THE SCHOOL DISTRICT PALM BEACH COUNTY

Active Employee
BENEFITS GUIDE

PLAN YEAR 2027



Piecing Together *Your Benefits*

Superintendent's Message



Dear Team Palm Beach,

As we welcome another Open Enrollment period in anticipation of Plan Year 2027, I want to take a moment to reaffirm our commitment to you and your families.

Navigating challenging financial times is a reality we all face, but our priority remains clear: protecting and providing high-quality, comprehensive health benefits for our dedicated employees without placing an added burden on your paychecks.

To maintain these high standards while remaining fiscally responsible, we are implementing key enhancements to our benefits strategy for 2026. These updates allow us to manage costs effectively—working together as a team so we can continue offering exceptional care.

1. Transition to Judi Rx for Pharmacy Coverage

Starting this plan year, we are transitioning our pharmacy benefits to Judi Rx . This pharmacy is designed to streamline prescription management, lower total healthcare spending by reducing the Rx ingredient costs, and deliver better value directly to you and your eligible dependents.

2. $0 Copay Specialty Medications via Rescription

To help manage high specialty medication costs, we are introducing a new specialty program through Rescription, integrated directly within your Judi Rx benefit.

- **$0 Copay Opportunity:** You can access specialty medications at no copay simply by completing a brief, convenient virtual medical appointment.
- **How to Participate:** We encourage all members taking specialty medications to meet us halfway by taking advantage of this program. It saves you out-of-pocket money while helping the District preserve funds for our overall benefits package.

3. Continued Engagement with PeopleOne Health

Our partnership with PeopleOne Health continues to be a cornerstone of our wellness strategy. As we continue this benefit for Plan Year 2027, we need your active participation to keep the program efficient and impactful:

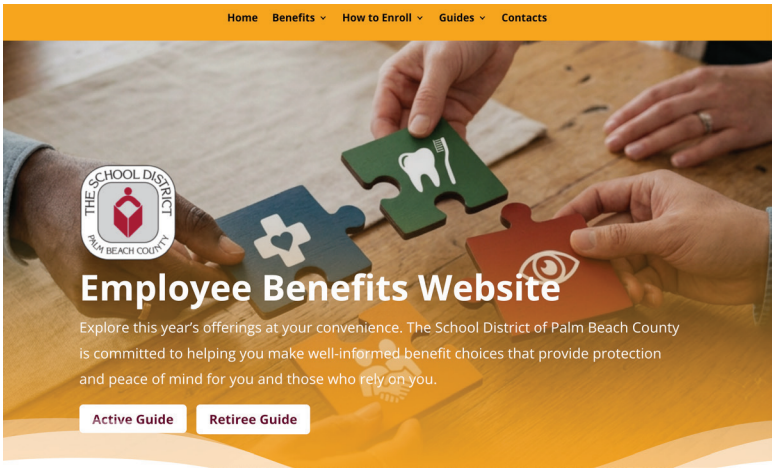
- **Active Engagement:** If you utilize PeopleOne Health as your primary medical home, please continue actively scheduling your appointments and engaging with your care team.
- **Membership Updates:** If you have chosen a different medical home outside of PeopleOne Health, we kindly ask that you actively discontinue your membership. This ensures our administrative resources and clinical slots remain open for team members actively utilizing the service.
- **Expanding Access:** We have recently learned PeopleOne Health is expanding into Broward County. Those locations will be opening soon and will extend access for our team members who reside or work near the area.

4. Low Option HMO Primary Care Physician Selection Starting in Plan Year 2027, our Low HMO option will require you to select a Primary Care Physician (PCP). While you won't be strictly required to see this PCP for your care, and you will continue to have open access to specialists within the network, selecting one ensures you have an assigned provider available when you need one.



Mike Burke, Superintendent

Benefit Website



For details about your Palm Beach benefits, plan options, and resources, please visit the District's Benefits website at **sdpbcbenefits.com**.

School District of Palm Beach County Non-Discrimination Statement

The School Board of Palm Beach County, Florida, prohibits discrimination in admission to or access to, or employment in its programs and activities, on the basis of race, color, national origin, sex or sexual orientation, marital status, age, religion, disability, genetic information, gender identity or expression, or any other characteristic prohibited by law. The School Board also provides equal access to the Boy Scouts and other designated youth groups. The School District of Palm Beach County offers the following career and technical programs, including career academies wherein students may earn industry certification, visit the Programs of Study page for more information as well as a list of classes. Lack of English language skills will not be a barrier to admission and participation. The district may assess each student's ability to benefit from specific programs through placement tests and counseling, and, if necessary, will provide services or referrals to better prepare students for successful participation.



Join 8,000+ Coworkers Saving on Care with PeopleOne Health!

Did you know you have access to an award-winning health benefit at no extra cost to you? If you are enrolled in a health plan option, PeopleOne Health is completely free to join ($0 out-of-pocket). Over 8,000 of your colleagues and their families are already using it to get high-quality, personalized care. Now it's your turn. Enrollment only takes a few minutes.

If you are enrolled in a health plan option, PeopleOne Health is completely free to join ($0 out-of-pocket)

PeopleOne Health Locations

PeopleOne Health Wellington | 937-552-5270
1397 Medical Park Blvd, Suite 220, Wellington, FL
Monday 7:00 a.m. - 6:00 p.m.
Tuesday & Thursday 7:00 a.m. - 7:00 p.m.
Wednesday 9:00 a.m. - 6:00 p.m.
Friday 7:00 a.m. - 4:00 p.m.

PeopleOne Health West Palm Beach | 937-552-5270
4601 N Congress Ave Suite 107, West Palm Beach, FL
Monday, Tuesday & Thursday 7:00 a.m. - 7:00 p.m.
Wednesday & Friday 7:00 a.m. - 4:00 p.m.

PeopleOne Health Boynton Beach | 937-552-5270
10075 S Jog Road Suite 101, Boynton Beach, FL
Monday, Tuesday & Thursday 7:00 a.m. - 7:00 p.m.
Wednesday 9:00 a.m. - 6:00 p.m.
Friday 7:00 a.m. - 4:00 p.m.

PeopleOne Health Boca Raton | 937-552-5270
21065 Powerline Road A2, Boca Raton, FL
Monday, Tuesday & Thursday 7:00 a.m. - 7:00 p.m.
Wednesday 9:00 a.m. - 6:00 p.m.
Friday 7:00 a.m. - 4:00 p.m.

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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 77 for more details.

Benefits Directory

The School District of Palm Beach County Risk & Benefits Management

Phone: 561-434-8580
Fax: 561-434-8103
http://l.sdpbc.net/6meuf

Medical

UnitedHealthcare® (UHC)
Group #: **704471**
www.myuhc.com

Member Services
(888) 380-0389

Onsite Service Account Managers:
A-K: (561) 434-8092
L-Z: (561) 357-7564

Health Engagement Nurse:
(561) 294-4539

Level2 - Type 2 Diabetes Program
(844) 302-2821
mylevel2.com/care

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

Prescription

Judi Rx
judi benefits
(833) 641-5138
RxBIN: 610852 / RxGRP: JD455
RxPCN: CHM / Issuer: 9151014609

Dental

Humana
Group #: **830206**
(800) 233-4013 DHMO & PPO Plans
www.myhumana.com

Dental Provider Search
http://humana.com/findadentist

DHMO Network:
Palm Beach Schools DHMO

PPO Network: Palm Beach Schools PPO

Vision

EyeMed Vision Care
Group #: **9705435**
Customer Service
(866) 723-0514
www.eyemed.com

Disability Claims Call Center

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

Life & Statement of Health

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

Spending Accounts

Health Savings Account (HSA)

Optum Bank Customer Care
(800) 791-9361
www.optumbank.com

Flexible Spending Accounts

Inspira Financial
PO Box 8396
Omaha, NE 68108
(844) 729-3539
mybenefits.inspirafinancial.com/

District Onsite Clinic

3300 Forest Hill Blvd
Building E
West Palm Beach, FL 33406
(Rear of Fulton-Holland)
(561) 899-0758

Register at: my.marathon-health.com/login

PeopleOne Health Centers

PeopleOne Health Wellington
1397 Medical Park Blvd, Suite 220,
Wellington, FL 33414
(937) 552-5270

PeopleOne Health West Palm Beach
4601 N Congress Ave Suite 107, West Palm Beach, FL, 33407
(937) 552-5270

PeopleOne Health Boynton Beach
10075 S Jog Road Suite 101, Boynton Beach, FL, 33437
(937) 552-5270

PeopleOne Health Boca Raton
21065 Powerline Road A2, Boca Raton, FL 33433
(937) 552-5270

Register at:
https://www.peopleonehealth.com/sdpbc

Retirement Savings Plans

401(a) Special Retirement Plan Administrator

BENCOR Administrative Services
(866) 296-9712
Plan ID#: 100260
www.bencorplans.com
Email: questions@bencorservices.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

Optum Emotional Wellbeing Solution Services
(888) 200-9207
supportfinder.optum.com/sdpbc

Voluntary Benefits

Universal Life Insurance
Accident Insurance
Critical HealthEvents Insurance
Hospital StayPay Insurance
Trustmark Insurance Company
(866) 636-5525
www.trustmarkvb.com
Email: pbsd@trustmarkins.com

Ocenture ID Commander
(855) 592-7941 / (561) 434-7442
www.idcommander.com/pbcs
FBMC On-Site Representative
(561) 434-7442

COBRA

Medical, Dental and Vision

Benefits Outsource, Inc. (BOI)
5599 S. University Drive, Suite 201
Davie, FL 33328
(888) 877-2780
www.boibenefits.com

Health Care FSA

Inspira Financial
PO Box 8396
Omaha, NE 68108
(844) 729-3539
mybenefits.inspirafinancial.com/

Eligibility Requirements



Newly Eligible for Benefits Enrollment Information

We are excited to provide you with online access to complete your Benefits Enrollment, which must be completed within 30 calendar days from your position start date or transfer to a benefit eligible position date. You are provided this time to review your benefits material. Instructions for accessing the online enrollment system can be found on page 13.

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?

If you and a family member both work for the District, you cannot cover each other as dependents under the medical or life insurance plans. For dental and vision insurance, you may enroll either as an employee or as an eligible dependent of another employee—but you cannot be enrolled under both.

401(a) Dollars are contributed to a special retirement plan for any benefit-eligible 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 73.

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



In 2022, the Office of Inspector General completed a dependent eligibility audit that revealed the need to perform a more complete audit of all covered dependents. It was also recommended that the required documents not only confirm an eligible relationship exists, but also that the relationship is current to allow for continued insurance coverage. Periodic mandatory audits will be conducted to ensure compliance with Board policy.

Board Policy 3.78 is the approved policy regarding Dependent Verification requirements.

Mandatory Dependent Audit

The School District of Palm Beach County will be conducting a Mandatory Dependent Audit during Open Enrollment which will be 11/2/26 through 11/16/26. If you currently cover your spouse, domestic partner and/or stepchild(ren) you will need to provide updated verification documents by November 19, 2026.

Dependent Audit Verification

Any dependent being enrolled in medical, dental or vision plans for the first time or who had a break in coverage, will need to be fully verified. Refer to page 8 for the complete list of the documents needed to verify your dependent.

During your enrollment period, you should submit documents (sufficient to verify eligibility) to **dependentverification@palmbeachschools.org** or fax the documents to 561.434.8103. Documents must be submitted within your enrollment period.

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

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.

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:

- Biological/Adopted child under age 26.
- Stepchild.
- Child of a covered Domestic Partner.
- Child placed in your home pending adoption.
- Child under legal guardianship.
- Newborn child of a covered family member (birth to 18 months).

NOTE: If a covered family member becomes ineligible for coverage, his/her child (newborn - 18 months) will also experience a loss of coverage at the end of the month in which the family member (child's parent) is ineligible.

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.

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 in which you are enrolled. The eligibility criteria are that the over-aged adult child:

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

The application for this type of coverage is available at **http://l.sdpbc.net/6z9hq**

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.

Benefit Staff are responsible for verifying documents emailed to dependentverification@palmbeachschools.org or faxed to (561) 434-8103. They are not responsible for adding dependent(s) to any plan. The employee is responsible for adding their dependent(s) to each plan and for providing the required documents in a timely manner.

Dependent Verification Guide

Submit your documents to Risk & Benefits Management by email:
dependentverification@palmbeachschools.org or fax (**561) 434-8103**

ELIGIBLE COVERED DEPENDENT	DOCUMENT(S) TO SUBMIT	ADDITIONAL REQUIREMENTS
Legal Spouse (married less than 1 year)	Government issued marriage certificate	None
Legal Spouse (married 1 year or more) **NOTE:** A divorce MUST be reported within 60 days and the ex-spouse removed from all plans.	Government issued marriage certificate PLUS additional Requirements (Financial information should be redacted for your privacy)	• Current or Prior Year Tax 1040 Form showing Married Filing Status OR • Proof of common residence AND • Proof of recent financial interdependence (examples: Joint Bank statement, joint auto insurance, utility bills dated within the past 60 days)
Domestic Partner (less than 1 year)	Registered Domestic Partnership Certificate and Receipt and SDPBC Domestic partner Affidavit	None
Domestic Partner (1 year or more)	Registered Domestic Partnership Certificate and receipt, SDPBC Affidavit PLUS the Additional Requirements	• Proof of current common residence (deed; lease; mortgage; utilities showing both names/same address) • Proof of current financial interdependence (current loan; bank statement in both names)
Biological or adopted child up to age 26	Government issued birth certificate or final adoption decree/certificate	None
Child under legal guardianship up to age 26	Court documents naming you or your legal spouse as guardian of the child	Periodic updates upon request
Child placed in your home pending adoption up to age 26	Court document placing child in your home	Periodic updates upon request
Step-child up to age 26	Government issued birth certificate Government issued marriage certificate (Financial information should be redacted out for your privacy)	If married less than 1 year: none If married 1 year or more, the following: • Current Federal Tax Return OR • Proof of common residence AND • Proof of financial interdependence
Child of covered Domestic Partner up to age 26	Government issued birth certificate	Domestic Partner Proof from above since Domestic Partner must also be enrolled
Disabled Child (Deemed disabled prior to 26) -- Unable to be self-sustaining and financially independent	Government issued birth certificate Social Security Administration letter deeming the child disabled prior to the child turning 26 years of age.	Periodic proof of continued disability status and financial dependency
Newborn child of a covered family member (up to a maximum of 18 months)	Government issued birth certificate if newborn's parent is enrolled	Your family member (the parent) must also be insured and eligible under the plan(s).
To qualify for coverage, a non-disabled adult child must meet all of the following requirements: **Marital Status:** Unmarried **Dependents:** Has no children of their own **Other Coverage:** Is not enrolled in, or eligible for, other major medical insurance **Residency / Student Status:** Must reside in Florida or be enrolled as a student **Other insurance** (must have been continuously insured)	• State ID as proof of FL residence • Current school registration • Proof of continuous insurance • Meet Florida Statute 627.6562	Over-aged medical application

Notes:
- District Employees are not allowed to cover another District employee as a dependent on medical or life insurance
- Disabled Children must have current evidence of medical verification of continued disabled status
- Redact any social security and detailed financial information prior to submission to protect your privacy

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: **http://l.sdpbc.net/8vigi**. This is a post-tax benefit.

- Elections may only be made/changed during an Open Enrollment or New Hire 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: **https://www.mypalmbeachclerk.com/services/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. You must provide the following to enroll:

Partnership of Less than 1 Year

- Completed Affidavit
- County Domestic Partner Certificate
- County Paid-Fee Receipt

Partnership of 1 Year or more

- Completed Affidavit
- County Domestic Partner Certificate
- County Paid-Fee Receipt
- Proof of **current joint residency**
  - **Proof of Current Joint Residency -** a copy of a deed, lease, mortgage, or utility bill with both names and same address. **- AND**
- Proof of **financial interdependence**
  - **Proof of Financial Interdependence -** a copy of a current joint loan or bank statement with both names and same address (financial information should be blacked out).

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 within 30 days as a new hire or during Open Enrollment.

Employees and their domestic partners must meet the following requirements in order to enroll in a medical plan:

- Must both be at least 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.
- Domestic Partners are not eligible for a Special Enrollment Period under Medicare and need to evaluate enrolling during the initial Medicare Enrollment Period. Once a domestic partner is Medicare eligible, District plans are no longer primary. District plans will pay as if Medicare Part A & B are primary regardless of your Medicare enrollment status.

A signed affidavit attesting to the above will be required by both partners. (See page 8 for the required documents.)

Imputed Income

The District subsidizes the actual plan costs, so you only pay the amounts beginning on page 27. 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 NOTE

Did you get married? If you and your registered domestic partner get married, please contact the Benefits Department to update your coverage and relationship status.

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. 2 - 16, 2026**.

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 18).

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 16 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.

The District subsidizes your medical insurance, resulting in significantly reduced premiums for you.

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 13 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.

Dependent Eligibility

Subject to dependent verification, you may enroll eligible dependents in most plans that you elect to enroll in. However, if you and your dependent are both employed by the District, keep in mind that you cannot have dual coverage under any benefit plan. Specifically, you and your employee-dependent cannot cover each other under the Medical or Life Insurance plans. For Dental and Vision, you may only be enrolled as either an employee or a dependent, but not both. Domestic partner enrollment is limited to medical, dental, and vision plans.

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 your child becomes ineligible for benefits, coverage for both your child and their child (your grandchild) will end at the end of the month in which eligibility is lost.

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

During Open Enrollment you should submit government-certified documents and additional documents as requested (to verify your relationship). Send documents to Risk & Benefits Management by fax or email. Please fax documents to (**561) 434-8103** or email to **dependentverification@palmbeachschools.org.**

Documents are required for any newly-enrolled dependents and for dependents being enrolled after a break in coverage.

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 $3,400.
- The Dependent Care FSA has an annual minimum of $300 and an annual maximum of $7,500.

Flexible Spending Account Enrollment

You MUST re-enroll in Flexible Spending Accounts (FSAs) annually. FSA deductions begin the month in which the FSA becomes effective. If you do not complete the enrollment process, your FSA benefits will not continue for the new 2027 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.

Once Open Enrollment has been closed and processed, navigate from the Portal page through PeopleSoft to My Benefits

Enter "01/01/2027" and refresh to view your 2027 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: Did you list all dependents you wish to cover? Please confirm the date of birth and social security information is entered correctly.

Flexible Spending Accounts (FSAs): It is Important to review your FSA election. Transfer of funds between FSA accounts is not allowed. You are also prohibited to 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 is based upon the IRS maximum).

Dependent Care FSA: This covers childcare and qualified elderly care expenses. You cannot use the DCFSA medical expenses.

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

Health Savings Account: If you enrolled in the CDHP medical plan, you may be eligible to enroll and activate an HSA account. Contributions to the HSA account from (employee and/or District) can only be made with an active HSA election.

All Spending Accounts: Health Care & Dependent Care FSAs: Funds do not automatically roll over. You must actively re-enroll to participate in the upcoming plan year!

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 medical plan becomes available during the Open Enrollment period following 18 months of benefits-eligible employment.

Benefit Enrollment help is always available!
Visit the HUB to find step-by-step instructions to help walk you through using PeopleSoft. For details about your School District of Palm Beach County benefits, plan options, and resources, please visit the District's Benefits website at **sdpbcbenefits.com**. New Hires should click on the OnBoarding Tile to complete their new hire requirements including Benefit Enrollment.

Need Help After Hours?

The PeopleSoft Benefits Assistant is an interactive digital assistant that guides you step-by-step through viewing and managing your health and welfare benefits. Use it to check your current coverage, explore plan options during Open Enrollment, and get answers to common benefits questions in real time.

Look for the Blue box in PeopleSoft - My Benefits.

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

Online Enrollment

- Go to: **www.mysdpbc.org**
- Log in to "PeopleSoft/Open 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 resources 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).

- Log in to the District Portal at https://www.mysdpbc.org
- Click on:
  - The profile icon is located in the top-right corner, then...
  - "Profile", then...
  - "Authentication Methods", then...
  - "Edit" next to the "Change Password" option
- Follow the prompts & click on "Change Password"
- Instructional and non-instructional staff will be asked to change their password periodically. You will be notified via email.

Log in to PeopleSoft

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

Employee Responsibilities

Payroll Contributions Will Start in the Effective Month of Coverage.

Responsibilities for Maintaining Benefits

- 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 updating 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.
- You are responsible for maintaining your personal information on PeopleSoft.
- 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.
- After your benefits become effective, review your online paycheck stub. It serves as your official confirmation of enrollment and verifies the payroll deductions for your selected benefits.
- 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 7.
- Benefit elections are irrevocable during the plan year, unless you experience a valid Change in Status (see page 17) and provide written documentation of the event. Your approved pre-tax benefit deductions will begin on the first day of the month following the submission of your completed change form and required documentation. This documentation must clearly show that your request is due to a qualifying life 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: **http://l.sdpbc.net/6meuf** 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.

Medical Waiver & 401(a) Contributions:

- 401(a) Benefit: If you waive District medical coverage and are not enrolled as a dependent on another District employee's plan, the District will contribute to a 401(a) Special Retirement Plan (administered by Bencor) in your name.
- Contribution Amounts:
  - Full-time eligible employees: $100 per month
  - Part-time eligible employees: $50 per month
- Proof of Other Coverage: To receive 401(a) contributions, you must have active major medical coverage through another non-District employer's plan.
- Ineligibility: Once you become eligible for District medical insurance as an employee, you cannot decline coverage to enroll as a dependent under another District employee's medical plan.

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. When you successfully enroll a new baby through a life event, their coverage will be retroactive to the date of birth. Any premiums or contributions due for that period will be applied, which may result in a payroll adjustment on your next paycheck.

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 the district's plan design, please contact your Benefit Technician. You must also provide proof 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 79.

For Life Event Changes please contact the Benefits Department at (561) 434-8580 or Benefits@palmbeachschools.org.

Changing Your Coverage

EVENT	PERMITTED CHANGES	DOCUMENTS REQUIRED
New marriage	• Add spouse • Add children of the spouse • Add previously eligible children if spouse/ partner is added • May waive coverage	• Marriage certificate • Birth certificate, paperwork from adoption or legal guardianship • Social Security Number for all enrolling • Must provide proof of other group coverage
Divorce	• Remove spouse • Enroll in plans only if you and/or dependents lost other coverage • Must remove stepchildren or children of former partner	• Copy of final judgment or • Proof of loss of other group coverage
New baby, a child placed for adoption, new step- children and/or legal guardianship	• Add newly eligible dependent • Add previously eligible, but not yet enrolled dependents	• Birth certificate, paperwork from adoption or legal guardianship • Social Security number for all enrolling **NOTE:** if the Social Security Number is not available, enroll the child and provide it later
Loss of a dependent: child reaches age 26, end of legal guardianship, stepchild removal due to divorce, death	• Remove dependent • Must keep all other currently covered dependents enrolled	• Divorce decree, death certificate, or other legal document providing proof of relationship status change
Employee and/or dependents gaining other group coverage	• Remove self and/or spouse & dependents	• Proof of other group coverage for each individual being removed
Employee and/or dependents lose other group coverage	• Add self/spouse/dependent who lost coverage • Add previously eligible dependents	• Proof of loss of group coverage • Dependent verification for newly enrolled dependent. • Social Security Numbers for all enrolling
Qualified Medical Support Order (QMSO)	• Add self if previously waived • Add dependent(s) per court order • Plan selection will be determined by court order; if not ordered, employee may make a plan selection; if no selection is made the default plan will be implemented	• Copy of Qualified Medical Support Order (QMSO) • Birth certificate, paperwork from adoption or legal guardianship • Social Security Number for all enrolling **NOTE:** if the employee has waived coverage, the employee AND the child will be added (even if a birth certificate, etc. is not provided)
Change in dependent's residence to outside of a service area	• Remove dependent that moved • Cannot drop other dependents	• Proof of the move (e.g. utility bill in the dependent's name, new driver's license, etc.)
Change in dependent's residence to inside of a service area	• Add dependent that moved • Add all other previously eligible dependents • Cannot drop other dependents	• Proof of the move (e.g. new driver's license, etc.) • Dependent verification for newly enrolled dependent • Social Security Number for all enrolling
Enrolled in Medicare	• Remove self/dependents gaining coverage	• Proof of coverage for individuals to be removed
A loss of Medicare	• Add self and/or dependents losing coverage • Add previously eligible dependents	• Proof of loss of coverage • Birth certificate, paperwork from adoption or legal guardianship • Marriage certificate • Social Security Numbers for all enrolling
A HIPAA special enrollment event -- Medicaid or FL KidCare	• Add or remove self and dependents (must have other coverage) • Add previously eligible, but not yet enrolled dependent	• Proof of loss of coverage • Proof of gain of coverage • Birth certificate, paperwork from adoption or legal guardianship

Employees have up to 60 days to notify the Benefits Department and submit documents for a Life Event Change.

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. If you are out using sick and/or vacation time for more than 10 consecutive days, you must apply for a leave of absence. 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. You may continue your Healthcare Flexible Spending Account. Please contact Inspira 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 various elimination periods for these plans are detailed in the Disability section of this guide. Failure to pay required premiums may result in the denial of disability claims. 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 premium waiver period, no premium payments are due. You will be given the right to convert your policy if your Continued Protection (waiver of premium) request is denied. You will have 31 days from the waiver of premium denial date to convert to an individual policy.

Other Leaves – Ineligible to Continue Life and Income Protection Plans

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

Approved 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 Leave Coverage

Other Benefits Impacted by an Unpaid Leave

We encourage you to contact the insurance providers/ administrators if you are enrolled in any group life plans, MetLife plans, Trustmark plans, and/or a Health Care FSA. They will be able to assist you with understanding how your leave of absence will impact your coverage in these plans. Please contact:

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

Flexible Spending Accounts (FSAs) While on Leave

Reimbursement for FSAs is 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. The length of your leave of absence may impact your benefit effective date.

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 FMLA leave may make benefit changes during Open Enrollment in PeopleSoft to their medical, dental, vision and Flexible Spending Accounts. Employees on non-FMLA leave may make changes once 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 within 30 calendar days of your return to work. If your last name starts with A-J, please call (561) 434-7478. If your last name starts with K-Z, please call (561) 434-8668.

Default Plan Enrollment and Open 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.

Open Enrollment will be available for employees on approved FMLA leave. If you completed enrollment, but are not eligible for benefits on the first working day of 2027, your election will not be processed. Coverage for certain benefits cannot be continued while you are on unpaid leave.

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/Inspira 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 and 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 re-enroll 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:

- Through the last day of the month:
- In which employment ends (all interim positions and 12-month employees are in this category).
- In which a leave of absence without pay begins.
- In which suspension without pay begins.
- In which you cease being in a benefits eligible position.
- For which required employee contributions are made.
- In which you do not work the majority of your duty days.
- In which you are in an unpaid status without an approved leave.

Exceptions:

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.

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 take effect on **the first day of the month** following 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 and are not Medicare eligible. If you are Medicare eligible, coverage will be offered through FSRBC.

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. The Florida School Retiree Benefit Consortium (FSRBC) will extend plans including medical, dental and vision to all Medicare eligible employees and eligible dependents. In order to be eligible to continue the health insurance benefits, you have to be pre-Medicare eligible, retired, up to date on insurance premium payments while you were actively employed and receiving monthly payments from FRS. 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 or benefits deductions were taken..

Termination followed by rehire within 30 days

If you terminate employment and are rehired within 30 calendar days or less after your termination date, the following rules apply:

1. Automatic Re-enrollment: Default Enrollment: We will automatically re-enroll you in the exact same benefit plans (including Medical, Dental, Vision, and your Health Care FSA) that you had in place before your termination.

2. Health Care FSA Balance: Full Access Restored: Your Health Care FSA balance will be fully restored. You will have access to the full annual limit for eligible expenses incurred after your return, minus any amounts you were reimbursed prior to termination.

3. Coverage Break and Waiting Periods: Break in Coverage: You may experience a short break in coverage between your termination date and your rehire date.

New Waiting Periods: You will be subject to new waiting periods for certain benefits (e.g., Short-Term Disability), as if you were a new employee.

Termination followed by rehire after 30 days

If you terminate employment and are rehired more than 30 days after your termination, you will be permitted to make a new election or you may 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.

Coverage Termination



Dependent Coverage

Your dependent's coverage will terminate on the earliest of the following dates:

- **Age Limit Reached**: The last day of the calendar month in which the dependent child turns 26 years old (coverage applies through age 25).
- **Loss of Eligibility:** The last day of the month in which the individual no longer meets the definition of an eligible dependent.
- **Employee Coverage Ends:** The date the primary employee's coverage terminates.
- **Employment Status Change:** The end of the month prior to the dependent becoming covered 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.
- **Flexible Spending Account (Health)** - FBMC Onsite Representative at (561) 434-7442 to apply for COBRA continuation on an after-tax basis of your Flexible Spending Health Care (FSA).
- **ID Commander** 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 and are not eligible for Medicare. If you are Medicare-eligible when you retire, coverage will be offered by FSRBC.

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**

The Retiree Benefit Analyst is available to answer questions you may have about Benefits.

When you are within 30 days of your retirement date, schedule an appointment with a Retiree Benefit Analyst to discuss your options. Please call (561) 434-8673 for more information.

Miriam Morales / Email: **Miriam.Morales@palmbeachschools.org**

Please refer to the Coverage Termination section for further information.

Retiree Q&A

What Should I Do When I Retire?

Health insurance continuation at the time of retirement can take two different paths.

Pre- Medicare (less than 65 years of age) will continue to have benefits administered by Risk & Benefits Management.

Medicare Eligible (65 or older)

The Florida School Retiree Benefits Consortium (FSRBC) offers comprehensive and competitive Medicare Medical, Dental and Vision plans tailored especially for those age 65 or older, who have retired from the Florida public school system.

FSRBC plan payment options vary depending upon your actual enrollment choice.

During the 90 days prior to your anticipated retirement date, contact Risk & Benefits Management, Retiree Analyst, at **561-434-8673** with questions regarding the continuation of retiree 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.

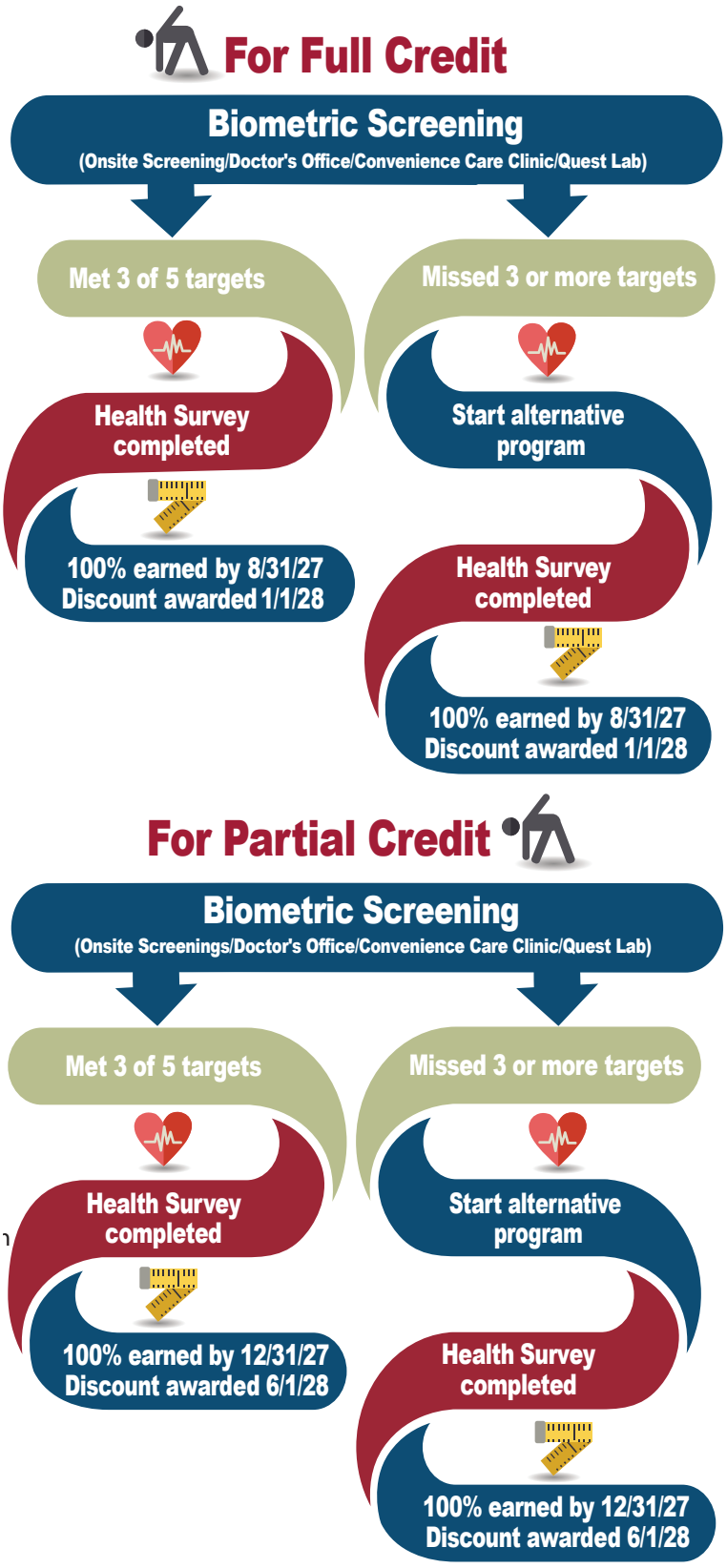
When I Retire, to Whom Do I Send Payments?

Retirees who are pre-medicare eligible (pre-65 years of age), may continue their health, dental, and/or vision plans through the district group plans. They 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.

Medicare Eligible Retirees - (65+ years of age)

Your choice for continuation of health, dental and/or vision service will be administered by Florida School Retiree Benefits Consortium (FSRBC). Payment options vary depending upon your plan enrollment choice. For more information visit **www.myfsrbc.com** or call **(833) 686-0983 (TTY 711)**

Health Rewards Credit



Note: Participant is responsible for tracking progress and submission of Physician Results Form.

Prepare Now and Earn a $50 per Month Medical Premium Credit in 2028

Earn up to $600 in premium credits by actively participating in the Health Rewards program. Complete required activities between January 1 and August 31, 2027 to earn full credit beginning January 1, 2028.

Complete the required activities by December 31, 2027 and you will receive partial credit (up to $350 for the year) beginning with the first premium due on or after June 1, 2028.

Any employee and spouse/domestic partner plan participant on a District medical plan is eligible to participate in the Health Rewards program. Each participant must earn 100% on UHC Rewards to complete the requirements. The premium credit incentive will be reflected in the employee's paycheck for anyone covered under that plan that earns the credit.

It is important for each plan participant to take full responsibility for tracking their progress. For those who use the Physician Results form, please be aware that only the first form submitted will apply. The participant is responsible for faxing or uploading that form.

- Complete the confidential Online Health Survey accessible through **www.myuhc.com**.
- Complete a Biometric Screening (first submitted screening data of 2027 will apply).
- Meet three of five Biometric Markers.
- If three 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 action programs. These programs will help you get on the right track by providing education and coaching on positive health behaviors.

For more information about the Health Rewards program, visit: **http://l.sdpbc.net/r007h**

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

A $50 per month tobacco surcharge will be added to the medical premium for employees who use tobacco products.*
Log in to: **http://l.sdpbc.net/aorzj** 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.

DOC District Onsite Clinic

Marathon Health

Primary care

with Marathon Health



As part of your benefits, you and your family members have access to the District Onsite Clinic, powered by Marathon Health

Primary care

- Same- and next-day visits for immediate care needs
- Little to no wait
- More time with your provider

Services

- Annual physical exams
- Condition management
- Health coaching
- Labs and onsite testing
- Occupational health
- School and sports physicals
- Sick and immediate care

Patient portal

- Access online or through the Marathon Health app
- Schedule appointments
- Secure video chats
- Communicate securely with your provider
- Manage your prescriptions and request refills
- Access your medical history, lab results, and other health documents
- Connect your health apps to track your progress

Schedule your appointment
561-899-0758 | my.marathon.health

THE SCHOOL DISTRICT PALM BEACH COUNTY

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PeopleOne Health Clinics



Award-Winning **Health Benefit**

100% Free With Your SDPBC Benefits, When You Are Enrolled in a Health Plan Option

We're excited to share the 100% free award-winning health benefit available to you through your School District of Palm Beach County medical benefits. You and your eligible dependents are able to join at no cost.

$0 Out-of-Pocket

Unlimited primary care visits for you and your eligible dependents

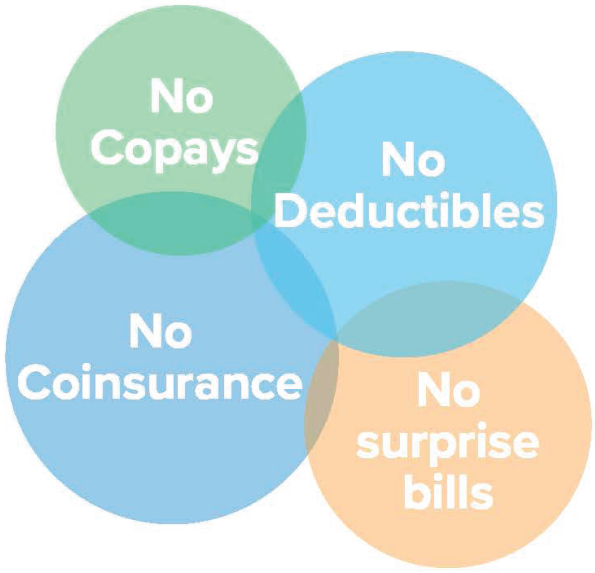
Access to same or next-day sick visits

24/7 On-Call Providers

90+ Net Promoter Score - meaning our patients love our services!

Elect to join anytime during the year*

*To remain in the program, members must meet with their care team within six months, as membership is limited



Medical Plan Cost



2027 Employee Per-Pay-Period Medical Contributions

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	$346.00	$77.00	$377.42	$83.99	$346.00	$77.00	$377.42	$83.99
EE + Child(ren)	$481.00	$120.00	$524.67	$130.90	$466.00	$135.00	$508.31	$147.26
EE + Spouse	$518.50	$141.00	$565.58	$153.80	$503.50	$156.00	$549.22	$170.16
EE + Family	$591.50	$203.00	$645.21	$221.43	$576.50	$218.00	$628.85	$237.79
HIGH OPTION HMO								
EE only	$371.00	$97.00	$404.69	$105.81	$321.00	$147.00	$350.15	$160.35
EE + Child(ren)	$506.00	$187.00	$551.94	$203.98	$441.00	$252.00	$481.04	$274.88
EE + Spouse	$541.00	$212.00	$590.12	$231.25	$476.00	$277.00	$519.22	$302.15
EE + Family	$641.00	$282.00	$699.20	$307.61	$576.00	$347.00	$628.30	$378.51
CDHP MEDICAL								
EE only	$286.00	$82.00	$311.97	$89.45	$286.00	$82.00	$311.97	$89.45
EE + Child(ren)	$416.00	$130.00	$453.77	$141.80	$401.00	$145.00	$437.41	$158.17
EE + Spouse	$436.00	$151.00	$475.59	$164.71	$421.00	$166.00	$459.23	$181.07
EE + Family	$506.00	$218.00	$551.94	$237.79	$491.00	$233.00	$535.58	$254.16

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 a Domestic Partner or Domestic partner and child(ren) 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

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

This plan requires each enrolled member to select a Primary Care Physician (PCP) within the NHP Network, with the flexibility to change PCPs monthly. You can visit any NHP Network specialist in Florida without a referral, and when outside of Florida, you have access to care through the nationwide UHC Choice Plus Network.

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 a Primary Care Physician (PCP) from the NHP Network. You may change your PCP monthly and visit any NHP Network specialist in Florida without a referral. When outside of Florida, you have access to the nationwide UHC Choice Plus Network.
Preventive Care	No charge
Office Visit (Primary Care)	$30 co-pay for UHC Tier 1 Premium Care Physician / $40 copay non-Premium Care Physician / Deductible does not apply
Specialist Office Visit	$55 co-pay for UHC Tier 1 Premium Care Physician / $60 co-pay 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 co-pay per visit[1] Deductible does not apply
Approved Durable Medical Equipment	20% of eligible expenses after deductible
Emergency Ambulance Trip	$150 co-pay per trip
Hospital Pre-Admission Requirement	Your doctor will take care of all prenotification requirements.
Emergency Room Care	$250 co-pay (waived if admitted)
Urgent Care Copay	$75 co-pay - Deductible does not apply
Convenience Care Clinic - Virtual Office Visits	$40 co-pay - Deductible does not apply $25 co-pay - Deductible does not apply
District Onsite Clinic Visit	$10 copay
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 "NHP HMO/POS Access."

[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 Now By JudiRx!

- 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. This plan becomes available during Open Enrollment after you have been benefit eligible for 18 months without a break in service.

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 co-pay for UHC Tier 1 Premium Care Physician/ $40 copay non-Premium Care Physician / Deductible does not apply
Specialist Office Visit	$40 co-pay for UHC Tier 1 Premium Care Physician/ $50 co-pay 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 co-pay per visit[1] Deductible does not apply
Approved Durable Medical Equipment	10% of eligible expenses after deductible
Emergency Ambulance Trip	10% of eligible expenses after deductible
Hospital Pre-Admission Requirement	Your doctor will take care of all prenotification requirements.
Emergency Room Care	15% of eligible expense after deductible
Urgent Care Copay	$50 co-pay Deductible does not apply
Convenience Care Clinic - Virtual Office Visits	$25 co-pay - Deductible does not apply $25 co-pay - Deductible does not apply
DOC District Onsite Clinic Visit	$10 copay
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."

[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 now by Judi Rx!

- 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
DOC District Onsite Clinic Visit	$25 copay	
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 Plus."

[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 Now By JudiRx!

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

Medical Plans



Naviguard handles out-of-network balance medical bills for you

Naviguard® is a UnitedHealthcare service that is designed to provide personalized advocacy to help reduce out-of-network health care costs. Our services are available at **no additional cost to you** through your UnitedHealthcare administered health plan benefits.

Guidance & Support

We help you know if you've been billed appropriately for out-of-network health care. Depending on the bill, we'll give you various options to resolve your balance medical bill.

Industry Expertise

Our highly trained experts have decades of health care experience and use reference-based pricing and provider network knowledge to resolve out-of-network balance medical bills.

Trusted Advocate

We deliver a best-in-class experience by providing 1-on-1 guidance to resolve out-of-network balance medical billing issues.

Tailored Approach

We help reduce anxiety and uncertainty by resolving out-of-network balance medical bills through out-of-network billing education and when appropriate, custom negotiation directly with providers on your behalf – so you can focus on what matters most.

continued

Medical Plans

2nd.MD

Access to doctors for a second opinion



Facing a new diagnosis or managing a chronic condition? Looking at possible surgery? A change in your medication? Get a virtual second opinion from a doctor with 2nd.MD. They'll provide you with evidence-based information to help you understand your options. Within days, you and your family will be connected with a doctor to receive personalized information and education by video or phone. And it's all coordinated with your health plan resources. This service can help with all adult and pediatric subspecialties.

Connect with 2nd.MD specialists for a second opinion, and then 2nd.MD will provide a summary for you to share with your treating provider.

Get in touch with a doctor now

Request a second opinion online 24/7 at **uhc.care/programs** or by calling **1-866-269-3534.**

United Healthcare®

2nd.MD

2nd.MD provides information and support as part of your health plan. It does not provide medical advice or other health services and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Members are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. 2nd.MD is not an insurance program and may be discontinued at any time. This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through this service is for your information only. It is provided as part of your health plan. Program nurses and other representatives cannot diagnose problems or suggest treatment. This program is not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. This is not an insurance program and may be discontinued at any time.

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

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Diabetes - Level2 Specialty Care

level2®



Level2 Specialty Care for Type 2 Diabetes

Included with your health plan – at no additional cost

About the Program

Level2 is a diabetes specialty care program designed to help you go beyond simply managing type 2 diabetes. It provides tools and support to help you work toward improving your glucose control and overall health.

When you join, you'll receive a continuous glucose monitor (CGM) at no extra cost. This device lets you track your glucose in real time — no fingersticks required. You'll also have access to a dedicated care team made up of providers, coaches, dietitians, and other experts who will guide you through each step of the process.

Why Join?

Managing diabetes can feel overwhelming at times. Maybe you're tired of fingersticks, unsure what to eat, or struggling to stay motivated. Level2 is here to make things easier and help you take back control of your health.

With personalized guidance and tools, Level2 helps you understand what's affecting your glucose levels so you can make lasting, healthy changes.

How It Works

Joining Level2 is simple. First, you enroll in the program, which is quick and easy. Once your eligibility is confirmed, a CGM will be shipped directly to you.

From there, you'll connect with your care team to create a personalized plan for improving your glucose control. As you move through the program, you'll gain real-time insights into how your actions affect your glucose and learn how to make positive changes.

Participation and CGM availability depend on health plan and clinical eligibility criteria.

Cost

Level2 is included with select UnitedHealthcare plans. There is no additional cost beyond your regular health plan premium.

Learn More & Enroll

Visit mylevel2.com/care or **call 1-844-302-2821 (TTY 711)** to learn more and get started.

Important Note

Level2 cannot guarantee specific health results. Talk with your doctor to determine if Level2 is right for you. CGM and program access are based on your health plan and clinical eligibility.



Healthcare Doctors



UnitedHealthcare is pleased that the School District of Palm Beach County has chosen us as the health plan provider for you and your family.

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 healthcare
- Make healthy choices
- Find answers
- Save money
- Take charge of your health

Benefits You'll Appreciate

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, an in-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.

Find a Network Doctor or Hospital

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

1. www.whyUHC.com/sdpbc
2. Click **"Health plans"**
3. Choose the health plan network that you want to view

Your Coverage Plan

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. You can also access an electronic copy of your ID card using the myUHC App.

Healthcare Doctors

Additional Features of Each 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 healthcare experience easier.

Health coaches offer telephonic and online support to help you 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, or by phone, in the comfort of your own home.

Other helpful tools include:

- Healthcare cost estimator
- Physician search
- Hospital comparison

UnitedHealth Premium® Care Physician - Find Recognized Doctors and Hospitals in the Network

With the UnitedHealth Premium Tier 1 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
- Get names quickly online
- Access 27 specialties, including primary care, cardiology and orthopedics, as well as facilities in specialties, including:
  - congenital heart disease
  - cardiac care
  - total joint replacement
  - spine surgery

Finding a UnitedHealth Premium® Care Physician

Visit your member website, **myuhc.com**, to search the directory and look for this 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®.*

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

Tips to Make Your Doctor's Visit Worthwhile

Before your appointment:

1. Make a list of all the 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, it's okay to ask them to explain until you understand.

Digital Tools for your Health Plan



Digital tools to help you get the most out of your health plan benefits

Avery makes it easier to navigate your benefits

Your personalized digital tools – the UnitedHealthcare® app and **myuhc.com®** – give you access to resources integrated with Avery, a digital resource for your health plan. Avery is an always-on intelligent assistant to help you maximize your benefits and provide quick answers – making it easier to find what you're looking for and take action.

- Review plan documents, like Explanation of Benefits and Health Statements
- Find quality network providers with Smart Choice search results, personalized to your preferences
- View and pay claims, understand your account balances and deductibles
- See your health plan ID card and add your plan details to your smartphone's digital wallet
- Understand cost estimates or average cost data and covered services before you get care
- Discover additional benefits to support your health and well-being available through your health plan
- Learn more about the programs and benefits that are available to you

Get connected

Scan this code to download the UnitedHealthcare app or visit **myuhc.com** and get started with Avery

Register once to access both tools

Start by opening the UnitedHealthcare app or going to **myuhc.com** and then:

- Tap **Create account** on the app, or select **Register Now** on the website
- To create your account, fill in the required fields and follow the **protect your account** steps
- Enter your identification number, create password and agree to the terms and conditions

Now that you're registered, you'll be able to manage your plan all year long.

United Healthcare®

Avery is an AI companion that uses generative artificial intelligence to provide general information and educational assistance. Avery's responses may be incomplete or inaccurate and should not be relied upon as error-free. Avery is provided for informational purposes only and does not constitute medical advice, professional advice, a benefit determination, a guarantee of coverage, a referral, or an authorization for health care services. Avery is not a substitute for the advice or judgment of your health care provider or other qualified professionals. Coverage and benefits are subject to the terms, conditions, limitations, and exclusions of your applicable health plan.

Smart Choice is proprietary to UnitedHealthcare designed to provide members with greater personalization and choice with respect to the provider search experience that considers member preferences quality care, costs, accessibility and convenience. Smart Choice is intended as a guide when selecting care. Smart Choice may rely on personal data. We do not endorse any particular provider or guarantee quality. Scores are generated using artificial intelligence (AI). The AI may not always be error-free and could include incomplete or inaccurate information. Judgement should be used when selecting care.

Where available, members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. Please refer to the Website or Mobile application terms of use under Benefits & Cost to access a cost estimate, and under Find Care to search for care. Level Funded and Neighborhood Health Partnership members can access average cost data online or on the mobile app. None of the average costs are intended to be a guarantee of your costs or benefits. Your actual costs may vary. Please refer to the Website or Mobile application terms of use under Benefits & Cost to access average cost data, and under Find Care to search for care.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

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

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

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Judi Rx

Judi Rx

Welcome to the Judi Rx family!

Judi Rx is an innovative pharmacy benefit manager or PBM. Our role is to oversee your prescription benefit plan. We work hard every day to ensure your pharmacy benefit plan is cost-effective and in line with our mission: your health.



What is a PBM?

A PBM is a pharmacy benefit manager. We process prescription drug claims on your behalf. Judi Rx works directly with pharmacy providers and drug companies to make sure you get the medications you need. We strive to provide the right balance of drug access and cost savings as part of your plan.

Transitioning Made Easy!

We are working closely with your current providers to make the move to Judi Rx smooth. We aspire to deliver the best service and resources needed to help you and your family make better healthcare choices each day.

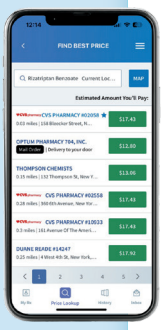


The support you count on today will continue, and Judi Rx will build on it with enhancements to make your experience even better.



Once active with Judi Rx, customer care experts are available 24 hours a day, 7 days a week to support you. You can reach us by dialing the number listed on your ID card.

We maintain relationships with 60,000+ pharmacies throughout the U.S.



Once active with Judi Rx, view and manage your pharmacy benefits with our app.

SCAN HERE TODAY TO DOWNLOAD THE JUDI RX APP

GET IT ON Google Play

Available on the App Store

To learn more about Judi Rx, visit judi.health

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Judi Rx

Welcome to Judi Rx - Your Prescription Benefit Program

Remember to Use Your Member ID Card at Retail Pharmacies

Don't forget to present your member ID card along with your prescription to one of our 60,000+ retail pharmacies. To find the nearest in-network pharmacy, log into the Judi Rx Member Portal. Click 'Care Search' and select 'Find Best Price.' Follow the prompts to locate the closest in-network pharmacy that offers the lowest cost.

Save time with Costco Mail Order Pharmacy

If you are prescribed a 90-day prescription for maintenance medications, you can fill your prescription through mail service.

Getting started with Costco Mail Order Pharmacy
Contact your healthcare provider and update your mail order pharmacy provider to Costco Mail Order Pharmacy. Prior to your first fill with Costco Mail Order Pharmacy, you will need to set up an account using one of the following methods.

> **Online:** Go to rx.costco.com and create a patient account.
>
> **Phone:** Call Customer Care and follow the prompts for 'medications delivered to your home'. When setting up your account be ready to provide payment and insurance information, preferred shipping address, and communication preferences.

Managing Your Prescriptions
Choose one of the following methods to manage your prescription(s) through Costco Mail Order Pharmacy:

> **Mail:** Go to rx.costco.com and access your patient account. Select refill prescriptions or new prescriptions. Follow the prompts to complete the request and mail your paper prescription to **Costco Mail Order Pharmacy, 6801 Seaway Blvd., Suite A-2, Everett, WA 98203**.
>
> **E-prescribe:** Have your healthcare provider electronically send your prescription to **Costco Mail Order Pharmacy, #1748, Zip Code 98203**.
>
> **Fax:** Have your healthcare provider fax your prescription to **1-877-258-9584**. Faxed prescriptions may only be sent by a healthcare provider's office and must include patient information.

You do not need a Costco membership to use Costco Mail Order Pharmacy

Rescription High Cost Drug Program (HCDP)

Some medications are very expensive. This program helps lower costs by filling them through our trusted pharmacy partner, Baton Rouge General Pharmacy. Your copayment for program medications is $0.

What this means for you:

- $0 copay and free home delivery for your program medication (CDHP deductible may apply).
- Same medication and doctor, plus support from a dedicated Care Guide and pharmacist.

What happens next:

- Watch for Rescription's call to complete enrollment and schedule a brief pharmacist visit.
- Rescription handle the transfer and delivery of your medication, so you don't need to do anything.

You don't have to wait for us to call
Ready to get started or have questions? Call 833-206-1245, Monday-Friday, 9 a.m.-6 p.m. ET, or email careguide@rescription.com.

You can fill specialty medications at Costco Specialty Pharmacy or any in-network pharmacy!

Once you get a new prescription for your specialty medication, you can follow these easy steps or fill at any in-network pharmacy:

1. Have your healthcare provider send your prescriptions electronically to **Costco Specialty Pharmacy #1710, Zip Code 53717** or fax your prescription to **1-855-213-0125**. Make sure your healthcare provider includes your contact information. If a prior authorization is required, your healthcare provider may need to take extra steps to process your prescription.
2. A representative from Costco Specialty Pharmacy will call you to obtain more information and schedule your first delivery. Call Customer Care and follow the prompts for 'specialty pharmacy' to confirm the receipt of your prescription.
3. Your prescription will arrive when and where you've requested it.

You do not need a Costco membership to use Costco Specialty Pharmacy

Accessing Your Benefits and Digital Tools

Scan the QR code to download the Judi Rx app and access all digital tools available! Judi Rx Customer Care is available 24 hours a day, 7 days a week. For support, please call the toll-free number on your ID card.

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 **www.Humana.com** called MyHumana. With a MyHumana account, 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 Care" 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 **www.MyHumana.com**
- Select "create an account" at the top of the page
- Create a username, password and security prompt and click "next"
- 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"

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 **www.MyHumana.com** and sign in/register for MyHumana (Have your Humana member ID or Social Security number available)
- Click "view ID cards" under "Tools & forms" in the lower right of your MyHumana home page
- 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. Eastern Time (TDD: 1-800-325-2026) to speak with a friendly, knowledgeable Customer Care specialist, or visit **www.MyHumana.com.**

Humana Info Video - Click Below to View



Dental Benefits

The 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 in the Humana DHMO network
- Same copayment to participating general dentist or specialist
- No referrals required to see a participating specialist
- Pediatric specialist care for age 16 and under
- Implant coverage

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.

DPPO Plan Benefit
Extended Annual Maximum*

With Humana's Dental PPO plans, the Extended Annual Maximum provides continued support after your annual maximum benefit has been reached. After the annual maximum is met, you still receive network discounts, and the plan will pay 30% of covered charges for eligible preventive, basic, and major services*.

This means you can continue getting important dental care for yourself and your covered dependents without having to postpone treatment.

*Excludes orthodontia

Finding an in-network dentist

Go to **https://humana.com/findadentist** anytime to find an in-network dentist.

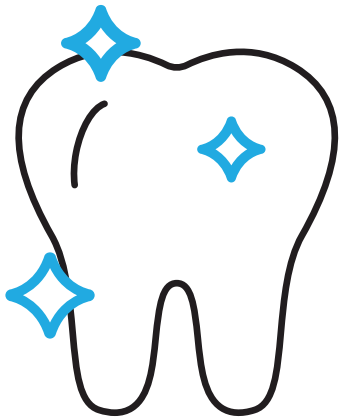
Under the Network drop down box, search for a provider by selecting one of the following networks:

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 1-800-233-4013 (TTY : 711), Monday through Friday , 8 a.m. to 6 p.m. Eastern Time

(TDD: 1-800-325-2026) to speak with Customer Care specialist



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	$8.09	$8.82	$6.15	$6.71	$17.95	$19.58	$14.16	$15.44
Employee + Child(ren)	$17.19	$18.75	$13.14	$14.34	$49.37	$53.85	$38.93	$42.47
Employee + Spouse	$14.16	$15.44	$10.69	$11.66	$43.99	$47.99	$34.68	$37.83
Employee + Family	$22.25	$24.27	$16.83	$18.36	$66.44	$72.47	$52.38	$57.14
Domestic Partner*	$6.07	$6.62	$4.54	$4.95	$26.04	$28.40	$20.53	$22.39
Domestic Partner + Children*	$14.16	$15.44	$10.68	$11.65	$48.48	$52.88	$38.23	$41.70

* **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.

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

Dental Benefits

Commonly Covered Procedures:

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

BENEFIT (Florida Only Networks)	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)	$20	$20
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
Implant- Surgical placement of implant body	$950	$950
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 - PLAN PAYS				
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 - PLAN PAYS				
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 - PLAN PAYS				
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 - PLAN PAYS				
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, 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:

- **Ultraviolet (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 (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 (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	$10 Co-Pay ($0 for Plus-Provider)	$35
Retinal Imaging	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; ($180 for Plus-Provider)	$65
STANDARD PLASTIC LENSES		
Single vision	$15 co-pay	$25
Bifocal	$15 co-pay	$40
Trifocal	$15 co-pay	$55
Standard progressive	$60 co-pay	$55
Premium progressive	$60 copay, 20% off retail price less $120 allowance	$55
LENS OPTIONS (PAID BY THE MEMBER AND ADDED TO THE BASE PRICE OF THE LENS)		
Anti-reflective - Standard	$45	N/A
Photochromic - Non-Glass	20% off retail price	Not Covered
Polycarbonate - Standard	$35	$3
Scratch-coating - Standard	$15	N/A
Tint (solid and gradient)	$12	$2
UV Coating	$12	$2
All other lens options	20% off retail price	N/A
CONTACT LENSES (INCLUDES MATERIALS ONLY; IN LIEU OF LENSES)		
Conventional	$0 co-pay; $125 allowance + 15% off balance over $125	$100
Disposables	$0 co-pay; $125 allowance + 100% of balance over $125	$100
Medically necessary	$0 co-pay, paid in full	$200
Contact Booster	$0 co-pay; you may receive additional allowances when purchasing through **contactsdirect.com**	N/A
HEARING CARE FROM AMPLIFON NETWORK†	64% off hearing aids	N/A
LASIK AND PRK VISION CORRECTION PROCEDURES††	15% off retail price OR 5% off promotional pricing	N/A
FREQUENCY		
Exams	Once every calendar year	
Frames	Once every other calendar year	
Standard plastic or contact lenses	Once every calendar year	

* 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.)
† Call 1 (877) 203-0675 for details & authorization.
†† LASIK and PRK correction procedures are provided by the U.S. laser network, owned by LCA-Vision. You must first call 1 (800) 988-4221 for the nearest facility and to receive authorization for the discount.

Vision Benefits

LensCrafters | TARGET Optical | eyeMed | Pearle Vision

EyeMed Vision Care Has Many Unique Online Capabilities, Including the Following:

- Locate the provider nearest you by going to **www.eyemed.com** and click on "Select" network.
- View your benefits, including service eligibility and the next date of service.
- Printable replacement ID cards.
- Online claims status.
- Ability to "go paperless" and receive explanation of benefits electronically.
- Learn more about the importance of vision care through Vision Wellness content.
- Access the mobile website to locate a provider, view ID cards, benefits and contact EyeMed.
- EyeMed mobile app available for iPhone, iPad and most Android touch devices.
- 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? Four 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 services are included with your vision plan at no added cost to you.

- 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 Savings 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.

Vision Benefits

AMPLIFON DISCOUNTS

See–and hear–life to the fullest

Hearing changes, whether temporary or indicative of permanent damage can occur gradually and go unnoticed. Regular hearing screenings every 3 to 5 years, and annual tests for those over 50, are crucial. That's why we give you access to affordable hearing care discounts through Amplifon.

HEARING EXAMS IN-PERSON OR ONLINE

Amplifon's guided virtual services allows you to confirm if hearing loss is detected from the comfort of home.

In-person hearing evaluation at a network clinic near you.
A hearing care professional will work with you to complete an in-depth evaluation of your hearing and propose solutions if hearing loss is detected.

YOUR AMPLIFON DISCOUNT INCLUDES

- Average of **66% savings** off hearing aids at thousands of convenient locations nationwide[1]
- **1 year of follow-up care** for cleaning, adjustment and other hearing aid services[2]
- **2-year battery supply** or a charging station to keep your hearing aids powered[3]
- **60-day hearing aid trial period** with no return or restocking fees
- Warranty protection with **coverage for loss, repairs or damage**[4]

amplifon Hearing Health Care.

Call 877-203-0675 TTY: 711 or log in to **eyemed.com/member** for more details

[1] Based on 2022 internal MSRP analysis. Your savings may vary. [2] Follow-up care – for one year following purchase. [3] One standard charger or two-year supply of batteries (80 cells/ear/year) at no additional cost. [4] For three years, exlusions and limitations may apply. Contact Amplifon 877-203-0675 for details.



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 well-being also produces good role models for students while supporting high student achievement.

Your Employee Wellness program offers many opportunities to improve your health, including onsite screenings, health challenges and programs, health education and benefit education, and support.

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 on the HUB for more information about our program offerings, including:

- Health Rewards
- Upcoming Wellness Events
- Support Groups
- Programs, Resources, and Support

https://employeehub.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 - MyUHC, MyHumana, EyeMed, Headspace, Calm Health, Kaia, Talkspace, and more
- Blood Pressure management programs
- Clinical program engagement
- Diabetes prevention and management programs
- Disease & care management
- Employee Assistance Program
- Health & wellness seminars
- Health Rewards
- On-site biometric, dermatology, and mammography screenings
- Online support and passion groups
- Online health information & resources
- Preventive care campaigns
- Real Appeal weight loss program
- Stress management strategies
- Substance Use Quit Kits
- Virtual visits
- Wellness Champion Program
- Wellness newsletter
- OnePass gym membership discounts
- On-site activities

Wellness Services to Help you Meet your Personal Health Goals

Find Support by Working with a Personal Health Coach

If you have health risks, the UHC 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 for your Mental Health

We know life's challenges can sometimes be hard to manage. We are here to help. We offer a wide variety of resources at little to no cost to you. So you can get the help you need, when you need it. Take a look at our continuum of mental health resources here: **http://l.sdpbc.net/asprg**

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 UHC Real Appeal program 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.

Wellness Services

Save Money on Healthcare with These Programs...

Health Rewards

- Up to $600 savings
- Disease and condition management and prevention

Know Where to Go

- DOC/CVS — $10-25
- Virtual Care — $25
- Primary Care — $30-60
- Urgent Care — $50-75
- ER — $250+

District Onsite Clinic

- Lower copays
- Free generic medications, health coaching, and labs
- Primary care and sick visits available

Virtual Medical Care

- Lower copay
- Convenient (save gas!)
- Primary care and sick visits
- Specialty visits for mental health, cardiac rehab, sleep, migraines, speech, women's health, gastroenterology, and dermatology

UHC Tier 1 Providers

- Lower costs
- Better outcomes
- Fewer hospital stays
- Look for the symbol!

EAP

- Six free counseling sessions per person, per year, per topic
- Help with finances, legal items, caregiving, and more
- Open to household members of any benefit-eligible employee

Supplemental Insurance

- Wellness and Benefit Rider
- ID Theft, Hospital Stay Pay, Accident, Critical Health Events and Universal LifeEvents

UHC OnePass

- More gym access for lower costs
- Free Paramount + and Instacart
- AARP discounts

PeopleOne Health Clinics

- Free primary care, sick visits, generic medications, health coaching, dietitian services, mental health counseling, imaging, and labs
- Open to all employees and family members on a UHC plan

EyeMed

- Vision services and products discounts available on the app
- Hearing assistance discounts

UHC Website/App

- Use the Find Care & Costs feature to know what your portion will be ahead of time for medical care

Other

- Employee Discounts on the HUB
- Free apps
- Fitness Video Library
- Flexible Spending Accounts
- Budgeting worksheet

wellness
The School District Of Palm Beach County

Employee Assistance Program (EAP)

Optum



When you have a long list of stressors – and a longer list of to-dos

When you're dealing with the pressures of everyday life, it can be easy to simply smile and say, "I'm fine." But sometimes, emotions like stress, sadness or even anger can linger.

In those moments, Employee Assistance Program is here for you. It's a modern and flexible employee assistance program that, together with WorkLife Services, offers support for everyday life. Call anytime to speak with an Emotional Wellbeing Navigation Specialist who'll listen to your needs and connect you with resources that can help. Skip the search when you need childcare, home repairs, eldercare or other resources in your community, and let WorkLife Services provide a vetted list. Or find helpful articles, videos and tools online. These services are available at no extra cost to all members of your household, including children living away from home.

Support for everyday life

To learn more, scan the QR code or visit **supportfinder.optum.com/sdpbc.**

24/7 availability | **Confidential** | **No cost to you**

Employee Assistance Program (EAP)

More information about what's available to you

Employee Assistance Program

Counseling and coaching

Take advantage of 6 coaching and counseling sessions either in person or virtually with a provider in our large network — at no cost.

Financial coaching from experts

Up to 60 minutes of free consultation (provided in 30-minute increments) with a credentialed financial coach. Access extensive financial tools including self-paced workshops, courses, financial assessments, calculators and more to help you take control of your finances.

Legal counseling and mediation services

No-cost 30-minute telephonic or in-person consultation with a state-specific attorney or qualified mediator per separate legal issue. Ongoing services are provided at 25% below the firm's current rates after the initial consultation.

Digital resources

Our digital experience provides access to a large suite of tools and resources. The conversational chat feature can help you navigate resources to address a range of concerns including stress, anxiety and depression, caregiver support, financial stressors, parenting and family issues and more. Resources are curated specific to your needs and accessible in one convenient digital experience.

Virtual Visits

HIPAA-compliant technology delivers video services in the privacy and comfort of your home or wherever you choose, providing convenience and accessibility. Licensed telemental health providers are available in every state.



Wellness Services

Caregiver support

- Grief/loss
- Retirement planning
- Adult daycare programs
- Financial and legal issues
- In-home/nurse care options

Child and family support

- Childcare options
- Adoption resources
- Day/summer camps
- Emergency/sick childcare
- Parent/family support groups

Chronic illness and condition support

- Respite services
- Caregiving services
- Assistive technology
- Affordable-housing resources
- Meal and transportation resources

Convenience services

- Pet services
- Traveling needs (business and leisure)
- Car and home repair and maintenance
- Shopping, dining and recreation recommendations

Educational resources

- Homeschooling
- Career consulting
- Adult education classes
- Individual educational plans
- School and college recommendations



Call

888-200-9207

24/7 availability | **Confidential** | **No cost to you**

Visit

supportfinder.optum.com/sdpbc.

This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. This program is not a substitute for a doctor's or professional's care. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and are subject to change. Coverage exclusions and limitations may apply. Stock photos. Posed by models.

Flexible Spending Accounts (FSAs)

What is a Flexible Spending Account (FSA)?

FSAs are tax-advantage accounts that let you use pre-tax dollars to pay for eligible medical expenses and dependent care expenses.

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.
- To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at www.fsafeds.gov/support/savingscalculators

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

A health FSA is a tax-favored account that pays for or reimburses the qualified medical expenses of an employee and his or her eligible dependents, including:

- Prescription drugs
- Eyeglasses
- Orthodontia

Dependent Care FSA (day care/elder care)

Dependent Care FSAs are tax-advantaged accounts that let you use pre-tax dollars to pay for eligible dependent care expenses. A qualifying 'dependent' may be a child under age 13, a disabled spouse, or an older parent in eldercare. Eligible expenses include:

- Daycare
- Nursery School Preschool
- Summer Day Camp
- Before or After School Programs
- Elder Day Care.

Receiving Reimbursement

With the Health Care FSA, the full annual election amount is available Day 1 (January 1st or the day your benefits take effect) on benefit start date. Complete and properly submitted claim forms are generally processed 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.

- Enroll in Direct Deposit by accessing your participant portal at mybenefits.inspirafinancial.com or by contacting Inspira at 1-844-729-3539.
- 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.

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 2027 plan year (December 31, 2027) for an FSA. This grace period ends on March 15th, 2028. 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 2027 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 31st, 2028. This is a period for filing claims incurred anytime during the 2027 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 Inspira 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).

Flexible Spending Accounts (FSAs)

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.

Where Can I Get Information About FSAs?

If you have specific questions about FSAs, contact the Customer Service department.
Visit **mybenefits.inspirafinancial.com** or call Inspira Customer Service at 1-844-729-3539.

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 **mybenefits.inspirafinancial.com** to obtain:

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

For more information call Inspira Customer Service at 1-844-729-3539 for further assistance.

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

On the Web and Mobile App

Inspira web and mobile tools ensure easy access, account management, and benefit fund security for our customers.

Fingerprint (Touch ID) and Facial Recognition. These capabilities protect participant account information without the hassle of remembering another password.

Picture to Pay. Take a picture of an eligible benefit expense then submit it via the Inspira mobile app. There are no forms to fill out and no need to sign in to a website. Just click and submit and we'll take care of the rest.

Expense Eligibility Check. Not sure an item is eligible for reimbursement? Find out in seconds on the app. It's the quickest way to make sure benefits are being spent correctly.

Mobile Alerts[1]. Participants are notified when we've received a request and when it's been paid, making it easy to stay on top of account activity and available funds. [1]Standard message and data rates may apply.

Pay the Provider. Instead of paying out of pocket and waiting to be reimbursed, participants can use their Inspira Card to pay for eligible expenses, or they can use our convenient web payment feature. Simply scan or take a picture of the provider bill and upload it. Inspira will then pay the bill directly from the appropriate benefit account.

Email Alerts. Participants are notified when requests are received and paid, making it easy to stay on top of account activity and available funds.

Seamless Account Management. Our website, mobile app, and customer care call center make it easy for participants to manage their account and get the support they need, anytime and anywhere! Plus, account information is connected across all platforms, which means participants don't have to re-enter data or restart a process between devices.

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, 2028) from 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 2027 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 2027 plan year. IRS regulation states that, any unused funds remaining in your FSA account after plan year and any applicable grace periods end, and all reimbursement requests have been submitted and processed, cannot be returned to you or carried forward to the upcoming plan year.

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*

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. You may use it for copays, prescriptions, medical supplies, and more. Click here for a more extensive list of what is covered: https://www.fsafeds.gov/explore/hcfsa/expenses

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?

Simply log in to your Inspira account, click **Request a Reimbursement**, and follow the steps for the fastest claim submission. Alternatively Inspira also has manual claim forms available at [mybenefits.inspirafinancial.com.](mybenefits.inspirafinancial.com)

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.

Mail to Inspira:
PO Box 8396
Omaha, NE 68108
Fax: 855-709-5305
Customer Service: 844-729-3539



Card Experience

The hassles of carrying multiple cards and trying to remember which card pays for what are a thing of the past with the Inspira Card. Just swipe this stacked card at the point of purchase and eligible expenses are paid automatically with smart technology to know which account to draw funds from. Every participating employee receives an Inspira Card and has access to several value-added card features.

Health Care FSA and Limited Expense Health Care FSA

You must have a receipt or an explanation of benefits from your insurance carrier for each health care claim you submit against your account.
For quick processing, make sure all receipts include these 5 pieces of information:

- Patient's Name – the name of the person who received the service or for whom the item was purchased. For retail store purchases, this information may be excluded.
- Provider's Name – the provider that delivered the service or the merchant where the item was purchased.
- Date of Service – the date when services were provided or the item was purchased.
- Type of Service – a detailed description of the service provided or item purchased. A pharmacy prescription receipt is sufficient for prescriptions.
- Cost – the amount paid for the service or product and/or the portion that is not reimbursed through your insurance carrier.

Please note: For some expenses, a Letter of Medical Necessity Form (PDF) from a doctor may be required.

Minimum Annual Deposit: $300

Maximum Annual Deposit: $3,400 (pending IRS update for 2027)

The IRS created the "use it or lose it" rule, which states that all money left in your FSA is forfeited after the benefit period ends. If you don't use all of your FSA funds during the benefit period, you risk losing money.

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 $3,750.
- If your filing status is Single or Head of Household, you can contribute up to $7,500 per year.
- If you are married and filing jointly, your maximum annual deposit is $7,500.
- If either you or your spouse earn less than $7,500 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 $6,000 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, unlike a Health Care FSA, your maximum contribution amount will not be 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 irs.gov and mybenefits.inspirafinancial.com to complete a tax savings analysis.

How do I Request Reimbursement?

With the Dependent Care FSA, your available balance increases as payroll deductions are made. Simply log in to your Inspira account, click **Request a Reimbursement**, and follow the steps for the fastest claim submission. Alternatively Inspira also has manual claim forms available by contacting 1-844-729-3539.

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. 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. Voluntary Employee contributions cannot 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?

For Employees participating 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?

You are automatically enrolled in e-statements to save time, paper, and ink. Statements are generated quarterly and available in your online portal under the Statements/Forms section. If you wish to receive a paper statement, please log in to your portal and select your statement delivery preference.

How do I Access my Account?

Go to **www.bencorplans.com** and click "Participant Log On." Select "New User" 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**

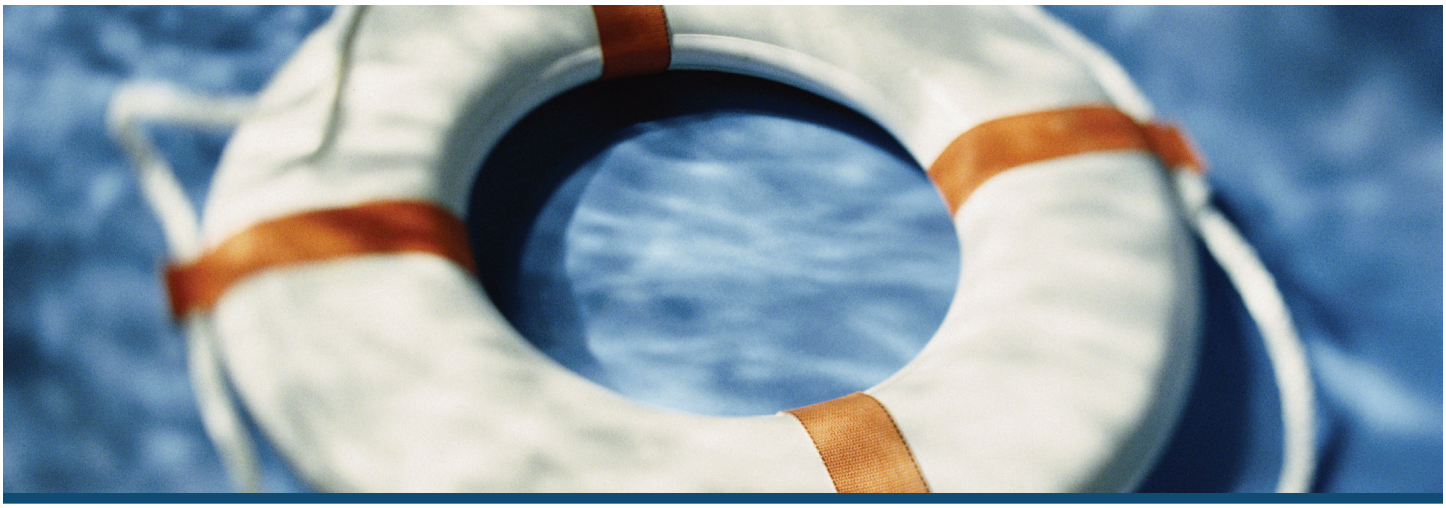
Features of the Participant Website

- Unit Values
- Account Balance
- Account Balance by Fund
- Fund Transfers
- Online Beneficiary Designation
- Investment Fund Objectives
- Fund Performance
- Update Phone Number and Email
- 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@bencorservices.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: **http://l.sdpbc.net/rn1y1**

Eligibility

This program is available to employees who are:

- Actively at work
- Part time (20 hours for regular employees and 18.75 for CTA bargaining group members).
- Full time (40 hours for regular employees and 37.5 for 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 limited to:

- Degree supplements
- Complexity level supplements
- Retention supplement (subject to renewal of tax referendum)
- 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 disability coverage, and the premium that is waived is disability 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. Plans provide varying lengths of coverage from 17 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 Short-Term 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 eligible 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 not pay benefits for any disability that results from, or is caused or contributed to by, a preexisting condition, unless at the time you became disabled:

- You have not received medical care for the condition for six months while insured under the plan; or,
- You have been continuously insured under the plan for 12 months.
- OR had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment in the 6 months before Your insurance under this certificate takes effect.

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.

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.

Definition of Long-Term Disability

Long-Term Disability begins after Short-Term Disability ends and you are:

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

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

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).

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 weekly benefit was paid. If you return to Active Work after you begin to receive Weekly Benefits, we will consider you to have recovered from your disability. If you return to Active Work for a period of 90 days or less, and then become disabled again due to the same or related sickness or accidental injury, we will not require you to complete a new Elimination Period. For the purpose of determining your benefits, we will consider such disability to be a part of the original disability and will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability.

Disability Income Protection

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 pre-disability monthly Salary;
- the greater of the Short Term Disability Maximum Benefit Period or 180 Days,
- 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.

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 – Claimants may be reimbursed 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 Americans 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 for a child, under age 13, whose care is being provided by a licensed child care provider who may not be a member of your immediate family or living in your residence 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.

Designated Beneficiary – We must receive the satisfactory proof for survivor income benefits within one year of the date of your death. In the event of death while disabled, and the employee was entitled to receive Monthly Benefits, MetLife will pay a benefit amount equal to 3 times the lesser of:

- the Monthly Benefit employee receives for the calendar month immediately preceding death,
- the Monthly Benefit employee was entitled to receive for the month they died, if the employee dies during the first month that Disability benefits are payable,

according to the following order:

1. Your Spouse, if alive;
2. Your child(ren), if there is no surviving Spouse;
3. Your estate, if there is no such surviving child.

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.

To view or print a copy of a certificate of coverage, visit:
https://l.sdpbc.net/rn1y1

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 ($0.611 for STD / $0.317 for LTD)	$122.20	$63.40
D. Divide by 24 (number of payroll deductions/yr)	$5.09	$2.64

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

EMPLOYEE'S AGE	OPTION A	OPTION B	OPTION C
54 & Under	$0.611	$0.423	$0.334
55 - 59	$0.804	$0.548	$0.438
60 - 64	$0.923	$0.628	$0.503
65 & Over	$1.122	$0.771	$0.611

Please contact the Benefits Office for the 22 Payroll Deduction Rates at (561) 434-8580

LONG-TERM DISABILITY RATES

EMPLOYEE'S AGE	RATES PER $100 OF COVERED PAYROLL
24 & Under	$0.037
25 - 29	$0.048
30 - 34	$0.074
35 - 39	$0.121
40 - 44	$0.169
45 - 49	$0.227
50 - 54	$0.317
55 - 59	$0.369
60 & Over	$0.385

Basic Life Insurance



Basic Life Insurance

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

What Are My Basic Life Insurance Benefits?

The School District of Palm Beach County provides you with basic life insurance in the amount of $20,000 for full-time employees and $10,000 for part-time instructional 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 64.

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.

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.

Post-tax Benefits

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

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

Life Insurance Reduction

At age 70, your Supplemental Life Insurance and Supplemental Accidental Death and Dismemberment Insurance will be determined by applying the appropriate percentage from the following table.

EMPLOYEE'S AGE	REDUCTION
70 - 74	35%
75 - 79	55%
+80	70%

Rates (Monthly)

Optional Life Insurance & Optional Accident Insurance

Employee only:	$0.159 per $1000 of coverage per month
Spouse:	$0.873 per $1,000 of coverage per month
Child:	$0.450 per $5,000 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.

During Open Enrollment, you must submit a completed Statement of Health Form directly to MetLife by mail, email, or fax by mid-December. Submission of an incomplete application will not extend the deadline.

To download the Statement of Health Form go to:
http://l.sdpbc.net/ke94g

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

Phone: (800) 638-6420, Option 1

FAX: (859) 225-7909

Email: SOHSubmissions@Metlife.com

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: **http://l.sdpbc.net/ke94g**

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 **http://l.sdpbc.net/ke94g** 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

Statement of Health Forms are available to download from the PeopleSoft system. Simply, download the application, fill in all required fields and mail, fax, or email the form directly to MetLife. MetLife will notify you of any additional steps and ultimately the final determination of your request.

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 may be subject to Underwriting Approval.

What are the Optional Life Insurance features?

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

For more information regarding these features, please refer to the product features section that starts on page 67.

Imputed Income

Imputed Income will apply for selected amounts over $50,000 for employees over the age of 50: Because our group rate is the same for all employees, the IRS requires employers to report taxable imputed income for each employee whose charged premium is lower than its published Rate Table. Visit the HUB's Benefits Page for more information on Imputed Income for Life Insurance.

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.

Post-tax Benefits Optional Accident Insurance

Provided alongside your Optional Life Insurance: Optional Life 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.

Optional Accident Coverage Amount

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

Your spouse – Your spouse will automatically receive an amount equal to your Optional Spouse Life Insurance.

Dependent Rate Information

You may need to request changes to your existing coverage if, in the future, you no longer have dependents who qualify for coverage.

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.

Exclusions

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;
- War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot;
- 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

Group Term Life Insurance

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;
- 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.

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: **http://l.sdpbc.net/do6q6**

Travel Services include:

- 24-Hour Toll-Free Access Worldwide
- Website access to AXA ASSISTANCE USA related travel information
- Referrals to Primary Care Physicians & Hospitals
- Referrals to Medical Specialists
- Dental Referrals
- Vaccination Recommendations/Insect Precautions
- Hospital Admission Guarantee
- Medical Monitoring
- Medical Transportation Services:
- Emergency Medical Evacuation
- Emergency Medical Repatriation
- Return of Mortal Remains
- Transport of a Family Member
- Escort of Dependent Children
- Emergency Prescription Transfer
- Shipment of Medication
- Urgent Message Relay
- Emergency Cash/Bail Assistance
- Legal Referrals
- Telephone Interpretation
- Lost Document and Luggage Assistance
- Claims Processing Assistance
- General Travel Assistance/ Information Services
- City Profiles
- Vehicle Repatriation Services
- Political Evacuation Arrangement Services
- Pet Concierge Services
- Travel Concierge Services
- Identity Theft Services*

Group Term Life Insurance

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 **http://l.sdpbc.net/do6q6** or can be accessed by contacting Risk & Benefits Management.

Retirement Investment Plans



How to Enroll

Employees can enroll in Voluntary Retirement Investment plans at any time of the year. Employees can also increase, decrease or suspend deductions at any time by using PeopleSoft.

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

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

Please review the list of our District's providers below or by visiting publicretirement.daybright.com. You would contact them directly to open an account.

Board members that receive W-2's are not eligible for 403(b) – only 457.

Visit our website for important information:

http://l.sdpbc.net/16qdu

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 publicretirement.daybright.com for a complete listing of what program each vendor offers.

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

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

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:

Corebridge
Elaine Roberts - (561) 684-3775 / (954) 946-1765 / (800) 448-2542

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

Equitable
Michael Goldberg - (561) 961-9305

Fidelity Retirement Services
(No Agent of Record) - (800) 343-0860
Group Code for 403(b): 88020 ; 457:86608

Horace Mann
Brooks Hannula - (561) 894-7933

Lincoln Investment
Mike Mracna - (561) 649-9200

MetLife
Kristina Bergman - (561) 207-2311

National Life Group a.k.a LSW
Tracee Williams - (800) 579-2878

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

Quick Enroll Plan B - (833) 264-1502

VOYA Financial
Keista Ransom - (866) 265-2660

VOYA Reliastar
Keista Ransom - (877) 882-5050

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 LifeEvents® Insurance with Accelerated Death Benefit for Long-Term Care Services

Trustmark Universal Life and Universal LifeEvents are 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

Trustmark Accident Insurance pays cash benefits directly to you for covered accidents and treatment services — helping you cover deductibles, copays, travel expenses, and everyday bills.

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

Trustmark Hospital StayPay®

Hospital stays can be really expensive, and health insurance might not cover everything. Trustmark Hospital StayPay helps you keep a hospital trip affordable. It's designed to pair with your medical plan so you can be more confident in your protection.

Hospital StayPay pays you a cash benefit when you're admitted to the hospital, and another for each day you spend there. With Hospital StayPay, you can worry less about your bills, and focus on recovering.

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 voluntary benefits period is an opportunity to learn about and to enroll in these Trustmark products. Information on how to schedule an appointment to meet with an FBMC Representative virtually will be sent to you electronically later in the year. Enrollment in Trustmark products is only available through your FBMC Representative.

Register for your Trustmark Portal Today

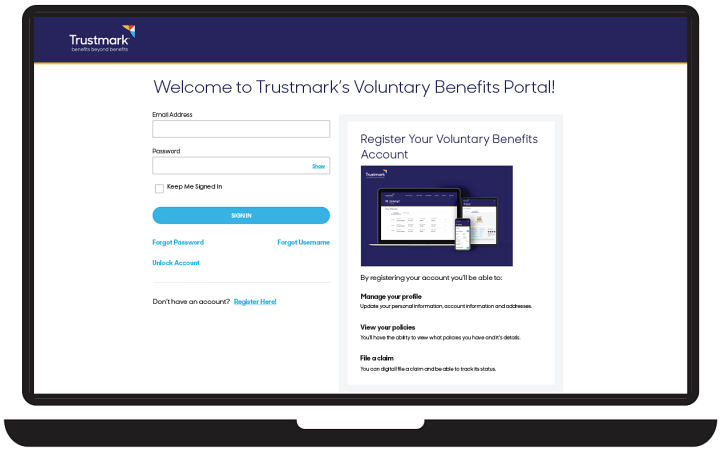
Please see the next page for more information.

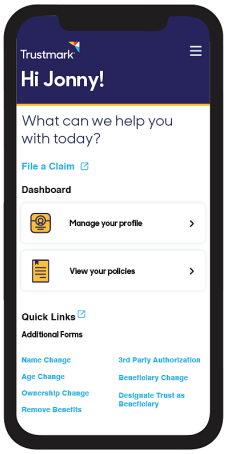
Underwritten by Trustmark Insurance Company, Lake Forest, Illinois. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Universal LifeEvents death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary; issue age is 18-64. Preexisting condition limitations may apply. Benefits, availability, exclusions and limitations may vary by state and may be named differently. Your policy will contain complete information. Trustmark®, LifeEvents®, Trustmark Critical HealthEvents® and Trustmark Hospital StayPay® are registered trademarks of Trustmark Insurance Company. This is a supplement to health insurance. It is not a substitute for medical or hospital expense insurance, a health maintenance organization (HMO) contract or major medical expense insurance. Products underwritten by Trustmark Insurance Company.

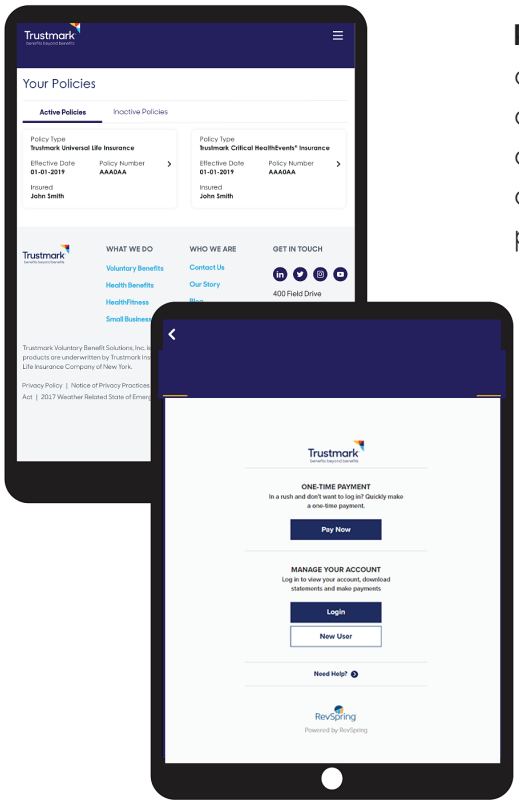
Special Benefits from Trustmark

Trustmark Voluntary Benefits' portals for policy owners

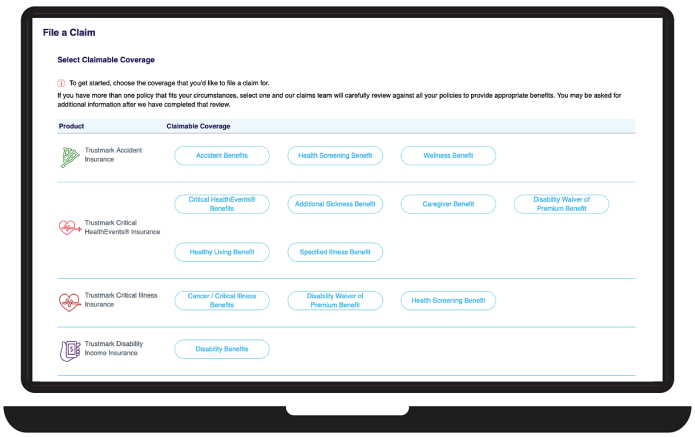
meet customers where they are 24/7, making interacting with us online at TrustmarkVB.com or by phone easy.







Policy owners can log in on laptops, mobile devices or tablets to view their personal policies and benefit details; update personal and contact information; quickly file claims online and enable text updates on claim status; and switch to direct bills or make payments online.



Underwritten by Trustmark Insurance Company and Trustmark Life Insurance Company of New York. Rated A- (EXCELLENT) A.M. Best

400 Field Drive • Lake Forest, IL 60045
TrustmarkVB.com

Trustmark
benefits beyond benefits

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.

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:
Inspira Financial
(844) 729-3539
mybenefits.inspirafinancial.com/

You may also obtain a copy of your COBRA election notice (Medical, Dental & Vision) by contacting Benefits Outsource, Inc. via email: cobra@boibenefits.com, or via mail: Benefits 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 Inspira/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 Inspira/FBMC.

For continuants enrolled on COBRA, address change notifications should be reported to Benefits Outsource, Inc. (BOI), via email: cobra@boibenefits.com; mail: Benefits Outsource, Inc. (BOI), 5599 S. University Drive, Suite 201, Davie, FL 33328 or calling 1-888-877-2780.

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).

Enroll in Health Insurance Marketplace coverage during Open Enrollment to ensure your policy takes effect on January 1. In the Marketplace, you could be eligible for a 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 spouse's 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:

Benefits 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 monthly coupons for use in making periodic payments.

Periodic payments for continuation coverage should be sent to:

Benefits 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. Benefits 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:

Benefits 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:

Benefits 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 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 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 the Benefits Department at (561) 434-8580.

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

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

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

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

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.ssa.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, 2026

Name of Entity: School District of Palm Beach County

Contact: Benefits Technician

Address: 3300 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 Tiles** provide 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 and benefit information including enrollment and dependent information
- remove and modify beneficiary information at your convenience.

Q: What am I able to view or change using PeopleSoft?

A: You can:

- **Manage Payroll Data**
  - **View/print paychecks or W2 information**
  - **Verify payroll deductions**
  - **Manage direct deposit**
  - **View payable time**
- **Manage Personal Information**
  - **Review/Manage Emergency Contact Information**
  - **Change Address**
  - **Change Phone Number and Email Address**
- **Manage Benefits 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: Who should I contact if I have questions on my Benefits?

A: Please contact the Benefits Department at (561) 434-8580 or email Benefits@palmbeachschools.org.

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

A: As a new hire, 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 the close of the Open Enrollment period.

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.

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 access the system and complete your enrollment. Make sure you check your School District email for important information and reminders.

Q: How do I get my User Name and Password?

A: District User ID and Password are assigned to you as a new employee. Do not share your password with anyone, including anyone presenting themselves as a member of the IT Department. All activities performed while using your District computer account will be attributed to you. Once you receive your initial password, and you have District Portal access, you will need to change your password. Please contact the IT Service Desk for assistance.

Q. How do I make sure my elections will be processed?

A: After making your benefit elections/changes in PeopleSoft, please make sure you finalize by clicking on the Submit Enrollment button.

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

Inspira, 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

Inspira Appeals
PO Box 8396
Omaha, NE 68108



FBMC
A LEAVITT GROUP AGENCY

Contract Administrator

ATTN: **Mail Slot 32,** PO Box 1878,
Tallahassee, FL 32302-2789

MyFBMC.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 or policies will be provided to participants following the start of the plan year, if applicable.