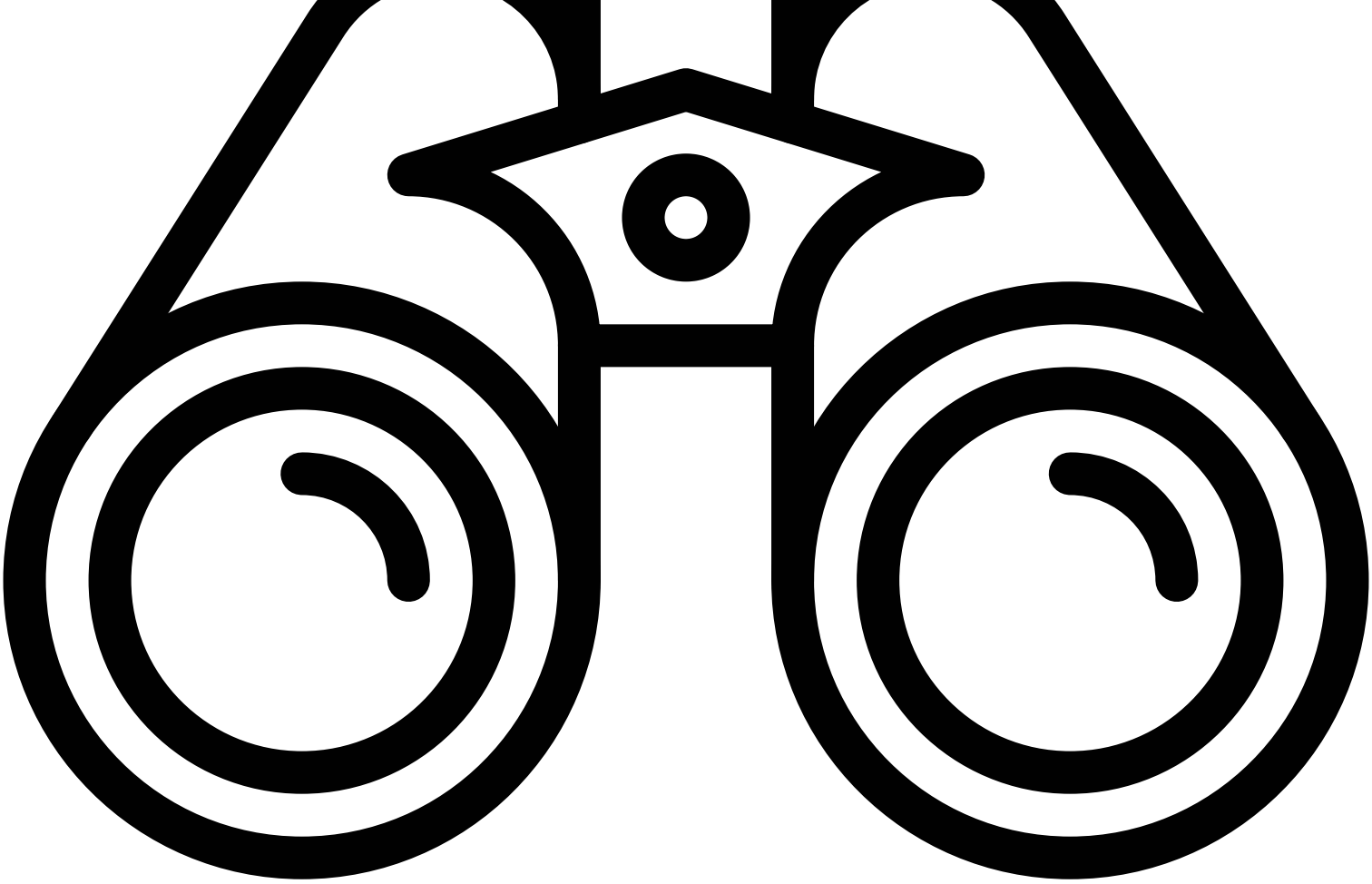


FORESIGHT IS 2020

EMPLOYEE BENEFITS

PLAN YEAR 2020

THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Superintendent's Message

Dear District Employees,

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

MEDICAL

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

HEALTH REWARDS PROGRAM

Our award winning Health Rewards Program is one of many wellness related programs offered to encourage a healthy lifestyle. The Health Rewards Program encourages you to be actively engaged in your health and well-being. For your efforts, you are rewarded with up to a $600 medical premium discount. Be sure to read the section titled Health Rewards for more information. Join our culture of health!

TERM LIFE

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

DENTAL, VISION, LIFE & DISABILITY

Dental, Vision, additional Term Life Insurance, and Disability are optional benefits you may wish to review and decide if they are right for you.

FLEXIBLE SPENDING ACCOUNTS

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

RETIREMENT PLANS

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

Sincerely,
Dr. Donald E. Fennoy II

alex® BENEFITS COUNSELOR

ALEX® Helps You Pick Your Benefit Plans

Before you make your enrollment decisions, be sure to spend a few minutes with ALEX, an easy to use online tool, to find the best-fit benefit plan for you and your family. ALEX can make sure you're in the right kind of plan for your needs, and that can save you and your family time and money.

Find the plan best for you at: myalex.com/pbcsd/2020

Table of Contents

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 68 for more details.

Connect With Us

Benefits Directory

The School District of Palm Beach County Risk & Benefits Management
Phone: 561-434-8580
Fax: 561-434-8103
www.hub.palmbeachschools.org/all_employees/benefits

Medical & Pharmacy Insurance
UnitedHealthcare® (UHC)

Group #: **704471**
www.myuhc.com

Member Services
888-380-0389

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

Telephone-based Coaching Program
800-478-1057

Diabetes Health Plan
1-888-380-0389

NurseLine
888-229-9322

Real Appeal
844-344-REAL(7325)
www.member.realappeal.com

Dental Insurance
Humana

Group #: **830206**
800-233-4013 DHMO & PPO Plans
myhumana.com (as of 01/01/2020)

Dental Provider Search

- DHMO - http://l.sdpBc.net/me0w5

- PPO - http://l.sdpbc.net/rcb7o

Open Enrollment Humana Support Line
(855) 811-0409
Hours: 8:00 a.m. - 8:00 p.m. ET
humana.com (prior to 01/01/20)

Vision Plan
EyeMed Vision Care

Group #: **9705435**

Provider Locator
866-299-1358
www.eyemed.com

Customer Service
866-723-0514
www.eyemed.com

Disability Income Protection Plan
Metropolitan Life Insurance Company

Group #: **106456-1-G**
(MetLife) 800-300-4296
www.MetLife.com/MyBenefits

Term Life and Accidental Death & Disability
Metropolitan Life Insurance Company

Group #: **106456-1-G**
(MetLife) 800-638-6420
www.MetLife.com/MyBenefits

Spending Accounts

Health Savings Account (HSA)
Optum Bank
Customer Care
800-791-9361

Flexible Spending Accounts
WageWorks® Customer Service
Mon - Fri, 8 a.m. - 8 p.m. ET
855-428-0446

FSA Debit Card Activation
24 hours a day
888-514-6845
www.wageworks.com

WageWorks® Flexible Spending Account Claims
P.O. Box 14053
Lexington, KY 40512
855-428-0446
Toll-Free Claims Fax: 1-877-353-9236
www.wageworks.com

Retirement Savings Plans

401(a) Special Retirement Plan Administrator
BENCOR Administrative Services
866-296-9712
www.bencorplans.com
Email: questions@bencorplans.com

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

Employee Assistance Program
Health Advocate Health Care Navigation & EAP WorkLife Assistance
855-424-8400
www.HealthAdvocate.com/palmbeachschools

Individual Portable Plans

Critical HealthEvents Universal LifeEvents Insurance Accident Insurance
Trustmark Insurance Company
866-636-5525
www.trustmarksolutions.com
Email: pbsd@trustmarkins.com

ID Theft Protection Plan
Ocenture ID Commander
855-592-7941 / 561-434-7442
www.idcommander.com/pbcs

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

Health Care FSA COBRA
WageWorks®
855-428-0446

On-Site Representatives
FBMC
Fulton-Holland Building, A-103
561-434-7442

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

Eligibility Requirements

Enrollment Eligibility Requirements

We are excited to provide you with online access to complete your Open 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 12**.

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

Who Is Eligible?

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

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

An eligible regular, full-time employee is defined as an employee who is in a paid status and works six or more hours per day (7.5 hours per day for those in the CTA bargaining group). Upon certain qualifying events, a covered employee, spouse and dependents may be eligible for group health plan continuation coverage under COBRA law. Refer to the COBRA section beginning on **page 64**.

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.

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

Dependent Eligibility

Dependent Audit Verification

All employees adding any dependent(s) to coverage in the medical, dental and/or vision plans must provide documentation of their dependent's eligibility. Review dependent audit requirements. (See page 7 for appropriate documentation.)

During your enrollment period, you should submit an original government certified document (sufficient to verify eligibility) to a benefits technician in Risk & Benefits Management. Office hours are Monday through Friday, 8 a.m. until 4:30 p.m. The document(s) will be reviewed and immediately returned.

Don't forget to actually enroll your dependent(s).

Dependent Eligibility

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

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

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

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

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

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

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.

Over-aged Adult Children

(F.S. 627.6562) Unmarried 26 - 30 years of age

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

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

The application for this type of coverage is available at **https://hub.palmbeachschools.org/all_employees/benefits/benefit_forms**

Unmarried Children with Disabilities

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

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

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

Dependent Verification Guide

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	• Notarized domestic partner affidavit (all) • Proof of domestic partner registration (county) • Receipt for recording fee (county) • Supporting proof as outlined in the non-resident section of the affidavit (non tri-county)
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 Maximum age 18	• 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 years	• Original government-issued birth certificate (birth registration cards not accepted) • Certificate of creditable coverage (request from prior insurance) • Application for over-aged adult child • Copy of student schedule - if child does not reside in Florida 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

Domestic Partnership Benefits

Guidelines for the domestic partnership benefit can be found on this page and on the Risk & Benefits Management page at **https://hub.palmbeachschools.org/all_employees/benefits/benefit_forms**. This is a post-tax benefit.

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

At the time of publication of this guide, information on how to register in Palm Beach County could be found at:
www.mypalmbeachclerk.com/records/domestic-partnership

- 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.

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.

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 7** for the required documents.)

Imputed Income

The District subsidizes the actual plan costs, so you only pay the amounts beginning on **page 22**. However, due to IRS regulations, the amount paid by the District will be imputed income and you will be taxed on that amount.

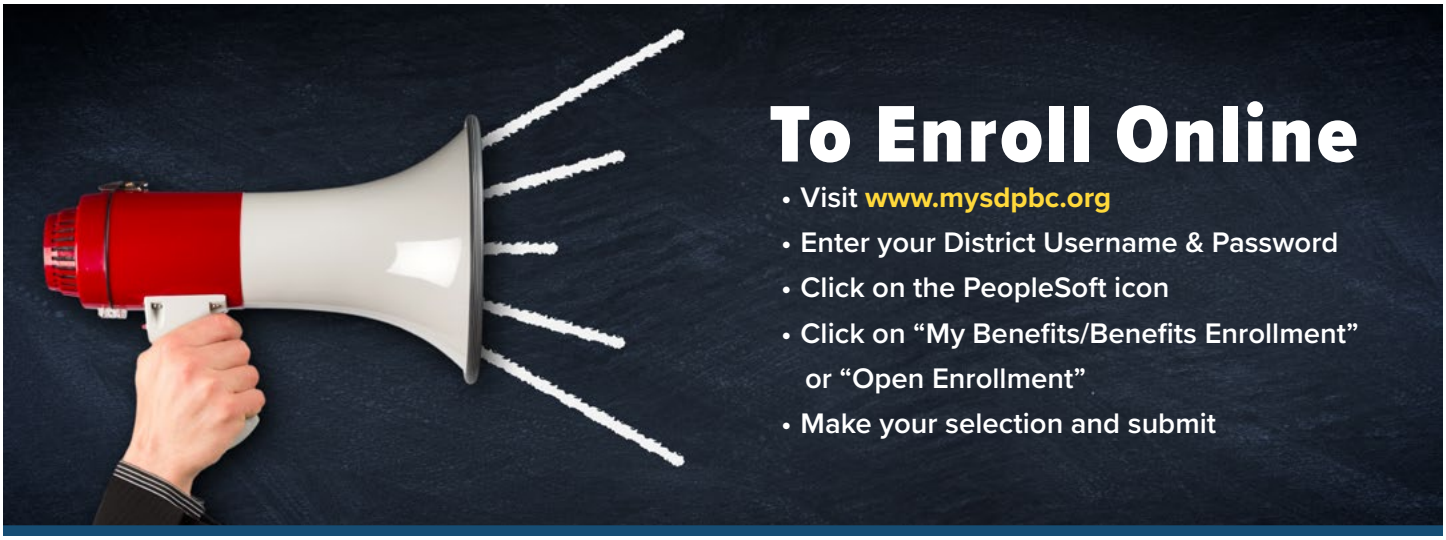
Remember to provide required documents to Risk & Benefits Management to finalize your elections.

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

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

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

Important Enrollment Information



Existing Employees

Existing employees are able to make changes to their benefits once per year during the Open Enrollment period. Please make any required changes during the Open Enrollment period which will be Nov. 4 - Nov. 15, 2019.

Employees Returning from Leave of Absence

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

If you fail to complete a benefits change form within 30 calendar days of your return from leave, you will be enrolled in the default Low Option HMO medical plan with employee-only coverage. (For additional information regarding your benefits while on leave, please refer to the leave information beginning on page 16).

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 15 of this guide for more information on permitted mid-plan year election changes).

New Hires

As a new employee you are eligible to enroll in many different benefits.

Medical insurance is subsidized by the District, so your premiums are low!

Full-time employees are also eligible for $20,000 in basic life coverage at no charge. Higher term life insurance limits as well as dental, vision, and disability plans are available to you at negotiated group rates.

You can find information on all the various benefit choices in this guide. We hope you are pleased with the selection available.

Don't forget to enroll within 30 days of your start date; otherwise, you will automatically be enrolled in employee-only Low Option HMO medical and basic term life. (See page 12 for information on how to enroll.)

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

Change in Status

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 calendar days of the birth or placement/adoption.

Important Enrollment Information

Default Plan Enrollment

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

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

Dependent Eligibility

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

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

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

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

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

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

Dependent Audit Verification

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

To enroll a newborn, you will need to provide proof of birth. Review dependent audit requirements.
(See page 7 for appropriate documentation.)

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

Flexible Spending Accounts (FSAs)

- FSAs do not continue from one year to the next. You **MUST** make an election each year to have an FSA in the new plan year. Please consult a tax expert for assistance with determining household maximums for FSAs.
- The Health Care FSA has an annual minimum of $300 and an annual maximum of $2750 or such lesser amount approved by IRS for 2020.
- The Dependent Care FSA has an annual minimum of $300 and an annual maximum of $5,000.

Flexible Spending Account Enrollment

You MUST reenroll in Flexible Spending Accounts (FSAs) annually. FSA deductions begin the month in which the FSA becomes effective. If you do not complete the enrollment process, your FSA benefits will not continue for the new 2020 plan year.

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

If You Already Have Insurance

- Waiving medical coverage is only an option for those who have medical coverage provided by another employer or an individual plan.
- Waiving medical coverage requires that an election be made. Otherwise, default enrollment in the Low Option HMO single coverage will be processed.

Important Enrollment Information

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

Review Your Choices and Current Information

It is important that you confirm your elections and entries prior to the end of your enrollment period. (Please see page 70 for further information.)

After Open Enrollment has ended, navigate from the Portal page through PeopleSoft to My Benefits/Benefits Summary

Enter 01/01/2020 and refresh to view your 2020 Benefit Elections

We will process the choices you have made. Anytime you want to view your confirmed elections, be sure to enter 01/01/2020 to view your 2020 benefit elections.

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

Don't Forget to Double Check!

The cost of medical services can vary greatly based solely on where you seek services. It pays to be a consumer when it comes to your health care for non-emergency needs.

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

Plan type: Which medical plan did you choose: Low Option HMO, High Option HMO or CDHP? Which dental plan did you choose: DHMO 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: $2,750).

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

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

How to Enroll

The Enrollment Process

New Hires/Newly Eligible

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

Online Benefits Enrollment: Secure, Private, and No Appointment Necessary!

Online Enrollment

- Go to: **www.mysdpbc.org**
- Log in to "PeopleSoft/My Benefits/Benefits Enrollment"
- You will need your user ID and password 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

How to Obtain your User ID and Password

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

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

Log in to PeopleSoft

- Click on "My Benefits"
- Then click on "Benefits Enrollment"

Employee Responsibilities

Payroll contributions will begin in the effective month of coverage.

Employee Responsibilities during Open Enrollment

- You are responsible for participating in the Open Enrollment process.
- 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 the information in the system is what you have elected.
- You are responsible for thoroughly reviewing your choices during the online enrollment and prior to submitting your elections.
- You are responsible for entering your enrollment data, including your dependents, your dependents' dates of birth, and their Social Security information within the established enrollment time frames.
- You are responsible for providing required documentation to satisfy the eligibility criteria for all enrolled dependents.
- Verify that complete and accurate information is properly reflected for your dependents. Otherwise, dependent coverage will be canceled.
- You are responsible for providing your tobacco status.
- Review your plan election information, including any dependents you may have attached to a benefits plan to ensure accurate enrollment.

Responsibilities for Maintaining Employee Benefits

- You are responsible for maintaining your personal information.
- Review your personal data such as mailing address and dates of birth for you and your covered dependents. You can update your personal information using the PeopleSoft My Personal Information tool.
- You are responsible for reviewing your paycheck stub (available online) when your benefits become effective in order to verify your enrollment and 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 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 6**.
- Benefit elections are irrevocable during the plan year, unless you experience a valid Change in Status (see **page 15**) 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.
- 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.

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

Find the most current information by logging in to: **https://hub.palmbeachschools.org/all_employees/benefits** and selecting the Benefits Reference Guide link.

Contribution Overview

Employee Payroll Contributions

Your portion of the benefits cost will be taken 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 contribute the dollar amount specified in the table below into a 401(a) Special Retirement Plan in your name. The 401(a) Special Retirement Plan is administered by Bencor.

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.

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.

PLAN	MONTHLY 401(A) DOLLARS	
	FULL-TIME	PART-TIME
Waive Medical	$100	$50

Changing Your Coverage

What Is My Period of Coverage?

Your period of coverage is your eligibility period (e.g. January 1 to December 31), unless you make a permitted mid-plan year election change.

Am I Permitted to Make Mid-Plan Year Election Changes?

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

What Events Qualify for a Change in Status According to the IRS?

Partial lists of permitted and not permitted qualifying events under the District's plan(s) appear below and throughout this guide. 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.

1. **Loss of Dependent Eligibility** – If a change in your marital or employment status involves a decrease or cessation of your spouse's or dependent's eligibility requirements for coverage due to your divorce, annulment from your spouse, your spouse's or dependent's death or a dependent ceasing to satisfy eligibility requirements, you may decrease or cancel coverage only for the individual involved. You cannot decrease or cancel any other individual's coverage under these circumstances. In most cases a change in plans is not allowed (e.g., HMO to CDHP).
2. **Gain of Coverage Eligibility Under Another Employer's Plan** – If you, your spouse or your dependent gains eligibility for coverage under another employer's plan as a result of a change in marital or employment status, you may cease or decrease that individual's coverage if that individual gains coverage or has coverage increased under the other employer's plan.
3. **Dependent Care Expenses** – You may change or terminate your Dependent Care FSA election when a Change in Status (CIS) event affects (i) eligibility for coverage under an employer's plan, or (ii) eligibility of dependent care expenses for the tax exclusion available under IRS§ (section) 129.
4. **Group Term Life Insurance** – For any valid CIS event, you may elect either to increase or decrease these types of coverage, as long as the request is consistent with the qualifying event (i.e., adding spouse life if the event is a marriage).

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

How Will Making a Change Affect My FSA?

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

However, expenses incurred before the permitted election change can only be reimbursed from the amount of the balance present in the Health Care FSA prior to the change. Mid-plan year election changes are approved only if the extenuating circumstances and supporting documentation are within the School District of Palm Beach County's Health Care FSA plan and the IRS regulations governing the plan.

Split periods of coverage do not apply to the Dependent Care FSA.

How to Make a Change with a Qualifying Event

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

Documentation supporting your election change request is required. Once your request has been reviewed, approved and processed, your existing elections and contribution amount will change (as appropriate). Approved changes will become effective on the first of the month following receipt of the election change and all required documentation. A full premium payment will be due for the period including that date. If your FSA election change request is denied, you will have 30 calendar days from the date you receive the denial to file a written appeal with FBMC. For more information, refer to the Appeals Process on **page 70**.

Leave of Absence Benefits

When Should You Apply for a Leave of Absence?

To protect your benefits you should apply for a leave of absence whenever you will be in an unpaid status. While you are using sick and/or vacation time, you do not need to apply for a leave of absence since you are still receiving pay from the District. However, if you miss work as a result of a work-related injury/illness, you should apply for a leave of absence even if you receive workers' compensation. Keep in mind that your benefits eligibility requires that you work the majority of your duty days. Therefore, anytime you are in an unpaid status, applying for a leave preserves your access to benefits. It's important for you to notify and keep your supervisor informed of all absences. Failure to report to work for the majority of your duty days could lead to a loss of benefits as well as job abandonment processing.

Employees on Leave

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

A. You are physically at work.
B. You are in a paid status using sick or annual days.
C. Your approved FMLA leave expires.
D. Payments are applied.

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

Approved Medical Leave (FMLA)

You may continue your benefits while on approved FMLA status. The District will make its contribution on your behalf for District paid benefits. You will be responsible for your regular contributions. Contact us at 561-434-7478 or 561-434-8668 if you do not receive a monthly billing statement. Coverage will be terminated for nonpayment if premium payments are not received within 30 days of the due date.

Non-FMLA Leave

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

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

Life/Income Protection for Personal Illness

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

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

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

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

Other Leaves – Ineligible to Continue Life and Income Protection Plans

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

Approved Nonpaid Leave

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

Other Benefits Impacted by an Unpaid Leave

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

Other Leave Coverage

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

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

Flexible Spending Accounts (FSAs) While on Leave

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

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

To Continue your Health Care FSA while on Leave, mail your check or money order to:

FBMC Benefits Management
ATTN: Benefits Administration
P. O. Box 1878
Tallahassee, FL 32302-1878

- Make your check payable to "**The School District of Palm Beach County.**" (FBMC is unable to accept online payments.) Write your 16-digit FBMC Member number on your check or money order. Contact FBMC's On-site Representative to obtain your 16-digit FBMC Member number.
- Include a note that indicates you are a School District of Palm Beach County employee on leave and you wish to continue contributing to your Health Care FSA.
- If you have any questions about continuing your Health Care FSA while on leave, please contact FBMC's On-site Representative at **561-434-7442**.

District-Paid Benefits While You Are in an Unpaid Status

You should apply for an approved leave of absence in order to continue your benefits. Once you are unpaid for the majority of your duty days in any given month (even if you are not on leave) you are no longer eligible for benefits. If you do not make sufficient payments to continue benefits, coverage will terminate at the end of the month in which you were eligible. District-paid benefits will begin again the first of the month after 30 calendar days of eligible paid employment.

Unpaid Status, No Approved Leave

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

Re-enrollment Upon Return from Leave

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

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 reelect these types of plans.

Contact Risk & Benefits Management at 561-434-7478 or 561-434-8668 within 30 calendar days of your return to work.

Default Plan Enrollment

If you fail to contact Risk & Benefits Management upon your return from leave, you will be automatically enrolled in the Low Option HMO employee-only medical plan and basic life insurance. No other benefits will be available.

Employee-only medical plan and basic life insurance: Open Enrollment will only be processed for actively working employees. If you completed enrollment, but are not actively at work on the first working day of 2020, your election will not be processed.

Other Leave Coverage

Frequently Asked Questions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage Termination

Employee Coverage

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

1. **Through the last day of the month:**
   a. In which employment ends (all interim positions and 12-month employees are in this category).
   b. In which a leave of absence without pay begins.
   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. Your position is continued and you qualify for the Family and Medical Leave Act (FMLA). In that case, coverage will end the last day of the month in which eligibility for FMLA ends, as long as required employee contributions are made.
   b. You are a regular, but less than a 12-month employee, and you are in paid status through the last day of your contract period. In this case, coverage ends the last day of the month for which the required employee contributions are made. Exception: Term Life and/or income protection coverage may end as early as June 30 but will not continue beyond the period for which contributions are made.

Change in Status Termination Requests

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

Termination Due to Change in Status

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

Retirement

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

PLEASE NOTE: Your retirement date must be in a month in which you are covered under the District's benefits plan in order to continue benefits as a retiree.

If you are eligible for Medicare upon retirement, Medicare will become the primary payer on the first month following your retirement date, regardless of your coverage through the District. In order to be eligible to continue the health insurance benefits you have to be retired and receiving monthly payments from FRS. Enrollment in the FRS investment plan may limit your eligibility to continue health benefits upon retirement. Please refer to School Board Policy 3.79 for more information.

Termination or Change to Non-Benefited Position

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

Termination followed by rehire within 30 days

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

Termination followed by rehire after 30 days

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

Dependent Coverage

Your dependent's coverage will terminate on:

- 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.
- The date you, the employee, lose coverage.
- 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-age adult child provision, or COBRA continuation is elected and premium payments are made.

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

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 toll-free at 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 1-855-428-0446 to apply for COBRA continuation on an after-tax basis of your Health Care FSA.
- **Ocenture** customer service directly toll-free at 855-592-7941 to continue your ID Commander ID Theft protection plan.

Retirement or Separation

In Case of Retirement or Separation

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.

Coordination of Benefits or Separation

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's 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

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.

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: **https://www.palmbeachschools.org/careers/benefits/retiree_health_benefits**

Ana Swanberg is available to answer questions you may have about Retiree Benefits.

When you are within 30 days of your retirement date, schedule an appointment by email with Ana to discuss your options.

Ana Swanberg / Email: **ana.swanberg@palmbeachschools.org**

Please refer to the Coverage Termination section for further information.

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.

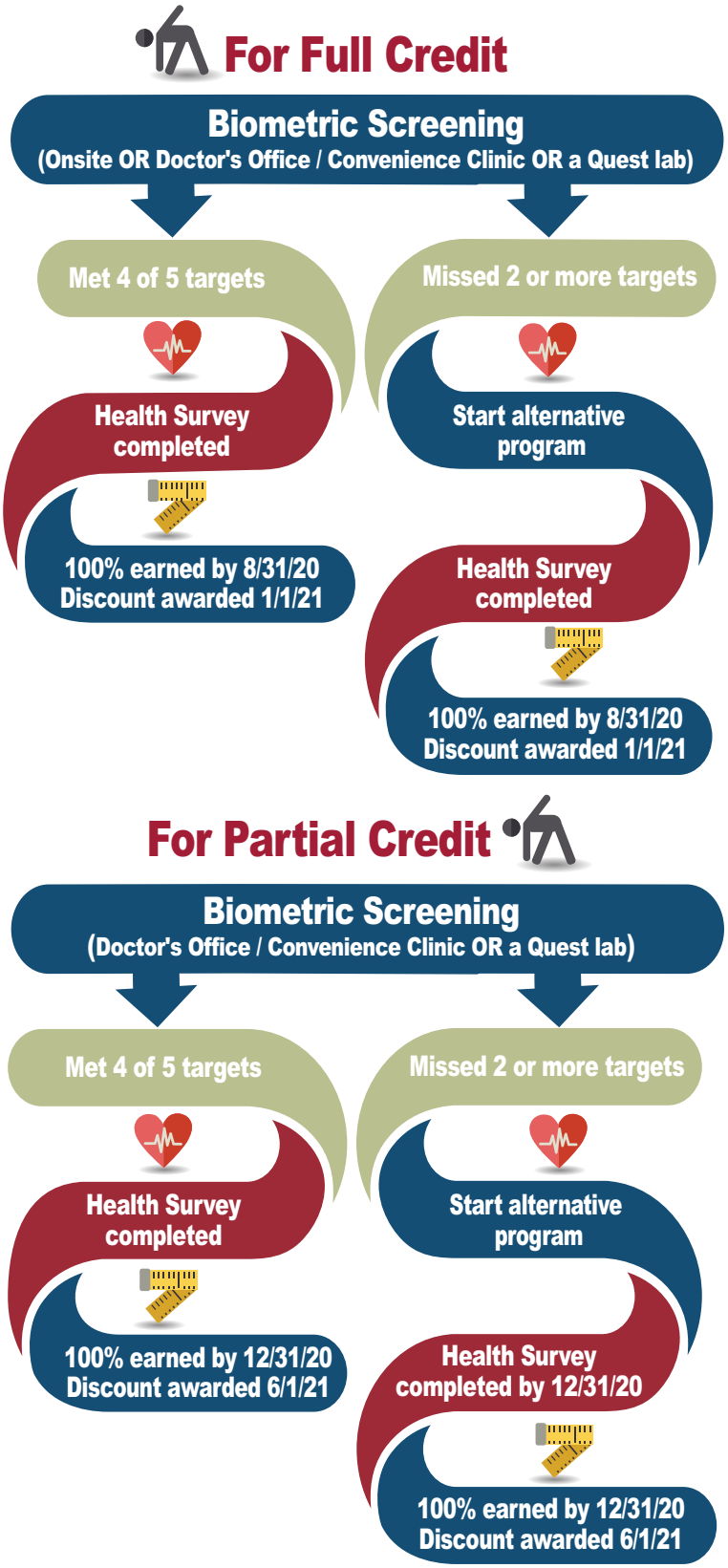
Special Consideration for Term Life Insurance

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.

Health Rewards Credit



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

Prepare now and earn a $50 per month medical premium credit in 2021

Earn a $50 medical premium credit by actively participating in the Health Rewards program. Complete required activities between January 1 and August 31, 2020 to earn full credit beginning January 1, 2021.

Complete the required activities by December 31, 2020 and you will receive partial credit beginning with the first premium due on or after June 1, 2021.

Your covered spouse/partner will also need to complete the Health Rewards required activities in order for the $50 per month Health Rewards credit to apply in 2021.

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

You are responsible for faxing that form.

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

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

Log in to: **https://hub.palmbeachschools.org/all_employees/employee_wellness** for available resources to help you be tobacco-free and save.

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

Read more at:
https://hub.palmbeachschools.org/all_employees/employee_wellness

Medical Plan Cost

2020 Employee Per-Pay-Period Medical Contributions

Rate does not reflect Health Rewards discount or tobacco surcharge. In order to enroll in any plan listed below, your per pay salary must support the deduction.

Per pay period pre-tax deductions are as follows:	FULL-TIME				PART-TIME**			
	24 DEDUCTIONS		22 DEDUCTIONS		24 DEDUCTIONS		22 DEDUCTIONS	
EE = EMPLOYEE	District Contribution	Employee Deductions	District Contribution	Employee Deductions	District Contribution	Employee Deductions	District Contribution	Employee Deductions
LOW OPTION HMO								
EE only	$245.00	$25.00	$267.25	$27.27	$245.00	$25.00	$267.25	$27.27
EE + Child(ren)	$380.00	$68.00	$414.50	$74.18	$365.00	$83.00	$398.14	$90.54
EE + Spouse	$417.50	$89.00	$455.41	$97.09	$402.50	$104.00	$439.05	$113.45
EE + Family	$490.50	$151.00	$535.04	$164.72	$475.50	$166.00	$518.68	$181.09
HIGH OPTION HMO								
EE only	$270.00	$45.00	$294.52	$49.09	$220.00	$95.00	$239.98	$103.63
EE + Child(ren)	$405.00	$135.00	$441.77	$147.27	$340.00	$200.00	$370.87	$218.18
EE + Spouse	$440.00	$160.00	$479.95	$174.54	$375.00	$225.00	$409.05	$245.45
EE + Family	$540.00	$230.00	$589.03	$250.88	$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
DISTRICT CONTRIBUTION - 401(A) DOLLARS								
Waive Health	$50.00		$54.54		$25.00		$27.27	

Amounts reflected on paychecks may vary slightly due to rounding. Rates above do not include Health Rewards discount or tobacco surcharge rates.
**Applies to CTA Bargaining units or those in part-time status as of 12/31/2011.

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.

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.

Medical Plans

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 healthcare, so we want to give you resources to help you:

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

Before You Enroll

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

The UnitedHealthcare Network:

Find a network doctor or hospital.

Search by facility, location, gender, and languages spoken.

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

Your ID Card - The Key to Accessing Care When You Need It

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

Always Carry your ID Card

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

These Extras Are Part of Every Plan

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

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

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

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

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

Other helpful tools include:

- **Find Care and Cost**
- **Manage Your Prescriptions**

Medical Plans

Benefits-at-a-Glance • UnitedHealthcare: Low Option HMO (Choice Network)

This plan gives you the freedom to see any doctor or other healthcare 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
Annual Medical Expense Deductible	$500 for individual / $1,000 family
Annual Out-of-Pocket Maximum	$6,000 individual / $12,000 family
Coinsurance/In-Patient Hospital Coinsurance	20% of eligible expenses after deductible
Primary Care Doctor Check United's provider directory before making your decision regarding your health care provider	Choose any doctor from the United Open Access Directory. You may access any participating specialist without a referral.
Preventive Care	No charge
Office Visit (Primary Care)	$30 copayment for UHC Premium Care Physician / $40 copay non-Premium Care Physician / Deductible does not apply
Specialist Office Visit	$55 copayment for UHC Premium Care Physician / $60 copayment non-Premium Care Physician / Deductible does not apply. No referral needed.
Outpatient Hospital and Surgical Services X-ray, Other diagnostic services (MRI, CT scan, lab test, etc.)	20% of eligible expenses after deductible
Outpatient Rehabilitation Therapy	$35 copayment per visit[1] Deductible does not apply
Approved Durable Medical Equipment	20% of eligible expenses after deductible
Emergency Ambulance Trip	$150 copayment per trip
Hospital Pre-Admission Requirement	Your doctor will take care of all prenotification requirements.
Emergency Room Care	$250 copayment (waived if admitted)
Urgent Care Copay	$75 copayment - Deductible does not apply
Convenience Care Clinic - Virtual Office Visits	$40 copayment - Deductible does not apply $25 copayment - Deductible does not apply
Outpatient Mental Health & Substance Abuse Services - Telemed Services include Mental/Substance Abuse Counseling	$35 Individual / $25 family Deductible does not apply

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

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

	RETAIL	MAIL-ORDER
DED	$100 Individual / $200 Family	No Deductible
Tier 1	$10 copay after deductible	$25 copay
Tier 2	$30 copay after deductible	$75 copay
Tier 3	$60 copay after deductible	$150 copay
Tier 4	$100 copay after deductible	$250 copay

Prescription Drugs

(**NOTE**: Walgreens no longer a participating pharmacy)

- **30-day supply per prescription at participating pharmacies**
- **Mail order for a 90-day supply of formulary maintenance medication per prescription**

Medical Plans

Benefits-at-a-Glance • UnitedHealthcare: High Option (Choice Network)

This plan gives you the freedom to see any doctor or other healthcare 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
Annual Medical Expense Deductible	$400 individual/ $800 family
Annual Out-of-Pocket Maximum	$4,000 individual/ $8,000 family
Coinsurance/In-Patient Hospital Coinsurance	10% of eligible expenses after deductible
Emergency Room Coinsurance	15% of eligible expenses after deductible
Primary Care Doctor Check United's provider directory before making your decision regarding your health care provider	Choose any doctor from the United Open Access Directory. You may access any participating specialist without a referral.
Preventive Care	No charge
Office Visit (Primary Care)	$30 copayment for UHC Premium Care Physician/ $40 copay non-Premium Care Physician / Deductible does not apply
Specialist Office Visit	$40 copayment for UHC Premium Care Physician/ $50 copayment for non-Premium Care Physician / Deductible does not apply. No referral needed.
Outpatient Hospital and Surgical Services, X-ray, Other diagnostic services (MRI, CT scan, lab test, etc.)	10% of eligible expenses after deductible
Outpatient Rehabilitation Therapy	$20 copayment per visit1 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 prenotification requirements.
Emergency Room Care	15% of eligible expense after deductible
Urgent Care Copay	$50 copayment Deductible does not apply
Convenience Care Clinic - Virtual Office Visits	$25 copayment - Deductible does not apply $25 copayment - Deductible does not apply
Outpatient Mental Health & Substance Abuse Services - Telemed Services include Mental/Substance Abuse Counseling	$20 individual/$15 group Deductible does not apply

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

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

	RETAIL	MAIL-ORDER
DED	$100 Individual / $200 Family	No Deductible
Tier 1	$10 copay after deductible	$25 copay
Tier 2	$30 copay after deductible	$75 copay
Tier 3	$60 copay after deductible	$150 copay
Tier 4	$100 copay after deductible	$250 copay

Prescription Drugs

(**NOTE**: Walgreens no longer a participating pharmacy)

- **30-day supply per prescription at participating pharmacies**
- **Mail order for a 90-day supply of formulary maintenance medication per prescription**

Medical Plans

Benefits-at-a-Glance • UnitedHealthcare: CDHP with an HSA* (Choice Plus Network)

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

MEMBER PAYMENTS	IN-NETWORK ONLY	OUT-OF-NETWORK ONLY
Annual Medical Expense Deductible	$3,000 individual / $6,000 family	$4,500 individual | $9,000 family
Annual Out-of-Pocket Maximum	$6,350 individual / $12,700 family	$10,000 individual | $20,000 family
Coinsurance/In-Patient Hospital Coinsurance	30% of contracted fee after deductible	40% of eligible expenses after deductible
Primary Care Doctor	Choose any doctor from the United network "UnitedHealthcare Choice Plus." Access any participating specialist without a referral.	Choose any licensed doctor
Preventive Care - Office visit - Routine mammogram**	 No charge No charge	 40% of eligible expenses after deductible 40% of eligible expenses after deductible
Office Visit (Primary Care)	30% of contracted fee after deductible	40% of eligible expenses after deductible
Specialist Office Visit	30% of contracted fee after deductible	40% of eligible expenses after deductible
Outpatient Hospital and Surgical Services, X-Ray, Other diagnostic services (MRI, CT scan, lab tests, etc.)	30% of contracted fee after deductible	40% of eligible expenses after deductible
Out-Patient Rehabilitation Therapy[1]	30% of contracted fee after deductible	40% of eligible expenses after deductible
Approved Durable Medical Equipment	30% of contracted fee after deductible	40% of eligible expenses after deductible
Emergency Ambulance Trip	30% of contracted fee after deductible	30% of eligible expenses after deductible
Hospital Pre-Admission Requirement	Your doctor will take care of prenotification	It is your responsibility to see that your doctor takes care of prenotification
Emergency Room Care	30% of contracted fee after deductible	30% of eligible expenses after deductible
Urgent Care Copay	30% of contracted fee after deductible	40% of eligible expenses after deductible
Convenience Care Clinic - Virtual Office Visits	30% of contracted fee after deductible $50 then 30% of contracted fee after deductible	40% of eligible expenses after deductible N/A
Outpatient Mental Health & Substance Abuse Services	30% of contracted fee after deductible	40% of eligible expenses after deductible

Network **www.myUHC.com**. Network name "UnitedHealthcare Choice." This network is for both the Low/High Option HMO.
[1] 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type; 36 visits per year for cardiac therapy.

	RETAIL	MAIL-ORDER
DED	Subject to Deductible	Subject to Deductible
Tier 1	$10 copay after deductible	$25 copay after deductible
Tier 2	$30 copay after deductible	$75 copay after deductible
Tier 3	$60 copay after deductible	$150 copay after deductible
Tier 4	$100 copay after deductible	$250 copay after deductible

Prescription Drugs

- **30-day supply per prescription at participating pharmacies**
- **Mail order for a 90-day supply of formulary maintenance medication per prescription**

Health Savings Account

OPTUM Bank®

UnitedHealthcare®

Introduction to Health Savings Accounts

A health savings account (HSA) allows you to save money for qualified medical expenses that you're expecting, such as contact lenses or monthly prescriptions, as well as unexpected ones — for this year and the future.

Why have an HSA?

You own it

The money is yours until you spend it, even deposits made by others, such as an employer or family member. You keep it, even if you change jobs, health plans or retire.

Tax savings

HSAs help you plan, save and pay for health care, all while saving on taxes.

- The money you deposit is federal income tax-free.
- Savings grow income tax-free.
- Withdrawals for qualified medical expenses are also income tax-free.

It's not just for doctor visits

Once you've contributed to your account, you can use the funds in your HSA to pay for qualified medical expenses such as:

- Dental care, including extractions and braces
- Vision care, including contact lenses, prescription sunglasses and LASIK surgery
- Prescription medications
- Chiropractic services
- Acupuncture

Save for the future

Your HSA rolls over from year to year, so you can continue to grow your savings and use it in the future - even into retirement.

Contribution limits

There are contribution limits, set by the Internal Revenue Service (IRS) and adjusted annually.

These limits are:

- **$3,500** for individual coverage in 2019; **$3,550** in 2020
- **$7,000** for family coverage in 2019; **$7,100** in 2020
- **$1,000** extra if you're 55 or older, also known as catch-up contributions

Health Savings Account

Who can open an HSA?

To be an eligible individual and qualify for an HSA, you must have a high-deductible health plan (HDHP) that meets IRS guidelines for the annual deductible and out-of-pocket maximum.

In addition, you must:

- Be covered under a qualifying HDHP on the first day of a given month.
- Not be covered by any other health coverage except what is permitted (dental, vision, disability and some other types of additional coverage are permissible).
- Not be enrolled in Medicare, TRICARE or TRICARE for Life.
- Have not received Department of Veterans Affairs (VA) benefits within the past three months, except for preventive care. If you are a veteran with a disability rating from the VA, this exclusion does not apply.
- Not be claimed as a dependent on someone else's tax return.
- Not have a health care flexible spending account (FSA) or health reimbursement account (HRA). Alternative plan designs, such as a limited-purpose FSA or HRA, might be permitted.

Other restrictions and exceptions also apply. Consult a tax, legal or financial advisor to discuss your personal circumstances.

Open your account

Check with your employer or benefits specialist to learn about your company's application process. You may be able to sign up through your employer or enroll at **optumbank.com** or through **myuhc.com®.** You cannot use your HSA to pay for medical expenses you had before you opened your account — so be sure to open your HSA as soon as you are eligible.

And be sure to save your receipts! For a full list of qualified medical expenses, visit **optumbank.com/qualifiedexpenses.**

Have questions?

Visit **optumbank.com** or download the mobile app.

Contributions add up quickly.

When Marcus started his new job, he decided to open an HSA and contribute $100 per month. Because he hasn't had many medical expenses, he decided not to touch the balance during his first year. Here's how his contributions added up:

Monthly contribution: **$100**

Annual contribution: **$1,200**

Annual income tax savings[1]: **$452**

[1] 25% federal | 5% state | 7.65% FICA

Use the HSA Calculator on **optumbank.com** to help determine your contributions and see how much you can save on taxes.

Open your HSA today.

The Optum Bank App is here!

Enjoy an easier way to manage your health savings account. You can pay bills, view transactions, upload receipts and more! Download today on your Apple or Android device.

Available on the App Store | GET IT ON Google Play

OPTUM Bank® Member FDIC

Health savings accounts (HSAs) are individual accounts offered or administered by Optum Bank®, Member FDIC, and are subject to eligibility requirements and restrictions on deposits and withdrawals to avoid IRS penalties. State taxes may apply. Fees may reduce earnings on account. This communication is not intended as legal or tax advice. Federal and state laws and regulations are subject to change.

Healthcare 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 Care Physician

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

- Find doctors and hospitals in your area that meet quality and cost-efficiency criteria
- Find doctors you can call directly, without prior approval
- Find names quickly online
- Get access to 27 specialties, including primary care, cardiology and orthopedics, as well as facilities in six specialties, including:
  - Congenital heart disease
  - Cardiac care
  - Neonatology
  - Infertility
  - Total joint replacement
  - Spine surgery

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

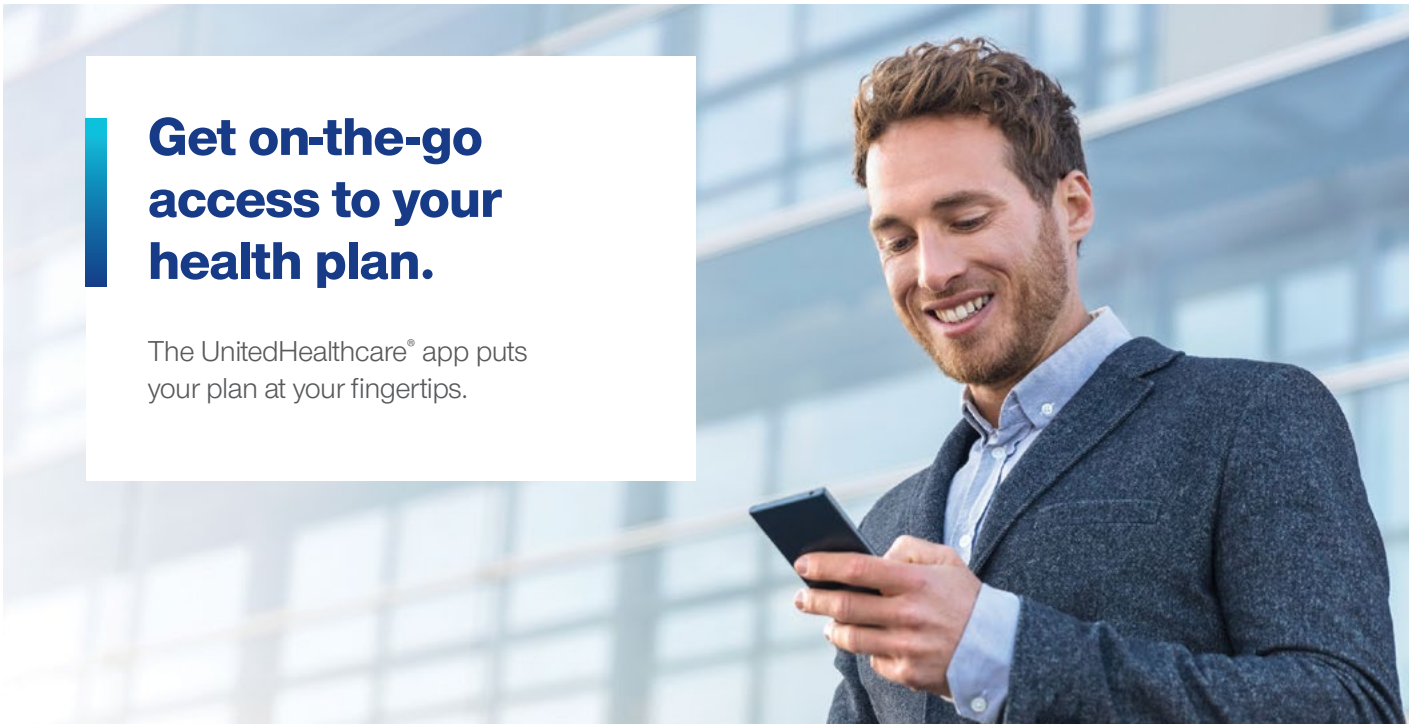
Premium Care Physician

Finding a UnitedHealth Premium Care Physician

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

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

Pharmacy Benefits



Get on-the-go access to your health plan.

The UnitedHealthcare® app puts your plan at your fingertips.

The app has you covered.

When you're out and about, you can do everything from managing your plan to getting convenient care. Just download the app to:

- Find nearby care options in your network.
- Estimate costs.
- Video chat with a doctor 24/7.
- View and share your health plan ID card.
- See your claim details and view progress toward your deductible.

Get the app and log on with Touch ID®.

The UnitedHealthcare app is available for download for iPhone® or Android™.

GET IT ON Google Play

Download on the App Store

UnitedHealthcare®

Pharmacy Benefits

Pharmacy
Specialty pharmacy program

Welcome to the UnitedHealthcare specialty pharmacy program.

Appropriate use of specialty medications can be important to maintaining or improving your health — and your quality of life. Our specialty pharmacy program provides the resources and personalized, condition-specific support you need to help you better manage your condition.

What is a specialty medication?

A specialty medication is used to treat complex, long-term conditions that require additional care and support. It may be injected, inhaled or taken by mouth. In addition, it:

- May require additional education and support for best management
- Has unique storage or shipping requirements
- May not be available at retail pharmacies

BriovaRx: A specialty pharmacy to meet your needs

BriovaRx®, the OptumRx® specialty pharmacy, offers support to help you manage your condition. Take advantage of personalized patient support — at no charge to you — from knowledgeable pharmacists and nurses who specialize in your condition. In addition, you'll receive:

- Access to your medications at the lowest cost
- Pharmacists available 24/7
- Support through clinical and adherence programs
- Any medication-related supplies at no additional cost
- Proactive refill reminders
- Timely delivery and shipping in confidential, temperature-sensitive packaging

Specialty medication resources

Customer service
Call the toll-free member phone number on the back of your health plan ID card or BriovaRx directly at **1-855-4BRIOVA (1-855-427-4682)**.

Online at myuhc.com
Look up information specific to your medication or condition and find additional resources.

Pharmacy Benefits

RxGuide for specialty medications

Guiding your health journey under the pharmacy benefit

We understand the challenge of living with and managing a complex health condition. That's where our specialty pharmacy program comes in, to help you every step of the way.

Getting started: Transferring your prescription

Call BriovaRx to enroll in the specialty pharmacy program
If you haven't done so yet, call us at **1-855-4BRIOVA (1-855-427-4682)** to get started.

Access to a pharmacist 24/7
Our specialty pharmacists are available 24/7 and will take care of everything for you, including:

- Transferring your prescription
- Helping you find affordable access to your medication
- Helping you manage any side effects

Personalized support
Once you enroll, experience personalized, one-on-one support from pharmacists and nurses specially trained in your condition. They can track your progress, help you follow your treatment and answer your questions.

Working with your pharmacist or nurse

Continued conversations
Tell your pharmacist or nurse about any changes or complications in your therapy, such as:

- Any side effects
- Trouble remembering to take your medication

Monitor your health
If you need help with anything else — from weight loss to back pain, or even smoking cessation — your specialty pharmacist or nurse can help you locate wellness coaching and disease management programs to help you stay on track with your health.

Follow your care plan
Be sure to follow your care plan and tell your pharmacist or nurse about any new medications you're taking.

Staying on track with your treatment

Quick and easy refills
We make it easy for you to remember to take your medication with a reminder phone call a few days before you need to refill your prescription.

Fast, safe delivery
With BriovaRx, shipping your medication is quick, easy and safe. Refrigerated medications will be delivered overnight to the location you choose, in a temperature-controlled package. Others will be shipped within 1-3 days. Supplies will also be provided at no extra cost.

Save more time and money
BriovaRx can only fill your specialty medications. Use your home delivery or retail pharmacy for your non-specialty prescriptions. If you're looking to save money on your medications, finding lower cost alternatives and filling your non-specialty prescriptions by mail can help.

briovaRx | UnitedHealthcare®

Dental Benefits

Getting started with Humana dental

We've given you a reason to smile with a selection of four flexible dental plans, paid through a voluntary, pretax benefit.

Register at Humana.com

As a Humana member, you have a secure website on **Humana.com** called MyHumana. With MyHumana, you have fast, easy access to your personalized benefits information.

Some of what you can do on MyHumana:

- Claims – Check if a claim has been paid along with your estimated cost, if any
- ID cards – View, print and email up-to-date dental Humana member ID cards
- Coverage details – Review deductibles, coverage levels and limits
- Provider search – Use "Find a doctor" to find in-network dentists near you
- Manage access – Give other adults on your policy permission to access your health information
- Update your communications preferences – Select which communications you want to receive from Humana and how you want to receive them — via paper or email

Registering is easy

- Have your Humana member ID or Social Security number available
- Go to **Humana.com**
- Select "Register" at the top of the page
- Choose "Member all other plan types"
- Fill in some basic information — like your Humana member ID number or Social Security number, date of birth, ZIP code, and email and click "next"
- Create a username, password and security prompt and click "next" to finish

Also, you can download the MyHumana mobile app from the app store on your smartphone to access plan information.

Access your digital ID Card and keep it with you

You will have access to view and print your dental ID cards via the Humana website or the Humana mobile app within 10 working days of enrollment. Here's how:

Via the website:

- Go to **Humana.com** and sign in/register for MyHumana (Have your Humana member ID or Social Security number available)
- Click "Access your ID Card" under "Tools & forms" in the lower right of your MyHumana home page or in the page's footer under "Tools & Resources"
- A new window will appear with links to the ID card or proof of coverage
- Print if desired.

Via the mobile app:

- Download the MyHumana App for iOS or Android
- Sign in using your MyHumana username and password
- Click "ID Cards" on the dashboard
- Your dental ID card information and an image of the front and back of the ID card will be visible

Humana Customer Care

For assistance or more information on the Humana Dental benefits simply call 1-800-233-4013 (TTY: 711), Monday through Friday, 8 a.m. to 6 p.m. Easter Time (TDD: 1-800-325-2025) to speak with a friendly, knowledgeableCustomer Care specialist, or visit **Humana.com**.

Dental Benefits

The Four Dental Options Offered Are:

Managed Care Plans

Option 1 (DHMO Enhanced) & **Option 2 (DHMO Basic)** provide a wide variety of benefits through your participating dentist. At the time of service, you pay the dentist for any applicable copayments according to your schedule of benefits.

Both plans feature:

- No primary dentist selection required
- No maximums
- No waiting periods
- No claims to file
- A large panel of providers to choose from
- Same copayment to participating general dentist or specialist
- No referrals required to see a participating specialist
- Pediatric specialist care for age 16 and under

Orthodontics

Both the **DHMO Enhanced** and **DHMO Basic** cover orthodontia services for both adults and children. Copayments under the **DHMO Enhanced** are set at $1,600 for children and adolescents; $1,950 for adults. Copayments under the **DHMO Basic** are set at $2,200 for children, $2,250 for adolescents and $2,350 for adults.

PPO Plans

Option 3 (PPO High) allows you and each covered family member to use the dentist of your choice; however, you'll receive a higher level of coverage when you choose a participating dentist. 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, plus an extended annual maximum benefit. This plan covers orthodontia for adults and children up to the age of 18. The lifetime orthodontic maximum benefit is $1,000 for adults and $2,000 for children.

Option 4 (PPO Low) allows you and each covered family member to use the dentist of your choice; however, you'll receive a higher level of coverage when you choose a participating dentist. 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, plus an extended annual maximum benefit. This plan does not cover orthodontic services.

Finding an in-network dentist

Go to **https://www.humana.com/dental-insurance/find-a-dentist** anytime to find an in-network dentist.

Under the Network drop down box, search for a provider by selecting one of the following networks:

Palm Beach Schools DHMO

Palm Beach Schools PPO

You can also access the list of in-network providers on your MyHumana mobile app or by calling the customer care number on this page.

How to refer a dentist

You can help us get your dentist on our participation list. Simply complete the form at **https://www.humana.com/provider/dentist-resources/refer-a-dentist**. We'll invite your dentist to participate in the Humana Dental network.

Transition of care

Orthodontic transition allows patients who are under an orthodontist's care through the prior carrier to continue seeing the same orthodontist that was treating their case prior to becoming a member of Humana.

PPO*

For members enrolling in the PPO High, if your dependent is in active orthodontia treatment without having experienced a lapse in coverage, Humana will subtract the amount the prior carrier covered from the orthodontic total case fee and orthodontic lifetime maximum. Humana will prorate the remaining charges over the remaining treatment period and systematically issue monthly payments, which are applied toward the lifetime orthodontic maximum.

Humana will work with your prior dental carrier to obtain information regarding the orthodontia treatment in progress.

*Prior DHMO plan moving to a PPO plan with orthodontic coverage: Humana will not apply the payment information that was rendered while under the DHMO plan to the participant's PPO plan. Humana will prorate the charges prior to the Humana effective date and issue benefits from the effective date forward under the Humana PPO plan.

DHMO

For members enrolling in the DHMO plan, Humana works with the prior carrier and member to obtain reports of the orthodontia treatment in progress covered under the contract holder's prior plan. To be eligible and covered under the Humana plan, the treatment must be shown on the member's schedule of benefits and they must have the subsequent treatment performed by a participating provider.

Dental Benefits

Your Dental Rates

Per pay period pre-tax deductions are as follows:

	HUMANA DHMO PLANS (FL Only Network)				HUMANA PPO PLANS (National Networks)			
	OPTION 1 - DHMO ENHANCED orthodontia		OPTION 2 - DHMO BASIC orthodontia		OPTION 3 - PPO DENTAL HIGH orthodontia		OPTION 4 - PPO DENTAL LOW	
	24 DED	22 DED	24 DED	22 DED	24 DED	22 DED	24 DED	22 DED
Employee only	$7.20	$7.85	$5.47	$5.97	$15.98	$17.43	$12.60	$13.74
Employee + Child(ren)	$15.30	$16.69	$11.70	$12.76	$43.95	$47.94	$34.65	$37.80
Employee + Spouse*	$12.60	$13.74	$9.52	$10.38	$39.16	$42.71	$30.87	$33.67
Employee + Family*	$19.80	$21.60	$14.98	$16.34	$59.14	$64.50	$46.63	$50.86

* **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.

Extended Annual Maximum*

As part of Humana's dental PPO Plans, the Extended Annual Maximum helps you save money by ensuring you have access to network discounts and 30% coinsurance, even after you have reached your annual maximum. You can achieve and maintain your best health by getting dental care when it's needed, before oral health issues may affect your overall health and well-being.

With Humana's extended annual maximum, you won't have to put off important dental care procedures for yourself or your covered dependents.

*Excludes orthodontia

Preventive Coverage

Early detection is the key to preventing more serious health conditions including diabetes, heart disease and stroke. Humana's enhanced preventive care benefits cover many services to help you achieve and maintain your best oral health and save on out-of-pocket expenses.

Our enhanced preventive care benefit covers four periodontal maintenance cleanings, as well as three routine cleanings every year, whichever is needed, helping you prevent oral health issues from becoming chronic conditions. Under enhanced preventive coverage, periodontal maintenance cleanings are covered under preventive services.

Additional preventive care through Humana:

- Three routine cleanings per year
- Four periodontal maintenance cleaning procedures per year—covered as a preventive service
- Oral cancer screenings for members aged 40 plus

Humana Cost Comparison

There are copayment differences between the prior Solstice DHMO benefits and the new Humana DHMO benefits.

Exclusions and limitations applied to certain Solstice benefits and the listed copayments did not include the cost of material and laboratory fees. Unexpected additional costs were applied to those benefits at the time of service.

Humana's DHMO plans have set copayments that include the cost of material and laboratory fees so there are no hidden additional charges. Below is an example:

	CURRENT PLAN			PREVIOUS PLAN		
MAJOR PROCEDURES	HUMANA - DHMO ENHANCED			SOLSTICE - DHMO S500PB		
	Copayment	Material & Laboratory Fees	Member Total Copayment	Copayment	Material & Laboratory Fees	Member Total Copayment
Crowns – porcelain, high noble metal	**$495**	**$0**	**$495**	$240	$130 high noble metal fee + $125 crown laboratory fee	$495

Dental Benefits

Commonly Covered Procedures:

Sample procedure codes, see full schedule for complete listing: **www.MyHumana.com**

BENEFIT	OPTION 1 - DHMO ENHANCED	OPTION 2 - DHMO BASIC
	YOU PAY	YOU PAY
DEDUCTIBLE		
Annual Deductible	None	None
Calendar Year Maximum	None	None
Claim Forms	None	None
Primary Dentist Required	None	None
PREVENTIVE & DIAGNOSTIC		
Office visit	No charge	No charge
Routine exams (2 per 12 Months)	No charge	No charge
Prophylaxis (cleaning) - basic (3 per 12 months)	No charge	No charge
Emergency treatment (palliative)	No charge	No charge
X-ray - complete series including bitewings (1 per 24 months)	No charge	No charge
Fluoride application (1 per 12 months)	$10	$15
BASIC/RESTORATIVE PROCEDURES		
Simple extractions	$10	$20
Amalgam fillings - 1 surface permanent	No charge	No charge
Anterior Root canals (1 canal)	$100	$110
Endodontic Therapy, Premolar Tooth	$185	$185
Endodontic Therapy, Molar Tooth	$225	$245
Composite resin fillings	No charge	No charge
Sealants (up to age 15)	No charge	No charge
MAJOR SERVICES		
Crowns - porcelain, high noble metal	$495	$500
Dentures - upper/lower	$460 each	$525 each
Bridges - porcelain, base metal	$420	$425
PERIODONTICS		
Periodontal Maintenance (limit 4 per year)	$0	$0
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

Network Palm Beach Schools DHMO

Dental Benefits

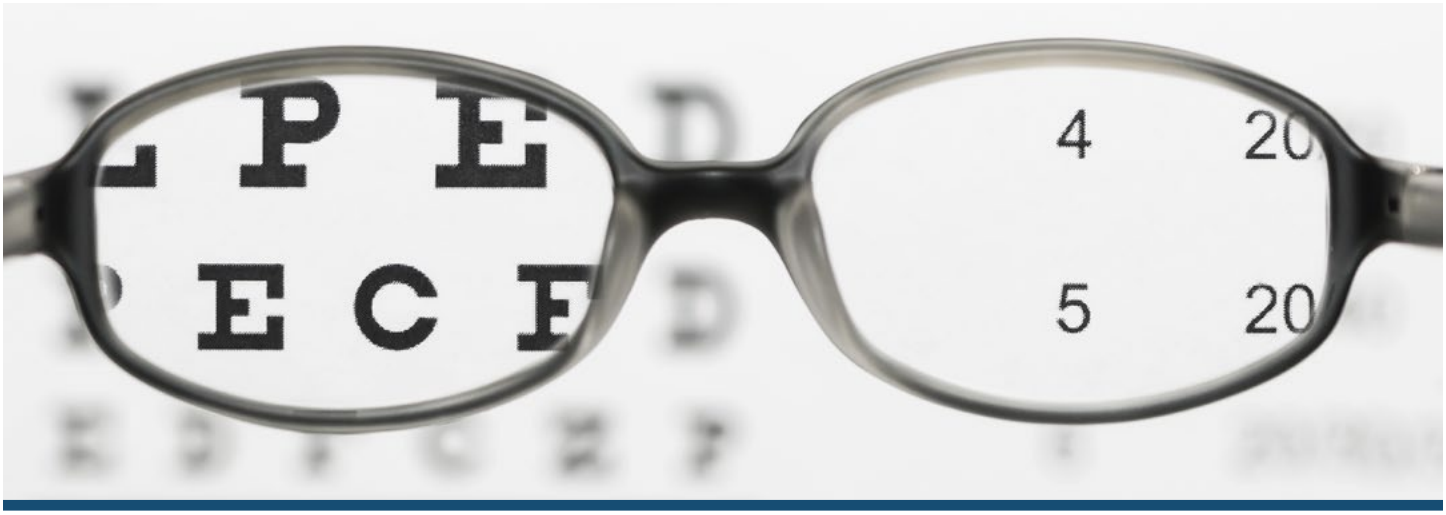
PPO Plans

Sample procedure codes, see full schedule for complete listing: **www.MyHumana.com**

BENEFIT	OPTION 3 - PPO HIGH		OPTION 4 - PPO LOW	
	IN-NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK*
DEDUCTIBLE (MAXIMUM 3 PER FAMILY) - CALENDAR YEAR IS JANUARY 1 - DECEMBER 31				
Class I	None	None	None	None
Class II, III, IV	$50 per year, individual		$50 per year, individual	
Calendar Year Maximum	$1,000 + Extended Annual Maximum		$1,000 + Extended Annual Maximum	
Lifetime Orthodontic Maximum	$1,000 Adults / $2,000 Children		Not covered	Not covered
CLASS I - PREVENTIVE & DIAGNOSTIC				
Routine Oral Exam	100%	90%	100%	80%
X-rays (diagnostic)	100%	90%	100%	80%
Routine Cleanings	100%	90%	100%	80%
Periodontal cleanings	100%	90%	100%	80%
Fluoride treatment	100%	90%	100%	80%
Sealants	100%	90%	100%	80%
Space maintainers	100%	90%	100%	80%
Oral Cancer Screening (ages 40+)	100%	90%	100%	80%
Panoramic x-rays	100%	90%	100%	80%
CLASS II - BASIC SERVICES				
Emergency care for pain relief	80%	70%	50%	40%
Amalgam / Composite fillings	80%	70%	50%	40%
Oral Surgery (includes extractions)	80%	70%	50%	40%
Harmful habit appliances	80%	70%	50%	40%
Periodontics	80%	70%	50%	40%
Endodontics	80%	70%	50%	40%
CLASS III - MAJOR SERVICES				
Inlays/onlays/crowns & bridges	50%	40%	50%	40%
Dentures and other removable prosthetics	50%	40%	50%	40%
Implants	50%	40%	50%	40%
CLASS IV - ORTHODONTIC SERVICES				
Orthodontia	50%	50%	Not covered	Not covered

*Out-of-network percentage is based on allowable charges.
Network Palm Beach Schools PPO

Vision Benefits



Vision Care Premiums

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

FULL-TIME OR PART-TIME	EYEMED VISION	
Deductions	24	22
Employee	$2.73	$2.97
Employee + Family*	$7.00	$7.64

*Amounts reflected on paychecks may vary slightly due to rounding.

Plan Provider: EyeMed Vision Care

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

- Glaucoma
- Diabetes
- Cataracts
- Hypertension

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

Eye examinations are also important for the health and safety of children. The American Optometric Association recommends that children receive their first eye examination from an eye care professional as early as six months of age. Afterward, your provider will advise you when to schedule your child's next eye examination.

EyeMed's thousands of provider locations allow you to begin receiving substantial savings on your eye care and eyewear needs at one of many locations nationwide.

Plan Features

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

- Eye examinations
- Contact lenses
- Glasses
- Rx sunglasses
- Lens options and accessories or
- LASIK and PRK laser vision correction discounts.

Claim Forms

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

Lens Options

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

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

Vision Benefits

Additional Purchases and Out-of-Pocket Discount

You will receive a 20% 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% 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% off the retail price of complete pair eyeglass purchases, 20% off partial pair purchases, and 15% off conventional contact lenses. See your EyeMed provider for details.

How to - Find a Provider

- Visit the EyeMed website at **www.eyemed.com**
- Click "Find an Eye Doctor"
- Enter your ZIP code to find a provider

For the most updated listing for members, visit our website at **www.eyemed.com** or call 1-866-723-0514.

To Locate an EyeMed Provider Near You:

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

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

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

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

Monday–Saturday, 7:30 a.m. - 11 p.m. EST
Sunday, 11 a.m. - 8 p.m. EST

Vision Benefits

EYEMED PLAN SERVICES	IN-NETWORK Member Cost	OUT-OF-NETWORK Maximum Reimbursement
Exam with dilation as necessary	$10 copayment	Up to $35
Retinal imaging benefit	Up to $39	N/A
EXAM OPTIONS		
Standard contact lens fit and follow-up* Premium contact lens fit and follow-up**	Up to $40 10% off retail price	N/A N/A
FRAMES	$0 copay; $130 allowance; 20% of balance over $130	$65
STANDARD PLASTIC LENSES:		
Single vision	$15 copayment	$25
Bifocal	$15 copayment	$40
Trifocal	$15 copayment	$55
Standard progressive	$60 copayment	$55
Premium progressive	$60, 80% of charge less $130 allowance	$55
LENS OPTIONS (PAID BY THE MEMBER AND ADDED TO THE BASE PRICE OF THE LENS):		
UV Coating	$12	$2
Tint (solid and gradient)	$12	$2
Standard scratch-coating	$15	N/A
Standard polycarbonate - adult	$35	$3
Standard polycarbonate - children under 19	$35	$3
Standard anti-reflective	$45	N/A
Polarized	20% off retail price	N/A
Other add-ons and services	20% off retail price	N/A
CONTACT LENSES (INCLUDES MATERIALS ONLY; IN LIEU OF LENSES)		
Conventional	$0 copayment; $125 allowance plus 15% off balance over $125	$100
Disposables	$0 copayment; $125 allowance plus balance over $125	$100
Medically necessary	$0 copayment, paid in full	$200
Contact Booster	$0 copayment; $145 allowance when lens are purchased through **contactsdirect.com**	N/A
LASIK AND PRK VISION CORRECTION PROCEDURES†	15% off retail price OR 5% off promotional pricing	N/A
FREQUENCY		
Exams	Once every 12 months	
Frames	Once every 24 months	
Standard plastic lenses or contact lenses	Once every 12 months	

* Standard contact lens fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)
** Premium contact lens fitting - all lens designs, materials and specialty fittings other than standard contact lenses (examples include toric, multifocal, etc.)
† LASIK and PRK correction procedures are provided by the U.S. laser network, owned by LCA-Vision. You must first call 1-877-5LASER6 for the nearest facility and to receive authorization for the discount.

Vision Benefits

LensCrafters | Target Optical | EyeMed | Sears Optical | Pearle Vision

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

- Locate the provider nearest you by going to **www.eyemed.com** and click on "Select" network.
- View your benefits, including service eligibility and the next date of service.
- Printable replacement ID cards.
- Online claims status.
- Ability to "go paperless" and receive explanation of benefits electronically.
- Learn more about the importance of vision care through Vision Wellness content.
- Access the mobile website to locate a provider, view ID cards, benefits and contact EyeMed.
- EyeMed mobile app available for iPhone, iPad and most Android touch users.
- Know-Before-You-Go- The newest feature that educates employees on the cost of their purchases with their benefits before visiting their provider!

Contactsdirect.com is an online in-network benefit

How Does the Program Work? Three easy steps:

Use your contact lens allowance online by using your in-network benefits. Simply go to **www.contactsdirect.com**. Select your lenses from a wide selection of top selling brands. In-network benefits instantly apply to your purchase, and contact lenses will ship as soon as the prescription* is verified-most ship the same day.

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

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

Additional services with your EyeMed Vision Plan Enrollment:

The following additional service are included with your vision plan at no added cost to you.

- Freedom Pass
  - Any frame, any price, any brand for $0 out-of-pocket at Sears® Optical or Target® Optical
  - Offer Code: 755288
  - Additional service link for more information: **http://l.sdpbc.net/6mf9r**
- ContactLens Booster
  - **Contactsdirect.com** on-line solutions
- International Travel Solutions
  - Temporary emergency glasses within 24 hours**
  - 24/7 support with translation services in 160 languages
  - Online directory of trusted providers in 20 countries
- Additional Saving and Resources
  - Mobile App Option
  - 40% additional pair discount
  - Emergency Solutions for international travel
  - 20% off non-prescription sunglasses
  - 20% off any remaining frame balance/non covered item
  - **Eyesiteonwellness.com** (Vision Wellness Resources)

** Available in most cases. Check your plan benefits to be sure.

Employee Wellness

Employee Wellness

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

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

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

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

Visit us online for more information, about the Health Rewards Program, including:

- Official Health Rewards Program Rules
- Health Rewards Personal Planner
- Upcoming Wellness Events
- Monthly Health Tips

https://hub.palmbeachschools.org/all_employees/employee_wellness

Key Components of Employee Wellness

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

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

Wellness Services

Wellness Services to Help you Meet your Personal Health Goals

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

Find Support by Working with a Personal Health Coach

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

Get Help to Stop Smoking or Quit Using Tobacco

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

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

Learn How We Can Help You Lose Weight

There are real advantages to losing weight. Being overweight can lead to diseases, such as heart disease, diabetes, high blood pressure and high cholesterol. Our online health coaches will guide you through a staged approach to learning about proper nutrition and how to plan healthy meals.

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

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

Avoid premium surcharges!

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

How Does it Work?

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

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

Flexible Spending Accounts (FSAs)

What is a Flexible Spending Account (FSA)?

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

FSAs Feature:

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

Is an FSA Right for Me?

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

- Decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- Save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a tax savings analysis by visiting the "tax calculators" link at **https://www.wageworks.com/employees/healthcare-benefits/healthcare-flexible-spending-account/** and **www.wageworks.com/mydcfsa**.

What Types of FSAs Are Available?

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

Health Care FSA

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

- Prescription drugs
- Eyeglasses
- Orthodontia

Dependent Care FSA (day care/elder care)

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

- Day care services
- In-home care
- Nursery and preschool
- Summer day camps

Receiving Reimbursement

Complete and properly submitted claim forms are generally process for reimbursement within five business days. To avoid delays, follow the instructions for FSA claims submissions.

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.

To apply, visit **www.wageworks.com**.

NOTE: Processing your FSA direct deposit enrollment may take between four and six weeks.

FSA Grace Period

An IRS Revenue Notice permits a "grace period" of two months and 15 days following the end of your 2020 plan year (December 31, 2020) for an FSA. This grace period ends on March 15, 2021. 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 2020 Health Care FSA or Dependent Care FSA.

You should not confuse the grace period with the plan's "run-out period". The run-out period extends until March 31, 2021. This is a period for filing claims incurred anytime during the 2020 plan year, as well as claims incurred during the grace period mentioned above.

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

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.

Flexible Spending Accounts (FSAs)

Where Can I Get Information About FSAs?

If you have specific questions about FSAs, contact the Customer Service department. Visit **www.wageworks.com** or call WageWorks Customer Service Mon - Fri, 8 a.m. - 8 p.m. ET at 855-428-0446.

NOTE: your account information will not be discussed with others without your verbal or written authorization.

How Do I Get the Forms I Need?

Log in to **www.wagewovrks.com** to obtain:

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

For more information call WageWorks Customer Service at 855-428-0446 for further assistance.

PRE-TAX BENEFITS SAVINGS EXAMPLE

(With FSA)		(Without FSA)
$30,000	**Annual Gross Income**	$30,000
- $2,700	**FSA Contributions**	- $0
$27,300	**Taxable Gross Income**	$30,000
- $3,689	**Est. Federal & Social Security Taxes***	- $4,845
$23,611	**Annual Net Income**	$25,155
- $300	**Eligible out-of pocket medical and dependent care expenses**	- $3,000
$23,311	**Spendable Income**	$22,155

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:

+ $1,156!

**Assumes standard deductions and four exemptions*

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Health Care FSA or vice versa.
3. You have a 90-day run-out period (until March 31, 2021) 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 2020 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 2020 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.
   - I will collect and maintain sufficient documentation to validate the foregoing.

Health Care FSA

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.

Whose expenses are eligible?

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

- Yourself
- Your spouse
- Your qualifying children
- Your qualifying relative

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.

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: 877-353-9236
Mail to: WageWorks
Claims Administrator
P.O. Box 14053
Lexington, KY 40512

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

Minimum Annual Deposit: $300

Maximum Annual Deposit: Up to IRS Published Maximum

What Is the WageWorks® Healthcare Card?

The WageWorks® Healthcare Card is a stored-value card. It allows electronic reimbursement of eligible expenses under the School District of Palm Beach County's plan and IRS guidelines. Your annual Health Care FSA contribution is available to you at the beginning of your plan year.

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

When Do I Send in Documentation for a WageWorks® Healthcare Card Expense?

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

- Name of the patient
- Name of the service provider
- Date of service
- Type of service (including prescription name) and
- Total amount of service

NOTE: This documentation must be sent with a properly completed claim form and cannot be processed without it. Like all other FSA documentation, you must keep the WageWorks® Healthcare Card expense documentation for a minimum of one year and submit it when requested.

How Do I Get a WageWorks® Healthcare Card?

You will automatically receive the WageWorks® Healthcare Card. One card will be sent to you in the mail.

You may visit **www.wageworks.com** to order a card for your spouse or eligible dependent. You should keep your card to use each plan year until its expiration date. You will have to activate your card. There are no fees for using the card!

Dependent Care FSA

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.

Whose Expenses Are Eligible?

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

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

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

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

- Is physically and/or mentally incapable of self-care
- Lives in your household for more than half of the taxable year
- Spends at least eight hours per day in your home

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

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

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

What Is My Maximum Annual Deposit?

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

When Are My Funds Available?

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

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 https://www.wageworks.com/employees/healthcare-benefits/healthcare-flexible-spending-account/ and www.wageworks.com/mydcfsa to complete a tax savings analysis.

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:

1-877-353-9236

Mail to:

WageWorks
Claims Administrator
P.O. Box 14053
Lexington, KY 40512

Accessing FSA Benefits

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

Personal Identification Number (PIN)

- The last four digits of your SSN will be your Wageworks ID Code.
- Your PIN is needed to register. Future logins will require username and password.
- If you forget your PIN, call the WageWorks Customer Service Center at 1-855-428-0446.

On the Web

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

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

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

Follow the link on the login page and register through the WageWorks Login.

Managing Your Account

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

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

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

Special Retirement Plan

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.

How Much Money Can I Contribute?

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

Am I Eligible for 401(a) Dollars and Medical Coverage as a Dependent?

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

How Does It Work?

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

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

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

When Do I Receive Statements?

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

How Do I Access My Account?

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

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

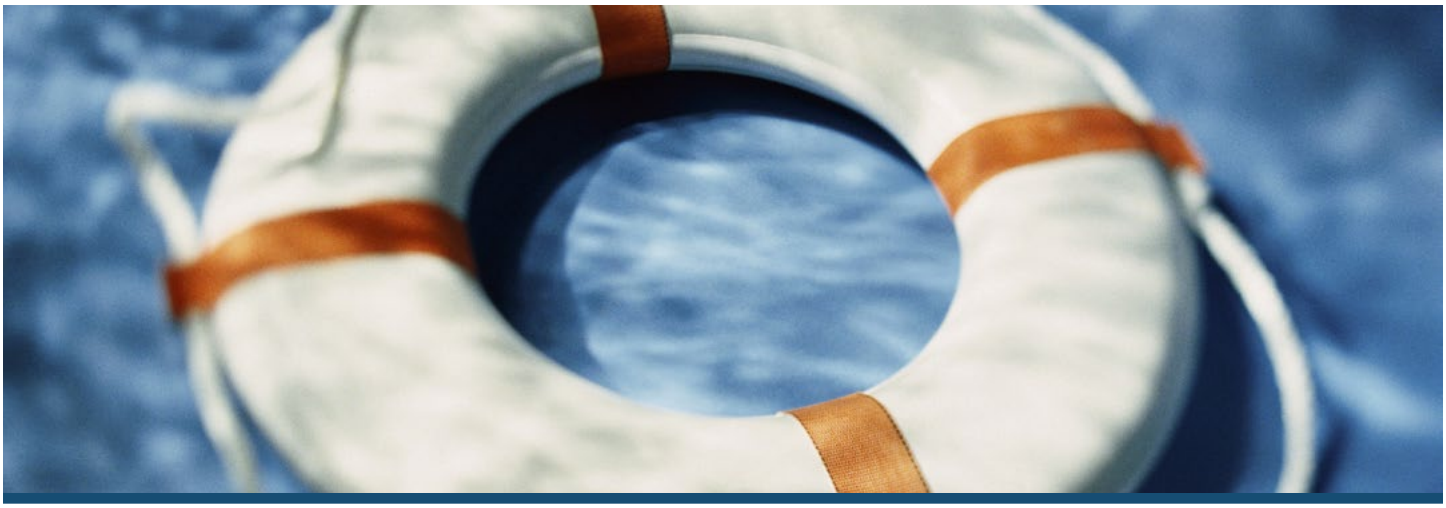
Features of the Participant Website

- 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

How Can I Get More Information?

Contact Bencor Administrative Services at 1-866-296-9712, or email: **questions@bencorplans.com**

Disability Income Protection



Plan Provider: Metropolitan Life Insurance Company (MetLife)

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

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

About the Plan Provider

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

The Disability Certificate issued by MetLife is available at: **https://hub.palmbeachschools.org/all_employees/benefits/disability**

Eligibility

This program is available to employees who:

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

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

Earning/Salary Definition

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

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

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

Provisions Affecting the STD and LTD Plans

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

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

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

Waiver of Premium – This provision applies to LTD disability coverage only, and the premium that is waived is Life Insurance Coverage. You do not pay premiums while disability benefits are payable. Premiums are waived beginning with the next premium due date following the completion of the elimination period, which is usually six months (or when you are notified by MetLife's Claims Department).

Disability Income Protection

Benefits for Mental Illness, Alcoholism, or Drug Abuse

Benefits are payable for a limited period.

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

Short-Term Disability Plan

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

Definition of Disability

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

- You are receiving appropriate care and treatment and complying with the requirements of such treatment; and
- You are unable to earn more than 80% of your pre disability earnings at your own occupation for any employer; and unable to perform each of the material duties of your own occupation.

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

	DISABILITY		
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 the disability certificate issued by MetLife.

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.

What's Not Covered

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

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

A benefit will not be paid for any disability caused or contributed to by elective treatment or procedures such as:

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

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

When Coverage Ends

Coverage ends on the earliest:

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

Preexisting Condition

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

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

Preexisting Condition Means a Sickness or Accidental Injury for which you

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

Disability Income Protection

When to Submit a Short-Term Disability Claim

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

How to Submit a Short-Term Disability Claim

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

Long-Term Disability Plan

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

- a benefit amount of up to 60% of your predisability 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?

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

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

You are, after such period:

- Unable to earn more than 60% of your predisability earnings at any gainful occupation for any employer in your local economy; and,
- Unable to perform the duties of any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.

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

What's Not Covered

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

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

When Coverage Ends

Coverage ends on the earliest of:

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

Preexisting Condition

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

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

Preexisting Condition Definition

Preexisting condition means a sickness or accidental injury for which you:

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

Recurrent Disability

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

When to Submit a Long-Term Disability Claim

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

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

Disability Income Protection

How to Submit a Long-Term Disability Claim

If you are enrolled in STD and switch to LTD, the transition process for a claim is automated by MetLife's claim system. A separate LTD claim form is not needed if you have already filed a claim under the STD plan during the transition. However, you must complete a claimant questionnaire. It is required and requests information about other income/offset information, past work experience/education and medical providers. MetLife may also obtain additional information from the School District of Palm Beach County.

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

What Benefits are Included in Long-Term Disability?

AGE ON DATE OF YOUR DISABILITY	BENEFIT PERIOD
Less than 63	The Later of your Normal Retirement Age or 42 months
63	The Later of your Normal Retirement Age or 36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

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

Work Incentive Benefit – When a medical provider states specific medical restrictions, MetLife's Rehabilitation team will work with employees who cannot do their own job, assisting them to be employable. During this time, if approved, a portion of benefits may be payable.

Rehabilitation and Return to Work Assistance – MetLife vocational rehabilitation experts provide qualified employees with formalized assessment and planning as well as financial support to help you return to productive, independent lifestyles. Monthly benefit is increased by 10 percent while participating in a MetLife approved rehabilitation program.
Moving Expense Incentive – Reimburses claimants for expenses associated with moving to a new residence if recommended as part of an approved MetLife rehabilitation — no dollar maximum or minimum distance requirement.

Worksite Modification Benefit – Assists the School District of Palm Beach County with the cost of making job modifications/accommodations and supports compliance with the American with Disabilities Act (ADA). The job modifications/accommodations have no stated dollar maximum or number of occurrences limit.
Worksite Modification Benefit and Survivor Benefit – Up to $400 per month per eligible family member for 24 months (no aggregate dollar or family number maximums) while employee is participating in approved MetLife Rehabilitation Program. Cannot be paid after the maximum benefit period ends.

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

1. Of your death; and
2. That the person claiming the benefit is entitled to it.

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

The survivor income benefit will only be paid:

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

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

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

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

To view or print a copy of a certificate of coverage, visit:
https://hub.palmbeachschools.org/all_employees/benefits/disability

Disability Income Protection

DISABILITY INCOME PROTECTION PROGRAM RATES:
24 Payroll Deductions Per Year For Employees

How to Estimate Payroll Deduction Based on 24 Payroll Deductions Per Year (for Employees Receiving 26 Payroll Checks Per Year)	SHORT-TERM	LONG-TERM
1. Enter Annual Salary	$ _____	$ _____
2. Divide by 100	$ _____	$ _____
3. Multiply by your appropriate rate below	$ _____	$ _____
4. Divide by number of payroll deductions/year	$ _____	$ _____

Example:	SHORT-TERM	LONG-TERM
A. Enter Annual Salary	$20,000.00	$20,000.00
B. Divide by 100	$200.00	$200.00
C. Multiply by your appropriate rate below ($.77 for STD / $.50 for LTD)	$154.00	$100.00
D. Divide by 24 (number of payroll deductions/yr)	$6.42	$4.62

SHORT-TERM DISABILITY MONTHLY RATES
Rates per $100 of Covered Payroll

EMPLOYEE'S AGE	OPTION A	OPTION B	OPTION C
54 & Under	$0.77	$0.53	$0.42
55 - 59	$1.01	$0.69	$0.55
60 - 64	$1.16	$0.79	$0.63
65 & Over	$1.41	$0.97	$0.77

LONG-TERM DISABILITY MONTHLY RATES

EMPLOYEE'S AGE	RATES PER $100 OF COVERED PAYROLL
24 & Under	$0.11
25 - 29	$0.14
30 - 34	$0.22
35 - 39	$0.36
40 - 44	$0.50
45 - 49	$0.67
50 - 54	$0.94
55 - 59	$1.09
60 & Over	$1.14

Disability Income Protection

DISABILITY INCOME PROTECTION PROGRAM RATES:
22 Payroll Deductions Per Year For Employees

How to Estimate Payroll Deduction Based on 22 Payroll Deductions Per Year	SHORT-TERM	LONG-TERM
1. Enter Annual Salary	$ _____	$ _____
2. Divide by 100	$ _____	$ _____
3. Multiply by your appropriate rate below	$ _____	$ _____
4. Divide by number of payroll deductions/year	$ _____	$ _____

Example:	SHORT-TERM	LONG-TERM
A. Enter Annual Salary	$20,000.00	$20,000.00
B. Divide by 100	$200.00	$200.00
C. Multiply by your appropriate rate below ($.91 for STD/ $.59 for LTD)	$182.00	$118.00
D. Divide by 22 (number of payroll deductions/yr)	$8.27	$5.36

SHORT-TERM DISABILITY MONTHLY RATES
Rates per $100 of Covered Payroll

EMPLOYEE'S AGE	OPTION A	OPTION B	OPTION C
54 & Under	$0.91	$0.63	$0.50
55 - 59	$1.19	$1.82	$1.65
60 - 64	$1.37	$0.93	$0.75
65 & Over	$1.67	$1.15	$0.91

LONG-TERM DISABILITY MONTHLY RATES

EMPLOYEE'S AGE	RATES PER $100 OF COVERED PAYROLL
24 & Under	$0.13
25 - 29	$0.17
30 - 34	$0.26
35 - 39	$0.43
40 - 44	$0.59
45 - 49	$0.80
50 - 54	$1.11
55 - 59	$1.29
60 & Over	$1.35

Basic Life Insurance

Post-tax Benefits

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

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

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

Basic Life Insurance

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

During Open Enrollment, you must submit a completed Statement of Health form directly to MetLife by mail or fax no later than December 17, 2019. Submission of an incomplete application will not extend the deadline.

To download the Statement of Health form go to:
https://hub.palmbeachschools.org/all_employees/benefits

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

Phone: 800-638-6420, Option 1

FAX: 1-859-225-7909

What Are My Basic Life Insurance Benefits?

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

What Are the Basic Life Insurance Features?

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

For more information regarding these features, please refer to the product features section on **page 60 - 61**.

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

Only valid for: Dependent children from age 6 months up to 26 years of age.

Personal Accident Insurance

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

Group Term Life Insurance

What benefits are available?

When enrolled in Basic Life Insurance you automatically receive Personal Accident Insurance in an amount equal to your Basic Life Insurance. Provided alongside your Basic Life Insurance, this coverage is designed to help safeguard you and your family from a financial loss due to an unexpected accidental death or injury.

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

Optional Life Insurance

What benefits are available?

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

What are my options? What are the maximum amounts I can apply for?

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

Life Insurance Reduction

If you are under age 70 on the effective date of your insurance, the amount of your Basic Life, Supplemental Life, Basic Accidental Death and Dismemberment Insurance and Supplemental Accidental Death and Dismemberment Insurance on and after age 70 will be determined by applying the appropriate percentage from the following table to the amount of your insurance in effect on the day before your 70th birthday: At age 70, providing you are still employed, your Optional Life coverage will decrease as follows:

- 65% reduction at age 70 but less than 75
- 45% reduction at age 75 but less than 80
- 30% reduction at age 80 and older

Premiums and coverage for your spouse will end at age 70; at that time your spouse may choose to convert this coverage to an individual Life Insurance policy.

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

Rates (Monthly)

Optional Life Insurance & Optional Accident Insurance

Employee only:	$.15 per $1,000 of coverage per month
Employee & Spouse:	$.66 per $1,000 of coverage per month

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

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

Group Term Life Insurance

Post-tax Benefits Guaranteed Issue: New Hires

At the time of hire and during the benefit selection process, a new hire employee may select up to five (5) times their basic annual salary in $20,000 increments, not to exceed $500,000, with a minimum selection amount of $20,000. A Statement of Health (SOH) form is required for coverage exceeding $100,000. To download the Statement of Health form go to: **https://hub.palmbeachschools.org/all_employees/benefits/benefit_forms**

For Optional Spouse Life Insurance, an employee may select coverage in $10,000 increments, not to exceed 50% of the employee's Optional Life Insurance coverage with a minimum amount of $10,000 and a maximum amount of $250,000. A Statement of Health (SOH) form for the spouse is required for coverage exceeding $50,000. Go to **https://hub.palmbeachschools.org/all_employees/benefits/benefit_forms** to download the Statement of Health form.

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

- Live birth to six months: $1,500; and
- Six months to 26 years: $5,000 or $10,000

During Open Enrollment

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

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

What are the Optional Life Insurance features?

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

For more information regarding these features, please refer to the product features section that starts on **page 59**.

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

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

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

Post-tax Benefits Optional Accident Insurance

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

What Benefits are available?

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

What are the Optional Accident Insurance features?

For Wearing a Seat Belt and Protection by an Airbag- Death benefits will be increased by 10%, but not more than $25,000, if the insured person dies as a direct result of injuries in a covered automobile accident while wearing a properly fastened seat belt. We will increase the death benefit by an additional 5%, but not more than $10,000, if the insured was in a seat protected by a properly functioning and deployed airbag.

For Child Care Expense - MetLife will pay a benefit for a surviving child under 13 who is enrolled in a licensed child care center at the time of the accident or within 90 days afterward. This benefit is three percent of the benefit amount, to a maximum of $3,000 a year for four continuous 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 doctor-certified as necessary for an independent lifestyle.

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

Group Term Life Insurance

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

- An academic year maximum of $10,000; and
- An overall maximum of 20% of the full amount of the benefit.

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

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

- $5,000 per year for one year
- Maximum: 5% of Full Amount

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

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

How much coverage can I buy?

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

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

Dependents

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.

If a divorce occurs, at time of claim, premium will be returned. If a dependent is over age 26, premium would be refunded at time of claim.

Post-tax Benefits

What is not covered?

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

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

Any incident related to travel in an aircraft or device:

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

  a. Taken or used as prescribed by a doctor, or;
  b. An "over the counter" drug, medication or sedative taken as directed;
- Alcohol in combination with any drug, medication, or sedative;
- Or Poison, gas, or fumes.

Product Features

Accelerated Benefit Option: Terminal Illness Benefit

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

Will Preparation and Estate Resolution Services –

Will preparation is offered by Hyatt Legal Plans, a MetLife company, and provides eligible employees and their spouses with face-to-face access to attorneys participating in Hyatt Legal Plan's network for preparing or updating a will, living will and power of attorney. When you choose a participating Hyatt Legal Plan's attorney, the attorney's fees are fully covered and there are no claim forms to file. You also have the flexibility of using a non-network attorney and being reimbursed for covered services according to a set fee schedule. **www.WillsCenter.com** is also available and provides online interactive tools to assist with the creation of a will and other legal documents on your own, at your own pace, 24 hours a day, 7 days a week. The site also provides access to other valuable financial educational materials. Face-to-Face Estate Resolution Services provides beneficiaries and executors/administrators access to face-to-face legal representation for probating your and your spouse's estates.

Group Term Life Insurance

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

Continued Protection (waiver of premium) and Extended Death Benefit
To make sure you can keep the life insurance protection you need during a difficult period of your life, the life insurance plan provides continued protection (waiver of premium). If you are totally disabled prior to age 60 and satisfy a nine-month waiting period, your life insurance will continue and you won't need to pay premiums while you are disabled. Once approved, continued protection (waiver of premium) can remain in force until age 65.

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

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

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

Online Plan Description
You will be able to review any of the Life and Accident Insurance provisions in more detail through the School District of Palm Beach County's website at: **https://hub.palmbeachschools.org/all_employees/benefits**

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

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

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

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

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

This service provides:

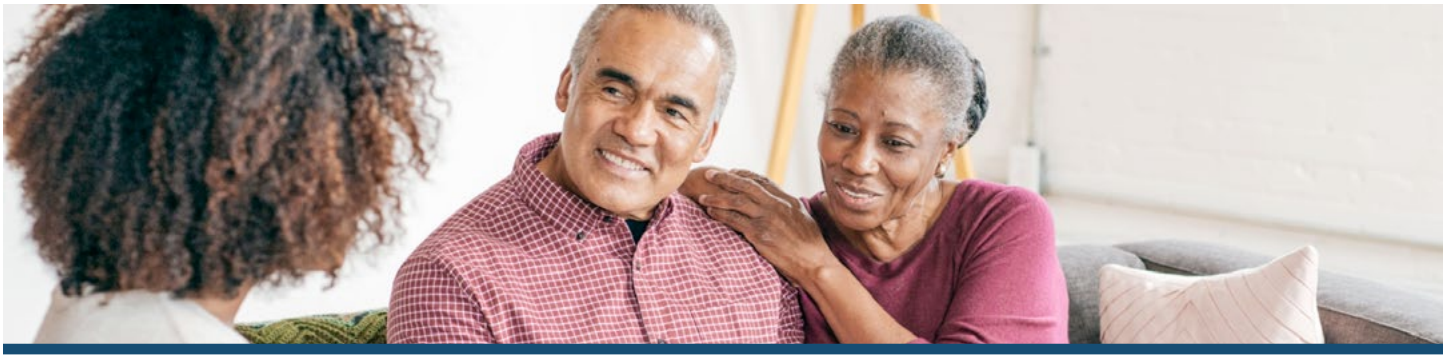
- Education & Protection: An identity theft risk and prevention toolkit and resolution guide;
- Personal Guidance: Assistance with filing and obtaining police and credit reports, contacting creditor fraud departments, taking inventory of lost or stolen items and more.
- Concierge Services: Also included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

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

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

A certificate of coverage for your Group Life Insurance Plan is available online at **https://hub.palmbeachschools.org/all_employees/benefits** or can be accessed by contacting Risk & Benefits Management.

Retirement Investment Plans



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

Want to start saving, but not sure where to invest?

Get started with Plan B, a quick enrollment plan that allows you to start saving and makes it easy for you to switch to an approved investment plan later.

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

Quick Enroll Plan B

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

All employees receiving a W-2 each year are eligible to participate in any of the voluntary retirement plans.

Visit our website for important information:

https://hub.palmbeachschools.org/all_employees/benefits/retirement

Traditional Pretax

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

Roth Post-Tax

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

Please visit: **www.tsacg.com/individual/plan-sponsor/florida/school-district-of-palm-beach-county** for a complete listing of what program each vendor offers.

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

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

Contact the Agent/Broker of Record for the company of your choice listed below for investment options and to schedule an appointment with a company representative:

AIG Retirement Service (VALIC)*
David Allen - 561-688-6301 / 954-946-1765 / 800-448-2542

AXA Equitable Life Assurance Co.*
Mario Basilone - 561-961-9343

Buttelman & Associates Financial Services (GWN)**
Michael Buttelman - 561-965-1000, ext. 1237

Fidelity Retirement Services
(No Agent of Record) - 800-343-0860

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

Horace Mann
Theresa Goulet - 561-743-1669

IPX (American Century Services)*
(No Agent of Record) - (844) 788-3474 ext. 5

Lincoln Investment
Mike Mracna - 561-649-9200

MetLife
Ken Suchy 561-746-6652

National Life Group a.k.a LSW
Jacob Marley - 800-579-2878

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

PFS Investments (Primerica)
R. Ken Sloan - 561-635-0947**

Quick Enroll Plan B - 1-866-752-6286

TIAA CREF
(No Agent of Record) - 800-842-2888

Voya Financial
Keista Ransom - 800-584-6001

Voya Reliastar
Keista Ransom - 877-882-5050

*Member of the IBC. The Independent Benefits Consortium (IBC) is a not-for-profit corporation made up by a coalition of The Florida Education Association, The Florida School Board Association, The Florida Association of District School Superintendents and The Florida Association of School Administrators. They developed the IBC 403(b) Model Plan. The companies selected by the IBC have agreed to offer favorable rates to all Districts. Ask your company to match the fees of the Model Plan. For more info: **www.theModelPlan.com**.
** 457(b) Service not offered

ID Theft Protection Plan

NEW! ID THEFT PROTECTION PLAN

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

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

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

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

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

Per Pay Period Payroll Deduction

Deductions	22	24
Individual	$ 5.73	$ 5.25
Family	$12.28	$ 11.25

Ultimate Protection Plan

Includes the following valuable benefits:

Restoration:

- Full-service identity restoration
- 24/7 lost wallet assistance
- $1 million insurance policy
- Identity safety resource center

Detection:

- Internet surveillance monitoring and alerts
- Social Security monitoring and alerts[1]
- Change of address monitoring and alerts
- Court/criminal monitoring and alerts
- Sex offender monitoring and alerts
- Payday loan monitoring and alerts
- Anti-virus/anti-spyware software
- Anti-phishing, Anti-spam software
- Software firewall
- Digital vault
- Digital file shredder

[1]Member must provide a Social Security number in order for the SSN Trace functionality to monitor SSN activity.

Note: Email address is required to receive notifications.

Take command of your future with ID Commander.

Online Enrollment Is Simple:

Visit **IDCommander.com/pbcs** to enroll for the ID Commander ID Theft plan today!

The ID Commander plan offers the convenience of payroll deduction. (See the chart above.)

Special Benefits from Trustmark

Voluntary insurance can pay cash benefits to you or your beneficiaries when that money is needed most. Protect your family, finances and future with these valuable benefits from Trustmark:

Trustmark Universal Life Insurance with Accelerated Death Benefit for Long-Term Care Services

Trustmark Universal Life combines permanent life insurance with an accelerated death benefit that can provide protection against the high costs of long-term care services. It features rates that won't increase due to age, and it builds cash value over time.

The Universal LifeEvents® option provides a higher death benefit – for the same rate – during your working years, when your need for protection is greatest. After age 70, the death benefit reduces to one-third, but the accelerated death benefit for long-term care services never reduces.

Trustmark Critical HealthEvents℠ Insurance

A major illness can come with hidden costs, even if you have health insurance. Trustmark Critical HealthEvents is critical illness insurance that pays you directly (independent of your health insurance) if you are diagnosed with cancer, heart attack or stroke, or a related covered condition.

Trustmark Critical HealthEvents provides a lifetime of benefits with a max benefit that refreshes every year. It pays not just for the most serious illnesses, but also for earlier stages and early identification of critical illnesses.

Increases are also available for policyholders with Trustmark's traditional Critical Illness plan.

Trustmark Accident Insurance

Accident insurance from Trustmark pays to help with the costs of medical treatment for accidental injuries – for instance, deductibles, co-payments, transportation and lodging costs, and everyday bills.

It pays benefits for a variety of covered off-the-job accidental injuries, such as fractures, dislocations, burns, and concussions, and for covered services like ambulance transport, hospital admissions, physical therapy and more.

With All Trustmark Benefits:

- Take your policy with you if you change jobs or retire.
- Pay through convenient payroll deduction.
- Apply for family members as well as for yourself.

Enrollment

The January 13 - February 11, 2020 voluntary benefits period is an opportunity to learn about and enroll in these Trustmark products. Information on how to schedule an appointment to meet with an FBMC Representative at your work location will be electronically sent to you in December 2019. Enrollment in Trustmark products is only available through your FBMC Representative.

COBRA Notification

Important Continuation Coverage Information

What Is Continuation Coverage?

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. This right extends to your plan's Health Care FSA.

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be downloaded from: **https://hub.palmbeachschools.org/all_employees/benefits**

How Long Will Continuation Coverage Last?

COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

For Health Care FSAs, continuation coverage is generally limited to the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the account for the year. For example, if you elected a Health Care FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Health Care FSA for the remainder of the plan year or until such time that you receive the maximum Health Care FSA benefit of $1,000.

If your employer funds all or any portion of your Health Care FSA, you may be eligible to continue your Health Care FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period. There are special continuation rules for employer-funded Health Care FSAs.

If you have questions about your Health Care FSA, call WageWorks at **855-428-0446**.

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

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

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.

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.

How Can You Elect Continuation Coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA election form. Failure to do so will result in loss of the right to elect continuation coverage under the plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

COBRA Notification

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep your employer and Wageworks/FBMC informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer and Wageworks/FBMC.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, U.S. Department of Labor.

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

Beginning with open enrollment in 2019, for an effective date of January 1, 2020, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that right away lowers your monthly premiums. You can see what the premium, deductibles and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, if you request enrollment within 30 days, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouses' plan), even if the plan generally does not accept late enrollees.

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. This amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). For Health Care FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

When and How Must Payments for Continuation Coverage Be Made?

First Payment for Continuation Coverage: If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA election form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the election notice is postmarked, if mailed). If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact BOI to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

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

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the plan, these periodic payments for continuation coverage are due on the first day of each month. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA election notice form. BOI will send coupons for use in making periodic payments.

Periodic payments for continuation coverage should be sent to:

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

Grace Periods for Periodic Payments

Although periodic payments are due on the first day of the month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay a periodic payment later than its due date but during its grace period, your coverage under the plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the plan.

General Notice of COBRA Continuation Coverage Rights Introduction

You are receiving this notice because you have recently become covered under a group health plan sponsored by the School District of Palm Beach County (the plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the plan and under federal law, you should either review the plan's summary plan description or get a copy of the plan document from the School District of Palm Beach County (Risk & Benefits Management).

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA Notification

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse. Your dependent children will become qualified beneficiaries if they will lose coverage under the plan because any of the following qualifying events happens:

    A. The parent-employee dies;
    B. The parent-employee's hours of employment are reduced;
    C. The parent-employee's employment ends for any reason other than his or her gross misconduct;
    D. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
    E. The parents become divorced or legally separated; or
    F. The child stops being eligible for coverage under the plan as a "dependent child."

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 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).

For more Information

This COBRA Q&A section does not fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available from your employer.

Beyond Your Benefits

Social Security

Social Security consists of two tax components: the FICA or OASDI component (the tax for old-age, survivors' and disability insurance) and the Medicare component. A separate maximum wage to which the tax is assessed applies to both tax components. There is no maximum taxable annual wage for Medicare. The maximum taxable annual wage for FICA is subject to federal regulatory change. If your annual salary after salary reduction is below the maximum wage cap for FICA, you are reducing the amount of taxes you pay and your Social Security benefits may be reduced at retirement time.
However, the tax savings realized through the Flexible Benefits Plan generally outweighs the Social Security reduction. Call FBMC Customer Care at 1-855-5MYFBMC (1-855-569-3262) for an approximation.

Itemized Deductions

The portion of your salary set aside for before-tax benefit premiums and flexible spending accounts through the School District of Palm Beach County's plans will not be included in the taxable salary or reported to the IRS on your W-2 form. However, your annualized Dependent Care FSA contributions will appear on your W-2 form as a non-taxable item. You will not have to claim these payments as deductions at the end of the calendar year. Your before-tax deductions cannot be used as itemized deductions for income tax purposes at the end of the calendar year.

Special Enrollment Rights Pertaining to Medical Benefits

If you are declining enrollment for yourself or your dependent (including your spouse) because of other health plan insurance coverage, you may in the future be able to enroll yourself or your dependent in the School District of Palm Beach County's plan provided that you request enrollment within 60 days after the other coverage ends.

Disclaimer - Health Insurance Benefits Provided Under Health Insurance Plan(s)

Health Insurance benefits will be provided, not by the School District of Palm Beach County's Flexible Benefits Plan, but by the Health Insurance Plan(s) Certificates of Coverage. The types and amounts of health insurance benefits available under the Health Insurance Plan(s), and the other terms and conditions of coverage and benefits of the Health Insurance Plan(s) are set forth from time to time in the Health Insurance Plan(s) Certificates of Coverage. All claims to receive benefits under the Health Insurance Plan(s) shall be subject to and governed by the terms and conditions of the Health Insurance Plan(s) Certificates of Coverage.

Notice of Administrator's Capacity

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

1. **Contract Administrator** – FBMC Benefits Management (FBMC) has been authorized by your employer to provide administrative services for your employer's insurance plans offered within your benefit program. In some instances, FBMC may also be authorized by one or more of the insurance companies underwriting the benefits to provide certain services, including, but not limited to: marketing; billing and collection of premiums; and processing insurance claims payments. FBMC is not the policyholder or the insurer.
2. **Policyholder** – This is the entity to whom the insurance policy has been issued; the employer is the policy holder for group insurance products and the employee is the policyholder for individual products. The policyholder is identified on either the face page or schedule page of the policy or certificate.
3. **Insurer** – The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

If FBMC is authorized to process claims for the insurance company, we will do so promptly.

In the event there are delays in claims processing, you will have no greater rights to interest or other remedies against FBMC than would otherwise be afforded to you by law. FBMC is not an insurance company.

FBMC Privacy Statement

This statement applies to products administered by FBMC Benefits Management, Inc. and its wholly-owned subsidiaries, including VISTA Management Company (collectively "FBMC"). FBMC takes your privacy very seriously. As a provider of products and services that involve compiling personal-and sometimes, sensitive-information, protecting the confidentiality of that information has been, and will continue to be, a top priority of FBMC. This Privacy Statement explains how FBMC handles and protects the personal information we collect. Please note that the information we collect and the extent to which we use it will vary depending on the product or service involved. In many cases, we may not collect all of the types of information noted below. Note this Privacy Statement is not meant to be a Privacy Notice as defined by the Health Insurance Portability and Accountability Act (HIPAA), as amended.

FBMC's privacy statement is as follows:

1. **We collect only the customer information necessary to consistently deliver responsive services**. FBMC collects information that helps serve your needs, provide high standards of customer service, and fulfill legal and regulatory requirements. The sources and types of information collected generally vary depending on the products or services you request and may include:
   - Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status, and spousal and beneficiary information.
   - Responses from you and others such as information relating to your employment and insurance coverage.
   - Information about your relationships with us, such as products and services purchased, transaction history, claims history, and premiums.
   - Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.
2. **Under Federal Law you have certain rights with respect to your protected health information.** You have rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with your Employer or with the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.
3. **We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information.** We maintain physical, electronic, and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies, and service providers who need to know that information to provide products or services to you.
4. **We limit how, and with whom, we share customer information.** We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We will share personal information of VISTA 401(k) participants with the plan's record keeper. We also may disclose personal information as permitted or required by law or regulation. For example, we may disclose information to comply with an inquiry by a government agency or regulator, in response to a subpoena, or to prevent fraud. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Medicare Part D

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.

Medicare Part D Certificate of Creditable Coverage

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 15 through December 7 and when they first become eligible for Medicare. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two month special enrollment period (SEP) to join a Medicare drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your UnitedHealthcare prescription drug coverage, be aware that you will not be able to get this coverage back. Prescription drug coverage is a part of the total health insurance plan offered by UnitedHealthcare and cannot be purchased separately.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

If you drop your coverage with the School District of Palm Beach County and enroll in a Medicare prescription drug plan, you will not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with the School District of Palm Beach County and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage: contact our office at 1-561-434-8580.

NOTE: You will receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, or if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage:

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

- Visit: **www.medicare.gov**
- Call your state health insurance assistance program for personalized help (see your copy of the "Medicare & You" handbook for their telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov** or by phone at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: October 1, 2019

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: 561-434-8580

PeopleSoft "My Homepage"

My Homepage Tiles

Keeping your data updated and close at hand just got a lot easier. The **PeopleSoft My Homepage Tiles** provides you with 24/7 access to your personal data. By taking advantage of the "My Homepage" feature of PeopleSoft, you can:

- view your personal data, including your benefit enrollment and dependent information
- and modify beneficiary information at your convenience.

Q: What am I able to view or change using "My Homepage"?

A: You can:

- Manage personal data
  - View/print paychecks or W2 information
  - Verify payroll deductions
  - Manage direct deposit
  - View payable time
  - Review/manage emergency and personal contact information
- Manage benefit actions
  - Review/change life insurance beneficiary information
  - View health plan coverage
  - Enroll/change 403(b)
  - Verify/update tobacco status
  - View/manage 1095-C information
- Manage eLearning courses
- And much more

Q: I cannot seem to log in to PeopleSoft to complete my benefits enrollment; who should I contact?

A: Make sure you have reviewed the instructions on how to obtain or reset your password. If you still need help, contact the IT Help Desk at 561-242-4100 for further assistance. Remember your enrollment is time sensitive, so do not delay completing your enrollment by the enrollment deadline.

Q: How much time do I have to complete my online enrollment?

A: You have up to 30 calendar days from your employment start date (or transfer to a benefited position) to complete your online benefits enrollment and tobacco affidavit. During Open Enrollment time, you have until 4:30 p.m. on the published deadline date.

Q: Will more time be granted to me if there is a holiday, system outage or if I have problems with my password?

A: In most cases, no additional time will be granted. Since you have 30 days to complete your enrollment, it is expected that you will act promptly and resolve any unexpected issues well before the final date to enroll.

Q: When should I be able to access the online enrollment system?

A: Within 48 to 72 hours of your start date, you should be able to create a password and then have immediate access to complete your enrollment.

Q: How do I create a password?

A: Follow the step-by-step enrollment instructions which explains how to create a password. It also includes information on how to get help if you have forgotten your password.

Appeals Process

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

If you experience one of the following types of enrollment errors FBMC will review and consider your request:

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

To ensure your appeal is handled promptly and with due consideration:

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

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

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

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

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

ENROLLMENT APPEALS:

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

All enrollment appeals decisions are final.

FSA Claim Appeals

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

FSA Appeals

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

OR FAX TO:

Fax Number: 1-877-220-3248

CONTRACT ADMINISTRATOR

FBMC Benefits Management, Inc.

PO Box 1878 • Tallahassee, FL 32302-1878

FBMC.com

This guide does not contain a complete listing of all terms, conditions, or exclusions of the benefits listed herein. Please refer to the policy and/or certificate of coverage for more information. *Information contained herein does not constitute an insurance certificate or policy. Certificates will be provided to participants following the start of the plan year, if applicable.*