2011 The School District of Palm Beach County

Flexible Benefits Plan Reference Guide

Employee Benefits Resource Directory

Risk & Benefits Management Department
(561)434-8580
Fax Number for Employee Benefits
(561)-434-8103
www.palmbeachschools.org /riskmgmt

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

Dental Insurance
UnitedHealthcare Dental®
1-877-816-3596 PPO Plans
1-800-955-4137 Managed Care Plans
www.myuhcdental.com
UHC on-site representative
Fulton Holland Building A-103
(561) 434-8092/(561) 357-7564

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

Employee Assistance Program (EAP)
Corporate Care Works (CCW)
1-800-327-9757
(561)433-9588
www.corporatecareworkspbc.com

Flexible Spending Accounts
Fringe Benefits Management Company Automated Services
24 hours a day
1-800-865-FBMC (3262)
www.myFBMC.com
Claims Fax Number:
1-866-440-7145
Customer Care
Mon - Fri, 7 a.m. - 10 p.m. EST
1-800-342-8017
FBMC on-site representative
Fulton Holland Building A-103
(561) 434-7442

myFBMC Card®
Activation
24 hours a day
www.myFBMC.com

Lost or Stolen Card
24 hours a day
1-888-462-1909

Dispute Line
FBMC Customer Care
1-800-342-8017

Health Insurance
UnitedHealthcare
www.myuhc.com
Member Services & Pharmacy Benefits HMO Choice 39
1-800-411-1147
EPO
1-866-633-2446
PPO
1-866-633-2479
UHC on-site representative
Fulton Holland Building A-103
(561) 434-8092/(561) 357-7564
Healthy Living Lessons for Life - NurseLine
1-888-229-9322

Long-Term Care Insurance (no new policies 8/1)
MetLife
1-800-438-6388
www.metlife.com/mybenefits

Term Life and Accident
Life Insurance Company of North America, a CIGNA company
1-800-423-1282
www.cigna.com
Identity Theft Hotline
1-888-226-4567
www.cigna.com/idtheft

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

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

TSA Consulting Group, Inc.
Participant Transactions
28 Ferry Rd. SE
Fort Walton Beach, FL 32548
Phone: 1-888-796-3786
Fax: 1-866-741-0645
e-mail for Transactions and ART Assistance (approval of loans, rollovers, hardships, distributions, exchanges, log-in assistance, etc.)
recordkeeping@tsacg.com

Vision Plan
EyeMed Vision Care
Provider Locator
1-866-299-1358
www.eyemedvisioncare.com
Customer Service
1-866-723-0514
www.eyemedvisioncare.com

Table of Contents

4 What's New for 2011?
5 Sample Documents needed for Dependent Coverage
7 Enrollment Information & Deadlines
8 Online Enrollment Confirmation Verification
9 Employee Responsibilities
10 Overview for 2011
11 Enrollment Process
13 Eligibility Requirements
15 Domestic Partnership
17 Sample Domestic Partner Affidavit
19 Changing Your Coverage
24 Benefits While On Leave of Absence
26 Leave of Absence - Summer Benefits
27 Coverage Termination
28 Retiring Employees
29 Appeals
30 Healthcare Benefits
40 UnitedHealthcare Medical pay period deduction rates
43 Medical Plan Comparison Charts
48 NurseLine Services
49 UnitedHealthcare Tools
53 Dental
57 Dental Pay Period Deduction Rates
59 Vision
60 Vision Pay Period Deduction rates
62 Replacement Contact Lens by Mail Service
63 Flexible Spending Accounts
66 Health FSA
70 myFBMC Card®
73 Dependent Care FSA
76 FSA Leave of Absence (LOA)
77 FSA Worksheets
78 Getting Answers
79 Special Retirement Plan
83 Bencore sample enrollment form(revised form available)
87 Disability Income Protection
92 Sample Disability plan premiums
96 Group Term Life
102 Long-Term Care (no new policies 8/1)
105 Employee Assistance Program
106 Critical Illness Insurance Plan
108 Voluntary Universal Life Insurance Plan
111 Tax Sheltered Annuities (TSA)
112 Florida Adoption Program
113 COBRA Notification
118 Beyond Your Benefits
119 Medicare Part D Certificate of Credible Coverage
121 Employee Self Service ePay
123 Your Paycheck Explained
124 Index
Back Nurseline

School District of Palm Beach County

What's **NEW** for 2011?

In this section...

- **New enrollment information**
- **New benefits**
- **Plan changes**
- **New Dependent Eligibility information**
- **Important reminders**
- **Annual Enrollment and Plan Year dates**

You are encouraged to read this booklet which provides the information necessary to help you decide the benefits that are right for you. **The EPO or Waive Option will be the medical plan options for those newly eligible for benefits.**

Benefit Enhancements:

- No deductibles or co-pays applied to preventative care in medical plans.
- Children may be covered as a dependent through age 25.
- Simplified Dependent Audit Verification (DAV). You no longer need to provide proof of student status, residency or IRS dependency.
- Premium increases for the PPO medical plan.
- All employees with dependent coverage must provide Social Security numbers via our on-line system. This is a new Medicare requirement; even for minor dependents.
- Dependent Audit Verification (DAV) is mandatory for all newly enrolled dependents. Original documents are required to establish your relationship for any dependent you wish to add to medical, dental and/or vision.
- The POS plan has been eliminated.
- The IRS eliminated Over-the-Counter drugs from reimbursement within a medical FSA unless you have a prescription.
- The myFBMC Card® remains active as long as you re-enroll in a Flexible Spending Account each year.
- NO FEES to use myFBMC Card®!
- New benefit plan for diabetics and pre-diabetics. You can save money on doctor visits, medication. services and supplies to manage your condition.
- Check out the Personal Health Kiosk- an innovative self-service health kiosk that allows you to measure, store and track key biometrics over time. Look for it at several locations

Prepare now to save $50 per month in Medical Premiums in 2012

Medical premiums will definitely go up in 2012 - even single coverage. You can obtain a $50 per month discount in 2012 if you do the following between January 1 and August 1, 2012.

1) Complete Biometric Screenings by visiting your in-network doctor and obtaining blood pressure and height/weight measurements (BMI) as well as a blood test measuring your fasting blood sugar and cholesterol levels (fasting HDL& LDL results).

2) Complete the confidential online Health Assessment accessed through **www.myuhc.com**. (You must login.) Don't forget to enter your height, weight and blood pressure, cholesterol (HDL & LDL) results from your doctor's visit.

There will be a $50 per month tobacco surcharge beginning January 1, 2012. Log into www.palmbeachschools.org/riskmgmt/wellness for available resources to help you stop and save in 2012!

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

Annual Enrollment Dates:
October 18, 2010 through November 19, 2010.

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.

Online Annual Enrollment Web Address: **www.palmbeachschools.org**
Click on the Employee Self Service link on the right.

School District of Palm Beach County

Sample Dependent Audit Verification Guidelines

(Documents must be provided by close of enrollment period)

We have listed the most commonly required supporting documentation for different types of dependent coverage. This list may not be all inclusive. The proof must substantiate the relationship.* Contact us for unusual circumstances. You must supply original documents to the on-site enroller (during annual enrollment) or to the Benefits Technician in the Risk & Benefits Management Department.

Covered Dependent	Verification Documents
Legal Spouse	**Original government issued Marriage Certificate**
Domestic Partner Palm Beach, Broward or Miami-Dade Residents Non Tri-county Residents	• Proof of Domestic Partner Registration (county) • Receipt for Recording Fee • Notarized Domestic Partner Affidavit - See 2011 Flexible Benefits Reference Guide for domestic partner information.
Birth Child *Maximum age 25*	• **Original government issued Birth Certificate (birth registration cards <u>not</u> accepted)**
Adopted Child *Maximum age 25*	**Legal Adoption Documents naming employee (subscriber) as parent** **If spouse (not employee) is adoptive parent - original government issued Marriage Certificate also required.**
Step Child *Maximum age 25*	• **Original government issued Marriage Certificate** • **Original government issued Birth Certificate (birth registration cards <u>not</u> accepted)**
Domestic Partner's Child (*Maximum age 25*)	• Original government issued **Birth Certificate** (birth registration cards <u>not</u> accepted) *Domestic Partner must also be enrolled*
Legal Guardianship/Custody	• Original government issued **Birth Certificate** (birth registration cards <u>not</u> accepted) • **Court Documents** naming employee (subscriber) as legal guardian / custodian if spouse (not employee) is guardian/custodian • Original Government issued **Marriage Certificate**
Grandchild *Birth to 18 month maximum*	• Original government issued **Birth Certificate** (birth registration cards <u>not</u> accepted) of grandchild • Original government issued **Birth Certificate** (birth registration cards <u>not</u> accepted) of covered **dependent birth parent** who is also enrolled in the plan
Disabled Adult Child *(Unmarried 26 years or older)*	• Original government issued **Birth Certificate** (birth registration cards <u>not</u> accepted) • Original **Social Security documents deeming the child disabled prior to turning 25 years old and while insured under the plan.**
Overage Adult Children *(Unmarried 26 - 30 yrs)*	• **Original government issued Birth Certificate (birth registration cards not accepted)** • **Certificate of Creditable Coverage (sample attached – request from prior insurance)** • **Application for Over Age Child** • **Copy of student schedule** - if child does not reside in FL **To be eligible for enrollment the Adult child must be:** • unmarried • have no dependents • other major medical insurance coverage is not available • lives in Florida <u>OR</u> does not live in FL and is a student
Be sure to enroll your eligible dependent using the online system and add them to each plan. You will need to enter the following required information: • **Dependents Legal Name** • **Date of Birth** • **Social Security Number**	

* Sometimes the documentation required can get complicated. For example: Usually a birth certificate would be the only documentation needed for a natural born child of an employee. However if, for example, the employee is the mother and her maiden name was Mary Jones and that is the name on the birth certificate. Now her name is Mary Jackson because she changed her name when she married Sam Jackson. Thus, we would need to see the child's birth certificate to establish the relationship and the employee's marriage license to prove she is Mary Jones, the same person listed on the birth certificate.

School District of Palm Beach County

Important Information

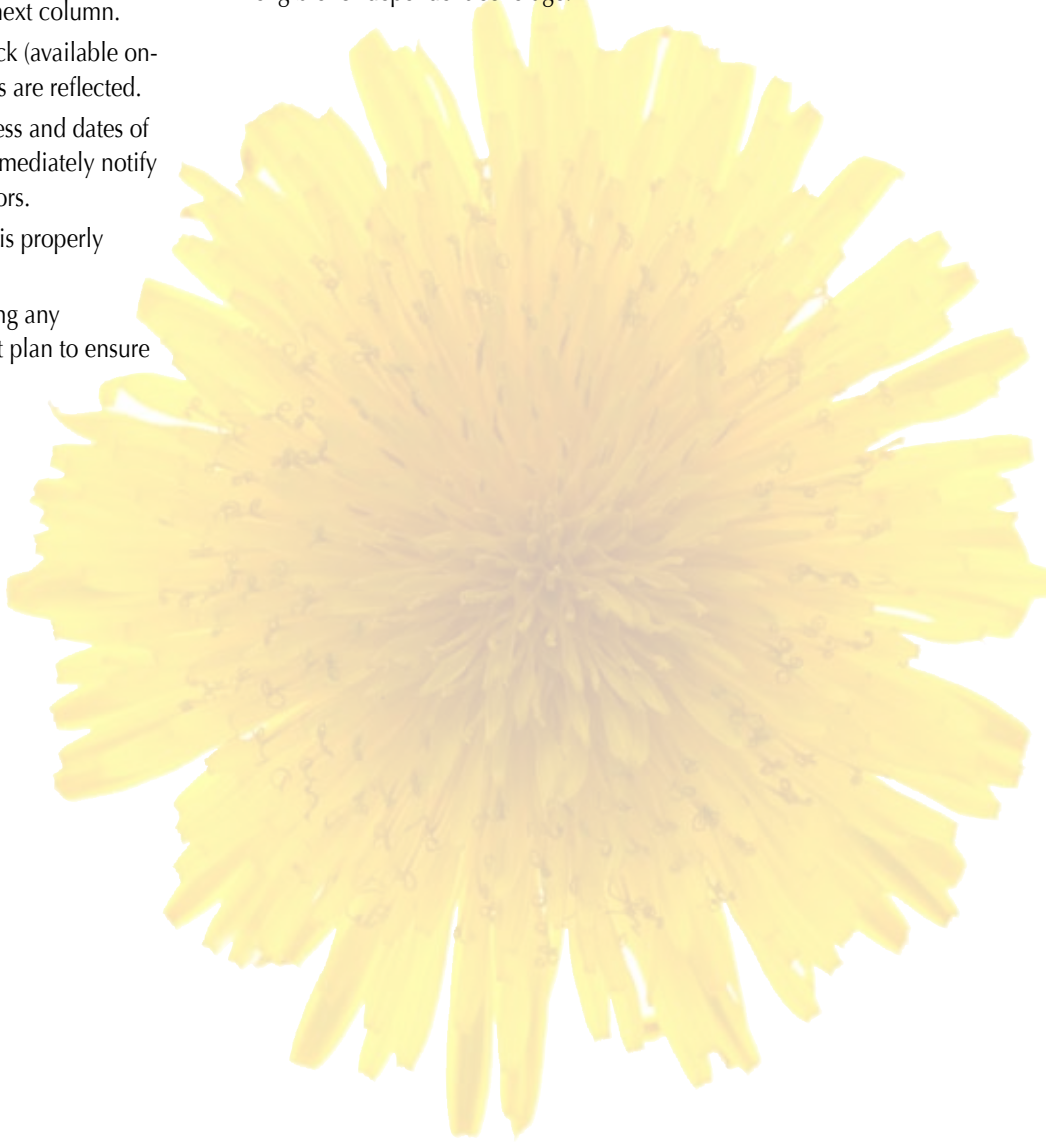
- Elections are irrevocable during the plan year, unless you experience a change in status (see page 19), provide written documentation of the event along with a written request for a change which shows that your request is consistent with and on account of the event.
- Flexible Spending Accounts (FSAs) do not continue from one year to the next. Remember, you must re-enroll in FSAs if you want to continue having an FSA in the new plan year.
- Review Eligibility Requirements (see page 13).
- Review Employee Responsibilities (see page 9). Newborns will not automatically be added to your plan. You will need to make a written request by completing a Benefit Change form and provide an original birth certification to enroll a newborn within 60 days of birth.
- Review Dependent Audit requirements in the next column.
- You are responsible for reviewing your paycheck (available on-line) to make sure the proper plans and charges are reflected.
- Review your personal data such as home address and dates of birth for you and your covered dependents. Immediately notify the head secretary at your work location of errors.
- Verify that complete and accurate information is properly reflected for your dependents.
- Review your plan election information including any dependents you may have attached to a benefit plan to ensure accurate enrollment.

Dependent Audit Verification

All employees adding any dependent to coverage in the medical, dental and/or vision plans must provide documentation of their dependent's eligibility. (See page 5 for appropriate documentation.)

- During Annual Enrollment you may bring an original government certified document sufficient to verify eligibility to the enrollment counselor at the time of your enrollment session. They will be reviewed and returned. **(Don't forget to actually enroll your dependent.)**
- You may also bring the documentation into the Risk & Benefits Management Department any Tuesday or Thursday between 2 to 4 p.m. during the enrollment period.

New hires: Enroll online by yourself and mail or bring in original required documents within 30 days of your hire date to be eligible for dependent coverage.



Enrollment Information & Deadlines

Important Dates to Remember

Your Annual Enrollment dates are:
October 18, 2010 through November 19, 2010.

Enrollment Counselor on campus
October 18, 2010 through November 5, 2010
(Check schedule for actual dates for your location)

Your Period of Coverage dates are:
January 1, 2011 through December 31, 2011.

Paperless Enrollment

Special Note: This is a paperless enrollment. You may view your 2011 enrollment confirmation online after December 7, 2010.

Log onto www.palmbeachschools.org and click on the Employee button. Click on Self Service under the Quick Link on the right of the web page. Select Benefits/Benefit Summary.

Please make sure you enter 1/1/2011 to view your 2011 benefit elections. You have until December 10, 2010 to submit, in writing, any enrollment concerns, to Risk & Benefits Management. Reported issues may not result in changes but will be reviewed, and a determination will be made based on the enrollment information stored at the close of the Annual Enrollment session.

Appeals

Fringe Benefits Management Company (FBMC) reviews and makes the final determination for all enrollment appeals based upon established guidelines. All annual enrollment appeals must be submitted directly to FBMC no later than December 18, 2010. All appeal determinations made by FBMC are deemed final.

Newly eligible employees must enroll on-line within 30 days or hire/rehire date. Medical plan options are limited to electing coverage in the EPO (catastrophic HMO) plan for a minimum of 12 months OR Waiving medical plan coverage.

If elections are not made within 30 days, enrollment will default to the EPO (catastrophic HMO) single coverage and basic life. All other coverage options will be waived.

Did you read about...

- **The new enrollment plan and benefit changes?**
- **The Dependent Eligibility information?**
- **The important reminders?**
- **The Annual Enrollment and Plan Year dates?**

Online Enrollment Confirmation Verification

This is a paperless enrollment. Your confirmation notice is available online. You will not receive a printed copy.

It is important that you view your 2011 enrollment confirmation online. Updated Information will be available after December 7, 2010.

Navigate in the PeopleSoft system to the Benefits Summary found at:
PeopleSoft/HCMHRPRD/SelfService/Benefits/BenefitSummary.

Please make sure you enter 1/1/2011 to view your 2011 benefit elections.

The enrollment confirmation provides a summary of your benefits choices for the 2011 plan (calendar) year. You will not be allowed to make changes unless you experience a valid qualifying event. (See page 19.)

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? HMO, EPO or PPO. Which dental plan did you choose? Managed Care or PPO.
- ❑ **Coverage Level:** Did you choose coverage for yourself only or did you include your dependent spouse and/or children?
- ❑ **Dependent Section:** Are all of the dependents you wish to cover listed? You should confirm that the date of birth and social security information has been entered and is correct.
- ❑ **Payroll Deduction:** In January check to make sure that the payroll deduction matches the plan and coverage level.

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

- ❑ **Health Care FSA:** medical, dental and vision items for you and your eligible dependents.
- ❑ **Dependent Care FSA:** child care/elder daycare expenses that enable you to work. You **cannot** use this FSA for your spouse or child's medical expenses.

Employee Responsibilities

In this section...

- **Your enrollment process responsibilities**
- **Premium deduction information**
- **401(a) dollar overview**
- **Outline of coverage levels**

Employee Responsibilities

- You are responsible for participating in and completing the online Web enrollment process.
- You may do this on your own or with an enrollment counselor when they are at your worksite. Counselors are available to assist with accessing the system and providing information on plan features. Counselors are not responsible for your enrollment data. Please carefully review your data to make sure that the information in the system is what you have elected.
- You are responsible for thoroughly reviewing your choices during the Web enrollment and prior to your online acceptance, even if you are enrolling with an enrollment counselor.
- Your are responsible for entering your enrollment data, including your dependents, dependent's dates of birth and social security information within the established enrollment time frames.
- You are responsible for maintaining your personal information such as your address.

Premium deductions will begin in the effective month of coverage.

- You are responsible for providing required documentation to satisfy the eligibility criteria for all enrolled dependents. Otherwise dependent coverage will be cancelled.
- You are responsible for reviewing your paycheck stub when your benefits become effective, in order to verify enrollment in and premiums for benefits you selected.
- You are responsible for notifying the Risk & Benefits Management Department immediately, within 30 days of the effective date of your benefits if premium payments are deducted for elections you have not made or if premium payments for required contributions are not deducted from your pay.
- You are responsible for participating in the Annual Enrollment process
- You are responsible for notifying the Risk & Benefits Management Department immediately, but not later than within 60 days of when a covered dependent no longer meets the eligibility requirements as defined on page 13.

The information contained in this book 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 onto **www.palmbeachschools.org /riskmgmt** and select the Quick Link to the 2011 Benefits Booklet.

Overview for 2011

Employee Premiums

Your premiums will be deducted through payroll deductions over 22 or 24 pays, depending on your paycheck schedule. Changes to your pay check schedule will impact your premium 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 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.

IMPORTANT TO NOTE: Employees who receive 26 paychecks will have deductions taken only twice during the months when three checks are issued.

401(a) Dollars

When an eligible employee waives medical coverage or enrolls in the EPO Medical Plan with employee-only coverage, the District will make a deposit of these 401(a) Dollars into a 401(a) special retirement plan in your name.

If you have other medical coverage (i.e. under your spouse'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. Please refer to page 40 for more detailed information and complete the required form.

PLAN	MONTHLY 401(a) DOLLARS	
	Full Time	Part Time
EPO Choice (employee-only)	$40	
Waive Medical	$100	$50

Coverage Levels

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

1. Employee Only
2. Employee + Child(ren)
3. Employee + Spouse
4. Employee + Family
5. Employee + Domestic Partner
6. Employee + Employee's Children + Domestic Partner
7. 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 health, dental and vision coverage separately. For example, you may need medical coverage for just you, but dental coverage for you and your family.

*** A Domestic Partner must be covered in order for their children to be covered.**

Overage Adult Children

A separate application and premium are required to enroll eligible adult children who meet State requirement and are between the ages of 26 and 30 years of age.

Did you read about...

- **Your responsibilities?**
- **The premium deduction information?**
- **The 401(a) dollar overview?**
- **The coverage level outline?**

Enrollment Process

In this section...

- **Enrollment process for current employees, new hires and employees returning from Leave of Absence**
- **How to obtain your User ID and Password for online enrollment**
- **Who should enroll during Annual Enrollment**

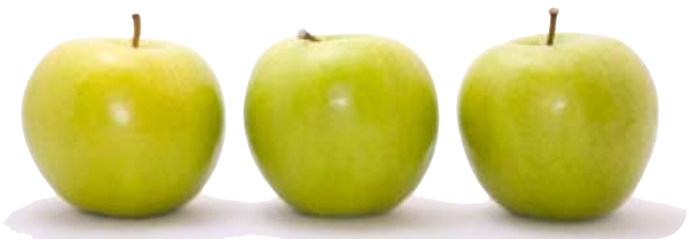
The Enrollment Process

New Hires/Newly Eligible

We are excited to provide our new hires and newly eligible employees with an online process to complete their benefit enrollment. Medical plan enrollment is limited to electing EPO (catastrophic HMO) plan coverage or waiving medical benefits. Enrollment is the EPO plan requires a minimum of 12 month enrollment.

Online Benefits Enrollment – secure, private and no appointment necessary! Visit **www.palmbeachschools.org**. Click on the Employee Self Service link (you will need your User ID and password in order to enroll).

- secure, encrypted information
- convenient – enroll 24/7
- allows your spouse to participate with you
- link to FAQs and providers
- allows online benefit election verification



Annual Enrollment

During our annual enrollment there are two enrollment methods. You may enroll online independently or you may meet with an enrollment counselor in one-on-one sessions. Enrollment Counselors are highly trained in the insurance field, and will assist you with completing your PeopleSoft online enrollment process. You **must** bring your User ID and password with you to your enrollment session.

During the annual enrollment. You may enroll in or change any benefit(s) for the 2011 Plan Year. Thereafter, changes during the year are allowed only if you experience a valid Change in Status event. See page 19 of this book for more information on permitted mid-plan year election changes.

Returning from Leave of Absence

Returning to work can be exciting and stressful. Within 30 days of your return from a leave of absence, it is critical that you contact the Risk & Benefits Management Department 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 days of your return from leave, you will be enrolled in the default EPO medical plan with employee only coverage. For additional information regarding your benefits while on leave, please refer to page 24 of this guide.

How to obtain your User ID and Password for the PeopleSoft E-Benefits Enrollment

(**Note:** If you already access PeopleSoft or District e-mail, you can use your current User ID and password to access PeopleSoft.)

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

Online Employee Self Service

- Click on Benefits
- Click on Benefits Enrollment

Enrollment Process

Who Should Participate in Annual Enrollment

Employees with Children 19 -25 year of age	Documentation and Social Security information required*
Employees who add dependents to plans	Documentation and Social Security information required*
Those wanting 2011 Flexible Spending Accounts	These plans must be elected each year
Employees interested in Trustmark Products	Enrollment Counselors process all of these requests
Employees who have questions	Enrollment Counselors are available to assist you
All Employees	To review plan information and changes, cost and verify data

*refer to 2011 Benefit Reference Guide for specific requirements

Enrollment and all documents required for verification must be provided to an Enrollment Counselor or presented to the Risk & Benefits Management Department no later than November 19, 2010.

Posters will be at your work location approximately ten days before Enrollment Counselors will be there. Check the Enrollment website for the enrollers' schedule: **http://myenrollmentschedule.com/palmbeach or call 1-866-998-2915**. Be sure to take advantage of the online Web enrollment program to review your current benefits and ensure enrollment in all desired plans.

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 2010 FSA benefits will **not** continue for the 2011 Plan Year.

Enrollment Counselors available
October 18 - November 5, 2010.

Please log onto
http://myenrollmentschedule.com/palmbeach
or call **1-866-998-2915** to make an appointment.

Did you read about...

- **The enrollment process for your specific employment status?**
- **How you can obtain your User ID and Password to enroll online?**
- **If you should enroll during Annual Enrollment?**

Eligibility Requirements

In this section...

- Who is eligible to enroll
- Default Plan Enrollment
- Dependent Eligibility

Initial Eligibility Enrollment Requirements

Carefully review your enrollment materials and make selections which best meet your insurance needs. Keep in mind that you will be making choices which 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.

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

Who Is Eligible?

As an employee of the District you may enroll in our health program as an employee **OR** as an eligible dependent of another employee. You may not enroll in any program as both an employee and a dependent. If you and your spouse both work for the District, only one of you may cover your eligible dependent children.

All regular employees who are in a paid status and work four or more hours per day are eligible (3.75 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 103.

Eligible Employee is defined as a regular employee who is employed in a paid status of four or more hours per day (3.75 hours per day for those in the CTA bargaining group).

Full-time employees are those eligible employees who work six or more hours per day.

Part-time employees are those eligible employees who work four or more hours per day (3.75 hours per day for those in the CTA bargaining group) but less than six hours per day.

New employees: If you are a newly hired employee, your period of coverage begins on the first day of the month following 30 calendar days of continuous employment. Your medical plan election will be limited to the EPO/Waive option for a minimum of 12 months.

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 EPO (catastrophic HMO) medical plan and basic term life insurance. All other plan options will be waived for that plan year.

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

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

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

You are ineligible to receive 401(a) Dollars if you are enrolled as a dependent on a medical plan offered by the District.

Eligibility Requirements

Dependent Eligibility

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

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

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

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

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

Benefit Coverage Overage Adult Children (Unmarried 26 - 30 years of age)

A separate enrollment and premium are required to enroll an unmarried overage adult child in the same medical plan you are enrolled in. The eligiblity criteria is that the overage adult child is:

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

The application for this type of of coverage is available at:
http://www.palmbeachschools.org/riskmgmt/Benefits/BenefitForms.asp

Extended Coverage for Unmarried Handicapped Children

Coverage for an unmarried enrolled dependent child who is incapable of self-sustaining employment because of mental retardation or physical handicap will be continued beyond the specified limiting age, provided that the child becomes so incapacitated prior to attainment of the limiting age (while covered as a dependent under this plan) and the child is primarily dependent upon you for support and maintenance. We require that you provide documentation from the Social Security Administration which indicates your child has been deemed disabled. Proof must be provided 30 days prior to when your child would no longer meet the eligibility age definition.

Did you read about...

- **Who is eligible to enroll?**
- **The default plan enrollment process?**
- **Dependent eligibility?**

Domestic Partnership

In this section...

- **Domestic Partner Eligibility Requirements**
- **How to enroll online**
- **Premium/Imputed Income**

Domestic Partnership Benefits

The guidelines for the Domestic Partnership benefit can be found on this page and are posted on the Risk & Benefit Management page at **www.palmbeachschools.org /riskmgmt**.

- This is a post-tax benefit
- Elections may only be made/changed during an Annual Enrollment Period
- Residents of Palm Beach, Broward or Miami-Dade County are required to submit a completed Domestic Partner Affidavit and proof of registration and recording as domestic partners through the county they reside in. At the time of publication of this book, information on how to register could be found at **www.pbcountyclerk.com/courtservices/circuitcivil/domesticpartner.htm.**
- Non-residents of the tri-county area are required to submit a completed Domestic Partner Affidavit and supporting proof as outlined on the non-resident section of the affidavit.
- All documents must be sent to the Risk & Benefits Management Department of the Palm Beach County School District.

  Annual Enrollment: Domestic Partner Affidavit and any other required documents must be sent by November 19, 2010.
  New Hires: Domestic Partner Affidavit and any other required documents must be sent within 30 days of your date of hire.

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.

Domestic Partnership Eligibility

All regular employees who are otherwise eligible for medical benefits are eligible to enroll their domestic partner in the medical, dental and/or vision plans. You may enroll as a new hire or during annual enrollment only. Once coverage is elected, changes may only be made during an Annual Enrollment Period.

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

- Must both be 18 years of age and mentally competent.
- Must not be related by blood in a manner that would bar marriage under the law of the State of Florida.
- Must be considered each others 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 others basic food, shelter, common necessities of life and welfare.
- Neither partner can have had another domestic partner at any time during the 12 months preceding this enrollment.

A signed affidavit attesting to the above will be required by both partners as well as proof that both are financially interdependent and living together. See page 18 for the required documents.

How To Enroll Online for Domestic Partner Benefits

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

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

Domestic Partnership

Premiums

Domestic partner rates will be the equivalent of the medical rates on page 40. The Employee-only rate will be pre-tax and the balance of the deduction will be taken on an after-tax basis.

Enrollment of any children and a Domestic Partner will be the equivalent of the above mentioned 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.

Imputed Income

The District subsidizes the actual premium, so you only pay the amounts listed on page 40. However, due to IRS regulations, the amount paid by the District will be imputed income and you will be taxed on that amount.

Did you read about...

- **The benefits overview?**
- **Domestic Partner eligibility requirements?**
- **How to enroll online?**
- **Premiums for Domestic Partners?**
- **Imputed income?**

PALM BEACH COUNTY SCHOOL DISTRICT DOMESTIC PARTNERSHIP ENROLLMENT GUIDELINES

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

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

Item 1. Complete, sign and have notarized the enclosed Domestic Partner Affidavit on page 18.

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

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

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

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

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

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

Requirements and Information for Group Insurance Benefits:

1. Eligible employees are those employees who are eligible for benefits.
2. You may enroll during annual enrollment or within 30 days of your hire date by completing the online enrollment and providing the required documentation.
3. The domestic partner must be your "sole spousal equivalent." You both must live together in an exclusive committed relationship and assume responsibility for each others basic living expenses.
4. You must meet all requirements of the affidavit on page 18.
5. The non-employee domestic partner and his/her dependents do not have rights to continue coverage under Federal or State laws.

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

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

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

This form must be received by the Risk & Benefits Management Department by 11/19/2010, for annual enrollment. New employees have 30 days from their hire date to provide this form and any other required supporting documentation to the Risk & Benefits Management Department.

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

Affidavit of Domestic Partnership

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

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

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

_____ _____
Employee (Please Print) Domestic Partner (Please Print)

_____ _____
Employee (Signature) Domestic Partner (Signature)

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

_____
NOTARY PUBLIC

NOTARY SEAL

Type of identification produced _____

Changing Your Coverage

In this section...

- **Proactive elections required for pre-tax changes**
- **Can you make a change?**
- **How to make a change**
- **Periods of coverage**
- **IRS Special Consistency Rules**
- **Allowable CIS events**

Am I permitted to make mid-plan year election changes?

Under some circumstances, the District's plan(s) and the IRS may permit you to make a mid-plan year election change to your elections or vary a salary reduction amount, depending on the qualifying event and requested change.

How do I make a change?

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

To Make a Change: Within **60 calendar days** of an event that is consistent with one of the events on the following page, you must complete and submit a Change in Status/Election Form to Risk & Benefits Management.

You may download the Change in Status form directly at **www.palmbeachschools.org /riskmgmt**. Documentation supporting your election change request is required. Once your request has been approved and processed, your existing elections and premiums will change (as appropriate). Approved changes will become effective on the event date. A full premium payment will be due for the period including that date. To avoid or minimize retro-active premium deductions, notify us immedicately of your change requests. If your FSA election change request is denied, you will have **30 days**, from the date you receive the denial, to file a written appeal with FBMC. For more information, refer to the "Appeal Process" section on page 29.

What is my Period of Coverage?

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

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

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

Split periods of coverage do not apply to Dependent Care FSAs.

Mid-Plan Year Change Example

An employee is married on September 17 and notifies us on November 10. The notice falls within the 60 day guideline. However, since this change will require a retroactive effective date of Sept. 17, post-tax deductions will be retroactively taken. Pre-tax deduction for this event would begin with the first pay after the notification was received.

Generally, mid-plan year, pre-tax election changes including Flexible Spending Accounts (FSAs) can only be made prospectively, no earlier than the first payroll after your election change request has been received by the Risk & Benefit Management, unless otherwise provided by law. Retroactive pre-tax deductions are permitted for births and adoptions when the change and documentation are received within 60 days. Best practice is to notify the Risk & Benefit Management as soon as possible to avoid retroactive deductions.

Changing Your Coverage

What are the IRS Special Consistency Rules governing Changes in Status?

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

Did you read about...

- **If you are eligible to make a change?**
- **How to make a mid-plan year change?**
- **Your periods of coverage?**
- **The IRS Special Consistency Rules?**
- **The explanation of allowable CIS events?**

Changing Your Coverage

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

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

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

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

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

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

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

Benefits While on Leave of Absence

In this section...

- **How leave affects your benefits**
- **Re-enrollment rules when you return**
- **When you should initiate a leave of absence request**

When should you apply for a Leave of Absence

To protect your benefits you should apply for a leave of absence whenever you will be in an unpaid status for more than 10 days. While you are using sick and/or vacation time, you do not need to apply for a leave of absence since you are still receiving pay from the District. However, if you miss work as a result of a work related injury/illness, you should apply for a leave of absence even if you receive Workers' Compensation. Keep in mind that your benefit 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 more than 10 days without notifying your supervisor could lead to 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) premium payments are applied

However, in most cases, your term life insurance ceases at the end of the month in which you stop being an actively at work employee. Refer to your policy for detailed coverage rules, conversion rights and application deadlines. If you do not pay required premiums 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 or a Dependent Care FSA.

Within 30 days of beginning (from) an approved unpaid leave of absence, contact:

- the Risk & Benefits Management Department to obtain and submit a Benefits Enrollment/Change Form to make a change to your existing pre-tax elections (except your Health Care FSA), and to arrange to continue certain benefits by paying your premium on an after-tax basis.

Approved Medical Leave (FMLA) – You may continue your benefits while on approved FMLA status. The District will make it contribution on your behalf for District paid benefits. You will be responsible for your regular premium contributions. Contact us at (561) 434-7478 or (561) 434-8668 if you do not receive a monthly billing statement to avoid benefit cancellation due to non-payment.

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 premiums prior to the last work day of the month in which your FMLA leave ends.

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

Please also refer to the special rules concerning continuation of term life and/or income protection plans as it relates a leave status. Please refer to page 23 for more information.

Life/Income Protection for Personal Illness – Employees who are enrolled in Short-Term and/or Long-Term disability plans and on a leave of absence due to their own personal illness or maternity will be billed for those plans from the first day of the leave through the date that the disability benefits are expected to begin. The elimination period, for these plans are outlined in the Disability section of this booklet. Failure to pay premiums may result in disability claims being denied. Employees on leave of absence other than for their own illness or maternity are not eligible to continue the Short-term or Long-Term disability plans once you are no longer receiving an income from the District. Premiums for these plans should not appear on any billing statements you may receive.

Benefits While on Leave of Absence

The reason for your leave also impacts your life insurance coverage. If you were actively at work immediately before your leave of absence, your life benefits will continue through the last day of your approved FMLA leave as long as required premium payments are made. If your leave continues beyond your approved FMLA period, you may continue your life benefits if your leave is due to your personal disability. Premium payments for your term life may continue for a maximum of 12 months from the date you were last actively at work. Prior to the expiration of the 12 months, you must apply to convert to an individual policy or be approved for a waiver of premium by the life insurance carrier. You may qualify for a waiver of premium if you are under age 60 and are totally and permanently disabled. You should apply for a Waiver of Premium once you have continued premiums payments for 6 to 9 months from the date you were last actively at work.

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

Approved Non-paid Leave – You can continue to receive coverage for certain benefits for the duration of your leave if you choose to elect COBRA continuation. Certain benefits, including Short and Long Term Disability, Life products and Dependent Flexible Spending Accounts 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 the Risk & Benefits Management Representative regarding premiums due for these benefits.

Other Benefits Impacted by an Unpaid Leave – We encourage you to contact the insurance providers/administrators if you are enrolled in any, Group life - CIGNA plans, Trustmark, Heath Care FSA or a Long Term Care plans.

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

- Trustmark directly at 1-866-636-5525 for information regarding payment of premiums if you had a Trustmark Universal Life, Cancer Protector or Critical Illness policy.
- The FBMC Customer Care Department at 1-800-342-8017 to apply for continuation of your Health Care FSA, on an after-tax basis.
- MetLife directly at 1-800-438-6388 for information regarding premium payments for Long-Term Care (LTC) coverage.
- NEBCO at 1-800-423-1282 for Life insurance conversion and/or waiver of premium information and applications.

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

Unpaid Status – No approved leave – If you are not in a paid status, your benefits will end at the end of the month in which the unpaid status began. Should you fail to have payroll deductions taken for any period, coverage would be retroactively terminated at the end of the month for which premium payments were last received.

Re-Enrollment upon Return from Leave

Employees on approved leave during our annual enrollment period may make changes to their medical, dental or vision plans and Flexible Spending Accounts when they return to active duty. Remember, 401(a) Dollars are not available until the first day of the month after you return to a paid status plus any applicable waiting periods if you did not continue your benefits while on leave. Changes to any other benefits or continuation or reinstatement of any benefits, may be made within 30 days of your return to work. If you do not contact the Risk & Benefit Management Department to complete a Change in Status form within 30 days of your return to work, you will be enrolled in the default medical plan and other voluntary benefits may be dropped.

If you fail to contact the Risk and Benefits Management Department upon your return from leave, you will be limited to the EPO Employee Only medical plan and Basic Life insurance.

Did you read about...

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

Leave of Absence - Summer Benefits

In this section...

- **Duty Day codes and required workdays**

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

All employees, other than 12-month employees or 216(R), must be in a paid status or on approved FMLA leave for the majority of their duty days in May and June, to be eligible for the normal School District contributions toward their June and July insurance benefits. Therefore, if your contract's last workday is June 3, 2011, you must be in a paid or FMLA status through May 20, 2011 (13 work days).

If you are not in an FMLA and/or paid status for the majority of your duty days in May and June, you will not receive District-paid insurance benefits until October 1, 2011 (provided that you return to work on the first duty day in a benefited position in August The waiting period will apply andyour benefits are reinstated the 1st of the month following 30-days of active employment.

Twelve (12) month employees are required to pay the full premium for any month in which they are not in a paid or FMLA status on the first of that month. If you have any questions, please feel free to contact Risk & Benefits Management at (561) 434-8668, PX 48668 or (561) 434-7478, PX 47478.

Below is a list of Duty Day codes and the required workdays:

Duty Day Groups	Return to Work by	FMLA Status by	Combined May/ June Duty Days	Be in a Paid Status through
180, 182(NT) 188(T)	5/17/11	5/18/11	13	6/02/11
187NT	5/17/11	5/18/11	13	6/03/11
190,193,196,206(TI)	5/17/11	5/18/11	13	6/03/11
193	5/17/11	5/18/11	14	6/06/11
206(NT), 216(TI)	5/19/11	5/20/11	15	6/09/11
226(E) NT	5/25/11	5/26/11	19	6/23/11
226(T&I, 216(NT)	5/23/11	5/24/11	17	6/16/11

Did you read about...

- **The required workdays to continue the employer contribution?**

Coverage Termination

In this section...

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

Employee Coverage

During the plan year, except as otherwise provided by law and in accordance with your employer's plan(s), terminating employees are covered as follows:

1. Through the last day of the month:
   a. in which employment ends (all interim positions and 12-month employees are in this category).
   b. in which a leave of absence without pay begins (refer to page 24 under the Employee on Leave section for more details).
   c. in which suspension without pay begins.
   d. in which you cease being in a benefited position.
   e. for which required employee contributions are made and in which the employee has not applied for or been approved for an unpaid leave and is no longer actively at work.
2. Exceptions:
   a. You qualify for the Family and Medical Leave Act (FMLA). In that case, coverage will end the last day of the month in which eligibility for FMLA ends, as long as required employee contributions are made.
   b. You are a regular, but less than a 12-month, employee and you are in paid status through the last day of your contract period. In this case, coverage ends the last day of July of the same year as long as required employee contributions are made (except for term life and/or income protection coverage, which will end on June 30).

WITHIN 30 DAYS OF YOUR TERMINATION OF EMPLOYMENT, CONTACT:

- the Risk & Benefits Management Department if you have not received information regarding your COBRA options or Retiree benefits or to apply for a conversion policy for optional term life.
- Trustmark directly for information regarding payment of premiums if you had a Trustmark Universal Life, Cancer Protector or Critical Illness policy.
- the FBMC Customer Care Department at 1-800-342-8017 to apply for COBRA continuation, on an after-tax basis, of your Health Care FSA.
- MetLife directly at 1-800-438-6388 for information regarding premium payments for Long Term Care (LTC) coverage.

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

Termination Followed by Re-Hire Within 30 Days – If you terminate employment and are re-hired thirty (30) days or less after termination, benefits you had in place prior to termination (including your Health Care FSA), unless otherwise provided by law. You will have access to the Health Care FSA balance, up to the full annual limit (reduced by prior reimbursement), for expenses incurred after you return. You may experience a break in coverage and will be subject to new waiting periods.

Termination Followed By Re-hire After 30 Days – If you terminate and are re-hired 30 days or more after termination, you may be permitted to make a new election or to elect reinstatement into the benefit election(s) you had prior to termination except you will be limited to the EPO medical plan. You will experience a break in coverage and will be subject to new waiting periods.

Dependent Coverage

Your dependent's coverage will terminate on the earlier of

1) the last day of the month in which they no longer meet the definition of eligible dependent
2) the date you, the employee, lose coverage or the date the dependent is deemed to fail to meet the definition of a dependent.
3) Maximum age for dependent coverage is 25 years of age. Coverage terminates on the last day of the calendar month.

Exception: If your child is disabled and you have provided documentation prior to termination of benefits or you have applied for coverage under the Overage Adult Child provision; or COBRA continuation is elected and premium payments are made.

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

Did you read about...

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

Retiring Employees

In this section...

- **How retiring affects benefits**
- **Your responsibilities when retiring**

Retiring Employees

Some plans are portable which means you can continue the same plan at the same premium rates. Other plans may be converted to an individual policy which may result in plan design changes and an increase in premium rates.

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 premium. You should make an appointment to meet with the Retiree Benefits Technician [by calling (561)434-8673] to review your options and obtain premium information about one month prior to retirement.

Please note: Your retirement date must be in a month in which you are covered under the District's benefits plan in order to continue benefits as a retiree. For example, for 12-month employees, benefits are provided for active employees until the end of the month in which you retire, provided you have actually worked during that month. For less than 12-month employees, the same rules apply except that at the end of the school year, if you complete your contract, most benefits will remain in place through the end of July. If you do not physically return to work in August, your benefits ended in July, so your retirement date must be in July. Continuing with this example, if you choose an August retirement date, you will not be eligible to continue benefits as a retiree. For more information regarding your retiree benefit options, visit www.palmbeach.k12.us/riskmgmt.

Did you read about...

- **How retirement will affect your benefits?**
- **Your responsibilities when you retire?**

Appeals

In this section...

- **How to initiate an appeal**
- **Appeal rules and requirements**

Annual Enrollment Appeals

If you notice a discrepancy in your enrollment election, please submit a written appeal directly to FBMC no later than December 18, 2010.

Since the plan year begins on January 1, 2011, requests for enrollment changes received after (date) will not be processed.

Appeals are approved only if the extenuating circumstances and supporting documentation are within the district, insurance provider and IRS regulations governing the plan.

Appeal Process

FSAs and Annual Enrollment

This section contains information regarding the Appeal Process for:

- FSAs
- Annual Enrollment

Approved appeals must comply with IRS regulations and the guidelines within the District's plan(s). If you have an FSA reimbursement claim, a request for a mid-plan year election change, post annual enrollment change request, or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request for review within 30 days of your receipt of the denial to your employer's designee:

Fringe Benefits Management Company (FBMC)
Attn: Appeals Committee
P.O. Box 1878
Tallahassee, Florida 32303

FBMC will, in its sole discretion, review on a uniform and consistent basis, the facts and circumstances of each timely submitted and processable appeal request.

Your written appeal must be signed, dated and state:

1. the name of your employer
2. the date of the services for which your request was denied
3. a copy of the denied request
4. the denial letter you received
5. why you think your request should not have been denied and
6. any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed upon receipt of it and its supporting documentation. You will be notified of the results of this review within 30 business days from receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within your employer, insurance provider and IRS regulations governing the plan.

Did you read about...

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

Employee Wellness

Feel Good. Be Healthy. Live Well

In this section...

- Wellness mission
- Wellness essentials
- Available programs
- Employee Assistance Program

Mission:

The School District of Palm Beach County's Employee Wellness Program seeks to establish a workplace that encourages and supports a healthy lifestyle by integrating health promotion activities and resources that help to enhance health and well-being.

The Palm Beach County School District is proud to offer an exciting workplace wellness program designed exclusively for all school district employees.

Our goal is to keep people healthy, reduce the risk factors among at-risk employees and improve the health of those who already have chronic conditions by encouraging them to make lifestyle changes. Employee Wellness offers various programs and opportunities to help lower the risk of disease and improve overall health.

Wellness is the ability to take responsibility for your own health by learning how to stay healthy and practicing good health habits. Knowing that wellness is a balance between all aspects of life, the information and activities provided by Employee Wellness will continue to assist employees in choosing positive health practices.

Essentials for Healthy Living You Can Do Today:

1. **Prevention** - Regular visits to your primary care physician and preventive health screenings can protect you and your family from illnesses.
2. **Nutrition** - Healthy eating is a great place to start. Why not try fruits and veggies for snacks instead of sweets?
3. **Quit Smoking** - There are various smoking-cessation programs, products and even new medications to help. It's never too late to benefit from quitting.
4. **Exercise/Lose Weight** - Did you know that by walking just 30 minutes a day you can add 1.3 years to your life? Or that consuming just 100 calories less a day equals a loss of 10 pounds in a year?
5. **Stress Management** - Relax and take time for yourself. Learn ways to help reduce stress in your life.

Employee Wellness Programs:

- **Education & Awareness:** Provision of workshops, classes and information on common health issues for school district employees such as healthy lifestyle behaviors, eating, physical activity and injury prevention.
- **Physical Activity:** Opportunities to integrate physical activity in the school day such as walking, jogging or yoga programs.
- **Healthy Foods & Beverages:** Access to healthy options for school district employees to eat and drink throughout the school day.
- **Weight Control Programs & Nutrition Programs:** Support and resources provided such as assessment of current diet and goal setting to eat healthier. Resources provided can include meal planning, education on healthy foods, weight check-ins, etc.
- **Immunization:** Provision of immunization for common illnesses found in the school environment such as the flu.
- **Health Screenings:** Periodic onsite screening for blood pressure, blood cholesterol, blood sugar, body mass index, bone density scans, mammography and other health indicators with advice on appropriate follow-up medical treatment.
- **Individual Health-Risk Appraisal:** to help school district employees establish personal health-improvement goals.
- **Stress Management:** Provision of workshops, information and counseling on how to manage stresses specific to the school environment and how to balance work and family.
- **Encouragement:** of school district employees to set medical appointments for screening for cancer, heart disease, diabetes and other diseases.
- **Disease Management:** Our disease management programs offer condition-specific education and information to help employees understand their disease better and take a more active role in controlling it. These programs, along with the sound advice of physicians, provide employees with the support to take charge of their health.
- **Ongoing Assessments:** of the staff wellness plan to update and improve the effectiveness.

This year we have some new and exciting programs available to you. Please make sure to visit http://www.palmbeachschools.org for monthly health tips and wellness events. For more information please contact Employee Wellness at (561)434-8044.

Employee Wellness

HealthyLiving-Lessons for Life Wellness Rewards

Wellness Rewards will begin on January 1, 2011. Healthcare costs are expected to rise and your premiums will significantly increase if you don't take action. Wellness Rewards will make you aware of potential health conditions of concern and suggest ways to take positive steps to prevent future health problems.

The School District of Palm Beach County cares about your health and wants to help you keep your monthly cost of insurance down as well as reward you for taking steps to lead a healthy lifestyle. Our wellness rewards program offers active employees with UnitedHealthcare the opportunity to earn an incentive of a $50 discount per month on your 2012 medical premiums –just for participating in the Wellness Rewards program. This discount is a premium that will be paid by the District and applies only while you are actively at work with the district.

Take Action Beginning Jan 1, 2011 – we cannot track participation beginning prior to Jan 1.

To participate in the wellness rewards program, the following **CONFIDENTIAL** activities must be completed by August 1, 2011. Your participation will remain confidential and reviewed only by healthcare professionals. The School District will be notified only that you have completed the following steps.

- Biometric Health Screenings
- Online Health Assessment

Biometric Health Screenings

The first step toward better health is to know your key measures. Biometric screenings include: BMI (Body Mass Index or Height/Weight), Fasting Total, HDL and LDL cholesterol, Fasting Blood Sugar/Glucose, and Blood Pressure. By knowing your key numbers you can assess your current health status and determine if you are at risk for health problems like heart disease and diabetes. Reviewing results with your doctor can provide personalized follow-up with recommended treatment and wellness tools to improve your health.

How to Complete a Biometric Screening

As part of an annual wellness visit at your physician's office, the physician will measure your height/weight and blood pressure and will send you to a lab for blood work if not taken in their office. *Your biometric screening is part of your preventive care benefits which are covered at 100%. This would include no co-payment as of January 1, 2011. All Blood work must be done through an in network lab (ie. Lab Corp) in order to count toward the Wellness Rewards program.

If you do not have a primary care physician, go to **www.myuhc.com**. Click on "Find Physician, Laboratory or Facility." Select "United HealthCare Choice" for providers accepting the HMO and /or EPO plans. Select "United HealthCare Options PPO" for the PPO plan.

Health Assessment

The Health Assessment is an online interactive tool which allows you to assess your lifestyle habits that are directly linked to health status and health care costs. These lifestyle habits include: activity/exercise, alcohol use, back care, driving, eating, exams, self-care, smoking, stress, weight control, and well-being. The results and recommendations from the health assessment provide immediate feedback to help you improve or maintain your health. It also assesses your risk for some key diseases like heart attack, diabetes, and cancer. Most importantly, your results are completely confidential and created especially for you, based on your answers to basic questions about your health habits. Once you receive the results of your assessment and set personalized wellness goals, you can begin achieving those goals. You'll feel better about yourself and enjoy the reward of making healthy choices.

How to Complete a Health Assessment

Once you have completed your Biometric Screenings and know your key numbers, complete the online Health Assessment (available in English and Spanish). It takes approximately 15 minutes to complete, and your responses will help you identify your personal health needs and access health improvement resources.

To complete the Health Assessment, go to **www.myuhc.com**. Log-in (If not registered click "Register Now" and enter requested information to create your username and password). Click on "Health & Wellness." Click on "Take the Health Assessment" (Make sure to have your results from your biometric screenings to enter into the health assessment).

Keep a Good Thing Going! Make a Healthy Change

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

2011 is your year to reap the rewards of wellness!

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

For more information or questions please visit: **http://www.palmbeachschools.org/riskmgmt/Wellness/**.

Employee Wellness

HealthyLiving-Lessons for Life Tobacco Cessation

Don't get Burned by Tobacco Use – Quit in 2011 to save in 2012

Avoid a premium surcharge in 2012!

You know that tobacco is bad for you. So, why not quit today? It's hurting your health, draining your wallet and leaving you behind in a world that's becoming tobacco-free. The School District wants to encourage healthy lifestyle choices, therefore in 2012 we will be implementing a tobacco insurance premium surcharge for all employees who use tobacco and elect medical coverage. To avoid facing an added premium cost of $50 per month we encourage you to take steps now to quit using tobacco products.

How does it work?

During next year's annual enrollment in 2011 (for coverage effective Jan 1, 2012) you will need to sign an electronic affidavit stating that you have been tobacco free for at least six months. If the answer is NO, you will have no monthly tobacco charges added to your insurance premium payroll deduction. In addition, just think of the added saving you'll have since you'll also no longer be spending money on tobacco products. If the answer is YES, effective January 1, 2012 a surcharge of $50 a month will be added to your insurance premium payroll deduction.

Take Advantage of Resources

If you're thinking about flushing all your cigarettes down the toilet and never lighting up again; Congratulations! Your desire to quit is the first step. However, because smoking/tobacco use involves a chemical addiction to the drug nicotine, sheer willpower may not be all you need to succeed. When you're ready, set a date to quit. And, stick to it. Don't let tobacco control you for one more day. Take charge of your habit and your health! It doesn't matter how long or how much you've smoked. Your health will begin to improve within hours of quitting.

In an effort to help you quit and save the School District will offer tobacco cessations resources. For a list of tobacco programs available please visit:
http://www.palmbeachschools.org/riskmgmt/Wellness/.

Beginning January 1, 2011 coverage will be provided for certain smoking cessation medications. The following medications will be covered for up to 6 fills at a retail pharmacy:

- Tier 1 - Bupropion and Bupropion SR;
- Tier 2 - Bupropion XL
- Tier 3 - Chantix.

UnitedHealthcare members also have access to HealthyLiving-Lessons for Life Nurseline at 1-888-229-9322 or visit **www.myuhc.com** for health information and support.

Employee Wellness

Discount Prescription Options

Kmart • WalMart • Target • Walgreens • Publix

Several discount options are available from free antibiotics to $5 prescriptions are available from several retail stores across the country. No insurance is necessary. Please look at the attached list to see if your prescription is available.

Employee Wellness

Prescription Drug Discount Programs

There are various discounts available for Prescription Drugs when you fill your prescription at one of the Popular Retailers below. A list of the medications covered under each of the respective Discount Programs is included for your convenience. Please consult with your doctor on any medications you are currently taking to discuss your options for taking advantage of these great cost saving opportunities.

$5.00 Generic Discount Program – You can receive a wide variety of Generic Medications for $5.00. Kmart requires that you enroll in their 90 days Generics Program to receive the $5.00 Prescription Program price. In addition Kmart offers a $10 90-Day Generics Program Formulary, a $15 90-Day Generics Program Formulary, and a Women's Health Program Formulary.

$4.00 Prescription Program – You can receive a 30 day supply of medication for $4.00.

$4.00 Generic Drug Program – You can receive a wide variety of Generic Medications for $4.00.

$12.99 for a 3-month supply Program – You can receive a three month supply of select medications for $12.99 for a 3-month supply. In addition you can receive savings on over 5,000 name brand and generic medications. A membership fee is required.

Free Oral Antibiotic Program – You can receive a prescription for a select list of Oral Antibiotics FREE. Also, Publix has introduced the Pharmacy Diabetes Management System, designed to help manage diabetes by providing free generic Metformin and other valuable resources.

Employee Wellness

Health Kiosk - Helps your employees monitor their health

A convenient and visible on-site solution helps motivate employees to make healthy behavior changes:

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

Biometrics measured and stored:

- Weight
- Body Mass Index (BMI)
- Body fat percentage
- Blood pressure (systolic and diastolic)
- Pulse
- Blood oxygen level
- Glucose (uploaded from USB-enabled glucose meter)
- Uploads to myuhc.com® Personal Health Record if UnitedHealthcare member; Lifeclinic.com Personal Health Record if not

Employee Wellness

Diabetes Health Plan – NEW PLAN to Help Fight Diabetes

Diabetes is a major health problem facing Americans, as well as all of us here at The School District. People with diabetes often have no warning signs and go undiagnosed for three to seven years.

Our goal is to look for ways to improve the health and quality of life for you and your family. Beginning in 2011 we are excited to offer a Diabetes Health Plan with specific plan designs to encourage those with Diabetes (or pre-diabetics) to take control and manage their health condition. With the Diabetes Health Plan from UnitedHealthcare, you can save money and receive resources to help you stay on track.

The Diabetes Health Plan features tools, so that those who face this condition will have access to better information allowing them to make informed health decisions and manage their serious health condition. Other plan incentives include: out of pocket savings for office visits, certain medications and diabetic-related medical supplies.

To qualify for the Diabetes Health Plan, you or any covered family member who is 18 or older must be diagnosed with diabetes or pre-diabetes. The goal of this plan is to detect diabetes as early as possible to help reduce or avoid complications.

More information will be made available as we get closer to our Diabetes Health Plan launch in January. Log onto **www.palmbeachschools.org/riskmgmt/wellness** for the updates!

UnitedHealthcare Diabetes Health Plan

Balancing incentives and greater compliance

- Supports diabetics, pre-diabetics and their non-diabetic family members (at least one member must be diagnosed and age 18 or older).
- Integrates condition-specific features for diabetic and pre-diabetic members.
- Reduces copayments by 50% for routine diabetic services and supplies. As well as certain Tier 1 and Tier 2 medications used to treat diabetes.
- Provides financial incentives for compliance, not just participation.

Primary Goals: To learn about diabetes, know diabetes ABCs, manage diabetes and have routine care to avoid problems. To remain in the program, the *diabetic member* must follow these guidelines which include:

Lab Evaluation: HbA1c (6 months), LDL, microalbuminuria/ creatinine

Professional Services: Regular primary care visits, retinal exam

Preventative Care: Cancer screening (mammography, colonoscopy)

Wellness Advocacy: Medical management program participation, health risk assessment

The *pre-diabetic member* must follow these guidelines which include:

Lab Evaluation: LDL

Professional Services: Premium primary care

Preventive Care: Cancer screening (mammography, colonoscopy)

Wellness: Weight management program participation, health rish assessment

Employee Wellness

Take advantage of your preventive care coverage

- Preventive care is covered at 100%
- Regular preventive care help
  - Reduce risk of disease
  - Detect health problems early
  - Protect you from higher costs down the road
  - May save your life
- No copayments - take advantage.

Preventive care services include:

Adult

- Annual routine office visit and exam
- Tetanus/Diphtheria booster
- Annual influenza vaccination (flu shot)
- Cholesterol screening
- Annual mammogram after age 40
- Annual Pap smear and pelvic exam
- Labs, pathology, chest X-ray, and EKG (when performed as preventive care)

Child

- Six visits 0 - 12 months
- Three visits 12 - 24 months
- Annual visits age 24 months through age 18
- Annual Pap smear and pelvic exam, as appropriate by age
- Lead-level testing
- Immunizations
- Labs, pathology, chest X-ray, and EKG (when performed as preventive care)

Preventive Care: Routine annual screenings to "prevent" illness or injury.

Non-preventive care: If diagnosed with a condition, some screenings often considered part of treatment. Be sure to talk to your doctor.

Preventive Care	Not Preventive Care
Mammogram - annually for women starting at age 40, or recommendation	Patient found lump in breast and doctor recommends mammogram to diagnose condition
Colonoscopy - every 10 years starting at age 50, recommendation	Patient has unexplained weight loss and constipation. Afraid it's colon cancer; schedules colonoscopy
Annual physical/preventive care exam - includes height, weight, blood pressure	Office visit due to fever and rash
Pap smear - once annually for women who are 18 year of age or older	Abnormal Pap smear; returns for second exam. this second exam would be considered non-preventive

Employee Wellness

HealthyLiving-Lessons for Life

The School District of Palm Beach County is committed to helping employees adopt a healthy lifestyle and improve their quality of life. Like many organizations, we provide a comprehensive wellness program for all employees. Our reason for providing this service includes our concern for the health & well-being of school district employees and their family members, as well as our concern about the escalating cost of healthcare.

The Employee Wellness Program seeks to establish a workplace that encourages and supports a healthy lifestyle by integrating health promotion activities and resources that help to enhance health & well-being. Our goal is to keep people healthy, reduce the risk factors among at-risk members and improve the health of those who already have chronic conditions by encouraging them to make lifestyle changes. To do this we give employees easy access to the resources needed to make well-informed decisions about their health and health care.

Ten Things to Do to Improve your Health and Feel Great:

1. Establish a Relationship with a Doctor
2. Eat a Healthy Breakfast
3. Eat more Fruits and Vegetables
4. Drink at Least 8 Glasses of Water
5. Don't forget Sunscreen
6. Do Something Physically Active
7. Keep Regular Sleep Hours
8. Connect with Other People
9. Relax and Take Time for yourself
10. Understand and take advantage of your health care

Key Components of Employee Wellness:

We have partnered with several organizations to provide an expansive offering of on-site health promotion. Some of our programs include:

- Wellness Newsletter & Tip Sheets
- Health & Wellness Seminars
- On-site Health Screenings & Immunizations
- Disease & Care Management
- Online Health Information & Resources
- Healthy Pregnancy Program
- Health & Fitness Discounts
- Confidential Health Assessments
- Online Health Coaching
- Weight Management & Smoking Cessation Programs
- Employee Assistance Program

Wellness Program Targets:

We firmly believe that any significant reduction in healthcare costs will depend ultimately on a commitment by our members to make healthier, more educated lifestyle choices, manage their illnesses better and become more knowledgeable about which healthcare services most cost-effectively serve their individual needs. We promote ongoing programs to all 21,000 employees in multiple ways throughout the school year. Our program targets include disease conditions and lifestyle behavior risk factors prevalent in our population that we can successfully impact through effective interventions. Good health is an extremely valuable asset to all of us. Our goal is to help employees and family members feel good, be healthy and live well.

For more information, monthly health tips and upcoming wellness events please visit:
http://www.palmbeachschools.org/riskmgmt/Wellness/
or contact Employee Wellness at (561)434-8044.

Healthcare Benefits

In this section...

- **Benefits comparison chart**
- **Money saving pharmacy benefit**
- **Benefit extras**
- **On-line tools and services**

Welcome - We're glad you're here

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

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

Before you enroll

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

The UnitedHealthcare network:

Find a network doctor or hospital.

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

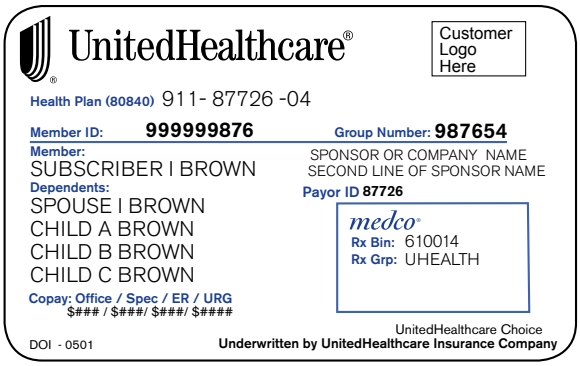
1. www.welcometouhc.com/
2. Click on "Physicians & Facilities."
3. Choose "Find a Physician."

Your ID Card - Your key to accessing care when you need it

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

Always carry your ID card

Your ID card has key information about you and your coverage. Put your card in your wallet or your pocketbook so you won't forget it. When you're at doctor's offices, drugstores and hospitals, show it to make sure you are not billed unnecessarily. You may also be asked to show a picture ID, such as your Driver's License or another government ID card with a picture on it, so be sure to bring this with you, too.



These extras are part of every plan

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

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

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

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

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

Other helpful tools include:

- Treatment cost estimator
- Physician match
- Hospital comparison

Healthcare Benefits

2011 Employee Per-Pay-Period Medical Premiums

Medical Plan	Full Time				Part Time			
EE = Employee	District Per Pay 24 pay periods	24 pay periods	District Per Pay 22 pay periods	22 pay periods	District Per Pay 24 pay periods	24 pay periods	District Per Pay 22 pay periods	22 pay periods
UNITED HMO CHOICE 39								
EE Only	$193.24	$0.00	$210.80	$0.00	$193.24	$0.00	$210.80	$0.00
EE + Child(ren)	$379.24	$84.52	$413.71	$92.20	$364.24	$99.52	$397.35	$108.56
EE + Spouse	$392.06	$110.33	$427.70	$120.36	$377.06	$125.33	$411.33	$136.72
EE + Family	$445.25	$164.19	$485.72	$179.11	$430.25	$179.19	$469.36	$195.47
EPO CHOICE								
EE Only	$164.54	$0.00	$179.49	$0.00	$164.54	$0.00	$179.49	$0.00
EE +Child(ren)	$355.33	$32.39	$387.63	$35.33	$340.33	$47.39	$371.26	$51.70
EE + Spouse	$36623	$53.87	$399.52	$58.77	$351.23	$68.87	$383.16	$75.13
EE + Family	$393.75	$115.62	$429.55	$126.13	$378.75	$130.62	$413.18	$142.49
PPO MEDICAL								
EE Only	$193.24	$194.44	$210.80	$212.11	$193.24	$204.44	$210.80	$223.02
EE +Child(ren)	$379.24	$552.44	$413.71	$602.66	$364.24	$567.44	$397.35	$619.03
EE + Spouse	$392.06	$617.23	$427.70	$673.34	$377.06	$632.23	$411.33	$689.71
EE + Family	$445.25	$779.12	$485.72	$849.95	$430.25	$794.12	$469.36	$866.31

401(a) Dollars Plan	Full Time				Part Time			
	District Per Pay 24 pay periods		District Per Pay 22 pay periods		District Per Pay 24 pay periods		District Per Pay 22 pay periods	
EPO CHOICE								
EE Only	$20.00		$21.82					
WAIVE HEALTH	$50.00		$64.55		$25.00		$27.27	

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.

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

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 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.

Healthcare Benefits

Tips to make your doctor's visit worthwhile

Before your appointment:

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

During your appointment:

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

UnitedHealth Premium® - Find recognized doctors and hospitals in the network

With the UnitedHealth Premium designation program*, we help you:

- Find doctors and hospitals in your area that meet quality and cost-efficiency criteria
- Find doctors you can call directly, without prior approval
- Get names quickly online
- Access to 20 specialties, including primary care, cardiology and orthopedics, as well as facilities in six specialties, including:
  - congenital heart disease
  - cardiac care
  - neonatology
  - infertility
  - total joint replacement
  - spine surgery

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

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

Finding a UnitedHealth Premium doctor

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

★★ UnitedHealth Premium quality and cost efficiency physician

★ UnitedHealth Premium quality physician

NCQA/ADA Diabetes Physician Recognition Program (DPRP)

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

Consult the Benefit Reference Guide throughout the year and refer to it for important information. www.palmbeachschools.org /riskmgmt

Healthcare Benefits

For more information, visit the Library at www.healthcareonline.com/welcomefi

Useful Terms

Health insurance has its own language. We want to make is easier for you to understand. Here are some basic definitions.

Benefits
Items and services that are covered by your insurance plan.

Co-insurance
This basically means you and your health plan share expenses. Each of you pays part of the total.

Copayments
The amount you pay at the time of service, such as when you go see your doctor.

Deductible
The amount you pay out of your own pocket before your insurance pays (if applicable to your plan).

Eligible Expense
The costs from a doctor's visit or other medical service that meets the requirements of your health care benefits.

Health Statement
A document showing recent claim and financial activity for all family members covered on your plan. It shows network and non-network information as well as remaining balances for deductibles and out-of-pocket costs.

Medical Claim Summary
A document showing claims (such as doctor visits, shots and other health care services) for all family members covered on your plan.

Network Provider
Doctors, hospitals, and other health care professionals with whom we have negotiated prices and are part of our network. Also called "in-network" provider and "participating" network provider.

Non-network provider
Doctors, hospitals and other health care professionals with whom we do not have negotiated prices. They are not part of our network. Also called "out-of-network" provider and "non-participating network" provider.

Out-of-pocket costs
Money you pay out of your own pocket. Out-of-pocket costs include deductibles, copayments and coinsurance.

Out-of-pocket maximum
The most you would have to pay in a single year out of your own pocket.

Personal health record
This is an online record that helps you organize and store all of your health data. It's a health history, a medical library, and a customizable organizer rolled into one secure and easy-to-use online tool that you create.

Prescription claim form
A form you will need to fill out oif you get a prescription with a pharmacy that is not in our network. Our network pharmacies normally take care of claim forms for you.

Quality and Cost Efficiency
A doctor who has met national medical standards for providing quality care, and has met local market benchmarks for providing cost-efficient care.

Urgent care
This is the type of care you need when your regular doctor isn't available and you don't need to go to the hospital emergency room.

Technology Terms

For our members who are new to using the Internet, we have provided some basic terms.

e-mail
A system for sending and receiving messages electronically over computer networks and personal computers.

Web site
A set of online pages that are maintained as a collection of information by a person, group or organization.

Online
When you are connected to the Internet of computer network.

Medical Plan Comparison Charts

United Healthcare
Benefits At A Glance

HMO Choice 39
Choice plan gives you the freedom to see any Physician or other health care professional from our National Network, including specialists, without a referral. In addition, you do not have to worry about any claim forms or bills.

Member Payments	In-Network Only
In-Patient Hospital Co-Insurance	10% of eligible expenses
Annual Out-of-Pocket Maximum	$3,000 for Individual, $6,000 for Family
Annual Medical Expense Deductible	None
Co-Insurance Rate	10% of eligible expenses
Primary Care Physician Check United's provider directory before making your decision regarding your health care provider	Choose any Physician from the United Open Access directory. You may access any participating specialist without a referral.
Physician Office Visit (Primary Care)	$25 Co-payment***
Specialist Office Visit Allergy Shots in Physician's Office	$35 Co-payment*** No referral needed
Preventive Care	No charge
Outpatient Hospital and Surgical Services X-Ray Other Diagnostic Services (MRI, CT scan, Etc.) Laboratory	10% of eligible expenses for surgery, therapeutic and major diagnostics No charge for X-rays and laboratory
Out-Patient Rehabilitation Therapy	$20 Co-payment per visit*** [1]
Approved Durable Medical Equipment	10% of eligible expenses, $10,000 maximum/calendar year
Emergency Ambulance Trip	10% of eligible expenses
Hospital Pre-Admission Requirement	Your Physician will take care of all pre-notification requirements
Emergency Room Care	$150 Co-pay (waived if admitted)***
Urgent Care Co-pay	$50 Co-payment***
Convenience Care Clinic	$25 Co-payment***
Outpatient Mental Health & Substance Abuse Services	$20 individual, $15 group***
Prescription Drugs • 30-day supply per prescription at participating pharmacists • Mail order for a 90-day supply of formulary maintenance medication per prescription	Annual deductible $100 individual (retail) / $200 family (retail) $10 Tier 1, $30 Tier 2, $60 Tier 3, $100 Tier 4 No deductible for Mail Order – $20 Tier 1, $60 Tier 2, $120 Tier 3, $200 Tier 4

***Does not apply to Out-of-Pocket maximum. [1] 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type. 36 visits per year for Cardiac therapy.

Medical Plan Comparison Charts

United Healthcare
Benefits At A Glance

	EPO Choice Choice plan gives you the freedom to see any Physician or other health care professional from our National Network, including specialists, without a referral. In addition, you do not have to worry about any claim forms or bills. The premiums are less than the HMO 39 plan however, the out of pocket expenses are slightly higher than the HMO 39 plan.
Member Payments	**In-Network Only**
In-Patient Hospital Co-Insurance	20% of eligible expenses after deductible
Annual Out-of-Pocket Maximum	$6,000 for Individual, $12,000 for Family
Annual Medical Expense Deductible	$500 for Individual, $1,000 for Family
Co-Insurance Rate	20% of eligible expenses after deductible
Primary Care Physician Check United's provider directory before making your decision regarding your health care provider	Choose any Physician from the United Open Access directory. You may access any participating specialist without a referral.
Physician Office Visit (Primary Care)	$40 Co-payment***
Specialist Office Visit Allergy Shots in Physician's Office	$60 Co-payment*** No referral needed
Preventive Care	No charge
Outpatient Hospital and Surgical Services X-Ray Other Diagnostic Services (MRI, CT scan, Etc.) Laboratory	20% of eligible expenses after deductible
Out-Patient Rehabilitation Therapy	$35 Co-payment per visit*** [1]
Approved Durable Medical Equipment	20% of eligible expenses after deductible, $10,000 maximum/calendar year
Emergency Ambulance Trip	$150 Co-payment per trip***
Hospital Pre-Admission Requirement	Your Physician will take care of all pre-notification requirements.
Emergency Room Care	$250 Co-pay (waived if admitted)***
Urgent Care Co-pay	$75 Co-payment***
Convenience Care Clinic	$40 Co-payment***
Outpatient Mental Health & Substance Abuse Services	$35 individual, $25 group***
Prescription Drugs • 30-day supply per prescription at participating pharmacists • Mail order for a 90-day supply of formulary maintenance medication per prescription	Annual deductible $100 individual (retail) / $200 family (retail) $10 Tier 1, $30 Tier 2, $60 Tier 3, $100 Tier 4 No deductible for Mail Order – $20 Tier 1, $60 Tier 2, $120 Tier 3, $200 Tier 4

***Does not apply to Out-of-Pocket maximum. [1] 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type. 36 visits per year for Cardiac therapy.

***Does not apply to Out-of-Pocket maximum. [1] 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type. 36 visits per year for Cardiac therapy.

Medical Plan Comparison Charts

United Healthcare
Benefits At A Glance

PPO
Options PPO plan gives you the freedom to see any Physician or other health care 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 physician, facility or other health care professional. You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a nonnetwork physician, facility or other health care professional means a higher deductible and Co-payment.

Member Payments	In-Network	Out-of-Network
In-Patient Hospital Co-Insurance	20% of contracted fee after deductible	40% of of eligible expenses after deductible
Annual Out-of-Pocket Maximum **Lifetime Maximum**	$5,000 for Individual and $10,000 for Family $1,000,000 per covered person	$10,000 for Individual and $20,000 for Family $1,000,000 per covered person
Annual Medical Expense Deductible	$500 for Individual and $1,000 for Family	$1,000 for Individual and $2,000 for Family
Co-Insurance Rate	20% of contracted fee	40% of eligible expenses after deductible
Primary Care Physician Check United's provider directory before making your decision regarding your health care provider	Choose any Physician from the UHC Options PPO directory	Choose any licensed Physician
Physician Office Visit (Primary Care)	$25 Co-payment***	40% of eligible expenses after deductible
Specialist Office Visit Allergy Shots in Physician's Office	$40 Co-payment***	40% of eligible expenses after deductible
Preventive Care Office visit Routine Mammogram (subject to the specified age groups)	No charge No charge	40% of eligible expenses after deductible No charge
Outpatient Hospital and Surgical Services X-Ray Other Diagnostic Services (MRI, CT scan, Etc.) Laboratory	20% of contracted fee after deductible 20% of contracted fee after deductible 20% of contracted fee after deductible 20% of contracted fee after deductible	40% of eligible expenses after deductible 40% of eligible expenses after deductible 40% of eligible expenses after deductible 40% of eligible expenses after deductible
Out-Patient Rehabilitation Therapy	$20 Co-payment per visit*** 1	40% of eligible expenses after deductible
Approved Durable Medical Equipment	20% after deductible, prior authorization required $10,000 combined maximum/calendar year	40% after deductible, prior authorization required $10,000 combined maximum/calendar year
Emergency Ambulance Trip	20% after deductible	40% of eligible expenses after deductible
Hospital Pre-Admission Requirement	Your Physician will take care of pre-notification	It is your responsibility to see that your Physician takes care of pre-notification
Emergency Room Care	$150 Co-payment (waived if admitted)***	$150 Co-payment (waived if admitted)***
Urgent Care Co-pay	$50 Co-payment	40% of eligible expenses after deductible
Convenience Care Clinic	$25 Co-payment	Select any Non-Network Physician, Specialist or Hospital
Outpatient Mental Health & Substance Abuse Services	$20 individual/$15 group	40% of eligible expenses after deductible
Prescription Drugs • 30-day supply per prescription at participating pharmacists • Mail order for a 90-day supply of formulary maintenance medication per prescription	Annual deductible $100 individual (retail) / $200 family (retail) $10 Tier 1, $30 Tier 2, $60 Tier 3, $100 Tier 4 No deductible for Mail Order – $20 Tier 1, $60 Tier 2, $120 Tier 3, $200 Tier 4	40% of eligible expenses after deductible Not covered

***Does not apply to Out-of-Pocket maximum. [1] 20 visits of physical, occupational, pulmonary and speech therapy per calendar year, per therapeutic type. 36 visits per year for Cardiac therapy.

Healthcare Benefits

About the pharmacy benefit

60,000 network retail pharmacies are available to you across the country.

Mail-order services can give you up to a 90-day supply of your medication(s), often at a lower price than retail. And it's delivered to your home with free standard shipping. Using mail order now? You may need to request a new prescription.

Understanding common pharmacy terms

What is a Prescription Drug List?

A prescription drug list (PDL) is a list of medications, products or devices that have been approved for your safety by the U.S. Food and Drug Administration. These medications and products are then placed into tiers.

Since the PDL may change, we encourage you to visit **myuhc.com** or call the number on the back of your ID card for the most current information.

What do the tiers mean?

Medications listed in the PDL are placed into tiers. Each tier is given a copayment amount. Medications in tier 1 will have the lowest copayment.

Not all drugs listed on the PDL are covered by all plans. Please check your official benefit plan information to find out what is covered under your plan.

Some plans may require you to pay the entire cost of the medication until the plan deductible has been met.

Specialty Pharmacy Program

Specialty medications are critical to improving the health and lives of individuals - and are also some of the most expensive medications being used today. We want to make these medications accessible and affordable for you and for your employer.

What is a specialty medication?

UnitedHealthcare defines specialty medications as having one or more of the following attributes:

- Cost greater than $250 per prescription
- Injectible or oral medications, including transfusions given in an outpatient setting
- Treats rare, unusual or complex diseases
- Requires additional clinical oversight and expertise for best management.

Pharmacy Benefit

You have a big network

- 60,000 network retail pharmacies available across the country

You have mail order

- 90-day supply
- Buy lower prices than retail
- Delivered to your home with free standard shipping

Using mail order now? You may need to request a new prescription.

UHC.com

- Look up pharmacy benefit information
- Find network pharmacies
- Price medications and learn about lower cost options
- Refill prescriptions
- Review your prescription history

Where should I go for care?

Helping you choose the right care center

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

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

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

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

Healthcare Benefits

Services and programs that support your personal health needs

Current members

For more information, log in to **myuhc.com** or call the number on the back of your ID card.

NurseLine℠ services
Call 1-888-229-9322

Registered nurses are available to help you anytime — at no extra cost to you. After all, peace of mind shouldn't have to wait.

- Recognize symptoms and help you choose appropriate care
- Find doctors or hospitals recognized for providing quality care
- Learn to manage your health condition and explore treatment options
- And much more

Note: If you do have a real emergency, please call 911 or travel to the nearest emergency room. Qualified emergency room visits are treated as network visits.

Care Coordination

If you are in the hospital or you will need hospital care, we can help you so that you have a successful recovery. We can work with your doctor on your treatment plan. And one of our registered nurses may call you to help you understand your follow-up care when you are back at home.

Healthy Pregnancy Program

We will help you through every stage of your pregnancy and delivery. And we will provide:

- 24-hour access to experienced nurses
- Helpful information or facts to help you identify risks and special needs
- Access to our online Healthy Pregnancy Owner's Manual and other materials
- Complimentary gifts and money-saving coupons

Current members

Enroll today by calling 1-800-411-7984 or you can visit www.healthy-pregnancy.com.

Behavioral Solutions

For when life's problems feel like too much to handle

Your benefits include confidential support on a wide range of personal issues - from everyday issues to more serious problems. The national network includes more than 80,000 licensed and certified professionals, including counselors, psychologists, psychiatrists and social workers.

You can check your benefit information and submit online requests for services at **www.liveandworkwell.com**. You also can search our online directory of clinicians, access information and resources for hundreds of everyday work and life issues in one of our many virtual help centers, and participate in interactive, customizable self-improvement programs. Even though they may not be covered under the plan, any member of your household may access these online services, including dependents living away from home.

People often call for such personal issues as:

- Depression, stress and anxiety
- Parenting and family problems
- Childcare and eldercare stress
- Relationship difficulties
- Substance abuse and recovery
- Dealing with domestic violence
- Eating disorders
- Balancing work and life issues
- And much more

Healthcare Benefits

Use your own private, personal website at myuhc.com.

- See your plan details
- View your current claims
- See your family's claims history in one view
- Find a network doctor in your area
- Learn more about a health condition
- Estimate treatment costs ahead of time
- Take health quizzes, use calculators and learn about common symptoms
- Look up pharmacy information and find lower cost drug options

DocGPS™ for mobile phones

DocGPS is our new mobile phone application, or App, which uses Google Maps™ mapping service to help you find network doctors and hospitals based on your location.

DocGPS can be used on many different phones, including the Apple® iPhone, and BlackBerry®.

Visit your mobile phone App website to see if DocGPS can be used on your phone and download it to your phone today.

Treatment Cost Estimator

This easy-to-use online tool can help you budget for a medical treatment. Results are personalized to your health plan, physician, plan and ZIP Code.

- Search and explore cost estimates of different treatments
- Compare network and non-network cost estimates
- Learn how the cost of a procedure affects your health account balances

Quicken Health Expense Tracker℠

Track your health care expenses the easy way. From the makers of the popular Quicken® software, this online tool provides a clear breakdown of medical claims, helping you understand what to pay and why.

Save time
Pay your medical bills online, and quickly find out if a medical bill has been paid.

Save money
Track your medical spending, so that you can budget for the future.

Save paper
Access your claims history electronically.

Welcome to Health Care Lane℠

Visit this virtual street that makes learning about health care easier and more enjoyable.

Learn about:

- Health insurance basics
- Tips on lowering costs
- What UnitedHealthcare is doing to help you

www.healthcarelane.com

Healthcare Benefits

Wellness services to help you live well

Current members - You can access our wellness services today. Just log in to **myuhc.com** and click on "Health & Wellness," or you can call the number on the back of your ID card.

Your personal health assessment

Complete an online health questionnaire to help you learn your current health status. You will receive quick and private results along with a report providing tips on ways to help you improve your health.

It won't take much more than 15 minutes to complete. That's about four songs on your radio or MP3 player.

Help to stop smoking and using tobacco

We know it's not easy to quit, but we'll give you the support you need. You'll set a "Quit Date" and begin a step-by-step approach to quitting. You'll also receive tips on how to quit and access to online tools to help you stay on track.

- Identify common obstacles to quitting
- Understand nicotine replacement therapy options
- Deal with temptations and prevent relapse

Help to 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. You'll take 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

Member discounts

Save 5 to 50 percent on wellness products and services with the Health Discount Program, including health care services that may not be covered by your benefit plan.

- Weight loss programs from Jenny Craig® among others
- Fitness clubs from the nationwide GlobalFit™ network, including select Gold's Gym, World Gym, Curves and Ladies Workout Express locations
- Natural products and foods
- Teeth-whitening
- Laser eye surgery and much more

Wellness tools and educational resources

Find information on a wide range of health and wellness topics, plus quizzes, calculators and charts. Topics include: family, fitness and nutrition, healthy aging, pregnancy, preventative medicine, addiction, relationships and more.

Your personal health record

It's your health history, medical library and organizer rolled into one secure tool.

- Review claim information, including lab results
- Record allergies and immunizations
- Record your family health history and personal contacts
- Track your blood pressure, cholesterol and weight
- Print and take your health information to a doctor's appointment

Healthcare Benefits

What do my UnitedHealthcare benefits offer me and my family?

Disease Management services

Take Charge of Your Health

Living with an illness can be difficult, but you don't have to go it alone.

Facing a long-term chronic illness or other complex health issue can take a huge toll on you and your family. You may feel overwhelmed by all of the information available online or the instructions from your doctor. That's why your employer offers disease management programs to you, at no additional cost. These programs are designed specifically to ease your worries and assist you every step of the way—so you'll have extra support if you or a loved one has a health issue such as diabetes or coronary artery disease.

What is disease management?

If you have asthma, heart disease, diabetes or heart failure, a registered nurse may reach out to you over the phone. The nurse will ask you questions about your health or condition to see if he or she can help. Once you enroll, you'll receive a welcome packet in the mail with education materials and health tools, such as a health log that you can share with your doctor. Then, a series of calls between you and the nurse will be scheduled at your convenience. These conversations will allow you to discuss your progress with the nurse. You also can ask any questions you may have, and learn more about how to manage your health.

Why is this program being provided?

Disease management programs are offered so you'll have added information and support if you or a family member has a chronic condition. It's important that you have the tools and resources you need to take an active role in your health care.

Will this program cost me any money?

No. These programs are offered at no additional cost to you and your family.

How do I participate?

Enrolling in a disease management program is easy—if a nurse calls, all you have to do is accept the invitation to join.

When would a nurse contact me?

A registered nurse may reach out to you over the phone if you have an existing chronic health condition. Programs are available for asthma, heart disease, heart failure and diabetes.

How will a nurse know who has a chronic condition?

Your recent prescriptions, doctor visits or hospital stays can indicate when a program may benefit you. Rest assured, your health information will be kept private in accordance with your health plan's privacy policy.

What sort of help can a nurse provide?

The nurses will work with you to help manage your condition by providing information, connecting you with resources and giving you tips for working with your doctor more effectively. They also can help you follow your treatment plan and manage your symptoms to avoid complications. Think of the nurse as a partner, working on your behalf to help you feel your best.

What qualifications do the nurses have?

All disease management nurses have years of clinical experience. Additionally, some may have extra expertise in working with people who have a specific condition or complex health situation.

I prefer to talk with my doctor when I have a medical concern.

None of the services offered by disease management programs are intended to take the place of your doctor's care. In fact, these programs are meant to complement and reinforce your doctor's instructions. By enrolling in a program, you'll have access with a nurse who can work with you, one-to-one, to address your health concerns. The nurse can give you self-care tips and help you determine whether to treat a health issue at home—possibly saving you from a doctor or emergency room visit.

Do I have to participate?

Disease management programs are voluntary. If you choose not to participate, simply tell the nurse that you don't want to enroll.

Will information shared during calls with the nurse be kept private?

Your privacy is important and will be protected in accordance with your health plan's privacy policy. If you're concerned about how your health information is protected, you can ask the nurse about it before sharing anything personal.

Healthcare Benefits

Healthy habits health tips

Simple tips to a healthier life

Tomatoes are rich in lycopene and may help prevent heart disease, prostate cancer, breast cancer and more.

Healthy eating on a budget:

- Buy in bulk
- Cook and store in bulk
- Be season-savvy
- Go generic

Deep green fruits and vegetables may help improve eyesight. So load up on avocados, artichokes, Granny Smith apples, spinach, broccoli, kiwi and other green goodies.

If you have high blood pressure, be careful with caffeine, especially when it comes from energy drinks. They may cause a temporary increase in blood pressure and/or interfere with blood pressure medications.

Including fish regularly in their diet may help reduce the risk of heart disease for women with type 2 diabetes. Eating fatty fish has also been associated with reduced risk of Alzheimer's disease.

The SPF number tells you how much longer you can stay in the sun without burning if you apply the sunscreen. For example, if you normally burn after 20 minutes of unprotected sun exposure, applying a sunscreen with an SPF of 15 gives you 15 times the protection and will protect you for as long as five hours.

Having your child immunized (vaccinated) can guard against a number of potentially serious diseases. Talk to your child's physician to make sure your child is protected.

Broccoli contains a compound that may protect against cancer.

Exercise can help combat serious ailments like osteoporosis, heart disease, diabetes and breast cancer.

Your cell phone can help you communicate your needs to first responders in the event of an accident or illness. Program your cell phone with ICE (In Case of Emergency) contact information.

These tips are provided through the Health & Wellness section of myuhc.com.

This content is for informational purposes only. It is not intended as a substitute for the advice provided by your own physician or health care provider and may not take your individual health situation into account. You should not use this information as a means of diagnosing a health problem or disease, or as a means of determining treatment.

If you have specific health questions, please talk with your doctor.

Register on myuhc.com® – it's as easy as 1,2,3...

1. Go to **myuhc.com** and click on the 'Register Now' button.
2. Follow the instructions, entering the information requested.
3. Select a user name and password and begin accessing **myuhc.com**.
4. For security purposes, keep your password and your user name in a safe location.

Did you read about...

- **Your medical plans?**
- **How to find a doctor?**
- **Prescription information?**

Dental

In this section...

- Dental plan options
- Orthodontics
- Prenatal dental care program
- Plan comparisons

UnitedHealthcare Dental®

We've given you a reason to smile with a selection of dental plans with exciting new enhancements. UnitedHealthcare Dental is a leading dental provider in Florida, and we are proud to have been selected as your dental carrier. We offer four flexible dental plans, paid through a voluntary, pre-tax benefit. With all of these options, we are sure you will find a plan that meets your dental needs.

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

Prenatal Dental Care Program

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

That's why we've created a dental program which provides additional in-network preventive dental care coverage for expectant mothers. If you are in your second or third trimester of pregnancy, you are eligible for this program's benefits as part of your benefit plan.

On your next visit, tell your dentist that you are pregnant. Provide the stage of your pregnancy and due date, and also make sure the dentist notes your attending physician's or obstetrician's name (this must be included on the claim form). All fees and expenses for cleanings, deep scaling (cleaning the teeth deeper down the tooth), debridement (removing dead or infected tissues) and periodontal maintenance will be waived, if your dentist determines you require these procedures.

The Four Options offered are:

Managed Care Plans

Option 1 (Plan S500PB) is a pre-paid plan. This plan offers a savings of 20% to 50% on all basic and major dental services. What you will pay the dentist on your visit is listed in your Schedule of Benefits. With this plan there are no hidden charges. Additionally, you will receive the following features:

- No waiting periods
- No claim forms to submit
- No primary dentist selection required
- Self-Referral to Specialist Dentist for a 25% discount
- Defined costs on 293 procedure codes
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included
- 25% discount on all procedure codes not listed

Option 2 (Plan S700) is a pre-paid plan. This plan offers a guaranteed savings of 25% to 50% on basic and major dental services. What you will pay the dentist on your visit is listed in your Schedule of Benefits. With this plan there are no hidden charges. Additionally, you will receive the following features:

- No waiting periods
- No claim forms to submit
- No primary dentist selection required
- Self- Referral to Specialist Dentist for a 25% discount
- Defined costs on 293 procedure codes
- Cosmetic procedures (teeth whitening, bonding, and veneers) are included
- 25% discount on all procedure codes not listed

Dental

Specialty Services for Managed Care Plan (S500PB and S700)

- The fees within this overview of services apply when such services are performed by a participating general dentist, unless otherwise authorized by UnitedHealthcare Dental.*
- If services are not listed within the Schedule of Benefits and are performed by a participating general dentist, fees will be charged at the dentist's usual and customary fee less 25%.
- The participating general dentist you select may not perform all outlined procedures. The co-payments shown apply to general dentists who perform these procedures. Therefore, you are encouraged to secure availability of the scheduled services with your participating general dentist.
- Should the services of a specialist (Oral Surgeon, Endodontist, Orthodontist, Periodontist, Prosthodontist or Pedodontist) be necessary, you may receive this care in one of two ways: (1) You may go directly to a participating specialist with no referral and receive a 25% reduction off the provider's usual and customary fee; or (2) You may obtain prior written authorization by UnitedHealthcare Dental* and receive specialty treatment by an approved participating specialist at the listed co-payments. Please refer to the Specialty Care Referral Policy in your member ID packet.

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

Managed Care Plans (S500PB and S700) – Features:

About fillings

The aforementioned UnitedHealthcare Dental managed care programs provide coverage for the following fillings benefits:

Amalgam (silver fillings) (S500PB and S700)

- No co-payments - Covered 100%
- Verify that your treating dentist provides amalgam fillings. If your dentist does not offer amalgam fillings, you will receive a resin (white filling) and you will be responsible for the following co-payments:

Composite Resin (white fillings)

S500PB

- Anterior Teeth - Co-payment will apply from $25 - $105
- Posterior Teeth - Co-payment will apply from $55 - $105

S700

- Anterior Teeth – Co-payment will apply from $30 - $115
- Posterior Teeth – Co-payment will apply from $65 - $115

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

Typical Annual Cost	OPTION I-S500PB What You Pay In-Network Only	OPTION 2-S700 What You Pay In-Network	OPTION 3-P5215 What You Pay** In-Network/Out-of-Network	OPTION 4-P5105 What You Pay** In-Network/Out-of-Network
Office Visit	No charge	No charge	0% / 10%	0% / 20%
Oral Examination (every 6 months)	No charge	No charge	0% / 10%	0% / 20%
Tooth Extraction (simple)	$10	$20	20% / 30%	50% / 60%
Silver Fillings	No charge	No charge	20% / 30%	50% / 60%
Prophylaxis (cleaning - every 6 months)	No charge	No charge	0% / 10%	0% / 20%
Crown*	$240*	$245*	50% / 60%	50% / 60%
Molar Root canal	$225	$245	20% / 30%	50% / 60%
Bridge - porcelain, base metal, per tooth*	$240*	$245*	50% / 60%	50% / 60%

*See Exclusion and Limitations

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

Dental

Using a Pedodontist

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

Orthodontics

Both the above managed care plans-S700 and S500PB-cover orthodontia. These managed care plans allow coverage for both adults and children. Co-payments under S700 are set at $2,200 for children, $2,250 for adolescents and $2,350 for adults. Co-payments under S500PB are set at $1,600 for children and adolescents; $1,950 for adults. These prices are based on 24 months of orthodontic treatment. Cases that require more than 24 months are subject to additional charges.

PPO Plans

Option 3 (PPO Plan P5215) is a high option PPO plan which allows you and each covered family member to use the provider of your choice; however, you'll receive a higher level of coverage when you choose a participating network provider. There is a deductible of $50 per person ($150 per family). There is no deductible for Preventive and Diagnostic Services. This plan has an annual maximum benefit of $1,000 and covers orthodontia for children up to the age of 19. The lifetime orthodontic maximum benefit is $2,000. There is a 12 month waiting period for major services and orthodontic services for new members.**

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

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

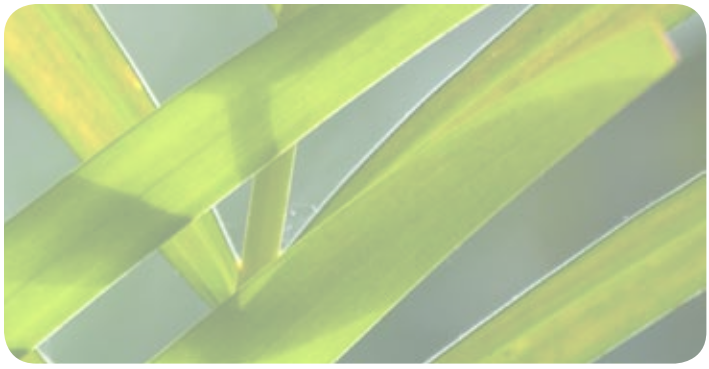
**Waiting periods will apply for new enrolling members and late entrants.

Your Dental Rates

Per pay period pre-tax deductions are as follows:

	24 pays	22 pays
Managed Care Plans		
Dental Option I - Plan S500PB with Orthodontia		
Employee Only	$8.00	$ 8.73
Employee & Child(ren)	$17.00	$18.55
*Employee & Spouse	$14.00	$15.27
*Employee & Family	$22.00	$24.00
Dental Option 2 - Plan S700 with Orthodontia		
Employee Only	$6.08	$6.63
Employee & Child(ren)	$13.00	$14.18
*Employee & Spouse	$10.57	$11.53
*Employee & Family	$16.65	$18.16
PPO Plans		
Dental Option 3 - PPO Plan P5215 with Orthodontia		
Employee Only	$13.32	$14.53
Employee & Child(ren)	$36.63	$39.96
*Employee & Spouse	$32.64	$35.60
*Employee & Family	$49.29	$53.77
Dental Option 4 - PPO Plan P5105 (No Orthodontia)		
Employee Only	$9.99	$10.90
Employee & Child(ren)	$27.47	$29.97
*Employee & Spouse	$24.48	$26.71
*Employee & Family	$36.97	$40.33

***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.



Dental

Oral Cancer Screening

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

Consumer MaxMultiplier℠

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

How awards are earned:

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

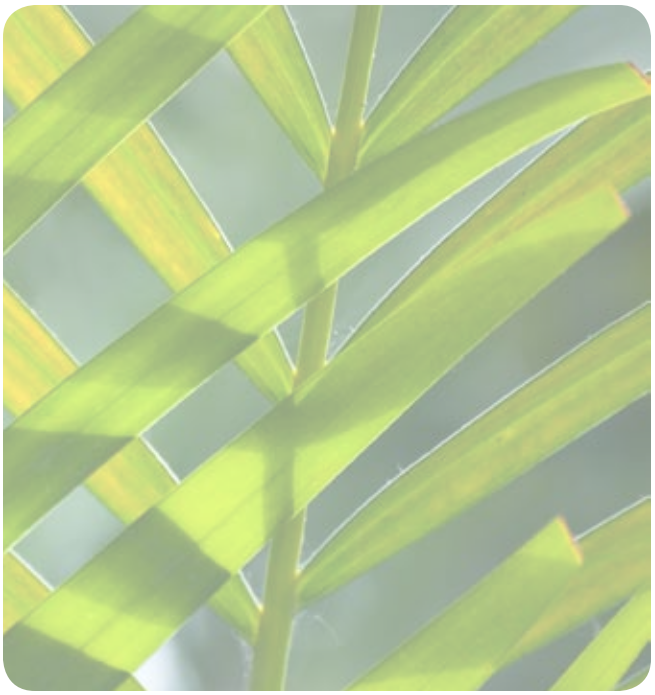
* (P5215 & P5105)

Using your awards:

The award balance can be used to fund additional claims for dental services when the member exceeds the original benefit period maximum.** Once a new benefit period maximum begins, the award account balance, if any, is carried over to the new benefit period and available for use should the member exceed the plan maximum.

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

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



Dental

Commonly Covered Procedures - Managed Care Plans (S500PB & S700)

BENEFIT	Option 1 Plan S500PB	Option 2 Plan S700
DEDUCTIBLE		
Yearly Deductible	None	None
Calendar Year Maximum	None	None
Claim Forms	None	None
Rosters	None	None
Primary Dentist Required	None	None
Diagnostic/Preventive	**You Pay**	**You Pay**
Office visit	No Charge	No Charge
Routine exams	No Charge (1 per 6 months)	No Charge (1 per 6 months)
Prophylaxis (cleaning) - basic	No Charge (1 per 6 months)	No Charge (1 per 6 months)
Emergency treatment (Palliative)	No Charge	No Charge
X-ray and complete series including bitewings	No Charge (1 per 60 months)	No Charge (1 per 60 months)
Fluoride application	No Charge (1 per 12 months)	No Charge (1 per 12 months)
BASIC/RESTORATIVE PROCEDURES* **		
Simple extractions	$10	$20
Amalgam fillings - 1 surface permanent	No Charge	No Charge
Root Canals (1 canal)	$100	$110
Root Canal (3 canals)	$225	$245
Sealants (age limit applies)**	No Charge	No Charge
MAJOR PROCEDURES		
Crowns - porcelain, base metal**	$240	$245
Dentures - upper/lower**	$260 each	$325 each
Bridges - porcelain base metal**	$240	$245
Periodontics		
Scaling and root planing per year	$45 per quadrant (limit 2 per year)**	$50 per quadrant (limit 2 per year)**
Orthodontics		
Pre-orthodontic treatment visit	$0	$35
Comprehensive treatment of transitional dentition	$1,600	$2,200
Comprehensive treatment of adolescent transitional dentition	$1,600	$2,250
Comprehensive treatment of adult dentition	$1,950	$2,350

** See exclusions and limitations.

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

Dental

PPO Plans (P5215 and P5105)

BENEFIT	Option 3 - PPO Plan P5215		Option 4 - PPO Plan P5105	
	In-Network	Out of Network	In-Network	Out of Network
DEDUCTIBLE (MAXIMUM 3 PER FAMILY) (Calendar Year is January 1 - December 31) Class I Class II, III, IV	 None $50 per year, individual	 None $50 per year, individual	 None $50 per year, individual	 None $50 per year, individual
CALENDAR YEAR MAXIMUM	$1,000	$1,000	$1,000	$1,000
LIFETIME ORTHODONTIC MAXIMUM	$2,000	$2,000	Not Covered	Not Covered
WAITING PERIOD Class I and II Class III Class IV	 None 12 Months 12 Months	 None 12 Months 12 Months	 None 12 Months N/A	 None 12 Months N/A
BENEFIT	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
CLASS I - PREVENTIVE & DIAGNOSTIC Oral Evaluation (Diagnostic) X-Rays (Diagnostic) Lab and Other Diagnostic Tests Prophylaxis (Preventative) Fluoride Treatment (Preventative) Sealants Space Maintainers	 100% 100% 100% 100% 100% 100% 100%	 90% 90% 90% 90% 90% 90% 90%	 100% 100% 100% 100% 100% 100% 100%	 80% 80% 80% 80% 80% 80% 80%
CLASS II - BASIC SERVICES Restoration (Amalgams and Resin Based Only) General Services (Emergency Treatment and Anesthesia) Simple Extractions Oral Surgery (includes surgical extractions) Periodontics Endodontics	 80% 80% 80% 80% 80% 80%	 70% 70% 70% 70% 70% 70%	 50% 50% 50% 50% 50% 50%	 40% 40% 40% 40% 40% 40%
CLASS III - MAJOR SERVICES Inlays/Onlays/Crowns and Bridges Dentures and other Removable Prosthetics Fixed Prosthetics	 50% 50% 50%	 40% 40% 40%	 50% 50% 50%	 40% 40% 40%
CLASS IV - ORTHODONTIC SERVICES Orthodontia (Child up to age 19)	 50%	 50%	 Not Covered	 Not Covered

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

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

The Solstice Dental Plans are offered by Dental Benefit Providers, Inc. and underwritten by Solstice Benefits, Inc., a licensed Prepaid Limited Health Service Organization, under F.S. 636.

Did you read about...

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

Vision

In this section...

- **Vision plan description**
- **Lens options**
- **How to locate a provider**
- **Mail-order contact lenses**

Plan Provider: EyeMed Vision Care

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

- glaucoma
- diabetes
- cataracts
- hypertension

Since early detection is key for treatment, periodic eye examinations play a vital role in ensuring the health of your eyes.

This is why EyeMed providers are dedicated to preserving your vision while also 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.

Begin receiving substantial savings on your eye care and eye wear needs at any one of EyeMed's thousands of provider locations nationwide.

Plan Features:

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

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

EyeMed Savings vs. Other Vision Care Plans

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

Please note: your benefit cannot be combined with any other discounts or promotional offers.

Claim Forms

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

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

- Locate the provider nearest you by going to **eyemedvisioncare.com** and click on the "Select" network.
- View your benefits, including service eligibility and the next date of service
- Printable replacement ID cards
- Online Claims Status
- Printable Explanation of Benefits
- Ability to "go paperless" and receive Explanation of Benefits electronically
- Learn more about the importance of vision care through Vision Wellness content

LensCrafters®

Pearle Vision

Sears Optical

Target Optical

EyeMed VISION CARE®

Vision

EyeMed Plan Services	In-Network Member Cost	Out-of-Network Maximum Reimbursement
EXAM WITH DILATION AS NECESSARY	$10 Co-payment	$35
EXAM OPTIONS		
Standard Contact Lens Fit and Follow-Up*	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up**	10% of Retail	N/A
FRAMES:	$0 Co-pay; $100 Allowance; 20% of balance over $100	$50
STANDARD PLASTIC LENSES:		
Single Vision	$15 Co-payment	$25
Bifocal	$15 Co-payment	$40
Trifocal	$15 Co-payment	$55
Standard Progressive	$60 Co-payment	$55
Premium Progressive	$60, 80% of Charge less $120 Allowance	$55
LENS OPTIONS (PAID BY THE MEMBER AND ADDED TO THE BASE PRICE OF THE LENS):		
UV Coating	$12	$2
Tint (Solid and Gradient)	$12	$2
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate - Adult	$35	$3
Standard Polycarbonate - Kids under 19	$35	$3
Standard Anti-Reflective	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
CONTACT LENSES (INCLUDES MATERIALS; ONLY IN LIEU OF LENSES):		
Conventional	$0 Co-pay; $115 Allowance plus 15% off balance over $115	$92
Disposables	$0 Co-pay; $115 Allowance plus balance over $115	$92
Medically Necessary	$0 Co-payment, paid in full	$200
LASIK AND PRK VISION CORRECTION PROCEDURES†	15% off retail price OR 5% off promotional pricing	N/A
FREQUENCY:		
Exams	Once every 12 months	
Frames	Once every 24 months	
Standard Plastic Lenses or Contact Lenses	Once every 12 months	

* Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)
** Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

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

Lens Options

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

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

Vision

Additional Purchases and Out-of-Pocket Discount

You will receive a 20 percent discount on items not covered by the plan at participating providers, which may not be combined with any other discounts or promotional offers, and 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 eye wear required by an employer as a condition of employment, and safety eye wear; services provided as a result of Workers' Compensation law; plano non-prescription lenses and non-prescription sunglasses (except for the 20 percent EyeMed discount); two pairs of glasses in lieu of bifocals; services or materials provided by any other group benefit providing for vision care. Benefit allowances provide no remaining balance for future use within the same benefit period. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit period.

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

VISION CARE PREMIUMS

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

FULL TIME OR PART TIME

	Per 24 Pay Periods	Per 22 Pay Periods
EyeMed Vision Care Option		
Employee Only	$2.62	$2.86
Employee & Family	$6.73	$7.34

To Locate An EyeMed Provider Near You:

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

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

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

Call EyeMed Customer Call Center at **1-866-299-1358** and choose the "Provider Locator" automated option, or speak to a Customer Service Rep during normal operating hours (Monday-Friday, 8 a.m. - 11 p.m.; Sunday, 11 a.m. - 8 p.m. EST).

Replacement Contact Lens by Mail Service

EyeMed

How does the program work?

Three Easy Steps

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

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

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

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

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

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

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

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

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

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

Can I submit expenses from this service as an Out-of-Network claim?

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

OUT-OF-NETWORK BENEFIT

VISION SERVICES	MEMBER REIMBURSEMENT**
Examination with dilation as necessary	Up to $35
Frame:	Up to $50
Lenses (one pair)	
Single Vision	Up to $25
Bifocal	Up to $40
Trifocal	Up to $55
Standard Progressive	Up to $55
Premium Progressive	Up to $55
Contact Lenses (includes materials; only in lieu of lenses)	
Conventional	Up to $92
Disposable	Up to $92
Medically Necessary	Up to $200

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

** Co-payment does not apply

Did you read about...

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

Flexible Spending Accounts

In this section...

- **Flexible Spending Account (FSA) details**
- **Types of FSAs**
- **FSA grace period**
- **Direct Deposit**

What is a Flexible Spending Account?

Fringe Benefits Management Company (FBMC) provides you with IRS tax-favored Flexible Spending Accounts (FSAs) to stretch your health care and dependent care dollars.

Flexible Spending Accounts feature:

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

Is an FSA right for me?

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

- You decide the amount you want deposited.
- You are reimbursed for eligible expenses before income and Social Security taxes are deducted.
- You save income and Social Security taxes each time you receive wages.
- Determine your potential savings with a Tax Savings Analysis by visiting the "Tax Calculators" link at **www.myFBMC.com**.

What types of FSAs are available?

Your employer offers you a Health Care FSA as well as a Dependent Care FSA. If you incur both types of expenses during a plan year, you can establish both types of FSAs.

Health Care FSAs

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

- birth control pills
- eyeglasses
- orthodontia.

Dependent Care FSAs (daycare/elder care)

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

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

Refer to the *Health Care FSA* and *Dependent Care FSA* sections of this Reference Guide for specifics on each type of FSA.

Flexible Spending Accounts

Receiving Reimbursement

Your reimbursement will be processed within five business days from the time FBMC receives your properly completed and signed FBMC Claim Form. To avoid delays, follow the instructions for submitting your requests located in the FSA materials you will receive following enrollment.

Direct Deposit

Enroll in Direct Deposit to expedite the time of your reimbursement.

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

To apply, complete the Direct Deposit Enrollment Form available from your **Enrollment Counselor**, visit **www.myFBMC.com** or call FBMC Customer Care at 1-800-342-8017. Please note that processing your Direct Deposit enrollment may take between four and six weeks.

Where can I get information about FSAs?

If you have specific questions about FSAs, contact FBMC's Customer Care Department.

- Visit **www.myFBMC.com**.
- Call **1-800-342-8017** (Monday - Friday, 7 a.m. - 10 p.m. ET).

Please note that due to FBMC's Privacy Policy, we will not discuss your account information with others without your verbal or written authorization.

FSA Guidelines:

1. The IRS does not allow you to pay your medical or other insurance premiums through either type of FSA.
2. You cannot transfer money between FSAs or pay a dependent care expense from your Health Care FSA or vice versa.
3. You have a 90-day run-out period (until March 31, 2011) at the end of the plan year for reimbursement of eligible FSA expenses incurred during your period of coverage and any applicable grace period within the 2011 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.

FSA Grace Period

A recent IRS Revenue Notice permits a "**grace period**" of two months and 15 days following the end of your 2011 Plan Year (December 31, 2011) for an FSA. This grace period ends on March 15, 2012. **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 2011 Health Care or Dependent Care FSA.

You should not confuse the grace period with the plan's "**run-out period**". The run-out period extends until March 31, 2012. This is a period for filing claims incurred anytime during the 2011 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 by FBMC, and your accounts will be debited accordingly. This is true for both paper claims and FBMC Payment 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.

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 2011 Plan Year. IRS regulations state that any unused funds that remain in your FSA after a plan year and any applicable grace period ends, and all reimbursable requests have been submitted and processed, cannot be returned to you or carried forward to the next plan year.
9. When enrolling in either or both FSAs, written notice of agreement with the following will be required.
   - I will only use my FSA to pay for IRS-qualified expenses eligible under my employer's plan, and only for my IRS-eligible dependents and myself
   - I will exhaust all other sources of reimbursement, including those provided under my employer's plan(s) before seeking reimbursement from my FSA
   - I will not seek reimbursement through any additional source and
   - I will collect and maintain sufficient documentation to validate the foregoing.

Flexible Spending Accounts

What documentation of expenses do I need to keep?

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

How do I get the forms I need?

Log onto **www.myFBMC.com** to obtain:

- FBMC Claim Forms
- Letter of Medical Need
- Direct Deposit Form

For more information, refer to the Getting Answers section of this Reference Guide or call FBMC Customer Care at 1-800-342-8017 for further assistance.

Will contributions affect my income taxes?

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

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information.

FSA Savings Example*

(With FSA)		*(Without FSA)*
$31,000	Annual Gross Income	$31,000
- 5,000	FSA Deposit for Recurring Expenses	- 0
$26,000	Taxable Gross Income	$31,000
- 5,889	Federal, Social Security Taxes	-7,021
$20,111	Annual Net Income	$23,979
- 0	Cost of Recurring Expenses	-5,000
$20,111	Spendable Income	$18,979

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

$1,132!

* Based upon a 22.65% tax rate (15% federal and 7.65% Social Security) calculated on a calendar year.

Did you read about...

- **How an FSA works?**
- **Direct Deposit?**
- **The grace period?**

Health Care FSA

In this section...

- **Whose expenses are eligible**
- **Changes to Over-the Counter Reimbursement**
- **Eligible expenses**
- **How to receive reimbursement**

What is a Health Care FSA?

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

Whose expenses are eligible?

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

- yourself
- your spouse
- your qualifying child or
- your qualifying relative.

An individual is a **qualifying child** if they are not someone else's qualifying child and:

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

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

- have a specified family-type relationship to you, are not someone else's qualifying child and receive more than one-half of their support from you during the taxable year or
- if no specified family-type relationship to you exists, are a member of and live in your household (without violating local law) for the entire taxable year and receive more than one-half of their support from you during the taxable year.

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

Minimum Annual Deposit: $300
Maximum Annual Deposit: $3,500

Visit www.myFBMC.com for a list of frequently asked questions (FAQs). You must keep your documentation for a minimum of one year and submit it to FBMC upon request.

Health Care FSA

Can travel expenses for medical care be reimbursed?

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

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

Are prescriptions eligible for reimbursement?

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

Changes to Over-the-Counter Reimbursement Rules

Under the Patient Protection and Affordable Care Act (PPACA) the rules for reimbursement Over-the-Counter (OTC) items have changed. **Effective January 1, 2011, topical and oral OTC items will no longer be eligible for reimbursement without a prescription or Letter of Medical Need from a physician.** For example this includes such items as Digestive Aids, Allergy and Sinus drugs, Pain relief, Cold medicines, Cough medicines, Laxatives, Motion Sickness and Stomach remedies, Sleep Aids, Cold Sore, Anti-Diarrheal and Anti-Gas meds, Anti-Itch items, Baby Rash creams, Insect Bite treatments, Respiratory Treatments and Anti-Infective medications.

For your convenience, a blank Letter of Medical Need is available for download at **www.myFBMC.com**. **This change applies January 1, 2011, regardless of when your plan year begins.** Be sure to review your enrollment materials carefully and check **www.myFBMC.com** regularly for updates.

Partial List of Medically Necessary Eligible Expenses*

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

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

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

Health Care FSA

Is orthodontic treatment reimbursable?

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

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

Reimbursement of the full or initial payment amount may only occur during the plan year in which the braces are first installed. For reimbursement options available under your employer's plan, including care that extends beyond one or more plan years, refer to the information provided following your enrollment, or call FBMC Customer Care at 1-800-342-8017.

When are my funds available?

Once you sign up for a Health Care FSA and decide how much to contribute, the maximum annual amount of reimbursement for eligible health care expenses will be available throughout your period of coverage.

Since you don't have to wait for the cash to accumulate in your account, you can use it to pay for your eligible health care expenses at the start of your deductions.

Should I claim my expenses on IRS Form 1040?

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

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

Are some expenses ineligible?

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

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

When do I request reimbursement?

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

Health Care FSA

How do I request reimbursement?

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

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

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

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax TOLL-FREE to: 1-866-440-7145

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

Did you read about...

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

myFBMC Card®

In this section...

- **How the myFBMC Card® works**
- **When to submit documentation**
- **myFBMC Card® advantages**
- **"Paper vs. Plastic" comparison**

What is the myFBMC Card®?

The myFBMC Card® is a stored-value card. It is a convenient Medical Expense FSA reimbursement option that allows FBMC to electronically reimburse eligible expenses under your employer's plan and IRS guidelines. Your annual Health Care FSA contribution is available to you at the beginning of your plan year.

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

When do I send in documentation for a myFBMC Card® expense?

You must send in documentation for certain myFBMC Card® transactions, such as those that are **not** a known office visit or prescription co-payments (as outlined in your health plan's Schedule of Benefits). When requested, you must send in documentation for these transactions. Documentation for an myFBMC Card® expense is a statement or bill showing:

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

Note: This documentation must be sent with an ***FBMC Claim Form*** and cannot be processed without it. Like all other FSA documentation, you must keep the myFBMC Card® expense documentation for a minimum of one year, and submit it to FBMC when requested.

As an FSA participant, you should go to **www.myFBMC.com** to see your account information and check for any outstanding myFBMC Card® transactions. If an outstanding transaction appears in **red** on the website or in **blue** in the *Outstanding Transactions Requiring Documentation* section of your monthly statement, you must submit the proper expense documentation to FBMC prior to the end of your run out period.

If you fail to send in the requested documentation for a myFBMC Card® expense, you will be subject to:

- withholding of payment for an eligible paper claim to offset any outstanding myFBMC Card® transaction
- suspension of myFBMC Card® privileges
- Payback through payroll
- the reporting of any outstanding myFBMC Card® transaction amounts as income on your W-2 at the end of the tax year.

What agreement am I making when I use the myFBMC Card®?

By using the myFBMC Card®, you are agreeing to the "FSA Guidelines" portion of this reference guide on page 55.

What are the myFBMC Card® advantages?

- instant **reimbursements** for health care expenses, including prescriptions, co-payments and mail-order prescription services
- instant **approval of some** medical, vision and dental expenses (others require documentation)
- no out-of-pocket expense and
- easy access to your Health Care FSA funds.

Note: You **cannot** use the myFBMC Card® for cosmetic dental expenses or eyeglass warranties.

How do I get a myFBMC Card®?

You will automatically receive the myFBMC Card®. Two cards will be sent to you in the mail; one for you and one for your spouse or eligible dependent. You should keep your cards to use each plan year until their expiration date. You will have to activate your card. Effective January 1, 2011, there is no are no fees for using the card!

myFBMC Card®

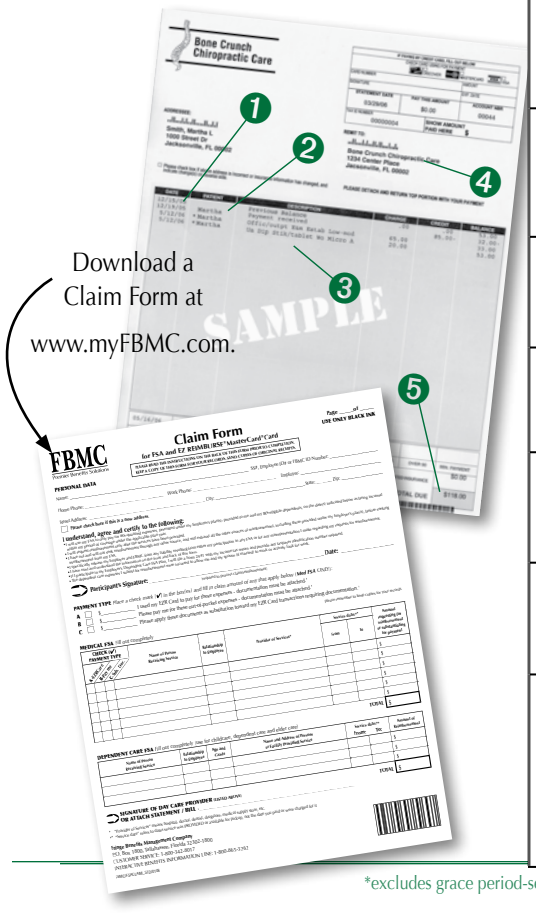
I used the myFBMC Card® at the doctor's office. Now what?

You may not have to do anything; however, when you receive your monthly statement and a transaction is listed in **blue type**, that means it's time to submit documentation. A legible copy of a statement, bill or invoice must be included with your Claim Form with the following information:

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

We've made it easy for you to send in confirmation for your myFBMC Card® purchases. Simply complete the Claim Form and fax or mail it to FBMC with your detailed invoice. You can check the status of your myFBMC Card® transactions online.

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



Download a Claim Form at www.myFBMC.com.

Heath Care FSA Reimbursement Comparison - Plastic vs. Paper!

myFBMC Card®	Paper Reimbursement
• Service must occur during benefit period: 01/01/11 to 12/31/11 • Deadline for services is 12/31/11* • Use it or lose it rule applies	• Service must occur during benefit period: 01/01/11 to 12/31/11 • Deadline for services is 12/31/11* • Use it or lose it applies
• Card can be used for eligible dental, medical and vision services. Insurance is not required, but if you have insurance coverage card may be used after insurance has been utilized. • Dependent expenses are eligible.	• Account can be used for eligible dental, medical and vision services. Insurance is not required. If you have insurance coverage, request reimbursement for out-of-pocket expenses after insurance has been utilized. • Dependent expenses are eligible.
• Claim form and documentation must be submitted to FMBC when using the card (except for certain co-pays) • Co-pays for medical known office visit and prescription services no longer require documentation to be submitted for substantiation. • All documentation should be kept by the employee for up to one year as the IRS requires documentation to be submitted upon their request. • Documentation must be submitted by 03/31/11.	• In order to receive reimbursement, a bill, statement or invoice **must always** accompany your Claim Form. • Documentation must be submitted by 03/31/11.
A card can be suspended when documentation is not received, incomplete, card transaction is deemed ineligible or transaction appears in Blue Print on your monthly FBMC statement for two consecutive statement periods.	Documentation can be accumulated and sent periodically or all at the same time, provided they are sent by the deadline mentioned above and for the current plan year only.
Documentation must include: patient name, type of service, date, provider and total amount. (who, what, when, where and how much)	Documentation must include: patient name, type of service, date, provider and total amount. (who, what, when, where and how much)
Claim Forms must be submitted with documentation. Visit **www.myFBMC.com** to download a claim form.	Claim Forms **must** be submitted in order to receive reimbursement. Visit **www.myFBMC.com** to download a copy.
Card expires 12/31 each year and reloads 01/01 of each year with your new annualized amount. (FSAs require annual re-enrollment.)	Account terminates 12/31 of each year and with new enrollment renews 01/01 of each year.
If your card is suspended due to outstanding card transactions, you will experience a payback deduction through your payroll.	Reimbursement Request is rejected if proper documentation is not provided.
Tax-free savings PLUS no out-of-pocket funds spent, no reimbursement wait time and no money spent on postage.	**Tax-free savings.**
• Example of an eligible payment card expense that does not require documentation: $20 co-pay for medical office visit. • Example of an eligible payment card expense that does require documentation: Purchase eye glasses from Lens Crafters.	Example of eligible reimbursable expense: 10% co-insurance for Outpatient Surgery.

*excludes grace period-see page 55

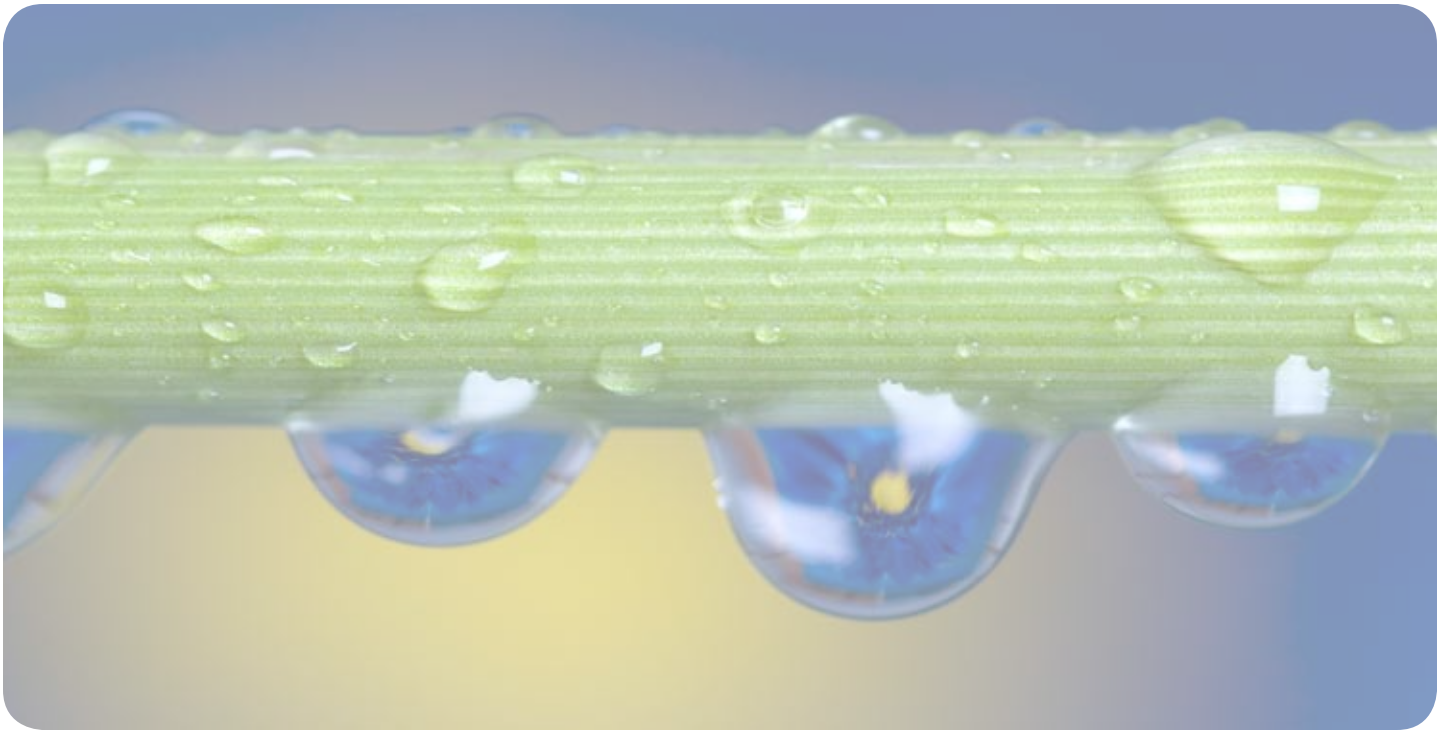
myFBMC Card®

How do I use my myFBMC Card®?

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

What happens if I have money left in my account at the end of the plan year?

As long as you submit a paper FBMC Claim form, the funds left in your account from the prior plan year will be used first until the account has been exhausted — through March 15, 2011, which is the grace period allowed by the IRS. Then subsequent claims will be debited from your new plan year account balance. For more information on the grace period, see page 55.



Did you read about...

- **How the myFBMC Card® works?**
- **When to submit documentation?**
- **How to receive a card?**

Dependent Care FSA

In this section...

- **Eligible Dependent Care expenses**
- **Maximum annual deposit**
- **Ineligible expenses**
- **How to request reimbursement**

What is a Dependent Care FSA?

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

Whose expenses are eligible?

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

A qualifying individual includes a **qualifying child**, if they:

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

A qualifying individual includes your **spouse**, if they:

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

A qualifying individual includes your **qualifying relative**, if they:

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

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

What is my maximum annual deposit?

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

Minimum Annual Deposit: $300
Maximum Annual Deposit: The maximum contribution depends on your tax filing status as the list in column two indicates.

Dependent Care FSA

Partial List of Eligible Expenses*

Before/After school care
Baby-sitting fees
Daycare services (childcare/elder care)
Eldercare services
In-home care/au pair services
Nursery and preschool
Summer day camps

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

When are my funds available?

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

Should I claim tax credits or exclusions?

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

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

To help you choose between the available taxable and tax-free benefits, or a combination of both, consult your tax adviser and/or the IRS for additional information. You may also visit **www.myFBMC.com** to complete a Tax Savings Analysis.

Are some expenses ineligible?

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

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

Will I need to keep any additional documentation?

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

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

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

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

Dependent Care FSA

When do I request reimbursement?

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

How do I request reimbursement?

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

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

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

Mail to: Contract Administrator
Fringe Benefits Management Company
P.O. Box 1800
Tallahassee, FL 32302-1800

Fax TOLL-FREE to: 1-866-440-7145

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

Did you read about...

- **Whose expenses are eligible?**
- **The maximum annual deposit?**
- **How to request reimbursement?**

FSA Leave of Absence (LOA)

Palm Beach LOA-FSA FAQs

Q. Can I continue my Medical Expense 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 Medical Expense FSA (MFSA) on a post-tax basis while on LOA. Although you lose the benefit of tax savings, this approach will keep your MFSA period of coverage active and any eligible expenses you incur while on leave may be submitted to FBMC and reimbursed while you are still on leave.

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

Q. What happens if I revoke my Medical Expense FSA while on Leave?

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

Q. How do I continue my MFSA while on LOA?

A. Participants should contact FBMC Customer Care at 1-800-342-8017 to set up a personal payment plan for their MFSA. Once you go on leave, make your MFSA contribution payments payable to "The School District of Palm Beach County" and mail to:

FBMC-Benefit Continuation
PO Box 730561
Ormond Beach, FL 32173-0561
(Please do not send cash.)

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

A. Because your FSA election is for the entire year, the District will resume taking payroll reductions until the end of the calendar year, UNLESS you have a valid Change in Status event. However, you can always opt out of re-enrolling in a FSA during the next Annual 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.

FSA Worksheets

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

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

HEALTH CARE FSA WORKSHEET

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

UNINSURED MEDICAL EXPENSES

Health insurance deductibles	$ _____
Co-insurance or co-payments	$ _____
Vision care	$ _____
Dental care	$ _____
Prescription drugs	$ _____
Travel costs for medical care	$ _____
Other eligible expenses (including OTCs)	$ _____
TOTAL (amount cannot exceed $3,500)	$ _____
DIVIDE by the number of scheduled deductions remaining in the plan year after your benefits effective date.*	$ _____
This is your pay period contribution.	$ _____

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

DEPENDENT CARE FSA WORKSHEET

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

CHILD CARE EXPENSES

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

ELDER CARE SERVICES

Daycare center	$ _____
In-home care	$ _____
TOTAL Remember, your total contribution cannot exceed IRS limits for the plan year and calendar year.	$ _____
DIVIDE by the number of scheduled deductions remaining in the plan year after your benefit effective date.*	$ _____
This is your pay period contribution.	$ _____

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

At your request, your FSA reimbursement checks may be deposited into your checking or savings account by enrolling in Direct Deposit.

Getting Answers

Getting answers to many of your Flexible Spending Account questions is now easier than ever. FBMC Customer Care offers you a variety of resources to make inquiries about your Flexible Spending Account, including information from the FBMC website, Interactive Voice Response system and Customer Care.

FBMC Web Site

FBMC's website provides comprehensive details about your Flexible Spending Account(s).

By entering **www.myFBMC.com** into your Internet browser, you will open FBMC's homepage. Answers to many of your Flexible Spending Account questions can be obtained by using the following navigational tabs located along the top portion of the homepage.

Account Information

At **www.myFBMC.com**, you'll be prompted to enter your e-mail address and password. After this login, the following menu items will be available to you.

- **My Account Transactions** – allows review of transactions from your current and previous plan years, including run-out period information
- **Account Balance** – gives specifics about account availability, paid amounts and payment status
- **My Claims** – provides information on open and current reimbursement claims such as date received, status and amount authorized
- **FBMC Payment Card** – download a card fact sheet or transmittal form, read detailed instructions on proper use and open our drugstore listings to maximize card convenience.
- **Tax Savings Analysis** – calculates potential per-pay-period and annual tax savings as well as long-term savings (no login required)

Downloading Forms

When you select the '**Download Forms**' tab, a choice of forms, including a Letter of Medical Need, FBMC FSA Claim Form and Direct Deposit Form are posted for your convenience.

Frequently Asked Questions

The '**Frequently Asked Questions**' tab provides answers to many of your general questions regarding Flexible Spending Accounts, and the **FBMC Payment Card**.

FBMC Customer Care

The '**Customer Care**' tab gives you a direct link to the FBMC Customer Care Center.

FBMC Interactive Benefits

FBMC's 24-hour automated phone system, Interactive Voice Response (IVR), can be reached by calling 1-800-865-FBMC (3262). This system allows you to access your Flexible Spending Account any time. By following the voice prompts, you can find out a great deal of information about your benefits.

- Current Account Balance(s)
- Claim Status
- Mailing Address Verification
- Obtain FSA Reimbursement Request Claim Forms
- Change Your FSA access PIN

Be sure to read about the "grace period" that applies to your FSAs (see page 55). It can help you avoid the "Use it or Lose it" rule.

Special Retirement Plan

In this section...

- **Special Retirement Plan description**
- **How much you can contribute**
- **How it works**
- **Investment options**

Plan Provider: BENCOR

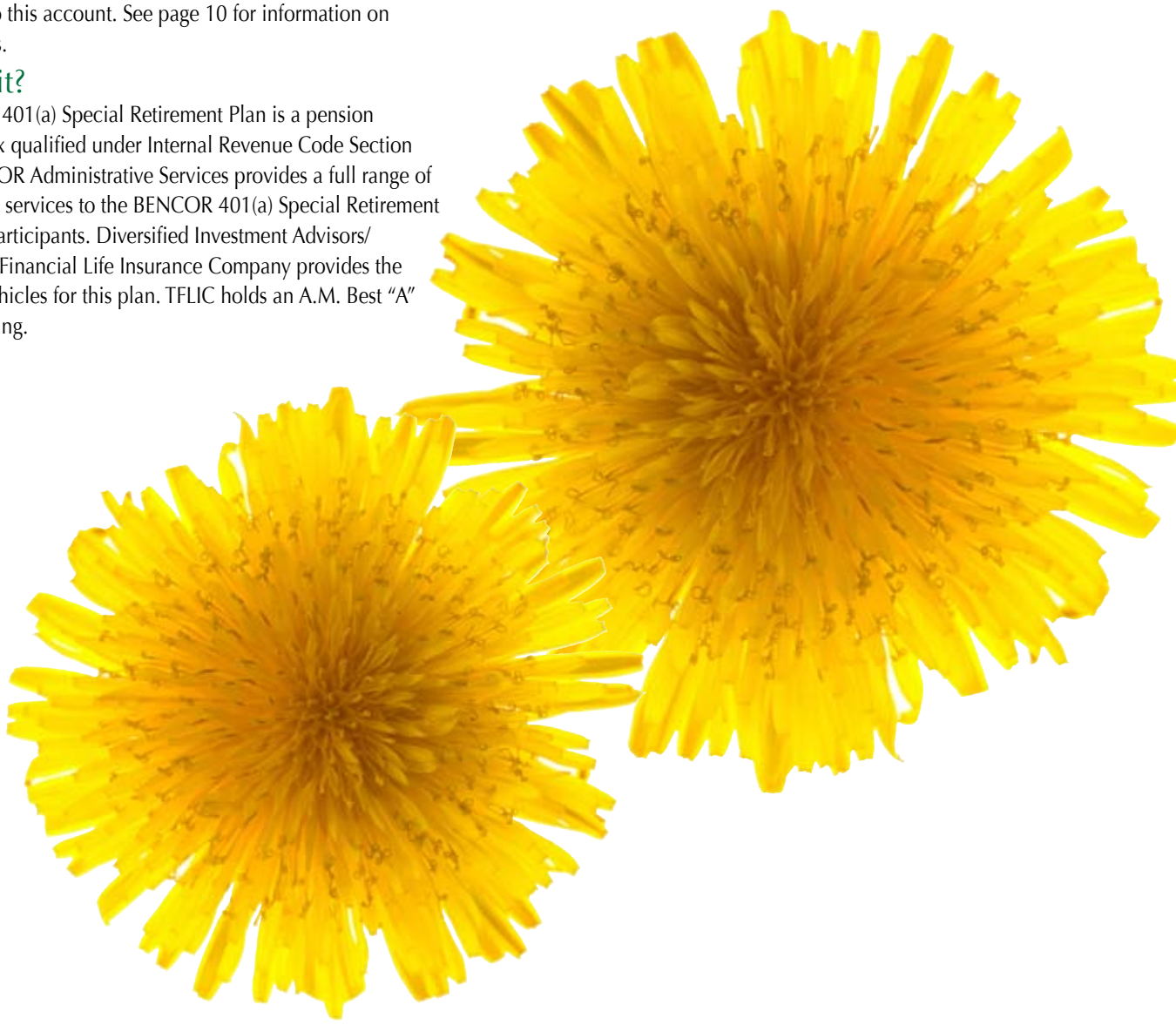
A 401(a) Special Retirement Plan is a benefit option you have as you create your benefits package. Only 401(a) Dollars can be deposited into this account. See page 10 for information on 401(a) Dollars.

What is it?

The BENCOR 401(a) Special Retirement Plan is a pension plan that 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. Diversified Investment Advisors/ Transamerica Financial Life Insurance Company provides the investment vehicles for this plan. TFLIC holds an A.M. Best "A" (Excellent) rating.

How Much Money Can I Contribute?

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



Special Retirement Plan

How Does it Work?

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

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

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

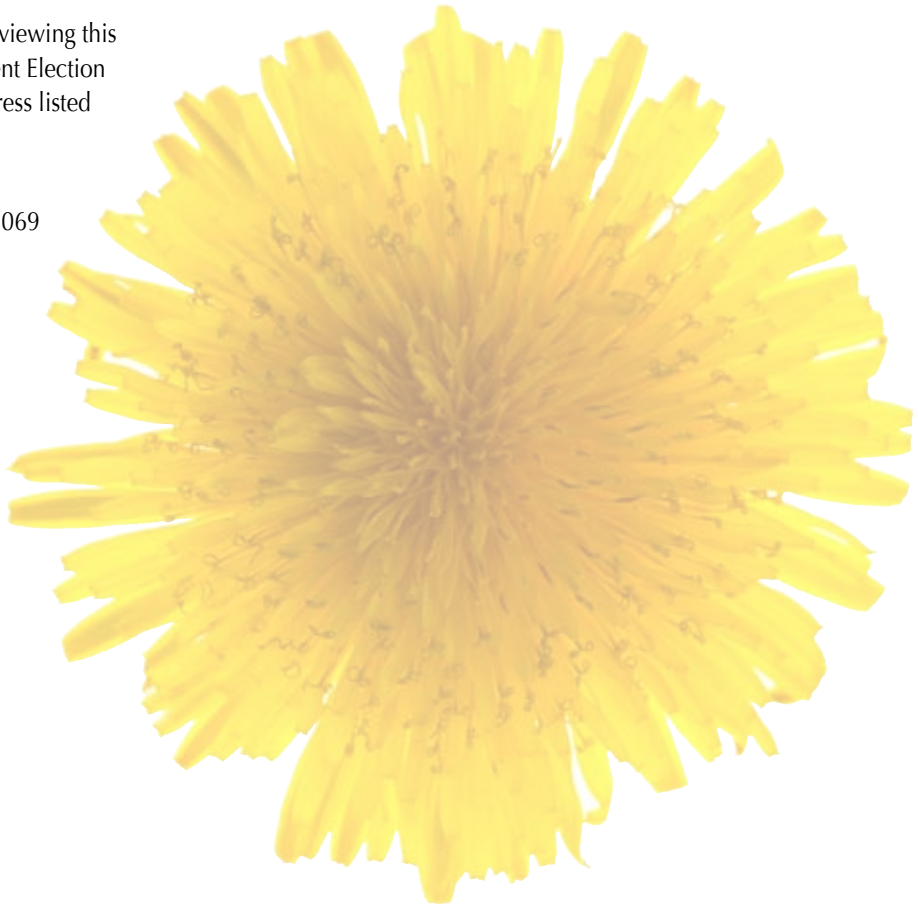
Please review the investment options listed. After reviewing this information, please return your completed Investment Election Form/Beneficiary Form to Bencor's office at the address listed below.

BENCOR ADMINISTRATIVE SERVICES

8488 Shepherd Farm Drive, West Chester, OH 45069
TOLL-FREE: 1-888-258-3422
FAX: (513)671-0651
Website: **www.bencorplans.com**

Enrollment

During the enrollment process you must complete the 401(a) Special Retirement Plan enrollment form and return it to BENCOR. BENCOR will send you statements semi-annually.



Special Retirement Plan

Investment Options

Diversified Investment Advisors is a national investment advisory firm specializing in retirement plans. The company's expertise covers the entire spectrum of defined contribution and defined benefit plans. Headquartered in Purchase, NY, Diversified helps more than 1.5 million participants save and invest wisely through retirement.

TFLIC Guaranteed Pooled Fund[1] seeks to provide maximum yield consistent with a guarantee of principal and interest. The portfolio is a guaranteed separate account of Transamerica Financial Life Insurance Company (TFLIC) that invests in a diverse pool of high quality fixed-income instruments and is offered through a group annuity contract. TFLIC has been rated A by A.M. Best. ***Advisor:*** Galliard Capital Management.

Transamerica Partners High Quality Bond[2,3] invests primarily in high quality debt securities with short and intermediate maturities. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Merganser Capital Management.

Transamerica Partners Core Bond[2,3] invests primarily in investment grade debt securities and U.S. government obligations, mortgage-backed securities guaranteed by U.S. government agencies and instrumentalities and those of private issuers. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** BlackRock Financial Management.

Transamerica Partners High Yield Bond[4] invests in high yield fixed income securities, rated BB or lower (by Moody's and Standard & Poor's rating agencies). ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Eaton Vance Management.

Transamerica Partners Large Value[5] invests primarilyin issuers listed on U.S. exchanges that the Fund's sub-adviser believes are seasoned, liquid and low priced, with effective management and positive momentum. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Aronson+Johnson+Ortiz, LP.

Transamerica Partners Stock Index[5] seeks to match the returns and volatility (risk) of the S&P 500 Equity Index. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Barclays Global Fund Advisors.

Transamerica Partners Large Growth[5] invests in a diversified portfolio of common stocks with the potential for above-average growth in earnings. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Jennison Associates, LLC, Wellington Management Co., and OFI Institutional Asset Management, Inc.

More Options - next page

There is no guarantee that a fund will meet its investment objective. All registered funds are available by prospectus only. The prospectus contains additional information about the funds, including the investment objectives, risks, charges and other expenses. For a prospectus on any of the options listed call 1-888-258-3422. You should consider all such information carefully before investing. Please read the prospectus carefully before you make your investment choices.

1 The Guaranteed Pooled Fund is a pooled separate account offered through Transamerica Financial Life Insurance Company (TFLIC), 440 Mamaroneck Avenue, Harrison, NY 10528, which provides the guarantee of principal and interest.

2 Any US Government guarantees of the securities held in this investment fund only pertain to those securities and not the Fund or its yield.

3 Bonds and bond funds are subject to interest rate risk, credit risk and inflation risk. Interest rate risk means that the value of bonds and bond funds generally falls when interest rates rise, causing an investor to lose money upon sale or redemption.

4 Lower rated high yield corporate debt securities represent a much greater risk of default and tend to be more volatile than higher rated or investment grade bonds.

5 Equity funds invest in equity securities, which include common stock, preferred stock and convertible securities. Because such securities represent ownership in a corporation, they tend to be more volatile than fixed income or debt securities, which do not represent ownership.

Special Retirement Plan

Investment Options

Transamerica Partners Mid Value[6,8] invests in a diversified portfolio of medium size value-oriented companies. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Cramer Rosenthal McGlynn, LLC, and JP Morgan Investment Management.
Transamerica Partners Mid Growth[6,7] invests in a diversified portfolio of medium size, growth-oriented companies. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Columbus Circle Investors.
Transamerica Partners Small Value[6,8] invests in a diversified portfolio of small, high-quality companies selling at large discounts to the underlying value of the business. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Wellington Management Co.
Transamerica Partners Small Growth[6,7] invests in a diversified portfolio of small, growth-oriented or emerging growth companies that are believed to offer above average opportunities for long-term price appreciation. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Perimeter Capital Management.
Transamerica Partners International Equity[9] invests primarily in the stock markets of the United Kingdom, continental Europe, Japan, Canada, and Australia. ***Advisor:*** Transamerica Asset Management, Inc. ***Subadvisor(s):*** Thornburg Investment Management.
Transamerica Asset Allocation-Short[10] seeks to attain its objective by investing in an array of Transamerica Partners' Funds. The primary emphasis is on fixed income funds with limited exposure to equity funds. ***Advisor:*** Transamerica Asset Management, Inc.
Transamerica Asset Allocation-Short/Intermediate[10] seeks to provide consistent returns with reduced volatility by investing in an array of Transamerica Partners' Funds. The portfolio invests in a combination of both fixed income and equity funds, maintaining limited exposure to the equity funds. ***Advisor:*** Transamerica Asset Management, Inc.
Transamerica Asset Allocation-Intermediate[10] seeks to provide greater potential for long-term return at moderate risk levels by investing in an array of Transamerica Partners' Funds. The portfolio invests in a combination of both fixed income and equity funds, maintaining approximately equal exposure to both asset classes. ***Advisor:*** Transamerica Asset Management, Inc.
Transamerica Asset Allocation-Intermediate/Long[10] seeks to provide greater opportunity for long-term return at higher risk levels by investing in an array of Transamerica Partners' Funds. The portfolio invests in a combination of equity and fixed income funds, with the greater emphasis on equity funds. ***Advisor:*** Transamerica Asset Management, Inc.
Transamerica Asset Allocation-Long Strategic Allocation Fund[10] seeks to attain its objective by investing in an array of Transamerica Partners' Funds with an emphasis on equity funds. The Fund has limited exposure to a variety of fixed income funds. ***Advisor:*** Transamerica Asset Management, Inc.

6 The securities of small and medium-sized companies, because of the issuers' lower market capitalization, may be more volatile than those of large companies.

7 Growth stocks tend to be more volatile than stocks that have below market valuations.

8 Value-based investments are subject to the risk that the broad market may not recognize their intrinsic values.

9 Foreign securities and markets pose different and possibly greater risks than those customarily associated with domestic securities, including currency fluctuations and political instability.

10 The Transamerica Asset Allocation Funds invest in combinations of the funds of the Transamerica Partners Funds Group, as determined by Transamerica Asset Management, Inc. ("TAM") based on each Fund's investment objective. The Asset Allocation Funds bear investment management fees in addition to the investment management fees and expenses of the underlying funds in which they invest.

Diversified Investors Securities Corp. (DISC), 440 Mamaroneck Avenue, Harrison, NY 10528, distributes securities products. Any fund offered under the plan is distributed by that particular fund's associated fund family and its affiliated broker-dealer or other brokerdealers with effective selling agreements such as DISC. If the Transamerica Funds, Transamerica Partners Funds, or Transamerica Premier Funds (collectively, the Transamerica Funds) are offered under the plan, the Transamerica funds are distributed by Transamerica Capital, Inc. (TCI) and are advised by Transamerica Asset Management (TAM). The Guaranteed Pooled Fund is made available under a group annuity contract issued by Transamerica Financial Life Insurance Company (TFLIC), 440 Mamaroneck Avenue, Harrison, NY 10528. Diversified, TAM, TCI, TFLIC and DISC are affiliated companies, but are not affiliated with BENCOR, Galliard nor any of the sub-advisors.

BENCOR INC.

BENCOR National Government Employees Retirement Plan Enrollment Form

SPECIAL RETIREMENT PLAN

GENERAL INFORMATION

Employer: THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Worksite Location: _____

Address: _____

City: _____ State: _____ Zip: _____

Participant Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____

Telephone #: _____

BENEFICIARY DESIGNATION

Participant Primary Beneficiary: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____

Relationship: _____

% Share: _____

Participant Contingent Beneficiary: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____

Relationship: _____

% Share: _____

Participant Contingent Beneficiary: _____

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Date of Birth: _____

Relationship: _____

% Share: _____

☐ Married Participant

I understand that I must select my spouse as sole Primary Beneficiary under this Plan unless he/she consents in writing to my naming another Primary Beneficiary. (Please contact BENCOR Administrative Services for a Spousal Consent form if naming a Primary Beneficiary other than your spouse.)

☐ Unmarried Participant

I understand that the following designation becomes null and void in the event of my marriage. I will promptly inform BENCOR of any change in my marital status.

I understand that if I outlive my Primary Beneficiary, benefits will be paid to my estate on my death unless I designate a Contingent Beneficiary(ies). (If additional space is required, please attach a separate page providing all designation information and the percentage share for each.)

Signature _____ Date _____

INVESTMENT ELECTION

Please ensure that the investment instructions provided below are accurate. We will be relying on your instructions to allocate your contributions. Please note that investment allocation percentages must total 100%.

All funds are deposited into the Guaranteed Pooled Fund unless you select other investment options below.

The investment allocation indicated below is for :

☐ Current Investments
☐ Future Investments
☐ Both Current & Future Investments

Withdrawals due to Employer-initiated events may be subject to restrictions and/or adjustments.

Stable Value Fund

_____ % TFLIC Guaranteed Pooled Fund

Stock Funds

_____ % Transamerica Partners Value Fund
_____ % Transamerica Partners Stock Index Fund
_____ % Transamerica Partners Large Core
_____ % Transamerica Partners Large Growth Fund
_____ % Transamerica Partners Mid Value Fund
_____ % Transamerica Partners Mid Growth Fund
_____ % Transamerica Partners Small Value Fund
_____ % Transamerica Partners Small Growth Fund
_____ % Transamerica Partners International Equity Fund

Multi-Asset Funds

_____ % Transamerica Asset Allocation-Short Horizon Fund
_____ % Transamerica Asset Allocation Short/Intermediate Fund
_____ % Transamerica Asset Allocation-Intermediate Horizon
_____ % Transamerica Asset Allocation-Intermed/Long Horizon
_____ % Transamerica Asset Allocation-Long Horizon

Bond Funds

_____ % Transamerica Partners Total Return Bond
_____ % Transamerica Partners High Yield Bond

100 % Total

Please return completed form to:

BENCOR Administrative Services, Inc.
8488 Shepherd Farm Drive
West Chester, Ohio 45069

For a prospectus on any of the options listed above or for customer service call **1-888-258-3422.**

Information

FRAUD WARNING

In some states, we are required to advise you of the following:

Florida Residents Only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicable to everyone, except Florida, New York, Oregon and Virginia Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and subjects such person to criminal and substantial civil penalties.

Special Retirement Plan

Annualized Rates of Return for Period Ending June 30, 2011

The performance figures represent past performance. Past performance does not guarantee future results. The investment return and principal value of an investment will fluctuate so that investor's shares, when redeemed, may be worth more or less than their original cost. Current performance may be lower or higher than the performance data quoted. Visit www.bencorplans.com to obtain performance data current to the most recent month-end and quarter-end.

— FUND —	1 YEAR	3 YEARS	5 YEARS	10 YEARS/ INCEPTION	INCEPTION DATE
STOCK FUNDS					
Transamerica Partners Large Value[1,2]	13.21%	-17.34%	-5.21%	0.50%	July 94
Transamerica Partners Stock Index Fund[1]	13.85%	-10.29%	-1.37%	-2.19%	April 99
Transamerica Partners Large Core[1]	9.75%	-12.19%	-3.07%	-5.29%	July 94
Transamerica Partners Large Growth[1,3]	14.01%	-7.69%	-1.43%	-4.73%	July 94
Transamerica Partners Mid Value[4,2]	19.00%	-10.17%	0.13%	5.88%	Aug 01
Transamerica Partners Mid Growth[4,3]	18.50%	-7.12%	0.40%	1.53%	Sep 01
Transamerica Partners Small Value[5,2]	21.36%	-9.26%	-3.01%	2.48%	July 02
Transamerica Partners Small Growth[5,3]	13.27%	-8.92%	-0.53%	4.93%	Aug 02
Transamerica Partners International Equity[6]	9.77%	-17.06%	-1.69%	-2.49%	Jan 96
MULTI-ASSET FUNDS					
Transamerica Asset Allocation - Short Horizon[9]	12.61%	4.18%	4.07%	4.66%	June 96
Transamerica Asset Allocation - Short/Intermediate Horizon[9]	12.98%	0.27%	2.61%	3.09%	May 98
Transamerica Asset Allocation - Intermediate Horizon[9]	13.18%	-3.38%	1.28%	1.69%	June 96
Transamerica Asset Allocation - Intermediate/Long Horizon[9]	13.86%	-7.10%	-0.22%	0.25%	June 96
Transamerica Asset Allocation - Long Horizon[9]	13.79%	-10.98%	-1.91%	-1.89%	May 98
BOND FUNDS					
Transamerica Partners Total Return Bond[7,8]	12.70%	7.07%	4.95%	5.65%	July 94
Transamerica Partners High Yield Bond[8,11]	26.30%	4.33%	6.03%	6.82%	Jan 96
STABLE FUND					
TFLIC Guaranteed Pooled[12]	The minimum guaranteed interest rate for calendar year 2011 is 3.00%				

1 Equity funds invest in equity securities, which include common stock, preferred stock and convertible securities. Because such securities represent ownership in a corporation, they tend to be more volatile than fixed income or debt securities, which do not represent ownership.

2 Value-based investments are subject to the risk that the broad market may not recognize their intrinsic values.

3 Growth stocks tend to be more volatile than stocks that have below market valuations.

4 The securities of medium-sized companies, because of the issuers' lower market capitalization, may be more volatile than those of large companies.

5 The securities of small-sized companies, because of the issuers' lower market capitalizations, may be more volatile than those of large or medium-sized companies.

6 Foreign securities and markets pose different and possibly greater risks than those customarily associated with domestic securities, including currency fluctuations and political instability.

7 Any US Government guarantees of the securities held in this investment fund only pertain to those securities and not the Fund or its yield.

8 Bonds and bond funds are subject to interest rate risk, credit risk and inflation risk. Interest rate risk means that the value of bonds and bond funds generally falls when interest rates rise, causing an investor to lose money upon sale or redemption.

9 Asset allocation funds are subject to the risks of the underlying funds in which they invest. To the extent the fund invests more of its assets in stock investments, and in particular, small-cap stocks and/or foreign stocks, it will be subject to greater risk than a fund investing more of its assets in bond funds. The Asset Allocation Funds bear investment management fees in addition to the investment management fees and expenses of the underlying funds in which they invest.

10 Market values of inflation-protected securities can be affected by changes in the market's inflation expectations or changes in real rates of interest.

11 Lower rated high yield corporate debt securities represent a much greater risk of default and tend to be more volatile than higher rated or investment grade bonds.

12 The Guaranteed Pooled Fund is a pooled separate account offered through Transamerica Financial Life Insurance Company (TFLIC), 440 Mamaroneck Avenue, Harrison, NY 10528, which provides the guarantee of principal and interest.TFLIC's claims paying ratings are: Standard & Poor's: AA: (Very Strong); Moody's: A1: (Good); A.M. Best: A: (Excellent)

3 Mortgage-backed securities are subject to prepayment risk and may be sensitive to changes in prevailing interest rates.

Certain performance data for such funds are provided by independent firms that track the investment industry (such as Lipper, Inc.), or from the fund family itself. Although data are gathered from sources believed to be reliable, neither the independent tracking firms nor Diversified can guarantee the completeness, accuracy, timeliness or reliability of the data. All data are historical and subject to change at any time. Independent tracking firms may use different methodologies for providing mutual fund performance information. The independent tracking firms reserve all rights in their respective proprietary data.

Diversified's presentation of performance information for the non-Transamerica Partners funds, if any, is for informational purposes only and should not be construed as an endorsement or recommendation by Diversified nor be the basis of any investment decision. Depending on the particular non Transamerica Partners , Diversified or its affiliate may receive remuneration from the fund family (or its service provider) for providing certain recordkeeping or other administrative services.

The Transamerica Asset Allocation Funds invest in combinations of the funds of the Transamerica Partners Funds Group, as determined by Transamerica Asset Management, Inc. ("TAM") based on each Fund's investment objective. The Asset Allocation Funds bear investment management fees in addition to the investment management fees and expenses of the underlying funds in which they invest.

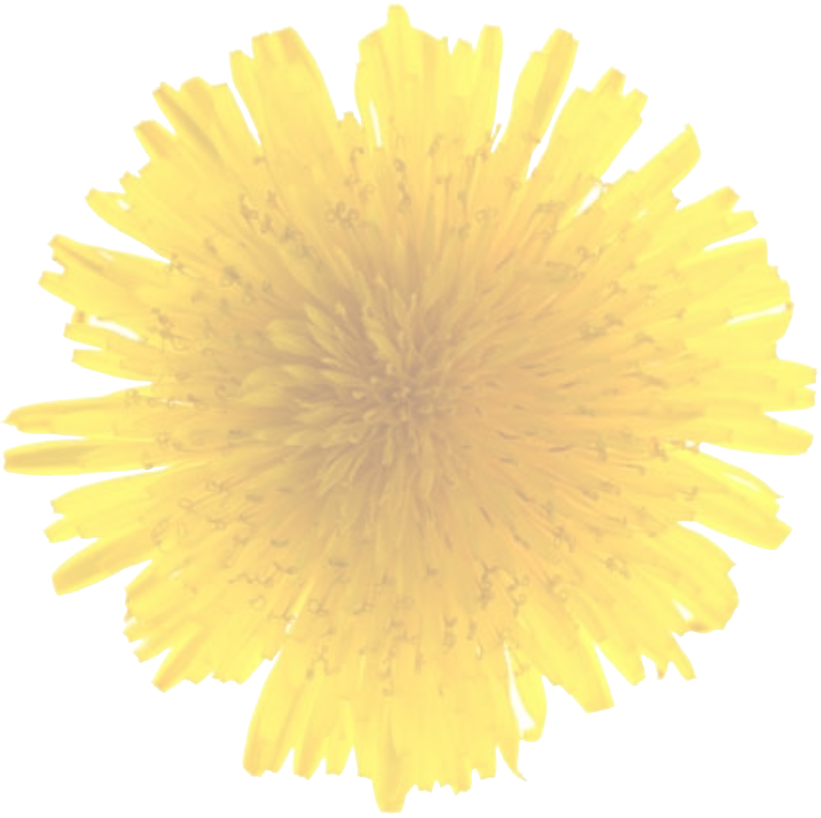
Special Retirement Plan

All registered investment funds are available by prospectus only. A prospectus may be obtained by contacting 1-888-258-3422. The prospectus contains additional information about the funds, including the investment objectives, risks, charges, and other expenses. You should consider all such information carefully before investing. Please read the prospectus carefully before you make your investment choices.

Diversified Investors Securities Corp. (DISC), 440 Mamaroneck Avenue, Harrison, NY 10528, distributes securities products. Any fund offered under the plan is distributed by that particular fund's associated fund family and its affiliated broker-dealer or other broker-dealers with effective selling agreements such as DISC. If the Transamerica Funds, Transamerica Partners Funds, or Transamerica Premier Funds (collectively, the Transamerica Funds) are offered under the plan, the Transamerica funds are distributed by Transamerica Capital, Inc. (TCI) and are advised by Transamerica Asset Management (TAM). If any stable, fixed or guaranteed funds are offered under the plan by Diversified, these funds are made available under a group annuity contract issued by Transamerica Financial Life Insurance Company (TFLIC), 440 Mamaroneck Avenue, Harrison, NY 10528. Diversified, TAM, TCI, TFLIC and DISC are affiliated companies, but are not affiliated with BENCOR.

The total rates of return for the Funds are calculated in accordance with SEC regulations for performance advertising. Performance reflects historical investment results (including changes in share price and reinvestment of dividends and capital gains) less charges and deductions of The Diversified Funds Group (including those of the underlying Core Funds). Returns are annualized. For certain funds, certain fees may have been waived or expenses advanced during the periods shown. Without such waivers or advance of expenses, the total returns shown would have been lower. Additionally, the employer's retirement plan may also assess an administrative fee, which would reduce the performance data quoted.

Each of the funds of the Transamerica Partners Funds Group (other than the Stock Index Fund) is available through a Core Fund & Feeder structure, under which each such 'Feeder' fund invests in a 'Core Fund' with a corresponding investment objective. The Feeder funds are separate series of a registered investment management company. The Core Funds are registered investment management companies. For Funds showing inception dates prior to 1996 (other than the High Yield Bond Fund), the underlying Core Funds were established on January 3, 1994 (except the International Equity Core Fund which was established in October of 1995) when corresponding pooled separate accounts of MONY Life Insurance Company (formerly, The Mutual Life Insurance Company Of New York) (the "predecessor pooled separate account(s)") with corresponding investment objectives, policies and restrictions contributed all of their assets to such investment management companies. These investment management companies thereupon became available for investment by certain institutional investors, including mutual funds. All other Core Funds were established on the inception dates shown and do not have predecessor pooled separate accounts. Fund returns for the periods prior to the commencement of operations are hypothetical and are based on the historical data from the Core Funds and, if applicable, the predecessor pooled separate accounts. The predecessor pooled separate accounts were not registered under the Investment Company Act of 1940 and, therefore, were not subject to certain investment restrictions imposed by that Act. If the predecessor pooled separate accounts had been registered under the Act, performance might have been adversely affected. Stock Index Fund returns for periods prior to the commencement of operations are hypothetical and are based on the historical data from the S&P 500 Index Master Investment Portfolio, established on August 31, 1993. Other classes of shares, with different fee structures, may be available from the Funds depending on the retirement plan investor status. Transamerica Asset Management, Inc. ("TAM") is the investment advisor to each of the Core Funds and has the ability to appoint sub-advisors to manage the portfolio of each Core Fund.



Did you read about...

- **How the plan works?**
- **How much you can contribute?**
- **Investment options?**

Disability Income Protection

Post-tax Benefits

In this section...

- **Eligibility**
- **Plan provisions**
- **Short and Long-Term options**
- **Additional benefits**

Plan Provider: Hartford Life and Accident Insurance Company

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

You may select the Short Term Disability plan (STD) or Long Term Disability plan (LTD), or both. These benefits work in conjunction with and not in addition to sick leave. Premiums are based on your age and salary and will be updated as your salary changes. See your Enrollment Counselor to obtain rate information.

Eligibility

The Voluntary Disability Program is available to employees who:

- are actively at work
- work full time or at least 20 hours per week for all regular employees or 18.75 hours per week for those in the CTA bargaining group
- meet the eligibility requirements of the School District.

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

Earning/Salary Definition

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

- degree supplements
- complexity level supplements
- shift differentials
- supervisory supplements and certifications
- other salary included in the Districts Multiple Components of Pay

Please refer to the disability plan document for further information.

Provisions Affecting Both Plans

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

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

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

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

Benefits for mental illness, alcoholism, or drug abuse – Benefits are payable for a limited period. See your Certificate(s) of Coverage for details.

Disability Income Protection

About the Plan Provider

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

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

Short-Term Disability Plan

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

	Benefit Amount	Benefit Begins	
OPTION	% OF WEEKLY INCOME	ACCIDENT	SICKNESS
A	66 ⅔%	1st day*	8th day*
B	60%	15th day*	15th day*
C	60%	61st day*	61st day*

*Except as otherwise stated in your policy.

What's Not Covered

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

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

When Coverage Ends

Coverage ends on the earliest of:

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

unless continued in accordance with any of the Continuation Provisions.

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

Pre-existing Limitation – The Short Term Disability plan contains a pre-existing condition limitation which will pay benefits for any disability that results from or is caused or contributed to by a pre-existing condition for four weeks, unless at the time you became disabled:

- You have not received medical care for the condition for 6 months while insured under the policy or
- You have been continuously insured under the policy for 12 months

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

Disability Income Protection

When to Submit a Short Term Disability Claim

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

How to Submit a Short Term Disability Claim

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

Long-Term Disability Plan

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

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

How Long are Benefits Payable?

Age at Disability	Benefit Duration
Prior to Age 63	To Normal Retirement Age (NRA) or 42 months if greater
63	To NRA or 36 months if greater
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 & over	12 months

What is the Definition of Disability?

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

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

What's Not Covered

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

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

Disability Income Protection

When Coverage Ends

Coverage ends on the earliest of:

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

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

- You have not received medical care for the condition for 6 months while insured under the policy or
- You have been continuously insured under the policy for 12 months

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

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

When to Submit a Long Term Disability Claim

If you have enrolled for Short –Term Disability, the transition process to Long-Term Disability is automated – you do not need to file a separate Long-Term Disability claim form.

If you have not enrolled in the Short-Term Disability plan and have enrolled in the Long-Term Disability plan only, you should file your claim with The Hartford half-way through your LTD elimination period.

How to Submit a Long-Term Disability Claim

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

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

What Benefits are Included in Long-Term Disability?

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

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

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

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

Disability Income Protection

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

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

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

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

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

Additional Benefits Included with the LTD Plan

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

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

Pre Trip Planning includes:

- Visa, Passport, inoculation and Immunization Requirements
- International "Hot Spots"
- Travel Advisories
- Foreign Exchange Rates
- Embassy and Consular Referrals

Emergency Medical Assistance includes:

- Medical Referrals, Medical Monitoring, and Medical Evacuation
- Repatriation
- Traveling Companion and Dependent Children Assistance
- Emergency Medical Payments
- Return of Mortal Remains
- Replacement of Medication and Eyeglasses

Emergency Personal Services includes:

- Sending and Receiving Emergency Messages
- Emergency Travel Arrangements
- Emergency Cash
- Locating Lost Items
- Legal Assistance
- Bail Advancement
- Translation

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

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

To view or print a copy of a Certificate of Coverage, log on to **www.palmbeach.schools.org/riskmgmt.**

Disability Income Protection

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

SHORT TERM DISABILITY

Sample Payroll Deductions & Benefits - 2011 Rates

Based on Bi-Monthly Payroll with 24 Payroll Deductions Per Year

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

LONG TERM DISABILITY

Sample Payroll Deductions & Benefits - 2011 Rates

Based on Bi-Monthly Payroll with 24 Payroll Deductions Per Year

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

Disability Income Protection

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

Voluntary Disability Program

How to Estimate Payroll Deduction – Based on **24** Payroll Deductions per year

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

EXAMPLE:	Short Term Disability	Long Term Disability
A. Enter Annual Salary	$20,000.00	$20,000.00
B. Divide by 100	$200.00	$200.00
C. Multiply by your appropriate rate below ($.89)	$178.00	$16.00
D. Divide by 24	$7.42	$ .67

Short Term Disability Rates

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

Long Term Disability Rates

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

Note: Rates effective January 1, 2011

Disability Income Protection

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

SHORT TERM DISABILITY															
Sample Payroll Deductions & Benefits - 2011 Rates															
Based on Bi-Monthly Payroll with 22 Payroll Deductions Per Year															
	PLAN A					PLAN B					PLAN C				
Annual Salary	Weekly Benefit Amount	EMPLOYEE'S AGE				Weekly Benefit Amount	EMPLOYEE'S AGE				Weekly Benefit Amount	EMPLOYEE'S AGE			
		54 & Under	55 - 59	60 - 64	65 & Over		54 & Under	55 - 59	60 - 64	65 & Over		54 & Under	55 - 59	60 - 64	65 & Over
$20,000	$256	$8.09	$10.64	$12.18	$14.82	$231	$5.55	$7.27	$8.27	$10.18	$231	$4.36	$5.82	$6.64	$8.09
25,000	321	$10.11	$13.30	$15.23	$18.52	$289	$6.93	$9.09	$10.34	$12.73	$289	$5.45	$7.27	$8.30	$10.11
30,000	385	$12.14	$15.95	$18.27	$22.23	$346	$8.32	$10.91	$12.41	$15.27	$346	$6.55	$8.73	$9.95	$12.14
35,000	449	$14.16	$18.61	$21.32	$25.93	$404	$9.70	$12.73	$14.48	$17.82	$404	$7.64	$10.18	$11.61	$14.16
40,000	513	$16.18	$21.27	$24.36	$29.64	$462	$11.09	$14.55	$16.55	$20.36	$462	$8.73	$11.64	$13.27	$16.18
45,000	577	$18.20	$23.93	$27.41	$33.34	$519	$12.48	$16.36	$18.61	$22.91	$519	$9.82	$13.09	$14.93	$18.20
50,000	641	$20.23	$26.59	$30.45	$37.05	$577	$13.86	$18.18	$20.68	$25.45	$577	$10.91	$14.55	$16.59	$20.23
55,000	705	$22.25	$29.25	$33.50	$40.75	$635	$15.25	$20.00	$22.75	$28.00	$635	$12.00	$16.00	$18.25	$22.25
60,000	769	$24.27	$31.91	$36.55	$44.45	$692	$16.64	$21.82	$24.82	$30.55	$692	$13.09	$17.45	$19.91	$24.27
65,000	833	$26.30	$34.57	$39.59	$48.16	$750	$18.02	$23.64	$26.89	$33.09	$750	$14.18	$18.91	$21.57	$26.30
70,000	897	$28.32	$37.23	$42.64	$51.86	$808	$19.41	$25.45	$28.95	$35.64	$808	$15.27	$20.36	$23.23	$28.32
75,000	962	$30.34	$39.89	$45.68	$55.57	$865	$20.80	$27.27	$31.02	$38.18	$865	$16.36	$21.82	$24.89	$30.34
80,000	1,026	$32.36	$42.55	$48.73	$59.27	$923	$22.18	$29.09	$33.09	$40.73	$923	$17.45	$23.27	$26.55	$32.36

LONG TERM DISABILITY										
Sample Payroll Deductions & Benefits - 2011 Rates										
Based on Bi-Monthly Payroll with 22 Payroll Deductions Per Year										
Annual Salary	Monthly Benefit Amount	EMPLOYEE'S AGE								
		24 & Under	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 & Over
$20,000	$1,000	$0.73	$1.00	$1.55	$2.45	$3.45	$4.64	$6.36	$7.45	$7.82
25,000	1,250	$0.91	$1.25	$1.93	$3.07	$4.32	$5.80	$7.95	$9.32	$9.77
30,000	1,500	$1.09	$1.50	$2.32	$3.68	$5.18	$6.95	$9.55	$11.18	$11.73
35,000	1,750	$1.27	$1.75	$2.70	$4.30	$6.05	$8.11	$11.14	$13.05	$13.68
40,000	2,000	$1.45	$2.00	$3.09	$4.91	$6.91	$9.27	$12.73	$14.91	$15.64
45,000	2,250	$1.64	$2.25	$3.48	$5.52	$7.77	$10.43	$14.32	$16.77	$17.59
50,000	2,500	$1.82	$2.50	$3.86	$6.14	$8.64	$11.59	$15.91	$18.64	$19.55
55,000	2,750	$2.00	$2.75	$4.25	$6.75	$9.50	$12.75	$17.50	$20.50	$21.50
60,000	3,000	$2.18	$3.00	$4.64	$7.36	$10.36	$13.91	$19.09	$22.36	$23.45
65,000	3,250	$2.36	$3.25	$5.02	$7.98	$11.23	$15.07	$20.68	$24.23	$25.41
70,000	3,500	$2.55	$3.50	$5.41	$8.59	$12.09	$16.23	$22.27	$26.09	$27.36
75,000	3,750	$2.73	$3.75	$5.80	$9.20	$12.95	$17.39	$23.86	$27.95	$29.32
80,000	4,000	$2.91	$4.00	$6.18	$9.82	$13.82	$18.55	$25.45	$29.82	$31.27

Disability Income Protection

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

Voluntary Disability Program

How to Estimate Payroll Deduction – Based on **22** Payroll Deductions per year

	Short Term Disability	Long Term Disability
A. Enter Annual Salary	$_____	$_____
B. Divide by 100	$_____	$_____
C. Multiply by your appropriate rate below	$_____	$_____
D. Divide by 22 (number of payroll deductions/yr)	$_____	$_____

EXAMPLE:	Short Term Disability	Long Term Disability
A. Enter Annual Salary	$20,000.00	$20,000.00
B. Divide by 100	$200.00	$200.00
C. Multiply by your appropriate rate below ($.89)	$178.00	$16.00
D. Divide by 22	$8.09	$ .73

Short Term Disability Rates

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

Long Term Disability Rates

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

Note: Rates effective January 1, 2011

Did you read about...

- **How the plan works?**
- **Coverage levels?**
- **Short and Long-Term options?**

Group Term Life

Post-tax Benefits

In this section...

- **Basic Life features**
- **Optional insurance**
- **Personal Accident insuarance**
- **Dependent Life features**

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

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

- Basic Life and Personal Accident Insurance (Employer Paid)
- Optional Life Insurance and Personal Accident Insurance (Employee Paid)
- Spouse Life and Personal Accident Insurance (Employee Paid)
- Dependent Life Insurance (Employee Paid)

Please Note: The Eligibility Waiting Period for both Basic Life and Accident is the 1st day of the month following 30 days of employment for both current and new employees.

You must submit a completed Statement of Health form directly to the Life Insurance Company of North America to the address noted below by December 7, 2010. Submission of an incomplete application will not extend the deadline.

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

Basic Life Insurance

Protecting your family's future is no doubt one of your highest priorities. One way to help achieve this goal is through life insurance. Your employer provides you with a valuable Basic Life Insurance plan at no cost to you.

What are my Basic Life Insurance benefits?

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

What are the Basic Life Insurance features?

- Conversion
- Accelerated Benefits
- Waiver of Premium

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

Exclusion - This plan will not pay benefits if loss of life is the result of suicide that occurs within the first two years of coverage.

Dependent Children

Coverage available: life insurance only

Amount of Coverage available: For dependent child(ren) from age 6 months to 19 years, or 25 years of age if a student and who is primarily financially supported by employee

Personal Accident Insurance Coverage

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

What benefits are available?

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

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

Two Options are available:

Life insurance only

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

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

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

Group Term Life

Post-tax Benefits

Optional Insurance

What benefits are available?

In addition to your Basic Life Benefits, your employer is offering the opportunity to purchase additional term life insurance protection through the Life Insurance Company of North America's Optional Life Insurance program. This benefit is designed to help provide financial security for you and your family. Since this coverage is an employee-paid benefit, premiums will be conveniently deducted from your paycheck post-tax. The monthly cost of both Optional Life and Personal Accident Insurance is only $3.28 per $20,000 of coverage.

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

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

Guaranteed Issue: New Hires

At the time of hire and during the benefit selection process, a new hire employee may select up to five (5) times their basic annual salary in $20,000 increments, not to exceed $500,000, with a minimum selection amount of $20,000. A Statement of Health form is required for coverage exceeding $100,000. The

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

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

- Live Birth to 6 months: $1,500
- 6 months to 19 years (25 if full time student): $5,000 or $10,000

During Annual Enrollment

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

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

What are the Optional Life Insurance features?

- Conversion
- Accelerated Benefits
- Will Preparation Services
- Waiver of Premium

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

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

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

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

Group Term Life

Post-tax Benefits

Personal Accident Insurance

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

What benefits are available?

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

What are the Personal Accident Insurance features?

- ***For Wearing a Seat belt and Protection by an Airbag*** - Death benefits will be increased by 10%, but not by more than $25,000, if the insured person dies as a direct result of injuries in a covered automobile accident while wearing a properly fastened seat belt. We will increase the death benefit by an additional 5%, but not more than $10,000, if the insured person was in a seat protected by a properly functioning and deployed airbag.
- ***For Child Care Expense*** - We will pay a benefit for a surviving child under 13 who is enrolled in a licensed child care center at the time of the accident or within 90 days afterward. This benefit is 3% of the benefit amount, to a maximum of $3,000 a year for 4 straight years or until the child turns 13, whichever occurs first.
- ***For Home Alteration and Vehicle Modification*** - If you or your insured spouse requires home alteration or vehicle modification within one year of a covered accident, we will pay 10% of your benefit amount, to a maximum of $25,000, for alterations or modifications that are physician-certified as necessary for an independent lifestyle.
- ***For Rehabilitation*** - If you or your insured spouse incurs rehabilitative expenses within two years of a covered loss, we will pay an additional 5% of the benefit amount, up to $10,000, for each covered accident.
- ***For Furthering Education*** - If you die in a covered accident, we will pay an extra benefit for each insured child who is enrolled in a school of higher learning or is in the 12th grade and enrolls within one year of the accident. We will increase your benefit amount by 3%, up to $3,000, for each qualifying child. This benefit is payable each year for four consecutive years as long as your children continue their education. If there is no qualifying child, we will pay an additional $1,000 to your beneficiary.
- ***For Training for Your Spouse*** - If you die in a covered accident and your insured spouse enrolls, within three years of your death, in an accredited school to gain skills needed for employment, we will pay the actual cost of this education or training program, up to 3% of your benefit amount, not to exceed $3,000.

Rates (Monthly)

Optional Life & Accident Insurance

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

How Much Coveage Can I Buy?

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

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

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

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

What is not covered?

(1) self-inflicted injuries or suicide, while sane or insane;

(2) commission or attempt to commit a felony or an assault;

(3) any act of war, declared or undeclared;

(4) any active participation in a riot or insurrection;

(5) bungee jumping; parachuting; skydiving; parasailing; hang-gliding;

(6) sickness, disease, physical or mental impairment or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. (This does not include bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning.)

Group Term Life

Post-tax Benefits

(7) voluntarily using any drug, narcotic, poison, gas or fumes, except one prescribed by a licensed physician and taken as prescribed;

(8) while operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant, including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it;

(9) while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days);

(10) traveling in an aircraft that is owned, leased or controlled by the sponsoring organization, or any of its subsidiaries or affiliates;

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

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

What are the Dependent Life Insurance features?

Conversion

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

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

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

Product Features

- **Accelerated Death Benefit – Terminal Illness –** Up to $50% of the death benefit (not to exceed $250,000) may be advanced to the insured who is diagnosed with a terminal illness (life expectancy of 12 months or less) by two unaffiliated physicians. This benefit is payable only once in the insured's lifetime, and will reduce the life insurance death benefit.
- **Will Preparation Services –** Online interactive tool helps covered employees and their spouses create a will and other legal documents. The site also provides access to other valuable financial educational materials.
- **Conversion –** If your coverage is reduced or ends due to age, disability or termination of employment, you can obtain an individual whole life policy, without proof of good health. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Eligible family members may convert their coverage as well. Converted policies are subject to additional restrictions if you convert because of termination or amendment of the group policy.

CIGNA's Will Preparation Program

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

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

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

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

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

Think you can't afford to create a will?

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

Not sure how to develop your will?

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

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

It's easy! Go to CIGNAWillCenter.com

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

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

[2] No legal advice is provided.

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

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

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

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

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

Plus, find information on:

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

it's time *to feel better*

CIGNA®

Group Term Life

Post-tax Benefits

- **Conversion Provisions -** If you retire, terminate employment, or cease being an actively at work employee (regardless of pay status):
  1. You and your dependents may be eligible to convert your optional coverage to an individual permanent policy.
  2. If you are retiring, you may be eligible to continue up to $50,000 of your Employee Only optional coverage on an age-rated premium basis. Coverage terminates at age 70. Premiums are paid on an annual basis.
- **Voluntary Term Life Coverage Reduction** - At age 70, providing you are still employed, your coverage will decrease to 65% of the benefit amount. It will decrease to 45% at age 75, and to 30 % at age 80 .Premiums and coverage for your spouse will end at age 70; at that time your spouse may choose to convert this coverage to a permanent life insurance policy.

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

- **Waiver of Premium (If you become totally disabled) -** To make sure you can keep the life insurance protection you need during a difficult period of your life, this plan provides a waiver of premium feature. If you are totally disabled prior to age 60 and can't work for at least 12 months, your coverage will continue and you won't need to pay premiums for your coverage while you are disabled, provided the insurance company approves you for this benefit. You must continue to pay premiums until the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until age 65, subject to proof of continuing disability each year. If you qualify for this benefit and have insured your spouse or children, the premium for their coverage is also waived.

- **Coverage Reduction for Optional Life plans –** At age 70, your coverage amount reduces to 65 percent. At age 75, your coverage reduces to 45 percent, and at age 80, coverage is reduced to 30 percent. When your coverage reduces, any dependent insurance you've purchased will reduce by the same percentage.
- **Online Plan Description –** you will be able to review any of these benefits and their provisions in more detail through the School District of Palm Beach County's website at **www.palmbeach.schools.org/riskmgmt.**

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

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

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

Licensed Resident Agent: Christine Carolyn Wise

License #E026735

Did you read about...

- **Basic Life description?**
- **Optional features?**
- **Dependent Life options?**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Minimally Invasive Procedures

MIP – Minimally Invasive Procedures

Similar to the development of arthroscopic surgery for knee disorders, MIP techniques are now offering a tremendous breakthrough in the treatment of a number of conditions including colon cancer and colon disease, appendicitis, ventral hernia, hemorrhoids, endometriosis, uterine cancer and acid reflux (GERD). MIP techniques are even used in diagnostic testing for breast cancer.

For most minimally invasive procedures, the surgeon makes a series of three to five small, dime-sized incisions in the patient's abdomen. Carbon dioxide gas is used to inflate the abdomen and create a working space between the internal organs and the skin. A small video camera, or scope, then is placed in one of the incisions, providing the surgeon with a magnified view of the patient's internal organs on a television monitor in the operating room.

For more information on minimally invasive procedures and a listing of local physicians performing MIP, visit www.MIPInfo.com or www.surgeryoptions.info.

Employee Assistance Program

Corporate Care Works

What is an Employee Assistance Program (EAP)?

An EAP is designed to help solve personal, work related or family problems.

When personal problems such as marital, emotional, financial, substance abuse, stress, parenting or job issues occur, it is helpful to talk to someone. Friends and family members may not always have the necessary knowledge to help.

Your EAP is staffed by licensed clinical professionals with masters or doctoral degrees. It is a confidential program that is protected by state and federal laws.

Plan Features

The Employee Assistance Program (EAP) will provide free professional, confidential counseling and coaching to you or an immediate family member with the following concerns:

- Substance abuse
- Dual career family issues
- Depression and anxiety
- Marital/relationship problems
- Parent/child relations
- Divorce, separation, single and step-parenting issues
- Sexual assault/harassment
- Crisis intervention following a traumatic event (e.g., accidental death, robbery)
- Eldercare
- Retirement
- Support for transferred employees and their families
- Stress management
- Domestic violence

If we do not provide a particular service you require, we will refer you to the appropriate resource. Through follow-up, we will make sure that you get the help you need.

We are here for you

There is counseling help available for you through your EAP benefits. Call us at Corporate Care Works. In accordance with State and Federal laws, your concerns will be held strictly confidential.

The EAP is available to help you:

- Gain a better understanding of your problems
- Locate the best professional help for your particular problem
- Decide upon a plan of action

What will the program cost me?

The School District's contract allows up to eight confidential sessions at no cost to you. The EAP covers all regular employees of the School District, both full time and permanent part time; immediate family members residing in the same household; family members including spouse, and unmarried dependent children under age 25. This benefit is available for 90 days after retiring or terminating your employment with the District.

How do I contact the EAP?

The EAP is available 24 hours a day, seven days a week.

To make an appointment or speak with a counselor immediately, simply call **1-800-327-9757**. Tell us your name, the name of your employer and that you want to use your EAP benefits. Also, in an emergency, you can phone us to receive assistance.

If you would like further information about your EAP and Corporate Care Works, just call **1-800-327-9757**.

You are invited to visit us online at **www.corporatecareworkspbc.com**, where you may access a variety of health and wellness articles, and information about stress or mental health concerns.

CORPORATE CARE WORKS
1-800-327-9757 OR (561)433-9588

TELEPHONIC OR IN-PERSON COUNSELING
COUNSELING LOCATIONS ARE THROUGHOUT PALM BEACH COUNTY

Did you read about...

- **Wellness mission?**
- **Available programs?**
- **Employee Assistance Program?**

Critical Illness Insurance Plan

A Payroll Deductible Post-tax Benefit

In this section...

- **Plan features**
- **Eligibility**
- **Underwriting guidelines**
- **Additional riders and benefits**

Trustmark Insurance Company

The Critical Illness Insurance Plan provides a lump sum benefit payment of $5,000 to $100,000 upon first diagnosis of a covered illness after the plan's effective date.

Plan Features

- Coverage will be effective on the date assigned to the policy, provided that the insured and family members qualify for coverage under Trustmark's normal underwriting guidelines.
- Renewability – Guaranteed renewable (for life) level premium. Trustmark reserves the right to change the premium on this policy based on experience.
- Portability – This plan is fully portable.

Who is eligible?

All eligible employees may purchase the Trustmark Critical Illness / Cancer coverage.

a. Employees who have NOT previously purchased the Cancer Coverage may apply for up to $100,000 of coverage.

b. Employees who have previously purchased Cancer Coverage may apply for a new Critical Illness/Cancer Plan up to a total $100,000 of coverage. The $100,000 is a combination of current Cancer Coverage (including past EZ Values) and new Critical Illness Insurance Plan coverage.

c. You can not increase your current Cancer Plan. You can purchase additional PremierSelect℠ coverage.

d. The EZ Value plan may be added to the Critical Illness Insurance Plan plan. Future EZ Value Plan increases can exceed the $100,000 maximum. (EZ Value increases will cease when the total coverage amount reaches $125,000.)

Issue Age:

- Employee 18 to 70
- Spouse 18 to 70
- Children Birth through age 23

Underwriting Guidelines:

Guaranteed Issue up to $25,000* to all new employees who have never applied for coverage. Employee amounts of $25,001 up to $100,000, are based on the response to six questions. Coverage of $5,000 to $100,000 for spouse and child coverage or any employee that applied for coverage that is no longer in force are based on the response to six questions. The six health questions are:

- 10 years cancer-free (breast cancer two years in Florida)
- AIDS question
- Major Illness or Disease question
- Height & Weight
- Ever had alcohol or drug treatment
- Two or more immediate family members diagnosed with same disease prior to age 60

Benefits from $50,001 up to $100,000 is limited to two times annual pay.

Policy form CACI-82001.

* Guaranteed Issue does not mean guaranteed benefits, if a person was previously diagnosed with a covered condition or illness prior to the plan effective date no benefit will be paid for a subsequent diagnosis of the same covered condition or illness after the plan effective date. Guaranteed Issue is contingent upon specific enrollment conditions being met. Guaranteed Issue is not available for employees who previously applied for Critical Illness or Cancer coverage.

Critical Illness Insurance Plan

A Payroll Deductible Post-tax Benefit

What payroll deduction premiums will I pay for this plan?

You select the coverage and premium that best fits your budget and family needs. As a School District of Palm Beach County employee, your group purchasing power ensures you receive a high insurance value at an affordable cost. Speak with your Enrollment Counselor for more information.

Can I continue my coverage if I terminate or retire?

Yes. This plan is portable after the first payroll deduction. You can continue with the full amount of insurance coverage and arrange for premiums to be billed directly to you.

Additional Riders and Benefits

Health Screening Benefit (optional)

Pays the cost of one screening test per calendar year (up to $50 or $100 benefit maximum). Eligible tests include:

- Low Dose Mammography
- Chest X-ray
- Pap Smear (women over age 18)
- Breast ultrasound
- Hemocult Stool Specimen
- Colonoscopy
- Prostate Specific Antigen
- Fasting blood glucose test
- Flexible Sigmoidoscopy
- Blood test for triglycerides
- Stress test on a bicycle or treadmill
- Bone marrow testing
- Serum cholesterol test to determine
- Thermography levels of HDL and LDL
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Serum Protein Electrophoresis (blood test for myeloma)

Waiver of Premium (optional)

Premiums for base coverage and added riders and benefits may be waived if the primary insured is totally disabled as defined in the rider prior to the policy anniversary date nearest his or her 60th birthday.

EZ Value Plan (optional)

Inflation-fighting option that automatically increases the lump sum benefit amount of your Critical Illness policy on each of the first five policy anniversaries. The increase equals an additional lump sum amount purchased by an additional $1 per week premium for each of the first five years at the attained age of the employee when the increase goes into effect. EZ Value cannot be added after age 60.

Plan Provider

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, has rated Trustmark "A-" (Excellent). Policy form CACI-82001

What if I have questions about my certificate?

After you enroll, you can get answers about your certificate by calling **Trustmark Customer Service at 1-866-636-5525**.

Did you read about...

- **Plan features?**
- **Underwriting guidelines?**
- **Optional riders?**

Voluntary Universal Life Insurance Plan

In this section...

- **Plan offerings**
- **Eligibility**
- **How to apply**
- **Payroll deduction premiums**

Plan Provider: Trustmark Insurance Company

Wouldn't you like to have life insurance you can take with you whenever you leave the school district...a plan that features portable coverage and may accumulate cash values?

Thanks to The School District of Palm Beach County, you have the opportunity to apply for this plan without a medical examination.

Who is eligible?

The following employees are eligible and may apply for coverage during an annual enrollment period:

- Full-time or regular part-time employees
- Employees between the ages of 18 and 80
- Employees actively working at the time of application and the first deduction date

Can I apply for my dependents?

Yes. Your spouse, children or grandchildren might also qualify for coverage. In fact, you don't have to get coverage for yourself to cover family members. There may be additional eligibility requirements to include your grandchildren. If you have any questions, please speak with your Enrollment Counselor.

What does the plan offer?

This plan offers more than just the peace of mind that your family will be taken care of if something happens to you. It also offers you and your family flexible benefits that include:

Accelerated Death Benefit — If a physician determines that you have 24 months or less to live, an advance death benefit pays up to 75 percent of the base certificate death benefit (up to $225,000). The Accelerated Death Benefit is subject to review by the insurer and reduces the final death benefit.

Interest-earning Cash Value — Interest is credited to your plan. Current tax law allows the cash value in this life insurance plan to accumulate on a tax-deferred basis (within guidelines).

Home Health, Adult Day Care & Long-Term Care Rider — If you are confined in a qualified long-term care facility, assisted living facility or require medically necessary home health or adult day care, this pays you a monthly benefit of 4 percent of your policy for up to 25 months. And you don't have to make your monthly payments while confined. Benefits are paid as advance death benefits and will proportionally reduce both the final death benefit payable to beneficiaries and the plan's cash value.

Optional Accidental Death Benefit — If you should die by accidental means before your 75th birthday, your death benefit will double. Available to ages 15 - 70.

Optional EZ Value Plan — This plan also offers the EZ Value Plan Option, an inflation-fighting option which automatically increases coverage annually on each of the first five or ten policy anniversaries. For employees and their spouses under 65, the amount of the Death Benefit Increase is equal to the amount of protection an additional $1 per week deduction (or $2 per week for employees only) would purchase on the first five anniversaries. An increase of $1 per week on each of the first 10 anniversaries is available to employees and spouses up to age 60. Existing EZ Value participants may extend to the 10-year options (with restrictions) if they choose to do so.

Voluntary Universal Life Insurance Plan

Death Benefit Restoration Rider — Automatically increases the Death Benefit to restore the advanced death benefits for home healthcare, adult day care or long-term care confinement in a nursing home.
Example: An insured party has a $50,000 death benefit with the Home Health and Long-Term Care rider and dies after 10 months of long-term care confinement.

	With Rider	Without Rider
Total Benefits Paid	$70,000	$50,000
Death Benefit	$50,000	$30,000
Living LTC Benefits	$20,000	$20,000

Long Term Care Rider Upgrade — For those with an older plan who haven't yet upgraded the LTC Rider**,** all current participants may request to receive the enhanced LTC benefits at no additional cost to you. The LTC enhancements include a 4% per month benefit for Nursing Home Confinement, Home Health and Adult Day Care Services (current rider provides a 2% per month benefit). It also provides benefits for ADL assistance in an Assisted Living Facility.

All new applicants will receive the LTC rider enhancements.

Waiver of Premium (optional)

Premiums for base coverage and added riders and benefits may be waived if the primary insured is totally disabled as defined in the rider prior to the policy anniversary date nearest his or her 60th birthday.

How do I apply?

Have your Enrollment Counselor fill out the Universal Life Insurance plan application.

Employees – Guaranteed Issue of amount purchased by $10 per week in premium (ages 18 - 64) who have never applied for coverage, plus you may apply for coverage amounts up to $200,000 (not to exceed $14 per week in premiums). Spouses may apply for up to $4 per week in premium, and children ages 0 days to 23 years may apply for up to $4.32 per week certificate. In most cases, only two medical questions will be asked.

Current Participants – Employees may apply for $5/week up to a total of new and existing coverage of $200,000; spouses may apply for an additional $2/week of coverage. Both employees and spouses may add the EZ Value Plan Option to their coverage. In most cases only two medical questions will be asked.

Any employee or spouse applying for amounts of insurance over these limits and up to the plan maximum of $300,000, or previous participants whose Trustmark coverage has terminated, must answer a few additional questions concerning health history.

Can I continue my Universal Life coverage if I terminate employment or retire?

Yes. This plan is portable after the first payroll deduction. You can continue with the full amount of insurance coverage and arrange for premiums to be billed directly to you. Your coverage and rates stay the same.

What about the group term life policy I already have with the School District?

This Universal Life Insurance plan complements any group term life insurance you may have, and enables you to vary your premiums, coverage, and cash value accumulation as your needs change. You can adjust the death benefit and premium upward and downward throughout your lifetime, subject to certificate limits.

What if I become disabled?

You can have your premiums waived in case of total disability with the optional Waiver of Premium rider, available to ages 18-60. Your Counselor can discuss with you the features and costs for this additional rider.

Voluntary Universal Life Insurance Plan

What payroll deduction premiums will I pay?

You select the coverage and premium that best fits your budget and family needs. As a School District of Palm Beach County employee, your group purchasing power ensures you receive a high insurance value at an affordable cost. Speak with your Enrollment Counselor for more information.

Remember, this contract is offered in addition to any employer coverage and is paid solely by the employee through post-tax contributions.

What if I have questions about my certificate?

After you enroll, you can get answers about your certificate by calling the dedicated **Trustmark Customer Service at 1-866-636-5525**.

How do I make changes to my coverage?

For more information regarding coverage changes, call Trustmark Customer Service at **1-866-636-5525.**.

Plan Provider

Trustmark Insurance Company, Lake Forest, Illinois, underwrites this plan. The A.M. Best Company, an organization that compares and rates the financial strength and performance of insurance companies, rates Trustmark "A-" (Excellent).

Universal Life Insurance is available on a post-tax basis, and a separate application is required. This employer-provided information is in advance of more complete coverage information from the insurer.

Issue Ages:

Employee	18 to 80
Spouses	18 to 70
Children	0 to 23*

*Children and grandchildren are eligible the day after they leave the hospital.

Policy Form GUL-205 and Riders HH/LTC and BRR

Did you read about...

- **Plan features?**
- **Eligibility?**
- **How to apply?**

Tax Sheltered Annuities (TSA)

& Roth Tax Sheltered Mutual Funds (TSM)

Enrollment in a TSA/TSM can take place at any time during the year.

Pre-Tax

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

Post-Tax

We are now able to allow Roth 403(b) and Roth 403(b)(7) plans. Roth plans allow you to invest funds from your salary on a post-tax basis. Your investments will grow tax-free and you will not have to pay any income tax on the investments or profits when the funds are withdrawn after you retire or otherwise qualify. Most of the vendors on this page also administer the Roth plans.

Please visit:
www.tsacg.com/employee_site/vendors/Florida/Palm_Beach_vendors.htm for a complete listing of what program each vendor offers.

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

All employees receiving a W-2 each year are eligible to participate in any of the 403(b) annuity or mutual funds.

See our website after January 1, 2011, for a copy of the plan document for 403(b) plans.

www.palmbeach.schools.org/riskmgmt, then click on "Benefits".

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

AXA Equitable Life Assurance Co. *
Anthony LoFaso (561)689-6775

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

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

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

Horace Mann
Theresa Goulet (561)743-1669

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

The Legend Group
Andrew Takach (561)694-0110

Life Insurance Company of the Southwest
Matt Bell (800)906-3310

Lincoln Investment Planning
Mike Mracna (561)649-9200

MetLife
Ken Suchy (561)746-6652

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

Primerica
Ray Krutz (561)642-7459

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

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

Florida Adoption Benefit Program

Palm Beach County School District is printing this to provide information on a state program available to School District employees.

What Law Authorizes the Adoption Benefit?

Section 409.1663, Florida Statutes, authorizes monetary benefits to certain employees who adopt a child for whom permanent custody was awarded to the Florida Department of Children and Family Services or a Florida licensed child-placing agency prior to adoption. In addition, Florida Administrative Code outlines the application process and payment disbursement procedures for eligible applicants who are awarded benefits. The administrative rule will be available through the Department of Children and Family Services website as soon as the new rule is promulgated.

Who Administers the Adoption Benefit?

The Department of Children and Family Services, Office of Family Safety, administers the program by providing information on program policies and procedures, benefit criteria and the application process. The Adoption Unit of the Office of Family Safety is responsible for accepting applications, verifying applicant eligibility and determining the benefit award for each eligible applicant. Call (850)488-8762 or check the website at the end of the next column for an application.

Who is an Eligible Applicant?

A full-time or part-time employee of the State (Executive, Legislative, and Judicial Branches, including the Department of Lottery), the State Universities, Community Colleges, School Board Districts, Water Management Districts and instructional personnel employed by the Florida School for the Deaf and Blind, provided the employee is paid from regular salary appropriations (not OPS or otherwise "temporary" or casual labor).

What Types of Adoption are Eligible for the Adoption Benefit?

If, prior to the adoption, the child was in the permanent custody of the Florida Department of Children and Family Services or a Florida licensed child-placing agency, and the final order of adoption was granted on or after October 1, 2000 (inception date of program), the following may be payable:

- **Adoption of a Special Needs Child:**

  A monetary benefit in the amount of $10,000 per child (Pro-rated for part-time employees).

- **Adoption of a Non-Special Needs Child:**

  A monetary benefit in the amount of $5,000 per child (Pro-rated for part-time employee).

Who is Considered a Special Needs Child?

A child whose permanent custody has been awarded to the Florida Department of Children and Family Services or to a Florida licensed child-placing agency and who meets one or more of the following criteria:

- Has established significant emotional ties with his or her foster parents
- Is eight years of age or older;
- Has a developmental disability;
- Has a physical or emotional handicap;
- Is of a black or racially mixed heritage; or
- Is a member of a sibling group of any age, provided that two or more members of a sibling group remain together for purposes of adoption.

When Are Applications Accepted for Adoption Benefits?

The Department of Children and Family Services will only accept benefit applications during the annual open enrollment period, which will begin each year on the first business day of August and conclude on the last business day of September. To be considered for benefits, applicants must submit an Application for Adoption Benefits along with a certified copy of the final order of adoption. The benefit application is available through the Department of Children and Families website. **Employees who applied in previous years and were not awarded a benefit must re-apply in order to be considered for the adoption benefit.**

What Else Should I Know About These Monetary Benefits?

All benefits are subject to funding by the Legislature each year and will only be awarded if appropriations are made. The amount of the annual appropriation affects how many awards are granted each year. By law, payments must be made in a lump sum. These awards are considered a supplemental wage and applicable payroll taxes will be deducted.

Go to:
www.dcf.state.fl.us/adoption/adoptbenefitsprogram.shtml.

COBRA Notification

Important Continuation Coverage Information

What is continuation coverage?

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

Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be obtained from Benefit Outsource, Inc. (BOI)

How long will continuation coverage last?

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

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

You may continue your Health Care FSA (on a post-tax basis) only for the remainder of the plan year in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Health Care FSA for the year. For example, if you elected a Health Care FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Health Care FSA for the remainder of the plan year or until such time that you receive the maximum Health Care FSA benefit of $1,000.

If you have questions about your Health Care FSA, you should call Fringe Benefits Management Company (FBMC) at 1-800-342-8017.

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

Keep Your Plan Informed of Address Changes

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

Benefit Outsource, Inc. (BOI)

5599 S. University Drive, Suite 201

Davie, FL 33328

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.

COBRA Notification

Important Continuation Coverage Information

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage, resulting in a maximum amount of continuation coverage of 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify BOI within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

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

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

COBRA Notification

Important Continuation Coverage Information

How much does continuation coverage cost?

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

When and how must payments for continuation coverage be made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

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

Your first payment for continuation coverage should be sent to:

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

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form. The BOI will send coupons for use in making periodic payments.

Periodic payments for continuation coverage should be sent to:

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

Grace Periods for Periodic Payments

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

General Notice Of COBRA Continuation Coverage Rights

Introduction

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

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

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

Important Continuation Coverage Information

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

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

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

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

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

Sometimes filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the School District of Palm Beach County, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after BOI has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer or enrollment of the employee in Medicare (Part A, Part B or both), BOI will offer COBRA continuation coverage to each qualified beneficiary.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify BOI. The Plan requires you to notify BOI within 60 days by completing the required notice form which is available on the District's website (see page 19) after the qualifying event occurs. Benefit Outsource, Inc. (BOI), 5599 S. University Drive, Suite 201, Davie, FL 33328.

Once BOI receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify BOI in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that BOI is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to:

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

You must attach a copy of the SSA Determination Letter to the notice.

COBRA Notification

Important Continuation Coverage Information

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that BOI is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

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

You must attach a copy of the applicable supporting documentation to the notice (i.e. the divorce decree, death certificate).

If You Have Questions

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

Retiree Q&A - What should I do when I retire?

During the 90 days prior to your anticipated retirement date, contact the Department of Employee Benefits, Retiree Technician, at (561)434-8673 to schedule an appointment for retirement and continuation of group health/life plans and flexible benefits.

Special Consideration for Term Life Insurance:

Refer to the Conversion Provision on the Group Term Life pages as well as your policy certificate for timelines and application requirements.

When I retire, to whom do I send payments?

Retirees continuing their eligible group health, dental, vision and/or term life ($1,000) insurance must elect to pay their full premium payments through deduction from the Florida Retirement System – provided the benefit would support the deduction. Until FRS deductions begin, payment by personal check or money order is required.

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 1-800-342-8017 for an approximation.

Itemized deductions

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

Special Enrollment Rights Pertaining to Medical Benefits

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

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

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

Notice of Administrator's Capacity

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

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

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

3. The insurance companies noted herein have been selected by your employer, and are liable for the funds to pay your insurance claims.

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

FBMC Privacy Notice 4/14/03

This notice applies to products administered by Fringe Benefits Management Company and its wholly-owned subsidiaries (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 notice 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. FBMC's privacy policy is as follows:

I. We collect only the customer information necessary to consistently deliver responsive services. FBMC collects information that helps serve your needs, provide high standards of customer service and fulfill legal and regulatory requirements. The sources and types of information collected generally varies depending on the products or services you request and may include:

- Information provided on enrollment and related forms - for example, name, age, address, Social Security number, e-mail address, annual income, health history, marital status and spousal and beneficiary information.
- Responses from you and others such as information relating to your employment and insurance coverage.
- Information about your relationships with us, such as products and services purchased, transaction history, claims history and premiums.
- Information from hospitals, doctors, laboratories and other companies about your health condition, used to process claims and prevent fraud.

II. Under HIPAA, 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 the Plan in care of FBMC's Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Additional information that describes how medical information about you may be used and disclosed and how you can get access to this information is provided electronically on our website: **www.myFBMC.com**. You have a right to a paper copy at any time. Contact FBMC Customer Care at 1-800-342-8017.

III. We maintain safeguards to ensure information security. We are committed to preventing unauthorized access to personal information. We maintain physical, electronic and procedural safeguards for protecting personal information. We restrict access to personal information to those employees, insurance companies and service providers who need to know that information to provide products or services to you. Any employee who violates our Privacy Policy is subject to disciplinary action.

IV. We limit how, and with whom, we share customer information. We do not sell lists of our customers, and under no circumstances do we share personal health information for marketing purposes. With the following exceptions, we will not disclose your personal information without your written authorization. We may share your personal information with insurance companies with whom you are applying for coverage, or to whom you are submitting a claim. We 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.

We will provide our Privacy Notice to current customers annually and whenever it changes. If you no longer have a customer relationship with us, we will still treat your information under our Privacy Policy, but we will no longer send notices to you. In this notice of our Privacy Policy, the words "you" and "customer" are used to mean any individual who obtains or has obtained an insurance, financial product or service from FBMC that is to be used primarily for personal or family purposes.

Medicare Part D Certificate of Credible Coverage

Important Notice from School District of Palm Beach County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with School District of Palm Beach County and prescription drug coverage available for people with Medicare.

It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

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.
2. 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.
3. The School District of Palm Beach County has determined that the prescription drug coverage offered by United Health Care 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.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

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.

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

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

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

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

For more information about this notice or your current prescription drug coverage…
Contact our office for further information 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, and if this coverage change. You also may request a copy.

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 (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Medicare Part D Certificate of Credible Coverage

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you call them 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, 2010
Name of Entity:	School District of Palm Beach County.
Contact:	Retiree Benefits Technician
Address:	3370 Forest Hill Boulevard, Suite A-103
	West Palm Beach, FL 33406-5870
Phone:	(561)434-8673

Employee Self Service

Self Service

Keeping your data updated and close at hand just got a lot easier. Employee Self Service provides you with 24/7 access to your personal data. You can view your personal data, including your benefit enrollment and dependent information. You can modify beneficiary information at your convenience you can take advantage of Employee Self Service

Q: What am I able to view or change using the Self-Service module of PeopleSoft?

A: You and view paycheck and W-2 information, you can update/change beneficiary information, you can change your life insurance beneficiary percentage, you can view which plans you are enrolled in as well as which dependents are enrolled.

Q: I can not seem to get logged in PeopleSoft to complete my benefits, who should I contact?

A: Make sure you have first followed the instruction on how to obtain or reset your password. If you still need help, contact the IT Help Desk at PX 44100 or 242-4100 for further assistance. Remember your enrollment is time sensitive, so do not delay completing your enrollment within 30 days.

Q: How much time do I have to complete my on-line enrollment?

A: You have 30 days calendar days from their start date to complete you on-line benefit enrollment

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

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

Q: When should I be able to access the on-line enrollment system?

A: Within 24 to 48 hours of your start date, you should be able to create a password and then have immediate access to complete your enrollment.

Q: How do I create a password?

A: Follow the step by step on-line enrollment instruction which explains how to create a password as well as how to get help if you have forgotten your password.

Your Paycheck Explained

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

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

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

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

Payroll
Counter which indicates the number of pays thus far.

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

Employee Information
This block contains your name and mailing address.

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

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

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

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

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

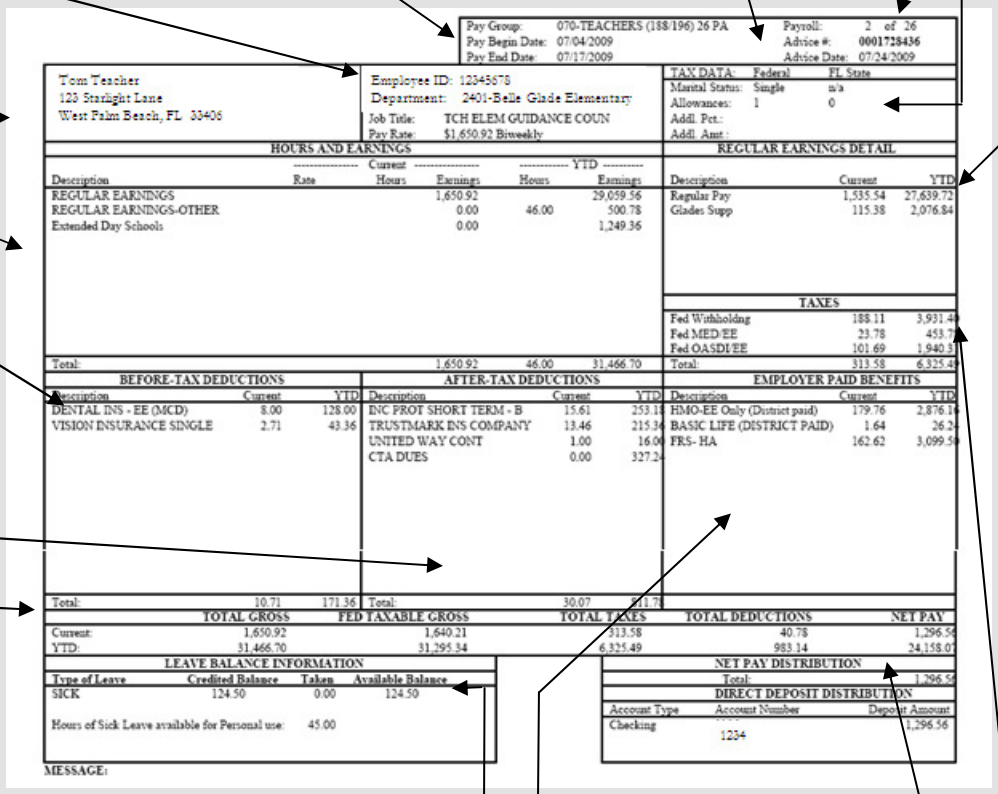
Leave Balances
This area lists your annual leave and sick leave balances.

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

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

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

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



Pay Group: 070-TEACHERS (188/196) 26 PA
Pay Begin Date: 07/04/2009
Pay End Date: 07/17/2009
Payroll: 2 of 26
Advice #: 0001728436
Advice Date: 07/24/2009

Tom Teacher
123 Starlight Lane
West Palm Beach, FL 33406

Employee ID: 12345678
Department: 2401-Belle Glade Elementary
Job Title: TCH ELEM GUIDANCE COUN
Pay Rate: $1,650.92 Biweekly

TAX DATA: Federal / FL State
Marital Status: Single / n/a
Allowances: 1 / 0
Addl. Pct.:
Addl. Amt.:

HOURS AND EARNINGS

Description	Rate	Current Hours	Current Earnings	YTD Hours	YTD Earnings
REGULAR EARNINGS			1,650.92		29,059.56
REGULAR EARNINGS-OTHER			0.00	46.00	500.78
Extended Day Schools			0.00		1,249.36
Total:			1,650.92	46.00	31,466.70

REGULAR EARNINGS DETAIL

Description	Current	YTD
Regular Pay	1,535.54	27,639.72
Glades Supp	115.38	2,076.84

TAXES

Fed Withholding	188.11	3,931.49
Fed MED/EE	23.78	453.7
Fed OASDI/EE	101.69	1,940.3
Total:	313.58	6,325.49

BEFORE-TAX DEDUCTIONS

Description	Current	YTD
DENTAL INS - EE (MCD)	8.00	128.00
VISION INSURANCE SINGLE	2.71	43.36

AFTER-TAX DEDUCTIONS

Description	Current	YTD
INC PROT SHORT TERM - B	15.61	253.18
TRUSTMARK INS COMPANY	13.46	215.36
UNITED WAY CONT	1.00	16.00
CTA DUES	0.00	327.24
Total:	30.07	811.78

EMPLOYER PAID BENEFITS

Description	Current	YTD
HMO-EE Only (District paid)	179.76	2,876.16
BASIC LIFE (DISTRICT PAID)	1.64	26.24
FRS- HA	162.62	3,099.59

	Total: 10.71	171.36

	TOTAL GROSS	FED TAXABLE GROSS	TOTAL TAXES	TOTAL DEDUCTIONS	NET PAY
Current:	1,650.92	1,640.21	313.58	40.78	1,296.56
YTD:	31,466.70	31,295.34	6,325.49	983.14	24,158.07

LEAVE BALANCE INFORMATION

Type of Leave	Credited Balance	Taken	Available Balance
SICK	124.50	0.00	124.50

Hours of Sick Leave available for Personal use: 45.00

NET PAY DISTRIBUTION
Total: 1,296.56

DIRECT DEPOSIT DISTRIBUTION

Account Type	Account Number	Deposit Amount
Checking	1234	1,296.56

MESSAGE:

INDEX

401(a) Dollars 10, 25, 31, 70, 71

A

Account Balance 47, 55, 63, 69, 71
Account Transactions 69

B

Bencor Form 74

C

Changes to Your Coverage 19-23
Claim Forms 33-35, 39, 44, 48, 50, 52, 56, 60-63, 66, 68-69, 80-81
Claims Status 69
COBRA Information 12, 25, 27, 103-107
Critical Illness Benefit 25, 27, 96-97

D

Dental Plans 8, 44-49
Dental Rates 46
Dependent Audit Verification 4, 6, 14
Dependent Care FSA 8, 19-24, 54-55, 64-67, 69, 108
Domestic Partnership Affidavit 15, 17

E

Eligibility 13-15, 20, 105

F

Florida Adoption Program 102
Frequently Asked Questions 43, 57, 69, 110
FSA Minimum & Maximum Contributions 57, 64
FSA Worksheets 68

G

Grace Period 55, 59, 62-63, 104
Group Term Life 21-23, 87-91, 99, 107

H

Healthcare Benefits 30-33, 38-43
Health Comparison Charts 34-37
Health Care FSA 19, 24, 27, 54-55, 57-61, 64, 68, 103, 105

I

Imputed Income 16
Interactive Benefits 69

L

Long-Term Care 25, 27, 92-93, 99

M

Medicare Part D 109-110
myFBMC Card® Visa® Card 61-63

N

Notice Administrator Capacity 108
NurseLine℠ Back Cover

P

Payroll Deduction 8, 52, 83-86, 96, 100

R

Retirement Rates 10, 70
Run-out Period 55, 69

S

Social Security 4, 5, 8, 9, 12, 14, 54, 56, 65, 71, 78, 103, 106, 108, 110

T

Tax Savings Analysis 54, 65, 69
Tax Sheltered Annuities 101

U

Universal Life Benefit 25, 27, 99, 100
Use - it or Lose - it Rule 55, 62

V

Vision Rates 51, 52, 53

W

Wellness Benefit 94

Need help making smart health care decisions? Let NurseLine℠ services point you in the right direction.

Call NurseLine℠ services and speak with a registered nurse to:

- Better manage an illness or injury.
- Find resources to better manage an illness or injury.
- Recognize urgent and emergency symptoms.
- Locate doctors and hospitals in your area that meet criteria for quality and efficiency.
- Understand medication interactions and how to reduce your prescription costs.
- Connect with resources for pregnancy, cancer, diabetes, asthma, heart disease and more.

Emotional support also is available from master's-level specialists when you need help dealing with life's challenges. Get help with stress, anxiety, depression, grief, marriage difficulties and much more. And best of all, NurseLine℠ services are included as part of your benefit plan. Call 1-888-229-9322 to speak with a NurseLine℠ nurse anytime, day or night.

FBMC

Premier Benefits Solutions

Contract Administrator
Fringe Benefits Management Company
P.O. Box 1878 • Tallahassee, Florida 32302-1878
Customer Care 1-800-342-8017 • 1-800-955-8771 (TDD)
www.myFBMC.com

FBMC/PB/1010