YOU'RE ALWAYS HERE FOR US

Even Better BENEFITS

Exclusively for the School District of Osceola County

ARE NOW HERE FOR YOU

EMPLOYEE BENEFITS GUIDE 2024–25

A MESSAGE FROM THE

Council of Kids Who Care

With all the change that's happened these past few years, we want to thank all the teachers and staff of the School District of Osceola for continuing to always care about us kids. You've never stopped showing up for us and giving your all so we can keep learning and growing. If we ever need to think of what it looks like to never give up, we have all of you to look up to. And that means everything to us.

We can't thank you enough for it all, and for inspiring us to always do our best. That means giving you the same level of care you give to us.

That's why this year's Even Better Benefits includes a few changes to make your life easier, plus the valuable benefits you've enjoyed in years past. So get ready for a lesson on the latest and greatest with this year's Even Better Benefits.

SUPERINTENDENT'S MESSAGE

Dear School District of Osceola County Employees,

I hope this message finds you well and enjoying a fulfilling and productive start of the school year. As we work together to take care of our students, we have our "Even Better Benefits" to help take care of you and your family. I am pleased to share that there are no cost increases to our medical plans this year, and improvements have been designed to provide you with both comprehensive coverage and peace of mind.

We are continuing our great partnerships with Prescriptions Unlimited, On Spot Dermatology, and our 3D Mobile Mammography bus as they continue to provide innovative and convenient services. The On Spot Dermatology, a full-service, mobile dermatology practice, is bringing its state-of-the-art medical clinic onsite to SDOC locations. I personally have used this benefit and found them to be as thorough, professional, and friendly as any dermatology office. With the introduction of our Mammogram Bus, we are taking another giant step towards bringing healthcare to you. This mobile mammography unit is equipped with state-of-the-art 3D technology and staffed by experienced healthcare professionals. It will travel to all school locations throughout the district this school year, providing employees easy access to life-saving screenings. Employees also can save time and money with our full-service pharmacy at the Center for Employee Health. In partnership with Prescriptions Unlimited, covered members on any of the three health services plans may get their medications at the onsite pharmacy. Copays are waived for all generic medications and waived for first 90-day brand medication fill. I also encourage you to participate in our wellness program, which is available to all employees at no cost. Our goal is to provide wellness resources to help you live a healthier, stronger, and more vibrant lifestyle. This includes nutrition counseling, financial wellness programs, onsite group exercise classes, wellness incentives and challenges, and more.

Our Risk and Benefits team is always here to support you in navigating these benefits and making the most of what is available to you. Thank you for your dedication and hard work. I value each of you, and I stand fully committed to supporting your health and wellness as you continue to inspire and educate our students.

Sincerely,

Dr. Mark Shanoff
Superintendent

CONTENTS

This guide is a summary of the benefit programs offered through the School District of Osceola County for the plan year October 1, 2024 through September 30, 2025.
The contents summarize the key features of each plan. Complete details are provided in Plan Documents, policy guidelines, and insurance contracts that legally govern the operation of each plan. If there is a discrepancy between this guide and the official Plan Documents, the Plan Documents will prevail.

WHAT'S HAPPENING THIS YEAR

Be on the lookout for programs that are made to make your benefits even better.

INTRODUCING THRIVEPASS OUR NEW FSA/DC FSA PROVIDER.

- Easy automatic way to pay for eligible health care/benefit expenses
- Easier substantiation process
- Effective October 1, 2024

PAGE 31

NEW DENTAL RATES AND ENHANCED DENTAL BENEFITS

- All benefit plan premiums except the DENTAL plans, will stay the same.
- Dental plan premiums have increased an average of 9.9%.
- Adding enhanced benefits such as adult orthodontia coverage and Silver Diamine Fluoride to PPO plans. See the new rate chart.

PAGE 11

PRESCRIPTIONS UNLIMITED NOW OFFERING

FREE DELIVERY (call to arrange delivery)

***Free-over the counter medications-(Limited formulary)**

PAGE 24

DON'T FORGET ABOUT SENTRY HEALTH!

The Medical Advocacy Program through Sentry Health (formerly MAP) is a nurse concierge service that connects you to the best provider and facilities for procedures.

PAGE 14

RECORD YOUR CHOICES

Keep a note of your elections as you read through
the guide and use this list when you meet with Explain My Benefits to enroll.

HEALTH SERVICES PLAN:

Plan type

- ☐ Healthy Essentials
- ☐ Healthy Essentials Wellness
- ☐ Healthy Advantage Plus
- ☐ Healthy Advantage Plus Wellness
- ☐ Health Center Plan
- ☐ Health Center Plan Wellness

Coverage level

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family
- ☐ Half Family Primary
- ☐ Half Family Secondary
- ☐ Adult Dependent Child Aged 26-30

*The wellness plans above are only available to those employees that completed the 100 wellness incentive points and new hires for the 2024–2025 school year.

HEALTHCARE FSA:

☐ $ _____ per pay

DEPENDENT CARE FSA:

☐ $ _____ per pay

DISABILITY INSURANCE:

Monthly benefit amount $ _____

- ☐ 14 days
- ☐ 30 days
- ☐ 60 days
- ☐ 90 days
- ☐ 180 days

DENTAL:

Plan type

- ☐ DHMO
- ☐ PPO – Low
- ☐ PPO – High

Coverage level

- ☐ Employee
- ☐ Employee + One
- ☐ Employee + Family

VISION:

Standard

- ☐ Employee
- ☐ Employee + Family

Enhanced

- ☐ Employee
- ☐ Employee + Family

☑ BASIC LIFE AND AD&D INSURANCE: $0

SUPPLEMENTAL LIFE INSURANCE:

- ☐ None
- ☐ 1x annual salary
- ☐ 2x annual salary
- ☐ Spouse Life Insurance
- ☐ Child Life Insurance

ACCIDENT INSURANCE:

- ☐ Employee
- ☐ Employee + Spouse
- ☐ Employee + Children
- ☐ Employee + Family

TAX SHELTERED ANNUITIES:

$ per pay

Happy with your choices or want to learn more about them?
Visit osceolaschools.net/benefits for more information on enrollment.

SIGNING UP IS LICKETY-SPLIT

OPEN ENROLLMENT (AUGUST 5 – AUGUST 23)

With Open Enrollment, signing up for your benefits is as easy as our favorite class: lunch time. All you have to do is go online and schedule an appointment. We'll take care of the rest from there.

Open Enrollment can be completed three ways: self-service enrollment at **SDOC-benefits.com**, through a 1-on-1 phone or in-person meeting with Explain My Benefits, or through the Explain My Benefits mobile app. All benefit-eligible employees, whether you wish to elect or opt-out of coverage, must complete the enrollment process. Here are the steps you need to schedule your Benefit Counseling Session:

My enrollment appointment day and time is:

OCTOBER 1, 2024

Your benefit elections are effective.

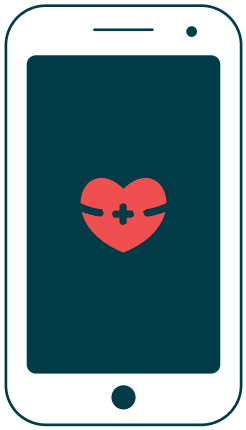
HOW TO COMPLETE YOUR SELF-SERVICE ENROLLMENT

Enroll in your benefits using any computer with internet access. Visit **sdoc-benefits.com**. You will be redirected to your online enrollment portal, follow the instructions to log in, and proceed with your elections for the new plan year.

HOW TO COMPLETE YOUR MOBILE APP ENROLLMENT

We've developed a benefits app, helping you understand and keep track of your health plan. This app also allows you to easily enroll in your Even Better Benefits.

See page 36 for more detailed Explain My Benefits Mobile App information.



HOW TO SCHEDULE YOUR 1-ON-1 ENROLLMENT APPOINTMENT

1. Once you've read this guide and made your elections, go online to schedule your 1-on-1 enrollment session whether in-person or telephonically. Spanish speaking counselors are available telephonically.
2. To schedule your 1-on-1 meeting, See QR codes below.
3. If telephonic, block out thirty minutes for your appointment and plan to be someplace you feel comfortable speaking out loud about your private benefits information.
4. Review your Open Enrollment Benefits Guide and have a good idea of what benefits you wish to elect. The benefits counselor will be able to answer your questions.
5. **Have critical pieces of information ready!** These include the Benefit Guide, dependent birth dates, social security numbers, names of healthcare providers, etc.
6. If telephonic, your benefits counselor will call you at the scheduled time and begin your enrollment. **All calls will come from a (321) area code.**

SCHEDULE YOUR APPOINTMENT

PHONE SCHEDULER

ON-SITE SCHEDULER

NEW TO THE OSCEOLA TEAM?

SCHEDULE YOUR APPOINTMENT

Your school or facility secretary will call you to let you know that you're cleared for employment. You'll then be able to enroll in benefits with Explain My Benefits. We'll also send emails to your District email address reminding you to enroll. It's vital that you check your email for updates from Risk & Benefits Management. If you don't receive your District e-mail details within a week of being cleared for employment, contact your supervisor.

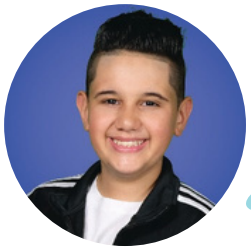
Your benefits are effective the first of the month after your date of hire. However, if this date has passed, you have not yet enrolled and are still within your enrollment period, insurance is effective the day of enrollment.

HIRED IN AUGUST?

If you are hired in August, your benefits become effective on September 1. During your enrollment, you will be asked to complete two enrollments - the New Hire Enrollment and Open Enrollment. If you do not complete both enrollments or only complete the new hire enrollment, you will default to the Healthy Essentials plan employee only coverage and the Board-paid Life Insurance for the remainder of the plan year.

To schedule your 1-on-1 enrollment meeting with Explain My Benefits visit osceolaschools.net/benefits.

QUALIFYING EVENTS

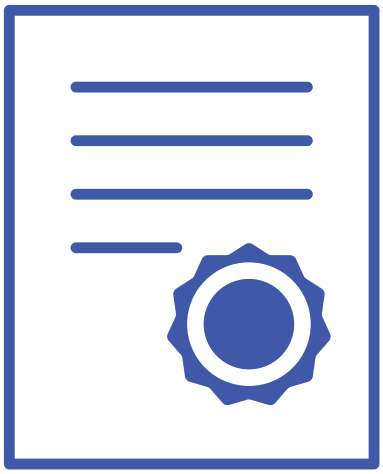


When my baby brother was born, I got to miss school AND my teacher gave me extra time to turn in my homework. Same goes for you—if something big happens in your life, you'll have a chance to change your benefit elections. Just be sure to tell Risk & Benefits Management within 30 days of your qualifying event.

QUALIFYING EVENTS INCLUDE, BUT ARE NOT LIMITED TO:

- Marriage, divorce, or legal separation (although legal separation isn't recognized in Florida);
- The death of spouse or other dependent;
- The birth or adoption of a child;
- A spouse's coverage is beginning or ending (must have coverage from previous employer);
- A dependent's eligibility status changing due to age, student status, marital status, or employment;
- You or your spouse experiencing a change in work hours that affect benefits eligibility;
- Relocation into or outside of your plan's service area;
- Voluntary or involuntary loss of other qualifying coverage or gaining other group coverage; or
- Your eligible child(ren) losing coverage under a federal or state sponsored health program.

The changes you make during the qualifying event window must be consistent with the event. For example, if you get married, you can add your spouse to your current medical coverage, but you cannot switch medical plans.



WHO'S ELIGIBLE TO BE A DEPENDENT?

Eligible dependents are defined as:

- Your legal spouse as defined under Federal law (Marriage Certificate required);
- Your domestic partner (refer to Benefit website for more information);
- Dependent children up to age 26, regardless of marital, financial, or student status (this doesn't include spouses of adult children), including:
  - o Your biological children, legally adopted children or stepchildren;
  - o Any children for whom you have been appointed legal guardian;
  - o Any children for whom the court has issued a Qualified Medical Child Support Order requiring you or your spouse to provide coverage; or
  - o Any dependents of a currently enrolled dependent (e.g., your grandchild), may be enrolled in a health plan for 18 months from birth only if born on plan.
- Dependent children aged 26 to 30 who meet all of the following eligibility criteria:
  - o Unmarried with no dependent children of their own;
  - o A resident of the state of Florida or a full-time or part-time student;
  - o Has no medical insurance as a named subscriber, insured enrollee, or covered person under any other group, blanket, or franchise health insurance policy or individual health benefits plan; and
  - o Is not entitled to benefits under Title XVII of the Social Security Act.

If in 30 days of your enrollment or qualifying event, you have not submitted your dependent documentation, your dependents will be retroactively terminated from the plan.

OTHER PLANS OFFERING DEPENDENT COVERAGE (DENTAL, VISION, AND LIFE INSURANCE)

Dependent eligibility varies by plan. Please refer to the summary plan descriptions for specific information on each plan.

- **Dental and Vision:** Coverage will cease at the end of the year in which your enrolled dependent children or domestic partner children reach age 26. Florida over age dependent law does not apply.
- **Accident:** Unmarried and dependent children can be covered up to age 26.
- **Universal Life Events:** Children can be covered up to age 18 (full-time student/dependent up to age 24).
- **Critical Illness:** Children can be covered up to age 26.
- **Hospital StayPay:** Unmarried and dependent children can be covered up to age 26.

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 pursuant to s.817.234, Florida Statues.

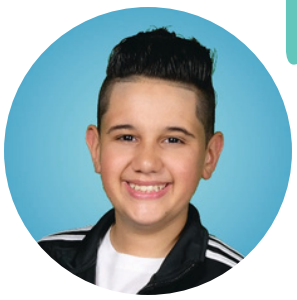
LESSON ONE:

AN OVERVIEW OF YOUR MEDICAL RATES

So you can understand how the different benefits will impact your paycheck, we've also included a summary of the per paycheck rates for our key benefits here, based on 20 paychecks per year.

Get this: the School Board contributes $7,498 per year towards your medical insurance! They're paying bigger bucks for your coverage so you won't have to. Sweet!

Think of this as a multiple choice test—just like the ones you used to take in class—except you get to choose the right answer. It's the coverage option that fits you and your family best.



MEDICAL:

	Healthy Essentials	Healthy Essentials Wellness	Healthy Advantage Plus	Healthy Advantage Plus Wellness	Health Center Plan	Health Center Plan Wellness
Employee Only	$25.00	$0.00	$75.00	$50.00	$25.00	$0.00
Employee + Spouse	$375.00	$325.00	$500.00	$450.00	$225.00	$175.00
Employee + Child(ren)	$202.00	$152.00	$325.00	$275.00	$75.00	$25.00
Employee + Family	$502.00	$452.00	$625.00	$575.00	$250.00	$200.00
Half Family Primary	$50.00	$20.00	$350.00	$300.00	$50.00	$0.00
Half Family Secondary	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Each Adult Dependent Child Aged 26-30	$375.00	$325.00	$500.00	$450.00	$225.00	$175.00

Half Family status – If you and your spouse work for SDOC, you are both eligible for benefits and if you have children, your status is considered **"Half-Family."** If you choose family coverage under one of the medical plans, only one spouse will have a payroll deduction for medical insurance. The spouse who is designated as **"Primary"** (for insurance purposes) will have the premiums deducted from his or her pay; the employee designated as **"Secondary"** will be covered under the Primary's medical plan. Note that this feature does not apply to employees with spouses in other school districts or government offices.

Job Share – Employees classified as Job Share pay half the Board contribution ($187.45 per pay) plus the premium listed based on your choice.

LESSON TWO:

AN OVERVIEW OF YOUR DENTAL & VISION RATES

SEEING THESE RATES WILL GIVE YOU SOMETHING TO SMILE ABOUT!

New Dental Rates Premium with an average of 9.9% increase with Enhanced Dental Benefits on select PPO plans

Check out your vision plan options and compare coverage on Page 28! Seeing things more clearly just got easier.

DENTAL:

	DHMO	PPO	
		Low Option	High Option
	Rate per pay	Rate per pay	Rate per pay
Employee	$8.25	$12.75	$20.89
Employee + One	$14.44	$26.15	$42.81
Employee + Family	$22.68	$45.75	$74.88

VISION:

	Standard	Enhanced
	Rate per pay	Rate per pay
Employee	$2.93	$6.56
Employee + Family	$8.10	$18.11

SECTION 125

Under Section 125 of the Internal Revenue Service (IRS) code, you're allowed to pay for certain group insurance premiums using pre-tax dollars. This means your premium deductions are taken before federal income and Social Security taxes are calculated. Depending on your tax bracket, your savings could be significant. The benefits that you can pretax are Medical, Dental, Vision, Accident, and FSA.

SCHEDULE YOUR ENROLLMENT MEETING WITH EXPLAIN MY BENEFITS.

STUDY GUIDE FOR YOUR MEDICAL PLANS

Choosing the best medical coverage can be complicated. So, we made you this handy study guide to help you figure out which plan—all provided by the district—would work best for you and your family.

EVOLUTIONS HEALTHCARE CUSTOM PROVIDER NETWORK

Evolutions Healthcare's network is made up of three tiers. Access to the tier is dependent upon which medical plan you select. The Health Center Plan is Tier 1/Tier 2 only.

Tier 1 (Evolutions Most Preferred Relationships) — This tier is for providers that offer great care and the greatest value for our plan. When you see a Tier 1 doctor, your copay will be the lowest out of all tiers. All hospitals in the Orlando Health system (including St. Cloud Hospital), Osceola Regional, Poinciana Medical Center, Lake Nona Medical Center and Nemours Children's Hospital, are Tier 1.

Tier 2 (Evolutions Preferred Relationships) —This tier for providers that are part of the Preferred Provider Network. So you'll get excellent care, and your co-pays will be a little less.

Tier 3 (Non-specified Providers) — This tier is of providers are not part of the Custom Provider Network Copays and deductibles are the highest for this tier. Advent Health and its affiliates are excluded from Tier 3 benefits except in cases of a true emergency at hospital facilities. Employees who elect to go to an Advent Health Provider will be responsible for services in full and will not qualify for any reimbursement under the health services plan. Tier 3 is not available under the Health Center Plan.

Both the Healthy Essentials and Healthy Advantage Plus plans give you the flexibility to visit any provider (doctor or facility), including specialists and Mental Health, without the need for a referral. Under the Health Center Plan, you must receive care at the Center for Employee Health, referrals are required for Specialists except for Pediatricians, Mental Health and OBGYNs. Only Tier 1 or Tier 2 providers covered under the Health Center Plan.

Want to nominate your doctor to become a Tier1provider? Just visit ehsppo.com/members and fill out the short "Nominate a Provider" online form!

NOMINATE YOUR PROVIDER

If your current provider isn't in Tier 1—don't worry—they may be able to become part of Evolutions' Custom Provider Network! All you have to do is fill out the "Nominate a Provider" form on Evolutions' website.

The process is simple and although we cannot guarantee your provider will choose to participate or that they will be moved up, we will do our best to make them part of the Tier 1 or Tier 2 network.

Watch this Video on How to Nominate Your Provider!

SO WHAT'S THE DIFFERENCE? YOUR OPTIONS ARE EASY AS A-B-C!

A **Healthy Essentials**

Under Health Essentials, you can visit Tier 1 and Tier 2 providers and specialists for a copay, but to visit Tier 3 providers you must pay a deductible and coinsurance. For anything outside the doctor's office, pay is based on tier deductible coinsurance and/or copay. Referrals to specialists are not required.

B **Healthy Advantage Plus**

Under Healthy Advantage Plus, you can visit Tier 3 providers for a copay, but Tier 1 and Tier 2 providers and specialists give you an even cheaper copay without having to meet the deductible first. For anything outside the doctor's office, pay is based on tier deductible coinsurance and/or copay. Referrals to specialists are not required.

C **Health Center Plan**

Under the Health Center plan, the Center for Employee Health is the Primary Care Provider (PCP) for those enrolled. Dependent children may continue to use their outside Pediatrician if the parent prefers. There is NO copay for Health Center or Pediatrician office visits.

Members will require a referral from their PCP to access Specialty care. The exceptions to the Referral process are OB-GYN, Pediatrician, Mental Health, Convenient Care (Minute Clinic), Urgent Care and Emergency Room. No referrals are needed for those providers. Only Tier 1 or Tier 2 providers are covered under this plan. The pharmacy network includes Prescriptions Unlimited, Walmart or Publix. No other pharmacies are included in the network. The Center for Employee Health coordinates needed referrals with Sentry Health. Members will be referred to one specialist as appropriately deemed by your provider.

Looking for some extra credit to boost your health grade? With our Wellness Incentive Program you earn points just for making healthy choices. Earn enough points to lower your premium.

Advent Health and its affiliates are excluded from Tier 3 benefits except in cases of a true emergency at hospital facilities. Employees who elect to go to an Advent Health Provider will be responsible for services in full and will not qualify for any reimbursement under the health services plan.

TRUE EMERGENCY DEFINITION

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

If you don't elect your benefits by the deadline, you'll automatically be enrolled in the Healthy Essentials Plan with Employee Only coverage and Board-paid Term Life Insurance.

MEDICAL ADVOCACY PROGRAM (MAP) FROM SENTRY HEALTH

Searching for the best provider or scheduling a medical procedure can be a time-consuming challenge—one we don't want you to go through. With our Medical Advocacy Program from Sentry Health, you no longer have to worry about finding the best doctor or facility or the best price. Sentry Health will take care of everything for you.

Sentry Health's MAP is a nurse concierge service that finds you the best providers and facilities for any medical procedure you may need. Your only job is to call a MAP Nurse Advocate (RN) – and they'll take care of the rest.

SENTRY HEALTH WILL:

- Find the best specialists in your area
- Identify the best quality and most cost-effective providers
- Figure out which provider and facility works best for you
- Find out who can work you into their schedule
- Answer questions about medical concerns
- Offer qualified second opinions and different treatment options available

If you follow through with the recommendation Sentry Health gives you, your deductible for that procedure will be waived!

The best part is that you don't even need to worry about the cost. MAP is a service that is completely free to members and is included in your Even Better Benefits!

CONTACT SENTRY HEALTH

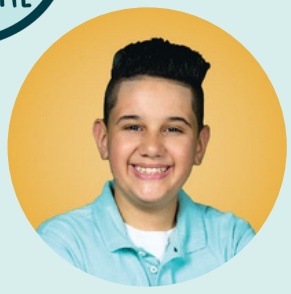
We have a hotline just for the district!

Call: 844-297-0747

Monday - Friday 8:30AM - 6:30PM

Visit: **sentryhealth.com/member-support**

Spend your YOU time focusing on more important things, while MAP does all the work for you!



HOW MAP WORKS

1. Contact Sentry Health at **1-844-297-0747** and speak with a Sentry Health Nurse Advocate about your medical concerns.
2. Your Sentry Health Nurse Advocate will listen, do research and then provide information, answers, and opinions.
3. Your Sentry Health Nurse Advocate will do further research and call you back to discuss results and options. They will also email you a user-friendly report. Now you are ready to contact and see your provider.

▶ Watch this Video on How the MAP Works!

Generic Medications are significantly less expensive than brand name alternatives. Under all plans, if you choose to purchase a brand name drug over the generic drug when the generic drug is available and appropriate, you will incur higher out-of-pocket costs.

Drug Quantity Limits means you may have coverage for a limited amount of a specific medication. Quantity limits set by the drug manufacturer are in place to ensure your medication is being used correctly and that you are getting the most appropriate treatment.

Drug Prior Authorization means that before a prescription is filled, your doctor, or your prescriber must first show that you have a medically necessary need for that particular drug and/or have met the prior authorization requirements for the drug.

Step Therapy is a type of prior authorization. In most cases, you must first try a less expensive drug that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug.

Both the Healthy Essentials and the Healthy Advantage Plus Plan include prescription drug coverage with a Preferred and Non-Preferred Pharmacy benefit. Preferred pharmacies include independent pharmacies such as Prescriptions Unlimited as well as Publix, Costco, Walmart and Walmart family of stores. Non-preferred pharmacies include CVS, Walgreens and RiteAid as an example.

The Health Center Plan allows you to obtain your prescriptions at Prescriptions Unlimited, Publix or Walmart and Walmart family stores.

ELECT Rx

If you have a medical condition that requires an expensive brand-name prescription medication, we have great news! With ElectRx you can get brand-name, high-cost medications delivered right to your door—and you won't have to pay a dime. ElectRx orders your medication from a Tier 1 pharmaceutical country such as Canada, England, and New Zealand where brand name drugs cost up to 70% less. These are high-cost medications that you would typically get right here in the U.S., but they cost our plan much less. And they cost you nothing.

ElectRx has just three simple steps:

1. If you have a condition that requires you to take a high cost brand name medication, check to see if ElectRx offers any of your medication(s). They've got dozens of popular, high-cost name brands. If your medication is available, make sure you have a 30-day supply on hand for the transition period.
2. Have your doctor send a prescription for up to a 90-day supply to ElectRx. ElectRx fills your prescription at a trustworthy pharmacy.
3. Once ElectRx has your basic personal information and the prescription from your physician, in 10-15 days, you will receive your 90-day supply of the prescription right in your mailbox!

Special delivery arrangements are made for medications that require temperature controls.

CONTACT ELECT Rx

Phone: 1-855-Elect RX (1-855-353-2879)
Fax: 1-833-Elect RX (1-833-353-2879)

GREEN IMAGING

Should you need medical imaging, you can get the diagnostic imaging you need at **no cost.** Just contact Green Imaging with the prescription and they'll make you an appointment with a network facility that is not only close to your home, but has the right type of equipment for the image your doctor ordered. You'll be issued a voucher to present at your appointment and then that's it! Your exam report will be immediately sent to your referring doctor and you won't need to worry about your co-pay or after procedure bill—Green Imaging and SDOC have you covered.

If you do not use Green Imaging's recommendation, you will need to pay the appropriate deductible and coinsurance.

CONTACT GREEN IMAGING

Call: 844-968-4647
Text: 713-524-9190
Chat: **greenimaging.net**

YOUR EVEN BETTER BENEFITS

LEGEND

EVOLUTIONS Health Care Systems has built custom relationships for SDOC with providers and facilities. These relationships will continue to grow. The **main** Tier 1 hospitals for Evolutions are **all** of the hospitals in the Orlando Health System and St. Cloud Hospital: Osceola Regional, Poinciana Medical Center, Lake Nona Medical Center and Nemours Children's Hospital.

Medical Advocacy Program (MAP) through Sentry Health:
Now this is something to get excited about! As a service to our members, we offer a nurse concierge service to assist in finding the **highest quality**, **cost effective**, in the **best tier** available. While this service is available for any claims, it is particularly important in choosing the best facility for any planned procedure (see page 8).

How the "MAP" plan works for planned procedures and services that require pre-certification:

Member calls Sentry and follows their advice:	Deductible is waived for that procedure
Member calls Sentry and does NOT follow Sentry Health's advice:	Claims will be denied. Retro effective referrals are not allowed under the plan.
Member does not call Sentry Health:	Claims will be denied. Retro effective referrals are not allowed under the plan.

Prescription Drug Benefits:
The Health Center Plan allows you to fill your prescriptions at Prescriptions Unlimited, Publix, Walmart and Walmart family of stores, including Sam's and Walmart Neighborhood Market). The ElectRx program is also available to those enrolled in the Health Center Plan.

HEALTH CENTER PLAN

Even Better BENEFITS

	HEALTH CENTER PLAN 2024-2025
	The Center for Employee Health is the Primary Care Provider (PCP) for those enrolled. Dependent children may continue to use their Pediatrician under the Evolutions Custom Network if the parent prefers. Referrals are required to see a Specialist except OB-GYN, Pediatrician, Mental Health, Convenient Care (Minute Clinic), Urgent Care and Emergency room
	Follow MAP recommendations and the deductible will be waived for that procedure. Claims will be denied without qualified Health Center and Sentry Health referrals.
Deductible (Individual/family)	$500 / $1,000
Co-Insurance	20%
Out of Pocket Maximum (Individual/family)	$4,000 / $8,000
SDOC Center for Employee Health Copay	$0
Telemedicine	$0
Preventive Care	$0
Pediatrician Office Visit (Non-SDOC Health Center)	$0
Specialist Office Visit	$30 (referral required)
Emergency Room	$400 copay (waived if admitted)
Urgent Care	$45
Labwork — Done at Independent Lab (Health Center, Quest or LabCorp)	$0
Labwork — All Other Facilities	20%, no deductible
Advanced Imaging	Deductible/Co-Insurance
Advanced Imaging Through Green Imaging	$0
Convenience Care (Minute Clinic)	$0

HEALTH CENTER PLAN 2024-2025	
Generic Prescription Drugs obtained through Prescriptions Unlimited at the Center for Employee Health are available at no cost to the Plan Participant.	
Covered Charges for PHARMACY expenses accrue toward the maximum out-of-pocket amount as shown in the Medical Schedule of Benefits.	
Health Center Plan Pharmacy Network: Prescriptions Unlimited (the health center and St. Cloud locations), Publix, Walmart and Walmart family of stores, including Sam's and Walmart Neighborhood Market). The ElectRx program is also available to those enrolled in the Health Center Plan.	
TYPE	HEALTH CENTER PLAN PHARMACY NETWORK*
RETAIL PHARMACY – 30-day supply per prescription.	
Generic Drugs	$0 copayment per prescription
Formulary Brand Name Drugs	$45 copayment per prescription
Non-Formulary Brand Name Drugs	50% copayment up to $150 per prescription
RETAIL PHARMACY – 31 to 60-day supply per prescription.	
Generic Drugs	$0 copayment per prescription
Formulary Brand Name Drugs	$90 copayment per prescription
Non-Formulary Brand Name Drugs	50% copayment up to $300 per prescription
RETAIL PHARMACY – 61 to 91-day supply per prescription.	
Generic Drugs	$0 copayment per prescription
Formulary Brand Name Drugs	$135 copayment per prescription
Non-Formulary Brand Name Drugs	50% copayment up to $450 per prescription
SPECIALTY DRUGS – limited to a 30-day supply per prescription.	
Specialty Drugs	$75 copayment per prescription
*In cases of emergency or travel, acute medications may be dispensed at any pharmacy. Call Ventegra if you're travelling for an extended period of time to ensure you receive your maintenance medications.	
Note: If a Plan Participant requests a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the difference in cost between the Generic drug and the Brand name drug in addition to the applicable Brand name drug copayment amount (if any). This difference in payment will not apply to the maximum out-of-pocket amount as stated in the Schedule of Benefits.	
Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies will not apply toward the maximum out-of-pocket amount.	

YOUR PREMIUMS

	HEALTH CENTER PLAN 2024-2025	
	Wellness Points Earned	Wellness Points Not Earned
Employees Only	$0	$25
Employee + Spouse	$175	$225
Employee + Children	$25	$75
Employee + Family	$200	$250
Half Family Primary	$0	$50
Half Family Secondary	$0	$0
Each Adult Dependent Child Age 26–30	$175	$225

YOUR EVEN BETTER BENEFITS

LEGEND

EVOLUTIONS Health Care Systems has built custom relationships for SDOC with providers and facilities. These relationships will continue to grow.
The **main** Tier 1 hospitals for Evolutions are **all** of the hospitals in the Orlando Health System and St. Cloud Hospital: Osceola Regional, Poinciana Medical Center, Lake Nona Medical Center and Nemours Children's Hospital.

Medical Advocacy Program (MAP) through Sentry Health:
Now this is something to get excited about! As a service to our members, we offer a nurse concierge service to assist in finding the **highest quality, cost effective,** in the **best tier** available. While this service is available for any claims, it is particularly important in choosing the best facility for any planned procedure (see page 14).

How the "MAP" plan works for planned procedures and services that require pre-certification:

Member calls Sentry Health and follows their advice:	Deductible is waived for that procedure
Member calls Sentry Health and does NOT follow Sentry Health's advice:	Plan pays usual benefits
Member does not call Sentry Health:	Plan pays usual benefits

Prescription Drug Benefits:
To save money, have your prescription filled at a Preferred Pharmacy (Independent and Local Community Pharmacies, Publix, Costco, Walmart and Walmart family of stores, including Sam's and Walmart Neighborhood Market) over a Non-Preferred Pharmacy (CVS, Walgreens, Rite-Aid) to get the most out of your Even Better Benefits!.

Advent Health and its affiliates are excluded from Tier 3 benefits except in cases of a true emergency at hospital facilities. Employees who elect to go to an Advent Health Provider will be responsible for services in full and will not qualify for any reimbursement under the health services plan.

Even Better BENEFITS

	HEALTHY ESSENTIALS BENEFITS PLAN 2024–25		
	GOOD	BETTER	BEST
	TIER 3 BENEFITS	**TIER 2 ENHANCEMENT** Evolutions Custom Network	**TIER 1 ENHANCEMENT** Evolutions Custom Network
	Follow MAP recommendations and the deductible will be waived for that procedure.	Follow MAP recommendations and the deductible will be waived for that procedure.	Follow MAP recommendations and the deductible will be waived for that procedure.
Deductible (Individual/family)	$1,250 / $2,500	$1,250 / $2,500	$900 / $1,800
Co-Insurance	30%	30%	30%
Out of Pocket Maximum (Individual/family)	$6,300 / $13,600	$6,300 / $13,600	$5,000 / $10,000
SDOC Center for Employee Health Copay	$0	$0	$0
Telemedicine	$0	$0	$0
Preventive Care	$0	$0	$0
PCP Office Visit (Non-SDOC Health Center)	Deductible/Co-Insurance	$40	$20
Specialist Office Visit	Deductible/Co-Insurance	$80	$40
Emergency Room	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Urgent Care	Deductible/Co-Insurance	$45	$45
Labwork — Done at Independent Lab	30%; No Deductible	30%; No Deductible (Ex. LabCorp)	$10 (Ex. Quest Diagnostics)
Labwork — All Other Facilities	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Advanced Imaging	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Advanced Imaging Through Green Imaging	$0	$0	$0
Convenience Care (Minute Clinic)	Deductible/Co-Insurance	$40	$20

HEALTHY ESSENTIALS BENEFITS PLAN 2024–25		
Generic Prescription Drugs obtained through Prescriptions Unlimited at the Center for Employee Health are available at no cost to the Plan Participant.		
Covered Charges for PREFERRED PHARMACY expenses accrue toward the TIER 1 PROVIDERS maximum out-of-pocket amount as shown under TIER 1 in the Medical Schedule of Benefits.		
Covered Charges for NON-PREFERRED PHARMACY expenses accrue toward the TIER 2 PROVIDERS maximum out-of-pocket amount as shown under TIER 2 in the Medical Schedule of Benefits.		
*NON-PREFERRED PHARMACY Plan Year deductible..... $300 per Plan Participant (does not apply to Formulary generic drugs)		
TYPE	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
RETAIL PHARMACY – 30-day supply per prescription.		
Generic Drugs	$6 copayment per prescription	$10 copayment per prescription (deductible waived)
Formulary Brand Name Drugs	$45 copayment per prescription	20% copayment up to $75 per prescription, after deductible
Non-Formulary Brand Name Drugs	50% copayment up to $150 per prescription	50% copayment up to $200 per prescription, after deductible
RETAIL PHARMACY – 31 to 60-day supply per prescription.		
Generic Drugs	$12 copayment per prescription	$20 copayment per prescription (deductible waived)
Formulary Brand Name Drugs	$90 copayment per prescription	20% copayment up to $150 per prescription, after deductible
Non-Formulary Brand Name Drugs	50% copayment up to $300 per prescription	50% copayment up to $400 per prescription, after deductible
RETAIL PHARMACY – 61 to 91-day supply per prescription.		
Generic Drugs	$18 copayment per prescription	$30 copayment per prescription (deductible waived)
Formulary Brand Name Drugs	$135 copayment per prescription	20% copayment up to $225 per prescription, after deductible
Non-Formulary Brand Name Drugs	50% copayment up to $450 per prescription	50% copayment up to $450 per prescription, after deductible
SPECIALTY DRUGS – limited to a 30-day supply per prescription.		
Specialty Drugs	50% copayment up to $200 per prescription	Not Covered
Note: If a Plan Participant requests a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the difference in cost between the Generic drug and the Brand name drug in addition to the applicable Brand name drug copayment amount (if any). This difference in payment will not apply to the maximum out-of-pocket amount as stated in the Schedule of Benefits.		
Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies will not apply toward the maximum out-of-pocket amount.		

YOUR PREMIUMS

	HEALTHY ESSENTIALS BENEFITS PLAN 2024-2025	
	Wellness Points Earned	Wellness Points Not Earned
Employees Only	$0	$25
Employee + Spouse	$325	$375
Employee + Children	$152	$202
Employee + Family	$452	$502
Half Family Primary	$20	$50
Half Family Secondary	$0	$0
Each Adult Dependent Child Age 26–30	$325	$375

EVEN BETTER BENEFITS

LEGEND

EVOLUTIONS Health Care Systems has built custom relationships for SDOC with providers and facilities. These relationships will continue to grow. The **main** Tier 1 hospitals for Evolutions are **all** of the hospitals in the Orlando Health System and St. Cloud Hospital: Osceola Regional, Poinciana Medical Center, Lake Nona Medical Center and Nemours Children's Hospital.

Medical Advocacy Program (MAP) through Sentry Health:
Now this is something to get excited about! As a service to our members, we offer a nurse concierge service to assist in finding the **highest quality, cost effective,** in the **best tier** available. While this service is available for any claims, it is particularly important in choosing the best facility for any planned procedure (see page 14).

How the "MAP" plan works for planned procedures and services that require pre-certification:

Member calls Sentry Health and follows their advice:	Deductible is waived for that procedure
Member calls Sentry Health and does NOT follow Sentry Health's advice:	Plan pays usual benefits
Member does not call Sentry Health:	Plan pays usual benefits

Prescription Drug Benefits:
To save money, have your prescription filled at a Preferred Pharmacy (Independent and Local Community Pharmacies, Publix, Costco, Walmart and Walmart family of stores, including Sam's and Walmart Neighborhood Market) over a Non-Preferred Pharmacy (CVS, Walgreens, Rite-Aid) to get the most out of your Even Better Benefits!.

Advent Health and its affiliates are excluded from Tier 3 benefits except in cases of a true emergency at hospital facilities. Employees who elect to go to an Advent Health Provider will be responsible for services in full and will not qualify for any reimbursement under the health services plan.

Even Better BENEFITS

	HEALTHY ADVANTAGE PLUS BENEFITS PLAN 2024–25		
	GOOD	BETTER	BEST
	TIER 3 BENEFITS	**TIER 2 ENHANCEMENT** Evolutions Custom Network	**TIER 1 ENHANCEMENT** Evolutions Custom Network
	Follow MAP recommendations and the deductible will be waived for that procedure.	Follow MAP recommendations and the deductible will be waived for that procedure.	Follow MAP recommendations and the deductible will be waived for that procedure.
Deductible (Individual/family)	$950 / $1,900	$950 / $1,900	$600 / $1,200
Co-Insurance	25%	25%	25%
Out of Pocket Maximum (Individual/family)	$6,700 / $12,400	$6,700 / $12,400	$4,000 / $8,000
SDOC Center for Employee Health Copay	$0	$0	$0
Telemedicine	$0	$0	$0
Preventive Care	$0	$0	$0
PCP Office Visit (Non-SDOC Health Center)	$30	$25	$15
Specialist Office Visit	$60	$50	$40
Emergency Room	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Urgent Care	$100 Copay	$45	$45
Labwork — Done at Independent Lab	25%; No Deductible	25%; No Deductible (Ex. LabCorp)	$5 (Ex. Quest Diagnostics)
Labwork — All Other Facilities	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Advanced Imaging	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Advanced Imaging Through Green Imaging	$0	$0	$0
Convenience Care (Minute Clinic)	$30	$25	$15

HEALTHY ADVANTAGE PLUS BENEFITS PLAN 2024 - 2025		
Generic Prescription Drugs obtained through Prescriptions Unlimited at the Center for Employee Health are available at no cost to the Plan Participant.		
Covered Charges for PREFERRED PHARMACY expenses accrue toward the TIER 1 PROVIDERS maximum out-of-pocket amount as shown under TIER 1 in the Medical Schedule of Benefits.		
Covered Charges for NON-PREFERRED PHARMACY expenses accrue toward the TIER 2 PROVIDERS maximum out-of-pocket amount as shown under TIER 2 in the Medical Schedule of Benefits.		
*NON-PREFERRED PHARMACY Plan Year deductible | $75 per Plan Participant (does not apply to Formulary generic drugs)		
TYPE	PREFERRED PHARMACY	NON-PREFERRED PHARMACY
RETAIL PHARMACY – 30-day supply per prescription.		
Generic Drugs	$5 copayment per prescription	$10 copayment per prescription (deductible waived)
Formulary Brand Name Drugs	$40 copayment per prescription	20% copayment up to $50 per prescription, after deductible
Non-Formulary Brand Name Drugs	50% copayment up to $125 per prescription	50% copayment up to $150 per prescription, after deductible
RETAIL PHARMACY – 31 to 60-day supply per prescription.		
Generic Drugs	$10 copayment per prescription	$20 copayment per prescription (deductible waived)
Formulary Brand Name Drugs	$80 copayment per prescription	20% copayment up to $100 per prescription, after deductible
Non-Formulary Brand Name Drugs	50% copayment up to $250 per prescription	50% copayment up to $300 per prescription, after deductible
RETAIL PHARMACY – 61 to 91-day supply per prescription.		
Generic Drugs	$15 copayment per prescription	$30 copayment per prescription (deductible waived)
Formulary Brand Name Drugs	$120 copayment per prescription	20% copayment up to $150 per prescription, after deductible
Non-Formulary Brand Name Drugs	50% copayment up to $375 per prescription	50% copayment up to $450 per prescription, after deductible
SPECIALTY DRUGS – limited to a 30-day supply per prescription.		
Specialty Drugs	50% copayment up to $200 per prescription	Not Covered
Note: If a Plan Participant requests a Brand name drug when a Generic equivalent is available, then the Plan Participant must pay the difference in cost between the Generic drug and the Brand name drug in addition to the applicable Brand name drug copayment amount (if any). This difference in payment will not apply to the maximum out-of-pocket amount as stated in the Schedule of Benefits.		
Prescription Drug Dispense As Written (DAW) penalties, and discounts and coupons provided through Prescription Drug assistance programs, drug manufacturers or Pharmacies will not apply toward the maximum out-of-pocket amount.		

YOUR PREMIUMS

	HEALTHY ADVANTAGE PLUS BENEFITS PLAN 2024-2025	
	Wellness Points Earned	Wellness Points Not Earned
Employees Only	$50	$75
Employee + Spouse	$450	$500
Employee + Children	$275	$325
Employee + Family	$575	$625
Half Family Primary	$300	$350
Half Family Secondary	$0	$0
Each Adult Dependent Child Age 26–30	$450	$500

TIER 3 POTENTIAL BALANCE BILLING AND THE PROCESS

DON'T FORGET TO OPEN YOUR MAIL

I've had to learn the hard way that procrastination isn't your friend. So take it from me and make sure you're staying on top of your medical bills. If you report your balance bill too late, it could lead to multiple bill notices.

WHAT IF A DOCTOR WON'T ACCEPT YOUR HEALTHY ESSENTIALS OR HEALTHY ADVANTAGE PLUS PLAN?

Usually when a provider says they won't take your plan it's because your card doesn't have a familiar logo on the front, or they don't realize the plan doesn't use a traditional network and benefits will be paid directly. Once your provider realizes they will be getting paid at a fair and reasonable rate, they will generally take your plan.

In the rare case that they still will not accept your plan, please follow the four simple steps outlined. SDOC, in partnership with EBMS, will ensure your provider is educated on the plan and its benefits.

IF YOUR PLAN ISN'T ACCEPTED

1. Receive services as usual. If the provider's office states they will not accept your plan, proceed to Step 2.
2. Ask to speak to the billing representative or office manager, and provide them with your updated card.
3. Ask the office manager or billing representative to call EBMS to verify coverage and eligibility.
4. If for any reason, after you've followed the above steps, the provider still states they will not accept your SDOC Plan, please call EBMS at **888-326-7240.** Provide EBMS the details of your situation and they will engage your benefits advocate.

HOW TO ADDRESS YOUR POTENTIAL BALANCE BILL

1. Contact EBMS at **888-326-7240**
2. Send EBMS a copy of the balance bill from your provider. Make sure your Explanation of Benefits matches your balance bill!
3. EBMS will review the bill and connect you with a Patient Advocate to contact the provider on your behalf.
4. Your Patient Advocate will keep you informed on the status of your balance bill until it is resolved.

If you do not report a Balance Bill in a timely fashion, it can lead to multiple notices of monies owed.

- Contact EBMS at 888-326-7240
- Send EBMS a copy of the balance bill from your provider

Make sure your Explanation of Benefits (EOB)...

From your health plan
(This is not a bill)

...Matches your bill

From the Provider

With the Healthy Essentials or Healthy Advantage Plus Plan, you have the flexibility to go to any doctors, hospitals, and facilities you choose except Advent Health. That's because our plan has a network of providers with direct contracts and agreed upon reimbursement rates where providers are paid well above what Medicare pays. (Tier 3 is not applicable to the new Health Center Plan).

While Tier 1 and Tier 2 providers of the Evolutions Network will readily accept this offer, Tier 3 providers may occasionally "push back" and send you a balance bill for any amount over your plan's allowance.

If this happens—don't worry—you are not personally responsible for any balance bill amounts! As long as all patient responsibility has been taken care of and plan payment was made, we'll negotiate a settlement with the provider.

What' s most important is that you contact us as soon as you receive your bill. The sooner you open your bill, the more time we have to negotiate and get it taken care of.

CENTER FOR EMPLOYEE HEALTH

RIGHT WHERE YOU NEED US

You've got tests to grade, lesson plans to make, dinner to be put on the table...a trip to the doctor can throw off your whole day. Good thing you don't have to go far, thanks to our on-site Center for Employee Health, which offers you high-quality, affordable health and wellness services right on the oTEC campus. So you and your family can get the medical service needed.

I heard at recess that you might want to be on the lookout for the new, full pharmacy at the SDOC Employee Health Center!

Our onsite Center for Employee Health—operated by RosenCare —gives you access to high quality, affordable healthcare services. The health center is an all-inclusive medical home, focusing on Primary Care medicine. Established patients may call in the morning for an acute care visit, if scheduling permits, however, walk-ins are not available.

The Center provides services you would normally receive at your primary care physician's office in addition to health services that focus on improving your health. Some examples of these services are:

- Primary Care
- Physical Therapy
- Medical Nutrition Therapy
- Occupational Health
- Retinal eye screening
- Retina specialist
- Treatment of on the job injuries
- On-Site Prescription Dispensing of certain generic medications
- On-Site X-Ray and EKG
- Chiropractor
- Mammograms

FREQUENTLY ASKED QUESTIONS

Are employees that opt-out of the District' s medical coverage able to visit the Center?
Individuals who are not covered by the District's medical plan will not be eligible to utilize the Health Center. This includes those employees that opt-out of medical coverage or dependents not covered by the plan.

Has the eligibility for the Center for Employee Health changed?
Employees, retirees and their family members (24 months and older) enrolled in one of the District's medical plan options may receive services at the Center at no cost.

Who is PeopleOne?
PeopleOne is RosenCare's premier partner for health center operations. You will see their name and logo on items such as employee name tags, the Patient Portal, new patient paperwork, online scheduling tools, health center communication pieces, etc.

What providers can I use on the new Health Center Plan?
Under the Health Center Plan, the Center for Employee Health is the Primary Care Provider (PCP) for those enrolled. Dependent children may continue to use their Evolutions Tier 1 or Tier 2 Pediatrician if the parent prefers or the child is under 2 years old. There is NO copay for the health center PCP or the pediatrician.

Do I need a referral for a Specialist under the New Health Center Plan?
Yes, members will require a referral from their PCP to access Specialty Care. No referrals are needed for OBGYN, Pediatrician, Mental Health, Convenience Care (Minute Clinic), Urgent Care or Emergency Room. However, the providers must be part of the Evolutions network except for emergencies.

APPOINTMENTS

407-483-5757
SDOCEmployeeHealthCenter.net
831 Simpson Road, Kissimmee, FL 34744

Monday – Friday: 7am to 7pm
Saturday: 8am to noon
Sunday: Closed

ONSITE PHARMACY

PRESCRIPTIONS UNLIMITED AT THE CENTER FOR EMPLOYEE HEALTH

Save time and money with our full service pharmacy at the Center for Employee Health. In partnership with Prescriptions Unlimited, covered members on any of the three health services plans may get their medications at the onsite pharmacy.

- Copay Waived for all Generic Medications;
- Copay Waived for first 90-day Brand Medication fill (May be filled in 30-day supply)
- Free Delivery (Call to arrange delivery).
- Free-over the counter medications (limited formulary)
- Accepts all provider prescriptions (must be enrolled in SDOC health plan).
- Medication Packaging (Ask our team for more information).
- Walk-In Immunizations Available
- Specialty Medications
- And Much More!

PRESCRIPTIONS UNLIMITED

831 Simpson Rd. Suite 102
Kissimmee, FL 34744

Call: 407-750-9313
Fax: 407-750-9314
Text: 407-794-7734

Monday - Friday 8:00AM - 6:00PM
Visit: **UnlimitedRX.com/SDOC**

Rx **Download the RxLocal app by texting RXLOCAL to 64890.**

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Balancing work, family, finances, health, and wellbeing is never easy. We want to make sure you always have someone to lend an ear and offer advice, just like you do for us. Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult, whenever and wherever you need them.

As a District employee, you, your immediate family members, and anyone living in your home, have access to a number of services, all at no cost, 24 hours a day, 365 days a year, including:

- Confidential Emotional Support
- Work-Life Solutions
- Legal Guidance
- Financial Resources
- Free Online Will Preparation
- Online Support

CONTACT INFORMATION

1-888-882-0797
1-800-697-0353 (TTY)
guidanceresources.com
using the web ID: OCSOCS

OPT-OUT CREDIT

If you don't see an option that fits you and your family? Opting out is an option too—think of it as the EVEN BETTER version "none of the above." As long as you're covered under another medical plan, either as a dependent or through individually acquired coverage, you can choose to opt out and decline medical coverage.

Since SDOC funds the basic level of the health services plan and there's no employee premium, if you choose to opt out of medical coverage, you'll receive up to a $750 annual credit which you may apply toward voluntary benefits, such as:

- Dental Employee Only coverage
- Vision Employee Only coverage
- A Flexible Spending Account (FSA)
- Disability Insurance

You cannot use credit dollars to pay for dental and vision coverage for your dependents, you can elect dependent coverage and pay for it through your own pre-tax payroll deductions. We've included a summary of the costs for dental and vision coverage using the opt out credit below.

Dental premiums

	HMO	PPO	
		Low option	High option
	Opt out credit Rate per pay	Opt out credit Rate per pay	Opt out credit Rate per pay
Employee	$ 0.00	$ 0.00	$ 0.00
Employee + One	$ 6.19	$13.40	$21.93
Employee + Family	$14.43	$33.00	$54.00

Vision premiums

	Standard	Enhanced
	Opt out credit Rate per pay	Opt out credit Rate per pay
Employee	$ 0.00	$ 0.00
Employee + Family	$5.17	$11.55

If you chose to take the opt out credit in an FSA contribution only – due to Healthcare Reform Regulations – the District is limited to a $500 contribution. The full $750 contribution can be made by the District if you do not elect any of the above voluntary benefits and you contribute a minimum of $750.

If you contribute $500 or more to your Health Care FSA, the District will match your contribution dollar for dollar up to $750. Any voluntary benefit elections you select using this opt out credit will not be counted towards the $750 in the District's matching dollar amount.

Example 1: You elect no voluntary benefits and contribute $0 to your Health Care FSA. The District will contribute $500 to your Health Care FSA.

Example 2: You elect no voluntary benefits and contribute $450 to your Health Care FSA. The District will contribute $500 to your Health Care FSA.

Example 3: You elect no voluntary benefits and contribute $650 to your FSA. The District will also contribute $650 to your Health Care FSA.

Example 4: You elect Employee + Family Vision Enhanced Plan and contribute $750 to your Health Care FSA. The District will contribute $618.80 to your Health Care FSA.
$6.56 × 20 pay periods = $131.20
$750 – $131.20 = $618.80

Example 5: See page 31 for the FSA benefit available to all employees. For employees who opt out of all voluntary benefits, to receive the full $1,000 match ($750 opt out credit and $250 new benefit), you must contribute $1,000 to your Health Care FSA.

Please note, this isn't a cash pay-out and can only be used for eligible expenses.

SMILES ALL AROUND

There's nothing better than seeing you smile. Smiles are contagious, after all. Choose from one of our three dental plans and we'll keep you and your whole family showing off those healthy, cheerful chompers.

Dental plan premiums have increased an average of 9.9% with Enhanced Dental Benefits on select PPO plans

We've provided a comparison of the plans below, but this is only a brief summary.
Check out page 11 for more information about the premiums you could pay for these plans and find full details about the plans at **humana.com** or visit the District benefits website.

HUMANA DENTAL HS195S DHMO

Humana Dental HS195S DHMO gives you and your covered family members access to the dental care you need through Humana's DHMO network of quality dentists.

Each covered family member can choose their own general dentist from the network. If you or your family members should need to seek services from a specialist, NO referrals are required. You simply search for a provider in the network and contact them for an appointment.

HUMANA DENTAL TRADITIONAL PREFERRED PPO

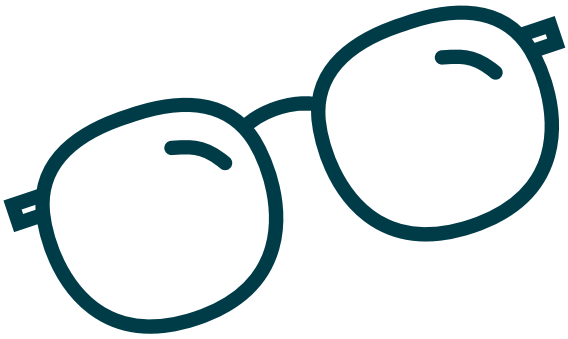
When you enroll in the Humana Traditional Preferred PPO, you and your covered family members can access the dental care you need through Humana Dental's extensive network of quality dentists.
You can visit any dentist, both in- and out-of-network, however, PPO in-network providers will almost always be less expensive. You also run the risk of balance billing from out-of-network providers. If you select the PPO option, you will then have two options for coverage; either the High option or Low option.

COVERAGE COMPARISON

	DHMO	PPO	
		Low Option	High Option
Network	In-network only	In- and out-of-network	In- and out-of-network
Annual deductible	None	$50 per subscriber, $150 per family Does not apply to Class 1 Care	
Annual maximum	None	$2,000 per covered person	
Class 1 - Diagnostic and Preventative			
Routine cleaning	No charge	20%	No charge
Fluoride application			
X-rays			
Sealants	No charge	No charge	No charge
Office visit fee			
Class 2 - Basic Restorative Care			
Periodontal maintenance cleanings	No charge for 2 cleanings per year (add'l $55)	20% (Four cleanings a year)	No charge (Four cleanings a year)
Amalgam fillings	No charge	40%	20%
Surgical extraction of impacted teeth	$50 - $100		
Class 3 - Major Restorative Care			
Crowns	$245*	50%	50%
Dentures	$325* + $425*		
Bridges	$245 (Per tooth/unit)		
Implants	Not covered		
Class 4 - Orthodontics			
Evaluation	$0	Dependent children – 50%	Dependent children – 50%
Orthodontic treatment	Dependent children & Adults — $1,850	Adults – 50% (No deductible)	Adults – 50% (No deductible)
Lifetime orthodontic maximum	N/A	$1,000	$1,000

* **Plus lab cost not to exceed $200.** This is only a brief summary of the plans and is intended for comparison purposes only.
Please visit **osceolaschools.net/benefits** for plan descriptions.

GREAT VISION COVERAGE? LOOK NO FURTHER



Even if you're not seeing with perfect 20/20 vision, we want to keep you feeling 20/20. Glasses, contacts and regular eye exams can quickly add up in cost, but we've got options to keep the strain off your eyes — and off your wallet.

With this year's vision package, you and your family have two vision plan options. VSP offers you low out-of-pocket costs, and with a wide range of in-network providers all around you, you can get the personalized care you need under the care you want. Plus, you can maximize your coverage with bonus offers and extra savings that are exclusive to Premier Program locations. Need a second pair of glasses? VSP offers you an extra $20 to spend on featured brands and up to 40% savings on lens enhancements.

Check out Page 11 for more information about the vision plan premiums.

Like shopping online? Visit eyeconic.com to use your vision benefits and shop over 50 brands of contacts, eyeglasses and sunglasses.

The following page contains only a brief summary of the plans and is intended for comparison purposes only.

Please call 800-877-7195 or go to **vsp.com** for plan descriptions including out-of-network reimbursements.

SUMMARY OF BENEFITS

Benefits	Standard		Enhanced	
Wellvision Exam	Description	Copay	Description	Copay
	• Focuses on your eyes and overall wellness • Every plan year	$10	• Focuses on your eyes and overall wellness • Every plan year	$10
Prescription Glasses				
Frame	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart®/Sam's Club® frame allowance • $80 Costco® frame allowance • Every other plan year	Included in Prescription Glasses	• $170 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart®/Sam's Club® frame allowance • $80 Costco® frame allowance • Every plan year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every plan year	Included in Prescription Glasses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every plan year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20 – 25% on other lens enhancements • Every plan year	$0 $95 – $105 $150 – $175	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every plan year	$0 $95 – $105 $150 – $175
Contacts (instead of glasses)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fi tting and evaluation) • Every plan year	Up to $40	• $120 allowance for contacts; copay does not apply • Contact lens exam (fi tting and evaluation) • Every plan year	Up to $40
Enhanced Upgrades			• An additional $100 frame allowance, or fully covered premium or custom progressive lenses, or fully covered light-reactive lenses, or fully covered anti-glare coating, or an additional $80 contact lens allowance • Every plan year	Included in Prescription Glasses
VSP Primary EyeCare(SM)	• Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. • Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. • Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details. • As needed			$0 $20 per exam
Enhanced Upgrades	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam			
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam			
	Laser Vision Correction • Average 15% savings on the regular price or 5% savings on the promotional price; discounts only available from contracted facilities			

Your Coverage with Out-of-Network Providers
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Enhanced Plan Benefits are not available at Walmart, Sam's Club, or Costco. VSP guarantees coverage from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

WITH YOU THROUGH IT ALL

There's no way to prepare for life's most unexpected moments. That's why we're prepared to provide you with the support you need when life decides to throw way too many tests your way.

BASIC LIFE AND AD&D INSURANCE

The District provides employees with basic group Term Life and Accidental Death & Dismemberment (AD&D) Insurance in the amount of one times your annual salary, at no cost to you. If your pay is based on over 10 years' experience, you'll also receive an additional one times your annual salary in life insurance at no additional cost to you. You don't have to do anything to elect this coverage, however don't forget you need to elect a beneficiary.

Professional Support Staff (non-instructional)
Negotiated Board-Paid Term Life Insurance Schedule

Annual Earnings (contract)	Amount of Life Insurance
$9,999 or less	$10,000
$10,000 - $14,999	$15,000
$15,000 - $19,999	$20,000
$20,000 or more	One times Annual Salary Rounded to the next $1,000

SUPPLEMENTAL LIFE INSURANCE

In addition to the District funded benefit, you can elect an additional one or two times annual salary in Term Life and AD&D Insurance. Please note that Professional Support employees earning less than $20,000 per year receive benefits based on the previously negotiated contract — see chart above.

You may also elect supplemental life insurance for your spouse and children.

Spouse - You may purchase, in $5,000 increments, up to $25,000 of life insurance for your spouse.
Child(ren) - You may purchase a $10,000 life insurance benefit for your child(ren).

METLIFE ADVANTAGES

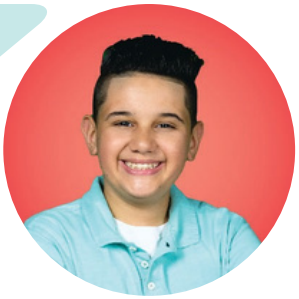
MetLife offers several additional resources that can make a difference in your life, including will preparation, grief counseling, retirement education, and much more. You can find more details at **metlife.com/mybenefits**.

For more information about these benefits:

1-800-638-6420

metlife.com/mybenefits

When you first become eligible for life insurance coverage, you must designate a beneficiary to receive these benefits in the event of your death. Changes can be made at any time, either through the Explain My Benefits system. If you do not designate a beneficiary, state laws determine who receives the benefit.



Premiums are based on your salary or salary schedule, so please review your elections carefully. Visit the Explain My Benefits Enrollment System for specific rates.

DISABILITY INSURANCE

If you aren't able to work due to illness or injury, Disability Insurance, offered by Lincoln Financial at an 8% premium reduction, can replace a portion of your income.

You have three considerations when electing coverage:

1. How much coverage do you need?

You can purchase a monthly benefit in $100 units, starting at a minimum of $200, up to two-thirds (66.6%) of your monthly earnings, with a maximum monthly benefit of $7,500.

2. When would you want coverage to start?

You choose an elimination period, which is the length of time of continuous disability that you must wait before you receive benefits. The options are 14, 30, 60, 90 or 180 days.

3. How long will coverage last?

Depending on the disability, your duration of benefits is determined by your age at the time you are disabled, as outlined in the table below.

1st Day Hospital Benefit: If you elect the 14 day or 30 day elimination period, you automatically receive a 1st day Hospital benefit. With the 1st day Hospital, benefits will begin on the 1st day if you are admitted to the hospital for 8+ hours.

Age at disability	Your duration of benefits for injury or sickness is:
Less than age 60	To age 65, but not less than five years
Age 60-64	Five years
Age 65-69	To age 70, but not less than one year
Age 70 and over	One year

If you're about to become a mommy, I'm happy to report that pregnancy and maternity are covered under the plan as long as your pregnancy isn't pre-existing at time of coverage enrollment.*

Premiums are based on Monthly Benefit Amount and elimination period selected. Visit the Explain My Benefits System for specific rates.

It's worth noting that the Plan won't cover any disability that begins in the first 12 months after your effective date of coverage that is caused by, contributed by, or resulting from a pre-existing condition. A pre-existing condition is any condition you have already received medical advice or treatment in the three months prior to enrollment.

Family Care Benefit

The Family Care Benefit helps pay for dependent care when an employee is out on claim. The benefit pays up to $350 for each dependent, per month, for up to 12 months.

Survivor Benefit

Your eligible survivor will be paid a lump sum benefit equal to three times the gross disability payment if, on the date of your death:

- your disability had continued for 180 or more consecutive days;
- and you were receiving or were entitled to receive payments under the plan.

If you have no eligible survivors, payment will be made to your estate, unless there is no estate. In this case, no payment will be made.

Minimum Indemnity for Accidental Dismemberment

A monthly Accidental Dismemberment benefit will be paid according to the Covered Losses and Benefit Amounts listed below if:

1. The Insured Employee sustains an Injury; and
2. Such Injury directly causes one of the following losses within 100 days of such Injury.

Covered Loss	Benefit Amount
One Hand or One Foot	23 monthly payments
Sight of One Eye	Five years
Age 65-69	15 monthly payments

For more information about these benefits:
1-800-423-2765, prompt 1
lincolnfinancial.com

*Subject to pre-existing condition limitation.

MANAGE YOUR EXPENSES WITH FSA

A Flexible Spending Account (FSA) helps you pay for your medical expenses incurred by medical insurance, or your dependent day care expenses. You make regular, pre-tax contributions to your account through payroll, which means you'll pay less in taxes, have more money to spend, and more money to save.

You can enroll in both a Healthcare and a Dependent Care FSA in the same way:

1. When you enroll in an FSA, you specify the dollar amount you'd like to direct into your account from each paycheck, up to the annual maximum;
2. You make deposits to your account through tax-free payroll deductions; then
3. You use the money in the account to pay for your eligible health or dependent day care expenses.

Estimate your account. Be sure to carefully estimate your FSA contribution amount. You can't transfer money between accounts and can only carry up to $640 into the next year's Healthcare FSA (you must enroll in an FSA for the subsequent year to be able to carry over).

Healthcare FSA

- Reimburses eligible medical, dental, or vision expenses for you, your spouse, or your eligible dependents.
- Can be used to pay for certain medical expenses not covered by another insurance plan, such as deductibles and coinsurance payments, for anyone you claim as a dependent on your tax return.
- You'll receive a ThrivePass Flexible Spending Account debit card (MasterCard), for easy access to your savings. Use it to pay for eligible health care goods and services at the point of purchase. ($5 replacement fee for lost cards)
- Funds will automatically be deducted from your Healthcare FSA, reducing your account balance and getting rid of the process of submitting reimbursement requests.

For more information and a list of most eligible and ineligible expenses, go to the ThrivePass member portal at thrivepass.com or review the IRS Publications available at irs.gov/pub/irs-pdf/p502.pdf

- Publication 502, "Medical and Dental Expenses"
- Publication 503, "Child and Dependent Care Expenses"

Dependent Care FSA

- Set aside money to pay for eligible non-medical dependent day care expenses such as child care or adult care center, a nursery school, summer day camp, or a caregiver for an elderly or incapacitated dependent.
- Your Dependent Care FSA is not prefunded. You are only reimbursed up to the balance in your account at the time you submit your claim/transaction (Can use ThrivePass Flexible Spending Card if balance is available).
- If your claim is more than your account balance, ThrivePass will automatically reimburse you as additional deductions are deposited into your account.

To make a claim, you will need to complete a claim form by logging into the ThrivePass member portal at app.thrivepass.com and attach itemized receipts that include:

- The dependent's name(s)
- The period during which the services were rendered; and
- The name, address, and Taxpayer ID or Social Security number of the individual or organization providing services.

Alternatively, if the above information is documented on the reimbursement form, you can have the provider sign the reimbursement form in place of a receipt.

Click Here to view your New Member Portal Guide

If you elect to contribute $750 to your Healthcare FSA, the District will contribute an additional $250 to your Healthcare FSA.

Annual FSA Contribution Limits

Type of FSA Account	Limits
Healthcare FSA	$240 minimum up to $3,200 maximum
Dependent Care FSA	Up to $5,000 if single or married filing a joint tax return, and up to $2,500 if married filing an individual tax return*

*You may be required to fi le Form 2441 with your annual income tax return. This form provides information about the person or organization providing the dependent care services.

If you think an FSA would benefit you, all you need to do is elect this as part of Open Enrollment.

You must elect the amount you want deferred every year during Open Enrollment.

September 2024	October 2024	November 2024	December 2024
EBMS FSA - Until 9/30/2024			FSA RUN OUT until 12/31/2024
	ThrivePass begins 10/1/2024	ThrivePass will calculate rollover balance into ThrivePass FSA	

FSA EMPLOYEE FAQ:

What is an FSA?

A healthcare flexible spending account (FSA) is an employer-sponsored benefit that allows you to set aside pre-tax dollars into an account to be used for eligible medical expenses.

Why should I participate in an FSA?

Contributions to the FSA are deducted from your paycheck on a pre-tax basis, reducing your taxable income. You can increase your spendable income by an average of 30% of your annual contribution with the tax savings.

How do I contribute money to my FSA?

Your annual election will be divided by the number of pay periods in your plan year. This amount will be deducted from your paycheck before taxes are assessed.

How much can I contribute to my FSA?

Annual contributions may not exceed $3,200 per year, as determined by the IRS.

Who is eligible under an FSA?

An FSA covers eligible expenses for you and all of your dependents, even if they are not covered under your primary health plan.

What expenses are eligible for reimbursement?

Health plan co-pays, deductibles, co-insurance, eyeglasses, dental care, medications, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

How do I determine the date my expenses were incurred?

Expenses are incurred at the time the medical care was provided, not when you are invoiced or pay the bill.

How do I get the funds out of my FSA?

If you have a benefits debit card, simply swipe it at the register. Otherwise, just file a claim including the receipt documenting the type, amount and date. Once approved, your reimbursement check will be mailed or deposited into your bank account.

Your EBMS Debit Card will turn off midnight, 9/30/2024. ThrivePass debit card can only be used for FSA and DC FSA effective 10/1/2024.

For more information, please call
+1-866-855-2844

FSA EMPLOYEE FAQ:

Plan does not have a grace period since it has a rollover. It has a run-out period until 12/31/2024 to submit claims incurred during the plan year 10/2/2023-9/30/2024. ThrivePass will administer run-out reimbursement claims submitted after 9/30/2024. You have until 12/31 or 92 days after the end of the plan year to submit for reimbursement.

What happens if I don't spend all of my FSA by the end of the plan year?

Your plan allows for a run-out period to submit eligible claims for reimbursement. Details about these options are available in your member portal or mobile app.

How soon can I start spending my FSA funds?

With a healthcare FSA, your entire annual election amount is available on the first day of the plan year even though you have not yet contributed that amount.

Can I change my election amount mid-year?

Elections can only be altered if you experience a change in status as defined by IRS regulations, such as marriage, divorce, birth, or death in your immediate family.

What happens to my FSA if my employment is terminated?

Participation in your FSA is also terminated. This means that only expenses that were incurred prior to your termination date are eligible for reimbursement.

What is the deadline for submitting claims?

You can submit claims for reimbursement at any time during the same plan year that you incur the expense.

Can I still deduct healthcare expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from your FSA.

Are over-the-counter (OTC) medications eligible for reimbursement?

Yes, OTC medications are FSA eligible.

What is a Letter of Medical Necessity?

The IRS mandates that eligible expenses be primarily for the diagnosis, treatment or prevention of disease or for treatment of conditions a ecting any functional part of the body. For example, vitamins are not typically covered because they are used for general wellness, but your doctor may prescribe a vitamin to treat your medical condition. The vitamin would then be eligible if your doctor verified the necessity in treatment.

For more information, please call
+1-866-855-2844

DCFSA EMPLOYEE FAQ:

Dependent Care FSA

What is a dependent care FSA (DCA)?

A DCA is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work.

Why should I participate?

Since contributions to the account are deducted from your paycheck before income taxes are assessed, your taxable income is reduced. Participants enjoy a 30% average tax savings on the total amount they contribute to the account.

How do I contribute money to my DCA?

Once you make your annual election during open enrollment, your employer will deduct this amount from your paycheck before taxes are assessed in equal amounts throughout the year.

How much can I contribute?

The IRS limits annual contributions to $5,000 on income tax returns for single or married filing jointly, and $2,500 for married filing separately.

Who qualifies as a dependent?

You can use your DCA to pay for care for children under age 13 that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support).

What type of care is eligible?

Eligible expenses must be for the purpose of allowing you to work or look for work. Services may be provided at a child or adult care center, nursery, preschool, after-school, summer day camp, or a nanny in your home.

What type of care is not eligible?

Care for a child over age 13, overnight camp, babysitting that is not work related, school fees for kindergarten and higher grades.

Do I have access to my entire DCA election amount at the beginning of the year?

No, you will only have access to DCA funds that have already been deducted from your paycheck.

Are there any rules about who can care for my dependents?

Yes. You can not use funds to pay for care provided by a spouse, a person you list as a dependent for income tax purposes, or one of your children under the age of 19.

How do I use the funds in my account?

If you have a benefits debit card and your care provider accepts credit cards, you may pay directly from your account. Otherwise, pay out-of-pocket and then file a reimbursement claim with your expense documentation. Your ThrivePass debit card allows for use with your DC FSA if a balance is available.

What happens if I don't spend all of my DCA funds by the end of the plan year?

It is essential to estimate conservatively during elections. Any unused funds at the end of the plan year are forfeited. This is called the use-it-or-lose-it rule. You have until 12/31 to submit eligible claims for reimbursement.

Can I change my election amount mid-year?

Typically, you cannot change your contribution mid- year. However, if you experience a status change event as determined by the IRS, such as the birth of a new child, or if your child care provider significantly changes their rates, you may be eligible to adjust your contribution.

What happens to my account if my employment is terminated?

Participation in the plan is also terminated. However, if you have a balance in your account, you may still incur and submit eligible expenses to spend down that balance.

For more information, please call
+1-866-855-2844

EMPLOYEE FAQ:

ThrivePass Card for FSA Accounts.

What is the ThrivePass card?

The ThrivePass FSA card is a special-purpose Mastercard® that gives participants an easy, automatic way to pay for eligible health care/benefit expenses. The card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as Flexible Spending Accounts (FSAs).

How does the ThrivePass FSA card work?

The value of the participant's account(s) contribution is stored on the card. Participants can use their card when they have eligible expenses at a business that accepts benefit debit cards. The amount of the eligible purchases will be automatically deducted from their account and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

Is the ThrivePass FSA card just like other Mastercards?

Your annual election will be divided by the number of pay periods in your plan year. This amount will be deducted from your paycheck before taxes are assessed.

Will participants receive a new ThrivePass FSA card each year?

No. The ThrivePass card is a special-purpose card that can only be used for eligible health care/benefits expenses. For example, it cannot be used at gas stations or restaurants. There are also no monthly bills or interest.

What if the ThrivePass FSA card is lost or stolen?

Participants can report a card lost or stolen and issue replacement card(s) through or using app.thrivepass.com our mobile app.

How do participants activate the card?

The card will automatically active upon the first card swipe.

What dollar amount is on the ThrivePass FSA card when it is activated?

For Health Care FSAs, the dollar value on the card will be the annual amount that participants elected to contribute to their respective employee benefit account(s) during open enrollment. Eligible expenses will be deducted from the total amount as participants use their card or submit manual claims. DC FSA funds must have an available balance for ThrivePass debit card use.

For more information, please call
+1-866-855-2844

EMPLOYEE FAQ:

ThrivePass Card for FSA Accounts.

Where may participants use the ThrivePass FSA card?

IRS regulations allow participants to use their ThrivePass FSA cards in participating pharmacies, mail order pharmacies, discount stores, department stores, and supermarkets that can identify FSA eligible items at checkout and accept benefit prepaid cards. Eligible expenses are deducted from the account balance at the point of sale. Participants and their other eligible users should always save itemized receipts for FSA purchases made with the ThrivePass FSA card. If the transaction cannot be auto substantiated, paper follow-up will be required.

Are there places the ThrivePass FSA card won't be accepted?

Yes. The card will not be accepted at locations that do not offer the eligible goods and services, such as hardware stores, restaurants, bookstores, gas stations, and home improvement stores.

If asked, should participants select "Debit" or "Credit"?

If the participant has elected to use a PIN (Personal Identification Number) with their ThrivePass FSA card, they should select "Debit" and enter the PIN when prompted. If the participant is not using a PIN with their ThrivePass FSA card, they should select "Credit" and will be asked to sign for the benefit card purchase. Participants cannot get cash with the ThrivePass FSA card.

How does the card work in participating pharmacies, discount stores, department stores, and supermarkets?

- Bring prescriptions, vision products, eligible OTCs, and other purchases to checkout.
- Use the card for payment.
- If the card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the products are FSA eligible), the amount of the FSA eligible purchase is deducted from the account balance. Another form of payment will be required for the non-FSA eligible items. If the card swipe transaction is declined, another form of payment will be required for the total amount of the purchase.
- The receipt may identify the FSA eligible items and may also show a subtotal of the FSA eligible purchases.
- In most cases, the participant will not receive requests for receipts for FSA eligible purchases made in participating pharmacies, discount stores, department stores, or supermarkets.

Why do participants need to save all of their itemized receipts?

Participants and their other eligible users should always save itemized receipts for FSA purchases made with the ThrivePass FSA card. They may be asked to submit receipts to verify that their expenses comply with IRS guidelines. Each receipt must show the merchant or provider name, the service received or the item purchased, the date, and the amount of the purchase. The IRS requires that card transactions be substantiated. This can occur through automated processing as outlined by the IRS (e.g. copay matching, etc.). If the automated processing is unable to substantiate a transaction, the IRS requires that itemized receipts must be submitted to validate expense eligibility.

For more information, please call
+1-866-855-2844

EMPLOYEE FAQ:

ThrivePass Card for FSA Accounts.

May participants use the ThrivePass FSA card if they receive a statement with a Patient Due Balance for a medical service?

Yes. If they have money in their account for the balance due, the services were incurred during the current plan year, and the provider accepts prepaid benefit debit cards, participants can provide the card information on their statement and send it back to the provider. Retain this statement in case a receipt is requested by ThrivePass.

Sometimes the participant is asked for the CVV when paying the balance due or when placing an order by phone or online. What is this and where is it found?

CVV stands for "Card Verification Value." It is a 3-digit number that can be found on the back of the card to the right of the signature panel.

How do participants know how much is in their account?

They can visit their personal account overview page at app.thrivepass.com or use our mobile app to view their current balance.

What if participants have an expense that is more than the amount left in their account?

When incurring an expense that is greater than the amount remaining in their account, participants may be able to split the cost at the register (check with the merchant). Alternatively, participants may pay by another means and submit the eligible transaction manually via a claim form with the appropriate documentation.

What are some reasons that the ThrivePass FSA card might not work at point of sale?

Common reasons why a card may be declined at the point of sale:

- Some locations may ask for a PIN when using the benefits debit card. If a participant doesn't know their PIN, they can select credit and sign instead.
- The participant has insufficient funds in his or her employee benefit account to cover the expense.
- Non-eligible expenses have been included at the point-of-sale. Participants should retry the transaction with the eligible expenses only.
- The merchant is encountering problems (e.g. coding or swipe box issues).
- The pharmacy, discount store, department store, or supermarket cannot identify FSA eligible items at checkout according to IRS rules.

For more information, please call
+1-866-855-2844

EMPLOYEE FAQ:

ThrivePass Card for FSA Accounts.

Whom do participants call if they have questions about the ThrivePass FSA card?

Contact ThrivePass at **1-866-855-2844 option 1**.

Can a participant use the ThrivePass FSA card to access last year's money left in the account this year?

No – once you are in a new plan year you must submit manual claims for the prior year.
There is an exception if your FSA includes a grace period. The IRS allows for grace period in the current year to use last years funds. Check with your administrator for your specific plan guidelines.

How will a participant know to submit receipts to verify a charge?

The participant will receive a letter or notification from ThrivePass if there is a need to submit a receipt. All receipts should be saved per the IRS regulations. ThrivePass also offers Carrier Connect for easier automatic substantiation process. See page 39 for more details.

What if a participant fails to submit receipts to verify a charge?

If receipts are not submitted as requested to verify a charge made with ThrivePass FSA card, then the card may be suspended until receipts are received. The participant may be required to repay the amount charged.

For more information, please call
+1-866-855-2844

CARRIER CONNECT

The days of manually submitting documentation for the debit card expenses are over! Carrier Connect makes it easy to verify debit card transactions.

Sign up in just 2 simple steps:*

1. Collect login credentials from your insurance company for you and any dependents.
2. Log in to the ThrivePass Member Portal, navigate to the Personal Dashboard, click on the "Connect Your Plans" widget, and follow the steps to complete your registration.

Every time a carrier issues an EOB, Carrier Connect will retrieve this information automatically.

Access through ThrivePass Member Portal

1. Access ThrivePass Member Portal at app.thrivepass.com
2. Click on "Pre-Tax"
3. Navigate to "Personal Dashboard"
4. Click "Connect Your Plans"
5. REGISTER: Follow the steps to complete registration

***Two factor authentication may be requested dependent upon the type of security authentication required by your carrier.**

Have questions? Contact us at:
tpa@thrivepass.com

www.thrivepass.com

CARRIER CONNECT FAQS:

Have a questions? We're here to help!

What is Carrier Connect?

Carrier Connect is a portal that gathers your Explanation of Benefits (EOBs) from your medical, dental, and vision carriers

What are the benefits to using Carrier Connect?

Carrier Connect eliminates frustrating and time-consuming claims documentation. Simply register your account and we'll take care of the rest for you!

How do I register for an account?

Log into your insurance carrier's website and retrieve your login information. Log into the ThrivePass Member Portal at app.thrivepass.com, click on "Pre-Tax" and then "Personal Dashboard." Once there, click on the "Connect Your Plans" widget and follow the steps to complete your registration.

1. Access ThrivePass Member Portal at app.thrivepass.com
2. Click on "Pre-Tax"
3. Navigate to "Personal Dashboard"
4. Click "Connect Your Plans".
5. Follow the steps to complete registration.

What will happen to my claims after I register for an account?

We'll begin retrieving your EOBs into the portal automatically, meaning less work for you!

Can I add my dependents to the account?

Yes! By adding a dependent's information to your account, his or her claims data will automatically be retrieved by Carrier Connect.

Will I still need to submit additional documentation to receive reimbursements?

Carrier Connect is set up to receive your EOBs automatically, eliminating the need for extra paperwork for verification of debit card payments and reimbursements. Note, there may be instances where the EOB amount(s) do not match the actual card transaction amount. In those cases, you may still be asked to submit documentation.

Have questions? Contact us at:
tpa@thrivepass.com

www.thrivepass.com

UNIVERSAL LIFEEVENTS® INSURANCE

Trustmark Universal LifeEvents Insurance combines permanent life insurance with long-term care service benefits to help give you peace of mind if the worst should happen.

Long term care coverage that provides nursing-home care, home-health care, personal or adult day care for individuals age 65 or older or with a chronic or disabling condition that needs constant supervision.

If elected, you'll receive coverage for:

- Death benefit to your beneficiaries if you pass away;
- Living benefits for long-term care; and
- You'll build up a cash value.

If you wish to cover your spouse and/or children, you must enroll. Coverage is available for both spouse ($25,000) and children (child term rider).

Special Underwriting at Initial Offering:
Guaranteed Issue - $150,000 (Employee Only)

Primary Care

Trustmark Universal Life with Long Term Care is a permanent life insurance policy that is designed to match your needs throughout your lifetime. It is priced to remain the same cost to you until age 100 and pays a higher death benefit during your working years, when expenses are high and you need maximum protection.

Then, at age 70 when the need for life insurance typically decreases, your death benefit is reduced.

Living benefits

In the event that you become ill and need long-term home healthcare, assisted living, nursing home care and adult day care, your coverage is accelerated to help cover these costs. You'll receive 4% of your death benefit for up to 25 months.

If you are diagnosed with a terminal illness with a life expectancy of 24 months or less, you'll be eligible for up to 75 percent of your death benefit.

If you use the Long Term Care benefit, your death benefit amount does not reduce due to the Benefit Restoration feature.

Click Here to learn how Universal LifeEvents and Hospital StayPay provides greater Financial Protection

HOSPITAL STAYPAY INSURANCE

Hospital stays can get expensive, and health insurance might not cover everything. With Trustmark Hospital StayPay, you can worry less about your bills, and focus more on recovering.

Hospital StayPay Coverage

Event	Benefit
Hospital Admission	$1,200 (paid once per calendar year)
Daily Hospital Confinement	$100 per day (pays for a maximum of 365 days per calendar year
Daily ICU Confinement	$200 per day (pays for a maximum of 365 days per calendar year)
Wellness Benefit	$100 every 2 years (claim free)
	***No pregnancy waiting period and no pre-ex**

*Treatment in government hospitals excluded

More Flexible Hospital StayPay Features

- Benefits paid directly to you with no restrictions on how you use them.
- Apply for family members as well as for yourself.
- Guaranteed issue with no medical questions, as long as you are actively at work.
- Once you have a policy, your rate is locked in and will not increase due to age.
- Fully portable — keep your coverage, at the same rate and benefits, if you change jobs or retire.

Did you know that Hospital StayPay is specially designed to pair with your medical plan? That way, you can receive benefi ts for hospital stays due to a covered sickness or accident, childbirth or mental wellness/addiction recovery. Watch this example on how Hospital StayPay works.
osceolaschools.net/benefits.

LINCOLN FINANCIAL CRITICAL ILLNESS INSURANCE

A major illness can have unexpected costs. Even if you have health insurance, you may still have large out-of-pocket expenses. Lincoln Financial Critical Illness insurance pays cash straight to you when you are diagnosed with a covered critical illness.

Employee may choose from the following benefit amount:
$10,000, $20,000, or $30,000.

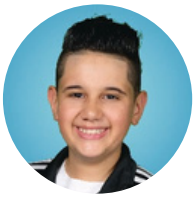
Spouse may choose from the following benefit amount:
up to 50% of employee election, $5,000, $10,000, $15,000
Child(ren) options:
$2,500, $5,000, $7,500, $10,000

100% Benefit	• Heart Attack • Stroke • Major Organ Failure • Renal Failure • Invasive Cancer
Supplemental Condition Benefits	• AIDS • Advanced Alzheimer's Disease • Advanced Parkinson's Disease • Advanced ALS • Advanced Huntington Disease • Advanced COPD • HIV • Hepatitis B, C, D
50% Benefit	• Benign Brain Tumor
30% Benefit	• Non-invasive cancer
25% Benefit	• Artterial/vascular disease • Advanced Multiple Sclerosis • Loss of speech, sight, hearing • Tuberculosis • MRSA • Tetanus • Rabies
Skin Cancer	• $250 (paid once per lifetime)

Get paid no matter what your health insurance covers and use the money for whatever you need. This way, when you get really sick, you can focus on your health and worry less about your wallet.

Guaranteed Issue at Initial Offering:

- **Employee:** $30,000
- **Spouse:** $15,000
- **Children:** $10,000



Life happens, or at least that's what my dad always loves to say. That's why we want to make sure you have a financial cushion for when you need it most.

Click Here to watch this quick video to learn more

A Health Screening Benefit is included in your Critical Illness Policy and Lincoln will pay $100 for each insured. Each covered person will get one screening/preventive measure test per calendar year.

The policy also includes an Additional Occurrence Benefit (diagnosis must be separated by 6 months) and a Recurrence Benefit (12 months treatment free).

ACCIDENT INSURANCE

We know you do everything you can to keep the people you love safe, but accidents happen. When they do, we have your back. Trustmark's Accident Insurance pays you to help with the cost of covered accidents at work or outside of work. Benefits are paid directly to you, so you can use them for whatever you need most. So you can stop worrying about money and focus on what really matters.

Benefits are paid directly to you without any restrictions on how you can use them. 24-hour coverage includes benefits for:

- **Hospital Admission;**
- **Hospital Confinement;**
- **Hospital Intensive Care Unit;**
- **Emergency Room Treatment.**
- **Initial Care Benefits:** Physician visit, ambulance, E.R. treatment, hospital benefits, lodging, blood, surgery, emergency dental
- **Injury Benefits**: Burn, concussion, dislocation, eye injury, fracture, herniated disc, laceration, loss of finger/toe/hand/foot/sight, tendon/ligament/rotator cuff injury, torn knee cartilage
- **Follow-up Care Benefits:** Physical therapy, appliances, prosthetic device, artificial limb, skin graft, transportation
- **Accidental Death Benefit**

Learn how the Accident Plan Works.

	Rate per pay
Employee	$11.65
Employee + Spouse	$20.08
Employee + Children	$28.75
Employee + Family	$37.18

You can also apply for coverage for your spouse, and children. There is no medical eligibility criteria, but you must be actively at work and your spouse or domestic partner must answer a disability question.

The policy is renewable as long as premiums are paid, and premiums and benefits won't change because of age. Even better, you can take your coverage with you and pay the same premium. It's yours to keep even if you change jobs or retire.

Wellness Benefit Rider

As part of your accident insurance, each person covered under your plan will receive two $100 payments each year for screening tests, routine physicals or immunizations, up to your benefit and plan maximums.

Covered tests include:

- Fasting blood glucose test
- Blood test for triglycerides
- Serum cholesterol test for HDL & LDL levels
- Routine mammogram
- Pap smear (Women 18+)
- Prostate Specific Antigen (PSA) for prostate cancer
- Colonoscopy
- Flexibly sigmoidoscopy
- Cardiac stress test
- Bone marrow testing
- Chest x-ray
- Hemoccult stool specimen
- CA 15-3 blood test for breast cancer
- CA 125 blood test for ovarian cancer
- CEA blood test for colon cancer
- Serum Protein Electrophoresis (SPEP) blood test for myeloma
- Thermograph

Example of Benefit Payments

Broken leg while playing softball	**$10,000**
Ambulance transportation	**$600**
Emergency room visit	**$150**
Follow-up visit with orthopedist	**$200**
Physical therapy (six visits)	**$600**
Knee roller/scooter (appliance)	**$250**
TOTAL	**$11,800**

NOTE: Benefit amounts shown are samples and not a guarantee. Benefit amount payable varies by injury/service and may vary by state. Benefits are payable only as the result of a covered accident. Most benefits are paid once per person per covered accident unless otherwise noted. Hospital Confinement and ICU Benefits cannot be paid at the same time. Your policy/certificate will contain a complete schedule of benefits.

TAX SHELTERED ANNUITIES

SDOC offers employees the opportunity to contribute to a 403(b) Tax Sheltered Annuity. Tax Sheltered Annuities are a type of retirement plan that's available to public education employees, which lets them save money for retirement.

If you are already contributing towards a Tax Sheltered Annuity, you can change your deduction (either increase or decrease).

For an up-to date listing of agents and board approved tax sheltered annuity companies to help you reach your financial goals, visit: osceolaschools.net/riskandbenefits

This website also has information on how to access the new self service portal.

There are many benefits to investing in a Tax Sheltered Annuity:

- Immediate income tax savings;
- You are taxed only on the amount
- distributed to you in that tax year; the funds remaining in your account continue to be tax-deferred;
- High annual contribution limits;
- Flexible loan provisions;
- Account portability;
- Beneficiary provisions; and Lifetime income options.

You can contribute to the following investment vehicles:

Fixed interest and variable annuities
Fixed interest annuities usually provide protection of principal and a current interest crediting rate. Variable annuities usually offer a fixed interest account along with separate accounts that are invested in bond and/or equity markets.

Service-based mutual funds and custodial accounts
Investment portfolios can include funds from a single fund family or a custodial platform that spans several fund families on a single statement.

No-load/low-fee mutual funds
No-load funds are described as investments with no sales fees on the market-based mutual funds offered. Ongoing investment management fees are charged to the funds selected. The no-load/low fee offerings are good for those individuals who don't want to work with an investment advisor.

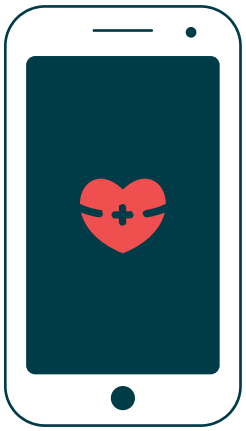
SDOC BOARD APPROVED TAX SHELTERED ANNUITY COMPANIES

403(b)/403(b)(7) Accounts			
Ameriprise Financial	1-800-862-7919	Ameriprise Financial	1-800-847-4836
*Invesco Oppenheimer Funds	1-800-959-4246	Thrivent Mutual Funds	1-800-847-4836
Lincoln National Life Insurance Co.	1-800-454-6265	Vanguard Investments	1-800-569-4903
*MetLife	1-800-560-5001		
403(b)/403(b)(7) Accounts and 457(b) Deferred Compensation Plans			
*AIG/VALIC	1-800-369-0314	*National Life Group	1-800-579-2878
*ASPire Financial Services	1-866-634-5873	*PlanMember Services	1-800-874-6910
*Equitable	1-800-628-6673	*ReliaStar	1-877-882-5050
*Fidelity Investments	1-800-343-0860	Security Benefi t Group	1-785-438-3076
*Horace Mann Insurance Co.	1-800-999-1030	The Legend Group	1-888-883-6710
IPX-American Century Services	1-844-788-3474	*VOYA Financial	1-800-584-6001
Lincoln Investment Planning	1-800-242-1421	Waddell & Reid	1-407-916-7700
Lincoln National Life Insurance Co.	1-800-454-6265		

*Also offer ROTH 403(b)

ALL YOUR BENEFITS, ALL IN ONE PLACE

There's a lot of good built in to your Even Better Benefits and keeping track of it all just got easier. The SDOC Benefits app and EBMS online portal have everything you need to help you understand your health plan.



EVEN BETTER BENEFITS APP

To enroll in your insurance benefits, view your current benefits and more, download the SDOC Benefits App powered by Explain My Benefits.

To download:

1. **Scan our QR code to find our app or text emb to 71441**
2. **Download by clicking the link for iOS or Android**
3. **Enter company code: sdoc**
4. **Select "Enroll" from the menu on the left and begin to log in to the benefit enrollment system**
5. **Login to the benefit enrollment system.**

   Enter User Name:
   1st Initial of First Name
   and 1st 6 Characters of your Last Name
   and Last 4 of SSN

   Example:
   Name: Tim Johnson
   SSN: 123-45-6789
   = tjohnso6789
6. **Enter Password:**
   Date of Birth (YYYYMMDD) and click login
7. **Select "Get Started" from the middle section of the screen**
8. **Confirm your information along with dependents**
9. **Shop for your insurance benefits**

THE EBMS miBenefits PORTAL

The EBMS portal is fast, simple and frustration-free. When you register, you can check your claims status in real time, view separate tabs for each family member on your plan and quickly track where you are with deductibles and out-of-pocket maximums. The EBMS portal also has:

1. **One login for everything** –
   medical, dental, vision, prescription and FSA
2. **Simplified navigation** –
   get 80% of what you need right from the home page
3. **Quick-links to find a physician,**
   order an ID card and perform other common tasks

To register for EBMS, please visit miBenefits.ebms.com.

OTHER INFORMATION

LEAVES OF ABSENCE

If you're going on a Leave of Absence (LOA), you can keep your District benefits while on District-approved leave. Employees who are granted a LOA may elect to continue coverage through their District benefits. Employees will be responsible for paying the full cost of premiums. This includes Board-Paid Medical and Life Insurance, Medical dependent coverage, supplemental Life Insurance, Dental, Vision, Disability Insurance, Flexible Spending Account contributions, Accident Insurance, LifeEvents, Hospital StayPay and Critical Illness.

Premiums must be paid directly to the Risk & Benefits Management office and are due by the first of every month (with a 10-day grace period). Failure to pay premiums by the end of the grace period will result in termination of benefits.
For leave at the end of the year, see below.

THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

The FMLA permits employees to take up to 12 weeks unpaid, job-protected leave, or on an intermittent basis (work a reduced schedule) for certain family and medical reasons, such as:

- The birth of a child;
- Adopting a child or becoming a foster parent;
- Caring for a seriously ill spouse, child or parent;
- A serious health condition;
- Caring for a covered service member who is recovering from a serious illness or injury sustained in the line of active duty (26 weeks); or
- Any "qualifying exigency" arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation (26 weeks).

Employees are eligible if they've worked for the District for at least one year, and have worked for 1,250 hours over the previous 12 months.
For questions about FMLA, contact Risk and Benefits Management at **407-870-4899.**

REQUESTING FMLA LEAVE

An employee should contact their facility secretary or Benefits Specialist when foreseeable within 30 days in advance to obtain an FMLA application. Physician-documented proof (medical certification form) of birth or illness is required for all FMLA-designated leaves. Once FMLA is approved, a letter detailing your rights and responsibilities will be mailed to the employee.

Please note, FMLA is a federally mandated leave. If an employee is absent for three consecutive days due to eligible FMLA circumstance and meets the criteria for the FMLA, they will be notified in writing by a Benefits Specialist. An application and physician certification will be sent to the employee to complete and return to Risk & Benefits Management.

Employees are required to use sick and/or vacation time concurrently with FMLA.

COBRA CONTINUATION OF COVERAGE

An employee's coverage ceases on the last day worked for the District. The District's COBRA administrator, EBMS, will mail a written notice to each terminated employee describing the employee's rights and obligations under COBRA.

Through federal legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you may choose to continue coverage by paying the full monthly premium cost plus an administrative charge of 2%. Each individual who is covered by a District plan immediately preceding the employee's COBRA event has independent election rights to continue his or her health, dental, and/or vision coverage.

The right to continuation of coverage ends at the earliest when:

- You, your spouse, or dependents become covered under another group health plan; or you become entitled to Medicare;
- You fail to pay the cost of coverage; or
- Your COBRA Continuation Period expires.

MAXIMUM COBRA CONTINUATION

Loss of Coverage is Due to	For You	For Your Covered Spouse	For Your Covered Child(ren)
Your employment ending for any reason (except gross misconduct) or your hours are reduced so you are no longer eligible for medical, dental, vision, and the health care flexible spending account	18 months	18 months	18 months
You or your covered spouse or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event, or becomes disabled during the first 60 days of COBRA continuation	29 months	29 months	29 months
Your death	-	36 months	36 months
Your divorce or legal separation	-	36 months	36 months
You become entitled to Medicare	-	36 months	36 months
Your covered child no longer qualifies as a dependent	-	-	36 months

COBRA PARTICIPANTS WITH FSAs

COBRA participants who have a Health Care FSA can elect to continue their FSA, only if their annual contributions exceed the amount that has been reimbursed to them (there is still money in the FSA) at the time they terminate. If there is still money in the account, the COBRA participant would be able to continue their FSA through the end of the calendar year. Contributions would be paid by the FSA participant directly to the FSA administrator. If you do not elect COBRA for your FSA, you may only be reimbursed for expenses incurred prior to your termination date up to the amount you contributed within 60 days of termination.

LIFE INSURANCE PORTABILITY

MetLife Group Term Life insurance provides an option to port your coverage after termination or retirement.

What happens to your coverage if you leave your job or retire?

You can continue your coverage at group rates when the coverage would otherwise end.

- Your coverage maximum amount is generally limited to the amounts you had at the time group benefits are terminated and may vary depending on the type of coverage you had.
- The combination of all your MetLife group life insurance and accidental death and dismemberment plans cannot exceed $800,000.
- You can apply for more coverage than you already have if you wish to complete evidence of insurability, which includes a medical history form or a physical exam. This can be ported up to $2,000,000 if the employee chooses to do so, with evidence of insurability.

How do you port?

At the time of separation you will automatically receive information in the mail from MetLife with your options. You must elect coverage within 31 days of termination.

END OF SCHOOL YEAR BENEFIT END DATES

The following scenarios explain how benefits are affected when an employee terminates employment at the end of their current contract.

You won't lose your benefits at the end of the current contract if:

- You resign at the end of the current contract – If you would have been reappointed for the coming year, but you know you will not be returning for the new contract year, you can resign your position now and have insurance benefits available to you until the day before you are due to return to work for the following school year.
- You would have been reappointed; however, a position is not available due to a reduction in force (RIF) – Benefits will terminate the day before you are due to return to work for the following school year.
- You are granted an LOA for the coming year – Your benefits will continue until August 1, 2025. Employees on LOAs will then have the option of keeping their benefits during the leave. A letter detailing insurance options will be sent to the LOA employee automatically.
- You retire at the end of your current contract – Your benefits will remain in effect until August 1, 2025. Retirees will then have the option of keeping their benefits. A letter detailing insurance options will be sent to the retiree automatically.
- You retire during the school year and do not finish the year – Your benefits end on your retirement day. Retirees will then have the option of keeping their benefits. A letter detailing insurance options will be sent to the retiree automatically.

Your benefits will terminate immediately if:

- You resign your position before the end of your current contract – Your insurance benefits will terminate on your last day.
- Your employment is terminated by the District (except for RIF employees as noted above) at the end of your current contract – Your insurance benefits will terminate the day your contract ends or the last day you work (if not completing the year).

If an Action Form is submitted terminating your employment and you later secure a position for the coming year, you are considered a new hire and may be required to work a probationary period in your new position.

Your school/worksite will inform you of your employment status. Benefits will remain in effect for all other employees.

KNOW YOUR RIGHTS

This section contains important information about your benefits and rights. Please read the following pages carefully and contact Risk and Benefits Management with any questions you have.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, you must request enrollment within 30 days of the end of your or your dependents' other coverage (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS-NOW or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Florida Medicaid
Website: **flmedicaidtplrecovery.com** Phone: **1-877-357-3268**

To see which other states participate in the premium assistance program, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
Website: **flmedicaidtplrecovery.com**
Phone: **1-866-444-EBSA (3272)**

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
Website: **cms.hhs.gov**
Phone: **1-877-267-2323, Menu Option 4, Ext. 61565**

SECTION 111

Effective January 1, 2009 Group Health Plans are required by the Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extension of 2007's new Medicare Secondary Payer regulations. This mandate is designed to assist in establishing financial liability of claim assignments. In other words, it will help to establish who pays first. The mandate requires Group Health Plans to collect additional information such as social security numbers for all enrollees, including dependents aged six months or older. Please be prepared to provide this information on your Benefit Enrollment Form when enrolling into benefits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses; and treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS' AND MOTHERS' HEALTH ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

AUTOMATIC LIABILITY INSURANCE COVERAGE

All full-time instructional personnel, as defined in the Florida Statutes section 1012.01(2), have $2 million of educator professional liability insurance. More about this policy is available at fldoe.org. To file a claim, contact Davies Claims Solutions at mbridgepenpclaims@davies-group.com or call 800-322-1276 ext. 2091, or 615-747-2270.

HIPAA PRIVACY ACT LEGISLATION

SDOC and your health insurance carrier(s) are obligated to protect your confidential protected health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. SDOC and your health insurance carrier(s) are required to notify you and your beneficiaries about our policies and practices to protect the confidentiality of your protected health information. A copy of SDOC privacy policy can be found on **osceolaschools.net/Domain/156** or you may request a copy from Risk & Benefit Management.

PATIENT PROTECTION

If your group health plan requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the group health plan will make one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.
For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application for coverage is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

> When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.
You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.
When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact:
The U.S. Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE (1-800-633-4227)
or visit **https://www.cms.gov/nosurprises** for more information about your right under federal law.

WELLNESS NOTICE - AMERICANS WITH DISABILITIES ACT (ADA)

The School District of Osceola County Live, Life, Well Wellness Incentive Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for blood pressure, cholesterol, blood sugar and body mass index (BMI) screening. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive point system for health plan premium reduction. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive said incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to reasonable accommodation or an alternative standard. You may request reasonable accommodation or an alternative standard by contacting Risk and Benefits Management 407-870-4899.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as additional health services offered. You also are encouraged to share your results or concerns with your own doctor.

TRUE EMERGENCY DEFINITION

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

KEY CONTACTS

Here are some frequently used telephone numbers and websites if you need more information about any of the benefits we offer.

Center for Employee Health	RosenCare	407-483-5757 **SDOCEmployeeHealthCenter.net**
Pharmacy/Prescriptions	Ventegra	1-877-867-0943 **ventegra.com**
Prescriptions Unlimited Health Center Pharmacy	Prescriptions Unlimited	p. 407-750-9313 f. 407-750-9314 t. 407-794-7734 **unlimitedRx.com/SDOC**
International Pharmacy/Prescriptions	ElectRx	1-855-353-2879 fax 1-833-353-2879 **electrx.com**
Imaging	Green Imaging	844-968-4647 text: 713-524-9190 **greenimaging.net**
First Stop Health (Formerly Sentry Health)	Medical Advocacy Program (MAP)	1-844-297-0747 **sentryhealth.com/member-support**
Custom Provider Network	Evolutions Healthcare Systems	800-308-2749 **ehsppo.com**
Health Insurance Third Party Administrator (claims and programs)	EBMS	888-326-7240 **mibenefits.ebms.com**
Dental Group ID 830049	Humana	1-800-233-4013 **humana.com**
Vision Group ID 30105858	VSP	1-800-877-7195 **vsp.com**
Life and AD&D Group ID 145776	MetLife	1-800-638-6420 **metlife.com/mybenefits**
Universal LifeEvents Accident Insurance Hospital StayPay	Trustmark	1-800-918-8877 **trustmarkins.com**
Critical Illness Disability Group ID OSCEOLACTY	Lincoln	1-800-423-2765, prompt 1 **lincolnfinancial.com**
Retirement benefits	Florida Retirement System	1-866-446-9377 **myFRS.com**
Employee Assistance Program (EAP)	ComPsych	1-888-882-0797 1-800-697-0353 (TDD) **guidanceresources.com** (web ID: OCSOCS)
Worker's Compensation, Linda Scheuer		407-870-4903; Internal Extension 67557 **workcomp@osceolaschools.net**
Johns Eastern Company, Inc.		1-800-749-3044
TSA Consulting Group		1-888-796-3786 Fax: 866-741-0645
Flexible Spending Account/Dependent Care Account	ThrivePass	866-855-2844 , option 1 **www.thrivepass.com**

Visit the Benefits Enrollment System at
osceolaschools.net/riskandbenefits

Risk and Benefits Management	t: 407-870-4899 f: 407-943-7749 **osceolaschools.net/riskandbenefits**
EBMS Client and Member Success Associate	t: 407-870-4900; Internal Extension 67559
Wellness Specialist	407-870-4840; Internal Extension 67515 **wellness@osceolaschools.net**
Benefits Education Specialist	t: 407-750-9845; Internal Extension 67562 **insurance@osceolaschools.net**

831 Simpson Road, STE 100
Kissimmee, Florida, 34744-5328