10.63	$14.58	$17.08	$17.92
55,000	2,750	$1.83	$2.52	$3.90	$6.19	$8.71	$11.69	$16.04	$18.79	$19.71
60,000	3,000	$2.00	$2.75	$4.25	$6.75	$9.50	$12.75	$17.50	$20.50	$21.50
65,000	3,250	$2.17	$2.98	$4.60	$7.31	$10.29	$13.81	$18.96	$22.21	$23.29
70,000	3,500	$2.33	$3.21	$4.96	$7.88	$11.08	$14.88	$20.42	$23.92	$25.08
75,000	3,750	$2.50	$3.44	$5.31	$8.44	$11.88	$15.94	$21.88	$25.63	$26.88
80,000	4,000	$2.67	$3.67	$5.67	$9.00	$12.67	$17.00	$23.33	$27.33	$28.67

Disability Income Protection

24 Payroll Deductions Per Year
For Employees Receiving 26 Pay Checks Per Year

Voluntary Disability 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	$200.00
C. Multiply by your appropriate rate below ($.89 for STD / $.08 for LTD)	$178.00	$16.00
D. Divide by 24	$7.42	$ .67

Short-Term Disability Rates

Employee's Age	Rates per $100 of Covered Payroll		
	A	B	C
54 & Under	$0.89	$0.61	$0.48
55 - 59	$1.17	$0.80	$0.64
60 - 64	$1.34	$0.91	$0.73
65 & Over	$1.63	$1.12	$0.89

Long-Term Disability Rates

Employee's Age	Rates per $100 of Covered Payroll
24 & Under	$0.08
25 - 29	$0.11
30 - 34	$0.17
35 - 39	$0.27
40 - 44	$0.38
45 - 49	$0.51
50 - 54	$0.70
55 - 59	$0.82
60 & Over	$0.86

NOTE: Rates effective January 1, 2014

Disability Income Protection

22 Payroll Deductions Per Year
For Employees Receiving 22 Pay Checks Per Year

SHORT-TERM DISABILITY

Sample Payroll Deductions & Benefits - 2014 Rates

Based on Bi-Monthly Payroll with 22 Payroll Deductions Per Year

	PLAN A					PLAN B					PLAN C				
Annual Salary	Weekly Benefit Amount	EMPLOYEE'S AGE				Weekly Benefit Amount	EMPLOYEE'S AGE				Weekly Benefit Amount	EMPLOYEE'S AGE			
		54 & Under	55 - 59	60 - 64	65 & Over		54 & Under	55 - 59	60 - 64	65 & Over		54 & Under	55 - 59	60 - 64	65 & Over
$20,000	$256	$8.09	$10.64	$12.18	$14.82	$231	$5.55	$7.27	$8.27	$10.18	$231	$4.36	$5.82	$6.64	$8.09
25,000	321	$10.11	$13.30	$15.23	$18.52	$289	$6.93	$9.09	$10.34	$12.73	$289	$5.45	$7.27	$8.30	$10.11
30,000	385	$12.14	$15.95	$18.27	$22.23	$346	$8.32	$10.91	$12.41	$15.27	$346	$6.55	$8.73	$9.95	$12.14
35,000	449	$14.16	$18.61	$21.32	$25.93	$404	$9.70	$12.73	$14.48	$17.82	$404	$7.64	$10.18	$11.61	$14.16
40,000	513	$16.18	$21.27	$24.36	$29.64	$462	$11.09	$14.55	$16.55	$20.36	$462	$8.73	$11.64	$13.27	$16.18
45,000	577	$18.20	$23.93	$27.41	$33.34	$519	$12.48	$16.36	$18.61	$22.91	$519	$9.82	$13.09	$14.93	$18.20
50,000	641	$20.23	$26.59	$30.45	$37.05	$577	$13.86	$18.18	$20.68	$25.45	$577	$10.91	$14.55	$16.59	$20.23
55,000	705	$22.25	$29.25	$33.50	$40.75	$635	$15.25	$20.00	$22.75	$28.00	$635	$12.00	$16.00	$18.25	$22.25
60,000	769	$24.27	$31.91	$36.55	$44.45	$692	$16.64	$21.82	$24.82	$30.55	$692	$13.09	$17.45	$19.91	$24.27
65,000	833	$26.30	$34.57	$39.59	$48.16	$750	$18.02	$23.64	$26.89	$33.09	$750	$14.18	$18.91	$21.57	$26.30
70,000	897	$28.32	$37.23	$42.64	$51.86	$808	$19.41	$25.45	$28.95	$35.64	$808	$15.27	$20.36	$23.23	$28.32
75,000	962	$30.34	$39.89	$45.68	$55.57	$865	$20.80	$27.27	$31.02	$38.18	$865	$16.36	$21.82	$24.89	$30.34
80,000	1,026	$32.36	$42.55	$48.73	$59.27	$923	$22.18	$29.09	$33.09	$40.73	$923	$17.45	$23.27	$26.55	$32.36

LONG-TERM DISABILITY

Sample Payroll Deductions & Benefits - 2014 Rates

Based on Bi-Monthly Payroll with 22 Payroll Deductions Per Year

Annual Salary	Monthly Benefit Amount	EMPLOYEE'S AGE								
		24 & Under	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 & Over
$20,000	$1,000	$0.73	$1.00	$1.55	$2.45	$3.45	$4.64	$6.36	$7.45	$7.82
25,000	1,250	$0.91	$1.25	$1.93	$3.07	$4.32	$5.80	$7.95	$9.32	$9.77
30,000	1,500	$1.09	$1.50	$2.32	$3.68	$5.18	$6.95	$9.55	$11.18	$11.73
35,000	1,750	$1.27	$1.75	$2.70	$4.30	$6.05	$8.11	$11.14	$13.05	$13.68
40,000	2,000	$1.45	$2.00	$3.09	$4.91	$6.91	$9.27	$12.73	$14.91	$15.64
45,000	2,250	$1.64	$2.25	$3.48	$5.52	$7.77	$10.43	$14.32	$16.77	$17.59
50,000	2,500	$1.82	$2.50	$3.86	$6.14	$8.64	$11.59	$15.91	$18.64	$19.55
55,000	2,750	$2.00	$2.75	$4.25	$6.75	$9.50	$12.75	$17.50	$20.50	$21.50
60,000	3,000	$2.18	$3.00	$4.64	$7.36	$10.36	$13.91	$19.09	$22.36	$23.45
65,000	3,250	$2.36	$3.25	$5.02	$7.98	$11.23	$15.07	$20.68	$24.23	$25.41
70,000	3,500	$2.55	$3.50	$5.41	$8.59	$12.09	$16.23	$22.27	$26.09	$27.36
75,000	3,750	$2.73	$3.75	$5.80	$9.20	$12.95	$17.39	$23.86	$27.95	$29.32
80,000	4,000	$2.91	$4.00	$6.18	$9.82	$13.82	$18.55	$25.45	$29.82	$31.27

Disability Income Protection

22 Payroll Deductions Per Year
For Employees Receiving 22 Pay Checks Per Year

Voluntary Disability Program

How to Estimate Payroll Deduction – Based on ***22*** 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 22 (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	$200.00
C. Multiply by your appropriate rate below ($.89 for STD / $.08 for LTD)	$178.00	$16.00
D. Divide by 22	$8.09	$ .73

Short-Term Disability Rates

Employee's	Rates per $100 Covered Payroll		
Age	A	B	C
54 & Under	$0.89	$0.61	$0.48
55 - 59	$1.17	$0.80	$0.64
60 - 64	$1.34	$0.91	$0.73
65 & Over	$1.63	$1.12	$0.89

Long-Term Disability Rates

Employee's	Rates per $100 of
Age	Covered Payroll
24 & Under	$0.08
25 - 29	$0.11
30 - 34	$0.17
35 - 39	$0.27
40 - 44	$0.38
45 - 49	$0.51
50 - 54	$0.70
55 - 59	$0.82
60 & Over	$0.86

NOTE: Rates effective January 1, 2014

DID YOU READ ABOUT...

- How the plan works?
- Coverage levels?
- Short and long-term options?

Group Term Life

Post-tax Benefits

IN THIS SECTION...

- Basic life features
- Optional insurance
- Personal accident insurance
- Dependent life features

Plan Provider: Underwritten by Life Insurance Company of North America, a CIGNA Company

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 coverage you need at a price you can afford. Getting the income protection needed to guard against life's uncertainties shouldn't be difficult or expensive. That's why the School District of Palm Beach County is offering you a life benefits plan from the Life Insurance Company of North America. 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 the Life Insurance Company of North America offers, including:

- Basic life and personal accident insurance (employer paid)
- Optional life insurance and personal accident insurance (employee paid)
- Spouse life and personal accident insurance (employee paid)
- Dependent life insurance (employee paid)

Please NOTE: The eligibility waiting period for both basic life and accident is the 1st day of the month following 30 days of employment for both current and new employees.

You must submit a completed statement of health form directly to the Life Insurance Company of North America to the address noted below by December 20, 2013. Submission of an incomplete application will not extend the deadline.

Life Insurance Company of North America
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Fax: 800.440.0856

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. Your employer provides you with a valuable Basic Life Insurance Plan at no cost to you.

What Are My Basic Life Insurance Benefits?

Your employer provides you with Basic Life Insurance coverage in the amount of $20,000 for full-time employees, and $10,000 for part time employees. This benefit is provided at no cost to you.

What Are the Basic Life Insurance Features?

- Conversion
- Accelerated benefits
- Waiver of premium
- Extension of benefit

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

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 6 months to 19 years, or 25 years of age if a student who is primarily financially supported by employee.

Personal Accident Insurance Coverage

The Life Insurance Company of North America insurance products are designed to provide full-time protection against accidental death or injuries – 24 hours a day, 365 days a year.

What benefits are available?

When enrolled in Basic Life Insurance coverage, you automatically receive Personal Accident Insurance in an amount equal to your Basic Life Insurance coverage. 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.

The Life Insurance Company of North America and School District of Palm Beach County know that you are the best judge of your life insurance needs.

Group Term Life

Post-tax Benefits

Two Options Are Available:

Life insurance only

Option One $5,000* at a **monthly** rate of $.30 for all children

Option Two $10,000* at a **monthly** rate of $.60 for all children

* For dependent child(ren) from live birth to 6 months, the benefit is $1,500. There is no matching amount of accident coverage for children.

Optional Insurance

What benefits are available?

In addition to your Basic Life Benefits, your employer is offering the opportunity to purchase additional term life insurance protection through the Life Insurance Company of North America'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. The monthly cost of both Optional Life and Personal Accident Insurance is only $3.28 per $20,000 of coverage.

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 life insurance protection is right for you.

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 form is required for coverage exceeding $100,000.

For optional spouse life, an employee may select optional spouse coverage in $10,000 increments, not to exceed 50 percent of the employee-optional coverage, with a minimum amount of $10,000 and a maximum amount of $250,000. A statement of health form for the spouse is required for coverage exceeding $50,000.

For optional child life, an employee may select optional child coverage in $5,000 increments with a minimum amount of $5,000 and a maximum amount of $10,000. A statement of health form is NOT required for either election as both elections are guaranteed issue. The following age limit payout and eligibility applies:

- Live birth to six months: $1,500
- Six months to 19 years (25 if full time student): $5,000 or $10,000

During Open Enrollment

You may enroll for an additional $20,000 of optional term life for yourself without providing a statement of good health, as long as you are currently enrolled for optional term life and carry less than five times your annual salary or $100,000 (whichever is less) of coverage.

For other optional coverage on yourself, your spouse or dependent child(ren), you may also apply at Open Enrollment.

What are the Optional Life insurance features?

- Conversion
- Accelerated benefits
- Will preparation services
- Waiver of premium

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

Optional Life coverage is provided under group insurance policy FLX-980074, issued in Florida to your employer by the Life Insurance Company of North America. Optional Life coverage under your employer's plan terminates when you are no longer eligible, your employment ceases, when your optional life contributions cease or upon termination of the group contract by your employer upon prior written notice to the Life Insurance Company of North America. Optional Life insurance does not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota) of an increase in coverage. (This exclusion does not apply in Missouri and Washington). This coverage may also be discontinued by the Life Insurance Company of North America for non-payment of premium or if participation requirements are not met.

Personal Accident Insurance

Provided alongside your Optional Life Insurance, Personal Accident Insurance offers a matching amount of Personal Accident Insurance benefits in addition to the Personal Accident Insurance coverage that your employer has made available to you.

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 Dependent Child(ren) 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.

Group Term Life

Post-tax Benefits

What Benefits Are Available?

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

What Are the Personal Accident Insurance Features?

- ***For Wearing a Seat Belt and Protection by an Airbag*** - Death benefits will be increased by 10%, but not by 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%, but not more than $10,000, if the insured person was in a seat protected by a properly functioning and deployed airbag.
- ***For Child Care Expense*** - We 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 3% of the benefit amount, to a maximum of $3,000 a year for 4 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% of your benefit amount, to a maximum of $25,000, for alterations or modifications that are physician-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% of the benefit amount, up to $10,000, for each covered accident.
- ***For Furthering Education*** - If you die in a covered accident, we will pay an extra benefit for each insured child who is enrolled in a school of higher learning or is in the 12th grade and enrolls within one year of the accident. We will increase your benefit amount by 3%, up to $3,000, for each qualifying child. This benefit is payable each year for four consecutive years as long as your children continue their education. If there is no qualifying child, we will pay an additional $1,000 to your beneficiary.
- ***For Training for Your Spouse*** - If you die in a covered accident and your insured spouse enrolls, within three years of your death, in an accredited school to gain skills needed for employment, we will pay the actual cost of this education or training program, up to 3% of your benefit amount, not to exceed $3,000.

How Much Coverage Can I Buy?

You – You will automatically receive an amount equal to your voluntary life insurance benefit in effect under Policy Number FLX-980074, underwritten by Life Insurance Company of North America.

Your Spouse – an amount equal to your voluntary life insurance benefit in effect under Policy Number FLX-980074, underwritten by Life Insurance Company of North America.

Your Children – 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.

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.

Rates (Monthly)

Optional Life & Accident Insurance

Employee only	**$3.28 per $20,000 of coverage**
Spouse	**$5.90 per $10,000 of coverage**

What is not covered?

(1) self-inflicted injuries or suicide, while sane or insane
(2) commission or attempt to commit a felony or an assault
(3) any act of war, declared or undeclared
(4) any active participation in a riot or insurrection
(5) bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
(6) sickness, disease, physical or mental impairment or medical 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).
(7) voluntarily using any drug, narcotic, poison, gas or fumes, except one prescribed by a licensed physician and taken as prescribed
(8) while operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant, including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it;
(9) while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days)
(10) traveling in an aircraft that is owned, leased or controlled by the sponsoring organization, or any of its subsidiaries or affiliates

(11) flying in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface, except as a passenger on a regularly scheduled commercial airline; that is: an ultra-light or glider; designed to be used in outer space; being used by any military authority, except the Air Mobility Command or its foreign equivalent; being flown by the covered person or in which the covered person is a member of the crew; being used for parachuting, hang-gliding, crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, skydiving, pipeline or power line inspection, aerial photography, or exploration, racing, endurance tests, stunt or acrobatic flying, or any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

(12) services or treatment rendered by a physician, nurse or any other person who is employed or retained by the subscriber or who is providing homeopathic, aroma-therapeutic or herbal therapeutic services, living in the covered person's household or a parent, sibling, spouse or child of the insured.

What Are the Dependent Life Insurance Features?

Conversion

Dependent Life Insurance coverage is provided under a group insurance policy (Group Policy Number 980074, on policy form TL-004700, issued in Florida) issued to your employer by the Life Insurance Company of North America.

Dependent Life coverage terminates when Dependent Life contributions cease, upon the death of the employee, when a dependent no longer qualifies as a dependent, or upon termination of the group contract by your employer upon prior written notice to the Life Insurance Company of North America.

This coverage may also be discontinued by the Life Insurance Company of North America for non-payment of premium or if participation requirements are not met. Dependent Life insurance does not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within the first two years (one year in North Dakota) of an increase in coverage (except in Missouri, Washington, and Massachusetts).

Product Features

- **Accelerated Death Benefit – Terminal Illness –** Up to 50% of the death benefit (not to exceed $250,000) may be advanced to the insured who is diagnosed with a terminal illness (life expectancy of 12 months or less) by two unaffiliated physicians. This benefit is payable only once in the insured's lifetime, and will reduce the life insurance death benefit.
- **Will Preparation Services –** Online interactive tool helps covered employees and their spouses create a will and other legal documents. The site also provides access to other valuable financial educational materials.
- **Conversion –** If your coverage is reduced or ends due to age, disability or termination of employment, you can obtain an individual whole life policy, without proof of good health. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Eligible family members 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.
- **Conversion Provisions -** If you retire, terminate employment, or cease being an actively at-work employee (regardless of pay status):
  1. You and your dependents may be eligible to convert your optional coverage to an individual permanent policy.
  2. If you are retiring, you may be eligible to continue up to $50,000 of your employee-only optional coverage on an age-rated premium basis. Premiums are paid on an annual basis.
- **Voluntary Term Life Coverage Reduction** - At age 70, providing you are still employed, your coverage will decrease to 65% of the benefit amount. It will decrease to 45% at age 75, and to 30 % 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 a permanent life insurance policy.

Group Term Life

Post-tax Benefits

You must submit your application to continue coverage within 31 days of termination and pay your premium. See your certificate of coverage booklet from the carrier for more details. It is the sole responsibility of the employee to apply for this benefit.

- **Waiver of Premium (if you become totally disabled) -** To make sure you can keep the life insurance protection you need during a difficult period of your life, this plan provides a waiver of premium feature. If you are totally disabled prior to age 60 and can't work for at least 12 months, your coverage will continue and you won't need to pay premiums for your coverage while you are disabled, provided the insurance company approves you for this benefit. You must continue to pay premiums until the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until age 65, subject to proof of continuing disability each year. If you qualify for this benefit and have insured your spouse or children, the premium for their coverage is also waived.
- **Coverage Reduction for Optional Life plans –** At age 70, your coverage amount reduces to 65 percent. At age 75, your coverage reduces to 45 percent, and at age 80, coverage is reduced to 30 percent. When your coverage reduces, any dependent insurance you've purchased will reduce by the same percentage.
- **Online Plan Description –** you will be able to review any of these benefits and their provisions in more detail through the School District of Palm Beach County's website at **www.palmbeachschools.org/riskmgmt**.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between the Life Insurance Company of North America and the School District of Palm Beach County. Specific details regarding these provisions can be found in the certificate of coverage booklet. If you have additional questions regarding the Life Insurance Program underwritten by the Life Insurance Company of North America, please contact your benefits administrator.

Coverage is underwritten by: Life Insurance Company of North America, 1601 Chestnut Street, Philadelphia, PA 19192.

A certificate of coverage for your Group Term Life Plan is available online at **www.palmbeachschools.org/riskmgmt** or can be accessed by contacting Risk & Benefits Management at **561-434-8580**.

Licensed Resident Agent: Christine Carolyn Wise

License #E026735

DID YOU READ ABOUT...

- Basic Life description?
- Optional features?
- Dependent Life options?

CIGNA's Will Preparation Program

CIGNA makes it easy for you to take charge of those difficult life and health legal decisions. There are no more reasons to hesitate planning for the future with our online will preparation services. Available to individuals who have CIGNA's Group life, accident, or disability coverage.

Think you don't need a will or living will?

If you're like most people, you don't like thinking about planning for your death. However, there are many good reasons why it's very important to have a will no matter what your personal circumstances might be. For example, to have a say in your healthcare treatment if you're not able to speak for yourself, to assign guardianship for minor children, and to secure your assets.

Think you don't have enough assets to need a will?

Nearly one in four (24%) of American adults say their biggest reason for not having a will is a lack of sufficient assets[1]. Not having a will puts your family in the position of having to guess about how to manage your personal and financial assets after your death.

Think you can't afford to create a will?

Now you can! CIGNA's Will Center allows you to easily complete essential life and health legal documents online at no cost to you.

Not sure how to develop your will?

Don't worry. CIGNA's Will Center is secure, easy to use, and available to you and your covered spouse seven days a week, 365 days a year. And, if you have any questions, phone representatives are available to assist you via a toll-free number[2]. Once registered on the site, you will have direct access to a Personal Estate Planning web page, where you can:

- create and maintain your personalized legal documents
- follow an intuitive, interactive question and answer process to create state-specific legal documents tailored to your situation
- preview, edit, download and print your legal documents for execution

It's easy! Go to CIGNAWillCenter.com

To access your Personal Estate Planning web page, simply complete the online form and register as a new user. When prompted for a registration code, provide your date of birth plus the last four digits of your Social Security number. Once this is completed you can immediately start building your will and other legal documents.

[1] National Association of Estate Planners and Councils. "Wills 101: Everything You Know But Don't Want to Think About." June 2006.

[2] No legal advice is provided.

Now is the time to get started. Visit CIGNAWillCenter.com to create your own personalized:

Last Will & Testament – specifies what is to be done with your property when you die, names the executor of your estate and allows you to name a guardian for your minor children.

Living Will – contains your wishes regarding the use of extraordinary life support or other life-sustaining medical treatment.

Healthcare Power of Attorney – allows you to grant someone permission to make medical decisions if you are unable to make them yourself.

Financial Power of Attorney – allows you to grant someone permission to make financial decisions on your behalf if you are unable to make them yourself.

Plus, find information on:

- **Estate Planning**
- **Identity Theft Information Kit**
- **CIGNA's Life and Disability Planning Kits** – access insurance calculators to determine whether you and your family have sufficient coverage for the future.

it's time *to feel better*

CIGNA®

CIGNA Identity Theft Program

IN THIS SECTION...

- Identity theft protection
- How to protect your identity

You've heard about it in the news—you may even know someone who has been a victim. Identity theft is America's fastest growing crime, victimizing almost 11 million people a year. It's a serious crime that occurs when an unauthorized person uses your personal information—your name, Social Security number, bank or credit account number(s), or driver's license number—for fraudulent use. It's also a silent crime—often taking a year or more to be discovered, and leaving victims with a cumbersome, time-intensive process to restore their credit records and good name. CIGNA's Identity Theft Program is available to individuals who have CIGNA's Group life, accident or disability coverage. This program provides resolution services to help you work through critical identity theft issues you may encounter.

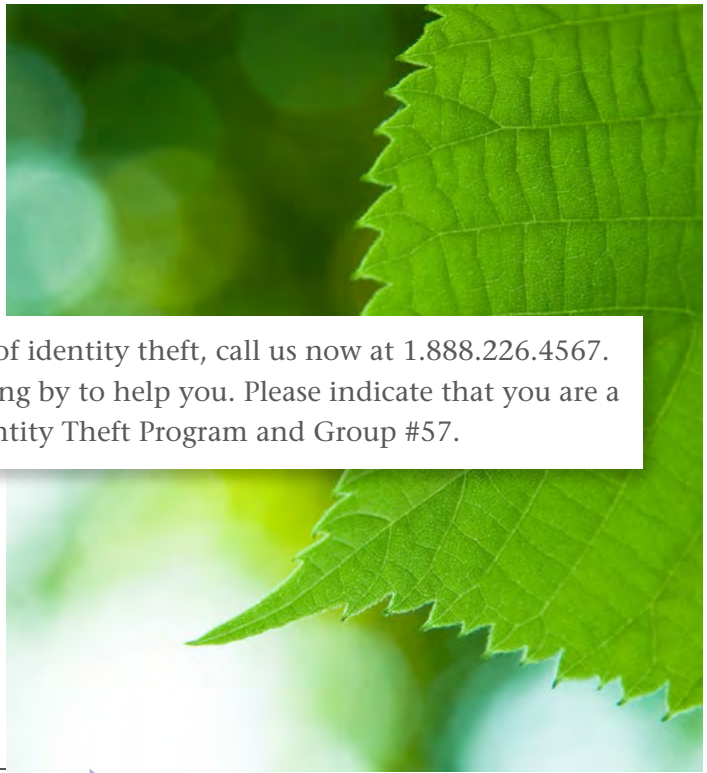
Valuable Help When You Need It Most

Our identity theft program provides:

- A review of credit information to determine if an identity theft has occurred
- An identity theft resolution kit and an identity theft affidavit for credit bureaus and creditors
- Help with reporting an identity theft to credit reporting agencies
- Assistance with placing a fraud alert on credit reports, and cancellation and replacement of lost or stolen credit cards
- Assistance with replacement of lost or stolen documents
- Access to free credit reports
- Education on how to identify and avoid identity theft
- $1,000 cash advance to cover financial shortages if needed
- Emergency message relay
- Help with emergency travel arrangements and translation services
- We assist with credit card fraud, and financial or medical identity theft.
- We provide real-time, one-on-one assistance—24 hours a day, 365 days a year—in every country in the world.
- You'll have unlimited access to our personal case managers until your problem is resolved.
- Our website offers helpful information to reduce your risk of identity theft before it happens.

Services for Every Situation

No matter where or when you come under the attack of identity theft, CIGNA's services are there for you.



If you suspect you might be a victim of identity theft, call us now at 1.888.226.4567. Our personal case managers are standing by to help you. Please indicate that you are a member of CIGNA's Identity Theft Program and Group #57.

CIGNA®

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CIGNA Identity Theft Program

Safeguard Yourself Against Identity Theft

Here are some important tips to help you manage your personal information and minimize your risk of identity theft.

Your wallet

- Carry only one or two credit cards in your wallet.
- Carry only the identification information that you actually need.
- Do not carry your Social Security card in your wallet; leave it in a secure place.
- If your purse or wallet is stolen, immediately report it to the police.

Your bank statement

- Review your bank and credit card statements monthly for signs of suspicious activity.
- If your statement is late by more than a couple of days, call your credit card company or bank to confirm your billing address and account balances.

Your credit report

- Check your credit reports from the three major credit bureaus—Equifax®, Experian® and TransUnion®— annually and correct any inaccuracies. You can do this at **www.annualcreditreport.com**.

Your credit cards

- Do not hand over your debit or credit cards to anyone.
- Cancel all unused credit card accounts.

Your Social Security number

- Give your Social Security number only when absolutely necessary, and before providing, ask to use other types of identifiers.
- Remove your Social Security number from any identification you carry in your wallet.

Your mail

- Deposit your outgoing mail in post office collection boxes or at your local post office, rather than in an unsecured mailbox.
- Promptly remove mail from your mailbox.

Your trash

- Tear or shred your charge receipts, copies of credit applications, insurance forms, physician statements, checks and bank statements, expired charge cards that you're discarding and credit offers you get in the mail.

Your workplace

- Secure personal information in your workplace.
- Keep your purse or wallet in a safe place at work; do the same with sensitive personal information such as your paycheck.

Your home

- Secure personal information in your home, especially if you have roommates, employ outside help or are having work done in your home.

Your computer

- Do not keep computers online when not in use. Either shut them off or physically disconnect them from an internet connection.
- Use antivirus software and a firewall.
- Be cautious about opening any attachment or downloading any files from e-mails you receive.

Your car

- Do not leave any personal information in your car.
- If your car is broken into report it to the police immediately.

For additional tips to reduce your risk and for guidance on what you should do if you become a victim, visit our website at **www.cigna.com/idtheft**.

DID YOU READ ABOUT...

- **Ways to protect your identity**
- **Ways that thieves steal identities**

[1] Javelin Strategy and Research, January, 2010.

[2] Provided with confirmation of reimbursement and if traveling more than 100 miles from home.

[3] Assistance with U.S. bank accounts only.

Tax Sheltered Annuities (TSA) &

Tax Sheltered Mutual Funds (TSM)

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:
https://www.tsacg.com/employee_site/districts/florida/palm_beach.htm 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 403(b) annuity or mutual funds.

See our website, for a copy of the plan document for 403(b) plans.

Visit www.palmbeachschools.org/riskmgmt. Click Benefits then TSA/403(b)

Coming Soon:
In the near future employees will be able to use the **"Self Service"** section of PeopleSoft to enroll in these benefits. An account must first be established with a particiapting vendor before payroll deductions can begin.

Presently, **"Self Service"** can be used to increase or decrease your existing contributions by simply logging in through **Self Service/ Benefits/Benefit Summary** and then clicking on the "EDIT" button of your existing savings plan.

American Century Services*
(No Agent of Record) 1-800-345-3533

AXA Equitable Life Assurance Co.*
Ryan McClaim 561-961-9343

Buttelman & Strehlow Financial Group
Michael Buttelman 561-965-1000, ext. 237

Fidelity Retirement Services
(No Agent of Record) 561-434-8959 or
(PX 4-8959) for a Fidelity Enrollment Kit

Great American Life Insurance Co.
Mike Mracna 561-649-9200

Horace Mann
Theresa Goulet 561-743-1669

ING/ReliaStar
ING/Life Insurance and Annuity Company
Paul Indianer 1-800-327-7888

The Legend Group
Jessica Kovachik 561-694-0110

Life Insurance Company of the Southwest
Maryann Ellis 1-866-243-7174

Lincoln Investment Planning
Mike Mracna 561-649-9200

MetLife
Ken Suchy 561-746-6652

Plan Member Services*
Richard Rush 1-800-874-6910 ext. 2332

Primerica
Ray Krutz 561-642-7459

TIAA CREF*
(No Agent of Record) 1-800-928-7302

VALIC (Variable Annuity Life)*
David Allen 561-684-3775 or 954-946-1765
1-800-854-7888

* Member of the IBC. The Independent Benefits (IBC) is a not-for-profit corporation made up by a coalition of The Florida Education Assoc., The Florida School Board Assoc., The Florida Assoc. of District School Superintendents and The Florida Assoc. 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**.

COBRA Notification

Important Continuation Coverage Information

What Is Continuation Coverage?

Federal law requires that most group health plans, including Health Care Flexible Spending Accounts (FSAs), give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. "Qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse and dependent children of the covered employee.

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.palmbeachschools.or/riskmgmt/

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You may continue your Health Care FSA (on a post-tax basis) only for 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 Health Care FSA 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 you have questions about your Health Care FSA, you should call WageWorks Customer Service at 1-855-428-0446.

A notice form is provided for your use and can be found on the District's website at www.palmbeachschools.org. You may also obtain the notice form by writing to Benefit Outsource, Inc. (BOI), 5599 S. University Drive, Suite 201, Davie, FL 33328 or by calling 1-888-877-2780.

Continuation coverage will be terminated before the end of the maximum period if:

a. any required premium is not paid on time, or
b. 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
c. if a covered employee enrolls in Medicare, or
d. if the employer ceases to provide any group health plan for its employees.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the School District of Palm Beach County informed of any changes in your address or in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the School District of Palm Beach County. Address changes should be sent to:

Benefit Outsource, Inc. (BOI)
5599 S. University Drive, Suite 201
Davie, FL 33328

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.

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.

COBRA Notification

Important Continuation Coverage Information

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.

The Health Insurance Marketplace is an available alternative health care coverage option for you and your dependent(s).

Beginning with open enrollment in 2013, for an effective date of January 1, 2014, 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. As well, 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.

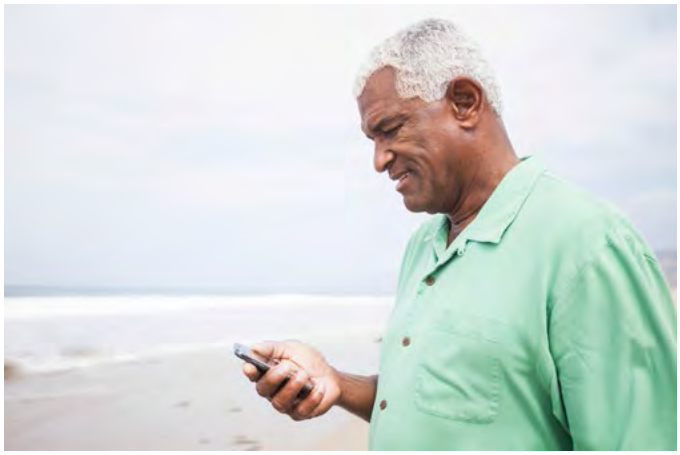
Your first payment for continuation coverage should be sent to:

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



COBRA Notification

Important Continuation Coverage Information

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:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. 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 19) 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.

QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact BOI at 1-888-877-2780 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa**.

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 your employer'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 your employer'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 your Employer'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

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

1. FBMC has been authorized by your employer to provide administrative services for your employer's insurance plans offered herein. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits offered herein to provide certain services, including (but not limited to) marketing, underwriting, billing and collection of premiums, processing claims payments, and other services. FBMC is not the insurance company or the policyholder.

2. The policyholder is the entity to whom the insurance policy has been issued. The policyholder is identified on either the face page or schedule page of the policy or certificate.

3. 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

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. We collect only the customer information necessary to deliver responsive services consistently. FBMC collects information that helps serve your needs, provide high standards of customer care and fulfill legal and regulatory requirements. The sources and types of information collected generally varies 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, Email 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.

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

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 may also 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.

Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA). You may receive a Privacy Notice from your employer or from the providers of various health plans in which you enroll. You should read these statements carefully to assure you understand your rights under HIPAA.

Medicare Part D Certificate of Credible 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 (2) 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% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% 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 (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, 2013
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

Self Service

Keeping your data updated and close at hand just got a lot easier.

Employee Self Service provides you with 24/7 access to your personal data. By taking advantage of the employee Self Service feature of the District's system, 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 the Self-Service module of PeopleSoft?

A: You can:

- update your address and emergency contact information.
- view 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.
- increase/decrease your 403(b) contribution amount
- view/update your Tobacco status
- view your benefit enrollment information

Q: I can not 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 to complete your online benefits enrollment and tobacco affidavit.

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.

Your Paycheck Explained

In our continued efforts to keep you informed, here is a sample paycheck explained. The key fields on the pay stub are described below.

Employee ID
Your Employee ID is listed here, as well as your Department, Location, Job Title, and Pay Rate.

Pay Period
The pay period and end dates indicate the span of time for which you are being paid.

Advice # and Advice Date
The advice number is a reference number for your check advice. The advice date is the pay date.

Payroll
Counter which indicates the number of pays thus far.

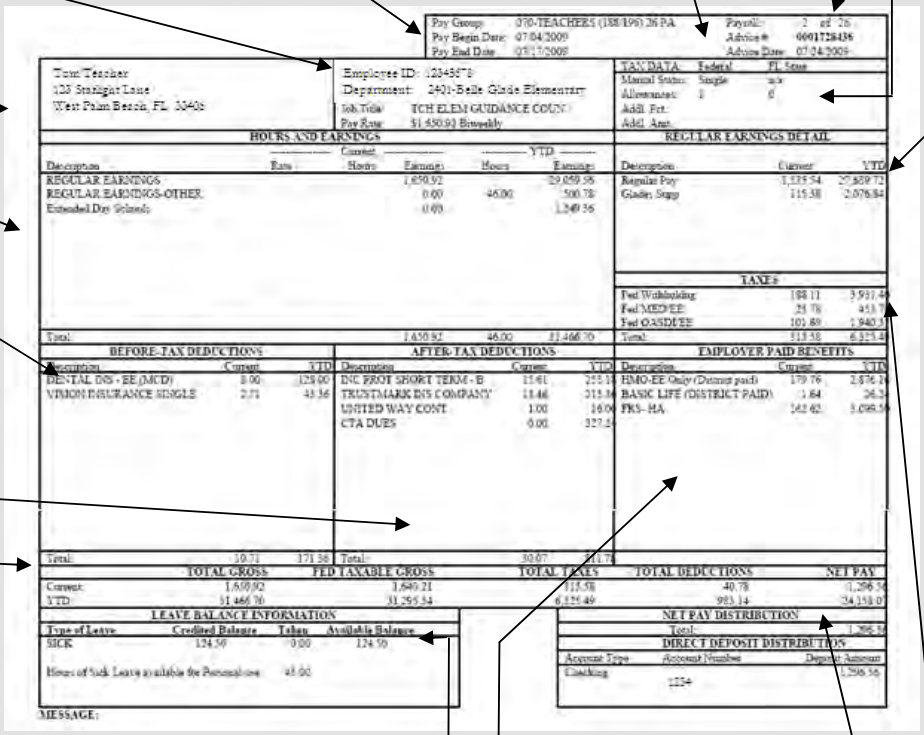
Tax Data
Your Federal tax withholding status is listed here. If you withhold an additional amount, that amount will be listed here.

Employee Information
This block contains your name and mailing address.

Hours and Earnings
This shows current and year-to-date calendar earnings.

Before-Tax Deductions
The items listed here are deducted from your gross pay before taxes are calculated.

After-Tax Deductions
Any additional items withheld from your pay, such as additional insurance or charitable contributions, are listed here. These items are deducted after your taxes are calculated.



Totals
This row lists your current and year-to-date Total Gross (total earnings before any deductions or taxes), Federal Taxable Gross (total earnings minus before-tax deductions), Total Taxes (total taxes withheld), Total Deductions (total deductions taken), and Net Pay (your earnings after deductions and taxes).

Leave Balances
This area lists your annual leave and sick leave balances.

- Please find below an explanation of balances:
  Credited Balance, as of the beginning of the pay period.
  Hours **Taken** during the current pay period.
  Available Balance as of the end of the current pay period.
  Hours of Sick Leave available for Personal use, as per District policy.
  If you have **Annual Leave hours which exceed the cap**, a message will be printed indicating the number of hours.

Employer Paid Benefits
The value of any benefits paid on your behalf by the School District of Palm Beach County, such as medical, basic life insurance, and retirement is detailed here.

Regular Earnings Detail
Many employees receive additional supplements on a year round basis that align with their primary job. Examples of these supplements are Degree Supplements, Teacher's Degree Supplements, Glades Supplements, Complexity Supplements, ESE/ Paraprofessional Supplements, just to name a few. If this compensation is included in your earnings, it will be displayed in this field.

Taxes
Your current and year-to-date calendar withholdings for Federal taxes are reflected here.

Net Pay Distribution
For Direct Deposit, this area shows how much was credited to your bank account(s). If you do not participate in Direct Deposit, this is the amount of your actual paycheck.

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