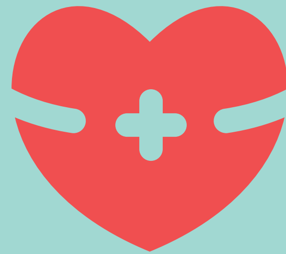
YOU'RE ALWAYS HERE FOR US



Even Better BENEFITS

Exclusively for the School District of Osceola County

ARE NOW HERE FOR YOU

RETIREE BENEFITS GUIDE 2024–25

SIGNING UP IS

LICKETY-SPLIT

RE-ENROLLMENT

With Re-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.

Re-enrollment can be completed three ways: self-service re-enrollment at **SDOC-benefits.com**, through a 1-on-1 phone meeting with Explain My Benefits, or through the Explain My Benefits mobile app.

My re-enrollment appointment day and time is:

OCTOBER 1, 2024

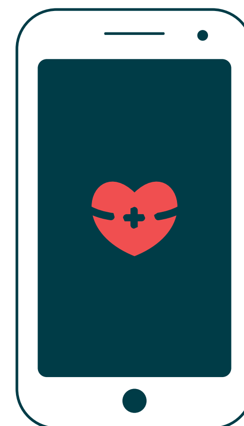
Your benefit elections are effective.

HOW TO COMPLETE YOUR SELF-SERVICE RE-ENROLLMENT

Enroll in your benefits using any computer with internet access. Visit **sdoc-benefits.com**. You will be redirected to your online re-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.



HOW TO SCHEDULE YOUR 1-ON-1 RE-ENROLLMENT APPOINTMENT

1. Once you've read this guide and made your elections, go online to schedule your 1-on-1 re-enrollment session whether in-person or telephonically. Spanish speaking counselors are available telephonically.
2. To schedule your 1-on-1 meeting, See QR code below.
3. Once you've read this guide and made your elections, go online to schedule your 1-on-1 re-enrollment session whether in-person or telephonically. Spanish speaking counselors are available telephonically. To schedule your 1-on-1 meeting, See QR code below.
4. Review your Re-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 benefi ts counselor will call you at the scheduled time and begin your re-enrollment. All calls will come from a (321) area code.

SCHEDULE YOUR APPOINTMENT

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

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:
  - Your biological children, legally adopted children or stepchildren;
  - Any children for whom you have been appointed legal guardian;
  - Any children for whom the court has issued a Qualified Medical Child Support Order requiring you or your spouse to provide coverage; or
  - 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:
  - Unmarried with no dependent children of their own;
  - A resident of the state of Florida or a full-time or part-time student;
  - 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
  - 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. * A Qualified Life Event is only applicable if the Retiree is already enrolled in said benefit.

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

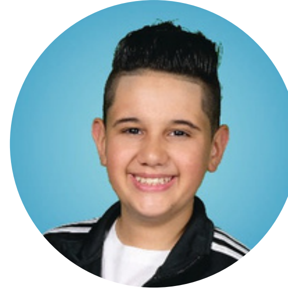
Dependent eligibility varies by plan. Please refer to the summary plan descriptions for specific information on each plan.

- **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.

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.

Even Better
BENEFITS

Exclusively for the School District of Osceola County



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.

LESSON ONE:

AN OVERVIEW OF YOUR MEDICAL RATES

So you can understand how the different benefits will impact your budget, we've also included a summary of the per month rates for our key benefits here.

MEDICAL:

	Healthy Essentials	Healthy Advantage Plus	Healthy Center Plan
Retiree Only	$588.17	$684.56	$473.78
Retiree + Spouse	$1,235.15	$1437.68	$994.96
Retiree + Child(ren)	$906.57	$1061.06	$734.36
Retiree + Family	$1,588.06	$1848.45	$1279.22

LESSON TWO:

AN OVERVIEW OF YOUR DENTAL & VISION RATES

DENTAL:

	DHMO	PPO	
		Low Option	High Option
	Rate per month	Rate per month	Rate per month
Retiree	$13.74	$21.24	$34.81
Retiree + One	$24.06	$43.58	$71.35
Retiree + Family	$37.79	$76.24	$124.80

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

VISION:

	Standard	Enchanced
Retiree	$4.89	$10.94
Retiree + Family	$13.50	$30.19

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 is 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.

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 this plan.

Want to nominate your doctor to become a Tier 1 provider? 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. NEW! Health Center Plan

C

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 offi ce 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.

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.

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

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!

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

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

▶ 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.

CONTACT ELECT Rx

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

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.

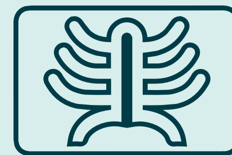
3) Once ElectRx has your basic personal information and the prescription from your physician, in 10-15 days, you will receive your 90-day supply of the prescription right in your mailbox!

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

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

	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 Offi ce 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 EVEN BETTER BENEFITS

LEGEND

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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.

	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 (Health Center, Quest or LabCorp)	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 ESSENTALS 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......................... $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.		

EVEN BETTER BENEFITS

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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.

	HEALTHY ADVANTAGE PLUS 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	Deductible/Co-Insurance	$45	$45
Labwork — Done at Independent Lab (Health Center, Quest or LabCorp)	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 2024–25		
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 | $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.		

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.

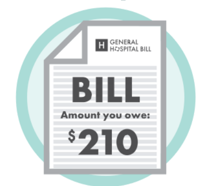
HOW TO ADDRESS YOUR POTENTIAL BALANCE BILL

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 Benefi ts (EOB)... **...Matches your bill**



From your health plan (this is not a 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 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 medial home, focusing on Primary Care medicine. Established patients may call in the morning for 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

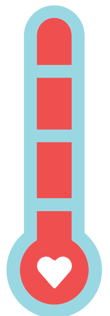
FREQUENTLY ASKED QUESTIONS

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 user 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 ther 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 new 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.**

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.

We've provided a comparison of the plans below, but this is only a brief summary. Check out page 6 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.

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

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.

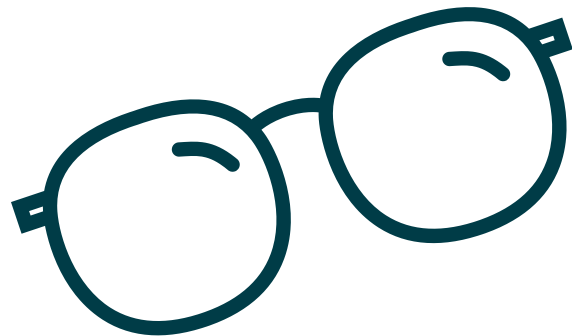
You can visit any dentist, both in- and out-of-network, however, PPO in-network providers will almost always be less expensive. You also run the risk of balance billing from out-of-network providers. If you select the PPO option, you will then have two options for coverage; either the High option or 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	Adults/Dependent children – 50%	Adults/Dependent children – 50%
Orthodontic treatment	Dependent children & Adults — $1,850		
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 5 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	
	Description	**Copay**	**Description**	**Copay**
Wellvision Exam	• 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 (fitting and evaluation) • Every plan year	Up to $40	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting 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 EyeCareSM	• 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
Extra Savings	**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.

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 fl doe.org. To fi le 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

IMPORTANT NOTICE FROM THE SCHOOL DISTRICT OF OSCEOLA COUNTY ABOUT YOUR PRESCRIPTIONS DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with School District Osceola County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. School District Osceola County has determined that the prescription drug coverage offered by the School District is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current School District Osceola County coverage will (or will not) be affected.

If you do decide to join a Medicare drug plan and drop your current School District Osceola County coverage, be aware that you and your dependents will (or will not) (Medigap issuers must insert "will not") be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with School District Osceola County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through School District Osceola County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	08/01/2025
Name of Entity/Sender:	School District Osceola County
Contact--Position/Office:	Risk and Benefits Management
Address:	831 Simpson Road, Suite 100 Kissimmee, Florida 34744-5328
Phone Number:	407-870-4899

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.

Health Services Plan

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
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**
Retirement benefits	Florida Retirement System	1-866-446-9377 **myFRS.com**
TSA Consulting Group		1-888-796-3786 Fax: 866-741-0645

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

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