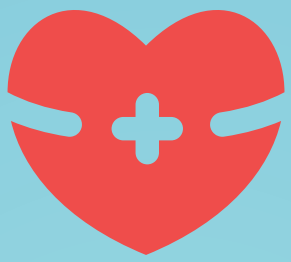
YOU'RE ALWAYS HERE FOR US



Even Better BENEFITS

Exclusively for the School District of Osceola County

ARE NOW HERE FOR YOU

EMPLOYEE BENEFITS GUIDE 2020–21

A MESSAGE FROM THE Council of Kids Who Care

If there's one thing we know about the teachers and staff of the School District of Osceola County, it's that you care. You care about the education, health, safety, and futures of your students. You care about the quality of the curriculum and the environment in their classrooms. You spend every day showing us how much you care, in so many different ways.

Now, The Council of Kids Who Care is here to show how much WE care about YOU– by teaching you all about your EVEN BETTER Benefits.

You might think you know all there is to know about your benefits program, but trust us kids on this one—a whole lot has changed, and in a great way. Now, you have access to programs that save you time and money on your medical needs. Bigger rewards for your healthy choices. And even more exciting perks! You've got a lot to learn, so let us take the lead and teach you a thing or two about your EVEN BETTER Benefits program.

SUPERINTENDENT'S MESSAGE

Dear School District of Osceola County Employees,

I would like to start by expressing my deepest thanks and appreciation for the hard work you do every day. Your unwavering care and compassion for our students is what makes our school district so extraordinary. These past few months must have made your work more difficult than it's ever been, and I'm so proud of, and grateful for, the way you've responded and risen to the challenge.

As we return to work and adjust to a new normal, these turbulent times have reaffirmed the commitment of your School Board, Superintendent, and district and school leaders to invest in the health and safety of you and your family. That's why we're introducing Even Better Benefits—a whole new health services plan and wellness program that will give you greater flexibility, value and access to high quality healthcare than ever before.

While you can still enjoy programs like ElectRx and Green Imaging, the Even Better Benefits program includes several new initiatives, one of which is the Medical Advocacy Program (MAP). MAP is a nurse concierge service that makes booking medical procedures easier by finding you the best provider based on their ratings, value and scheduling availability. The district is also proud to partner with Evolutions Healthcare, along with a new partner, Aither Health, to give you access to an expanded network of preferred providers. Save more than ever by utilizing in-network doctors or easily nominate your own doctor if they aren't part of Evolutions already. As we approach Open Enrollment, be sure to keep an eye out for our new and improved way to enroll with Explain My Benefits. We heard you and wanted to make Open Enrollment as convenient and stress-free for you as possible. With the help of Explain My Benefits, all you have to do is schedule your one-on-one phone meeting and their team will walk you through your options. After that, your Benefits Counselor will help you sign up and review everything you need to ensure you get the best benefits possible.

I would like to end this message by emphasizing the magnitude of the work you do each day. We recognize that the endless care and time you put towards your students doesn't leave much room for worrying about your own health and wellbeing. That's why we worked hard to develop the Even Better Benefits Program—to offer you the support and resources you need to take care of yourself and your family.

Thank you for your continued support and contribution to our district's success, and very best wishes for the coming school year.

Dr. Debra Pace
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, 2020 through September 30, 2021.

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.

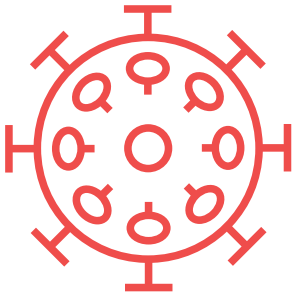
WHAT'S NEW THIS YEAR

Be on the lookout for these new programs that are making your benefits even better than before.

MEDICAL ADVOCACY PROGRAM (MAP)

This nurse concierge service connects you to the best providers and facilities for procedures.

PAGE 11



FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

How the School District of Osceola County can help you during this stressful time.

PAGE 30

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

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 50 wellness incentive points and new hires for the 2020-2021 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:

- ☐ Employee
- ☐ Employee + Family

☑ BASIC LIFE AND AD&D INSURANCE:

$0

SUPPLEMENTAL LIFE INSURANCE:

- ☐ None
- ☐ 1x annual salary
- ☐ 2x annual salary

ACCIDENT INSURANCE:

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

TAX SHELTERED ANNUITIES:

$ _____ per pay

View more information on all of your choices here.

Happy with your choices? To enroll go to http://osceolaschools.net/benefits

SIGNING UP IS LICKETY-SPLIT

OPEN ENROLLMENT (AUGUST 10 – AUGUST 28)

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.

To make sure you and your family get the best benefits possible, Open Enrollment can only be completed through a 1-on-1 phone meeting with Explain My Benefits. 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:

GO ONLINE TO SCHEDULE YOUR ENROLLMENT APPOINTMENT.

1. Once you've read this guide and made your elections, go online to schedule your 1-on-1 enrollment session, which is available in both English and Spanish.
2. Go to https://booknow.appointment-plus.com/b8xzjm4m
3. **You must schedule your appointment no later than August 7th.**

Scheduled by August 7, 2020
My appointment day and time is:

_____

August 10-28, 2020
Open Enrollment

October 1, 2020
Your benefit elections are effective.

BE READY TO ENROLL BY PHONE AT YOUR CHOSEN TIME.

4. Block out thirty minutes for your appointment and plan to be someplace you feel comfortable speaking out loud about your private benefits information.
5. 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.
6. **Have critical pieces of information ready!** These include the Benefit Guide, dependent birth dates, social security numbers, names of healthcare providers, etc.
7. Your benefits counselor **will call you at the scheduled time** and begin your enrollment. All calls will come from a (321) area code.

NEW TO THE OSCEOLA TEAM?

NEW HIRES

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.

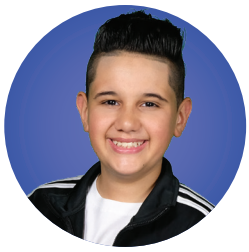
Click Here to Schedule your phone enrollment meeting with Explain My Benefits

QUALIFYING EVENTS

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.



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.

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), who 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.**

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 LifeEvents:** 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.

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 $6,826 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
Employee Only	$25.00	$0.00	$50.00	$25.00
Employee + Spouse	$375.00	$325.00	$435.00	$385.00
Employee + Child(ren)	$202.00	$152.00	$245.00	$195.00
Employee + Family	$502.00	$452.00	$580.00	$530.00
Half Family Primary	$50.00	$20.00	$220.00	$170.00
Half Family Secondary	$0.00	$0.00	$0.00	$0.00
Each Adult Dependent Child Aged 26-30	$375.00	$325.00	$435.00	$385.00

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 ($170.65 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!

Check out your dental plan options and compare coverage on Page 20! Protecting those pearly whites just got easier.

DENTAL:

	DHMO	PPO	
		Low Option	High Option
	Rate per pay	Rate per pay	Rate per pay
Employee	$7.50	$11.60	$19.00
Employee + One	$13.14	$23.79	$38.95
Employee + Family	$20.64	$41.62	$68.14

VISION:

Employee	$3.67
Employee + Family	$11.23

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 PHONE 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.

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 and you won't see an increase in your premiums.

EVOLUTIONS HEALTHCARE CUSTOM PROVIDER NETWORK

Both the Healthy Essentials and Healthy Advantage Plus plans give you the flexibility to visit any provider (doctor or facility), including specialists, without the need for a referral. Evolutions Healthcare's network is made up of three tiers:

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 much lower than it is today. Currently, all hospitals in the Orlando Health system, including St. Cloud 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 than they are now.

Tier 3 (Non-specified Providers) - This tier is of providers are not part of the Custom Provider Network but, you can still see these doctors for the same copay that you have today.

Save money by utilizing Tier 1 or Tier 2 providers, or you can easily nominate your Tier 3 provider to become Tier 1. If your Tier 3 provider agrees to our terms, they can become a part of the Tier 1 network. While we cannot guarantee your physician will choose to participate, we will do our best to make them become part of Tier 1 or Tier 2.

SO WHAT'S THE DIFFERENCE?

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.

While this plan costs you less per pay period and you still have protection against large unexpected claims, you have to pay a little more when you receive services.

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.

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.

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!

Want to nominate your doctor to become a Tier 1 provider? Just visit **www.ehsppo.com/members/** and fill out the short **"Nominate a Provider"** online form!

MEDICAL ADVOCACY PROGRAM (MAP)

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 all-new Medical Advocacy Program, you no longer have to worry about finding the best doctor or facility or the best price. MAP will take care of everything for you.

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.

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!

MAP 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 MAP gives you, your deductible for that procedure will be waived! If you call MAP and don't follow their advice, the plan pays usual benefits.

CONTACT MAP

We have a hotline just for the district!

Call: 888-289-0700
Monday - Friday 8:30AM - 6:30PM
Visit: http://mapmember.com/

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

HOW MAP WORKS

1. Contact MAP at **1-888-289-0700** and speak with a MAP Nurse Advocate about your medical concerns.
2. Your MAP Nurse Advocate will listen, do research and then provide information, answers, and opinions.
3. Your MAP 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 MAP Works!

Generic Medications are significantly less expensive than brand name alternatives. Under both 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-prefeered pharmacies include CVS, Walgreens and RiteAid as an example. You will not be asked to repeat any step therapy already done. You may need to have your physician confirm your status.

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

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 DOCTOR WON'T ACCEPT YOUR 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 Aither, 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 Aither Health 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 Aither Health at **1-833-575-0724.** Provide Aither the details of your situation and they will engage your benefits advocate.

HOW TO ADDRESS YOUR POTENTIAL BALANCE BILL

1. Contact Aither Health (AH) at 1-833-575-0724
2. Send AH a copy of the balance bill from your provider. Make sure your Explanation of Benefits matches your balance bill!
3. AH 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 Aither Health (AH) at 1-833-433-7686
- Send AH 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

No matter your plan, you have the flexibility to go to any doctors,hospitals, and facilities you choose. 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.

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.

INTRODUCING YOUR EVEN BETTER BENEFITS

Even Better BENEFITS

	HEALTHY ESSENTIALS BENEFITS PLAN 2020–21		
	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 / $12,600	$6,300 / $12,600	$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)	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	Deductible/Co-Insurance	Deductible/Co-Insurance
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

HEALTHY ESSENTIALS BENEFITS PLAN 2020–21		
Prescription Drug Benefit	Non-Preferred Pharmacy (CVS, Walgreens, RiteAid)	PREFERRED PHARMACY (Independent pharmacies, Publix, Walmart family of stores, and Costco)
Deductible (Waived for Preferred Generics)	$300 waived for preferred generics	No Deductible
Generics Obtained at SDOC Health Center	$0	$0
Preferred Generic	$10	$6
Preferred Brand	20% up to $75	$45
Non-Preferred Brand	50% up to $200	50% up to $150
Specialty	Preferred Pharmacy Only	50% up to $200
International Program with ElectRx	$0	$0

YOUR PREMIUMS

	HEALTHY ESSENTIALS BENEFITS PLAN 2020–21	
	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

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.

Medical Advocacy Program (MAP):
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 11).

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

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

Direct Cash Pay Program for Tier 2 and Tier 3 Claims:
When a member calls MAP for assistance with a pre-planned procedure, MAP may reach out to the facility to try and negotiate a "cash up front" arrangement in order to secure the best price.

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!.

EVEN BETTER BENEFITS

Even Better BENEFITS

	HEALTHY ADVANTAGE PLUS BENEFITS PLAN 2020–21		
	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)	$5,700 / $11,400	$5,700 / $11,400	$3,000 / $6,000
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	$100	$100
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

HEALTHY ADVANTAGE PLUS BENEFITS PLAN 2020–21		
Prescription Drug Benefit	Non-Preferred Pharmacy (CVS, Walgreens, RiteAid)	PREFERRED PHARMACY (Independent pharmacies, Publix, Walmart family of stores, and Costco)
Deductible (Waived for Preferred Generics)	$75 waived for preferred generics	No Deductible
Generics Obtained at SDOC Health Center	$0	$0
Preferred Generic	$10	$6
Preferred Brand	20% up to $50	$45
Non-Preferred Brand	50% up to $150	50% up to $150
Specialty	Preferred pharmacy only	50% up to $200
International Program with ElectRx	$0	$0

YOUR PREMIUMS

	HEALTHY ESSENTIALS BENEFITS PLAN 2020–21	
	Wellness Points Earned	Wellness Points Not Earned
Employees Only	$25	$50
Employee + Spouse	$385	$435
Employee + Children	$195	$245
Employee + Family	$530	$580
Half Family Primary	$170	$220
Half Family Secondary	$0	$0
Each Adult Dependent Child Age 26–30	$385	$435

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.

Medical Advocacy Program (MAP):
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 11).

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

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

Direct Cash Pay Program for Tier 2 and Tier 3 Claims:
When a member calls MAP for assistance with a pre-planned procedure, MAP may reach out to the facility to try and negotiate a "cash up front" arrangement in order to secure the best price.

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!

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 oTECH campus. So you and your family can get the medical service needed.

Our onsite Center for Employee Health—operated by RosenCare Solutions—gives you access to high quality, affordable healthcare services. However, you'll notice a change in the focus of the Center from an acute care clinic to an all-inclusive medical home.

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
- On-Site Prescription Dispensing of certain generic medications
- On-Site X-Ray and EKG

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 will be able to receive services at the Center at no cost.

Who is Healics?
Healics 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.

APPOINTMENTS

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

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

I heard at recess that you might want to be on the lookout for additional Center for Employee Health locations in the future!

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)

www.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); and
- 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	$ 5.64	$12.19	$19.95
Employee + Family	$13.14	$30.02	$49.14

Vision premiums

	Rate per pay
Employee	$0.00
Employee + Family	$7.56

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 and contribute $750 to your Health Care FSA. The District will contribute $676.60 to your Health Care FSA.

$3.67 x 20 pay periods = $73.40
$750 - $73.40 = $676.60

Example 5: See page 24 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.

We've provided a comparison of the plans below, but this is only a brief summary.
Check out page 7 for more information about the premiums you could pay for these plans and find full details about the plans at **www.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.

See more information on page 9.

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.

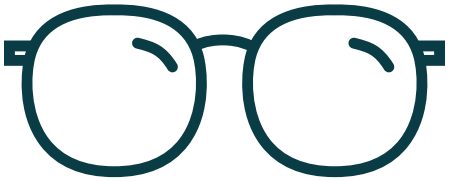
You can visit any dentist, both in- and out-of-network, however, PPO in-network providers will almost always be less expensive. You also run the risk of balance billing from out-of-network providers. If you select the PPO option, you will then have two options for coverage; either the High option or 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 – Not covered	Adults – Not covered
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 go to www.humana.com 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.

EyeMed offers you a wide range of in-network providers, and there are additional benefits to using an in-network provider as you'll also be eligible to receive discounts on prescription eyeglasses and services. You can also visit out-of-network providers if you have a preferred optometrist. Need a second pair of glasses? EyeMed offers you a 40% discount on additional pairs.

Check out Page 9 for more information about the vision plan premiums.

SUMMARY OF BENEFITS

Coverage Type		In-Network Benefit	Out-of-Network Reimbursement
Plan Basics	Eye Exam with Dilation as Necessary	$10 co-pay	Up to $35 reimbursement
	Frequency:		
	Exam	Once every 12 months	
	Lens	Once every 12 months (glasses or contact lenses)	
	Frames	Once every 24 months	
Lenses & Frames	Frames	$0 co-pay; $130; retail allowance 20% off balance over $130	Up to $45 reimbursement
	Lenses:		
	Single	$15 co-pay	Up to $25 reimbursement
	Bifocal	$15 co-pay	Up to $40 reimbursement
	Trifocal	$15 co-pay	Up to $60 reimbursement
Contacts	Conventional	$0 co-pay; $120 allowance; 15% off balance over $120	Up to $120 reimbursement
	Disposable	$0 co-pay; $120 allowance; plus balance over $120	Up to $120 reimbursement
	Medically Necessary	$0 co-pay, Paid-in-Full	Up to $120 reimbursement

This is only a brief summary of the plans and is intended for comparison purposes only.

Please go to **www.eyemed.com** for plan descriptions including out-of-network reimbursements.

Curious about Lasik, but just can't see paying that much for surgery? With EyeMed you can receive 15% off the retail price or 5% off the promotional price in the U.S. Laser Network. Call 1-877-5LASER6 for more information.

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.

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 www.metlife.com/mybenefits.

For more information about these benefits:

1-800-638-6420

www.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.

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, 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

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.

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.

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	15 monthly payments

For more information about these benefits:
1-800-423-2765, prompt 1
www.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 $500 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 an Aither Health 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.
- 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 www.myaitherhealth.com or review the IRS

Publications available at
https://www.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.
- If your claim is more than your account balance, Aither Health will automatically reimburse you as additional deductions are deposited into your account

To make a claim, you will need to complete a claim form (available at www.myaitherhealth.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.

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 $2,750 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 file 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 2020	October 2020	December 2020	January 2021
Cigna FSA — until 9/30/2020		Cigna FSA RUN OUT until 12/31/2020	Cigna send rollover balance to Aither
	Aither FSA begins 10/1/2020		Aither loads rollover balance into Aither FSA

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)

Employees with an existing policy can add an additional $30,000 in coverage at a guaranteed issue during this open enrollment 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**

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 benefits for hospital stays due to a covered sickness or accident, childbirth or mental wellness/addiction recovery. Watch this example on how Hospital StayPay works. Click here!

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:
up to 50% of employee election, $2,500, $5,000, $10,000

Examples of covered conditions:

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:** $15,000

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
- Colonscopy
- 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, or at least that's what my dad told me to say.

This plan is optional and is offered in addition to your Florida Retirement System retirement benefits.

If you are already contributing towards a Tax Sheltered Annuity, you can change your deduction (either increase or decrease) at any time during the year.

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.

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/benefits

This website also has information if you wish to suspend a current deduction and the Salary Reduction Form.

SDOC BOARD APPROVED TAX SHELTERED ANNUITY COMPANIES

403(b)/403(b)(7) Accounts	
Ameriprise Financial	1-800-862-7919
*MetLife	1-800-560-5001
Pacific Life	1-800-722-2333
403(b)/403(b)(7) Accounts and 457(b) Deferred Compensation Plans	
*AIG/VALIC	1-800-369-0314
American Century	1-800-345-3533
Aspire Financial	1-866-634-5873
*AXA Equitable	1-800-628-6673
Fidelity Investments	1-800-343-0860
Great American (GALIC)	1-800-854-3649
*Horace Mann Company	1-800-999-1030
VOYA Retirement Plans (formerly ING)	1-800-584-6001
The Legend Group	1-800-749-4221
*LSW - National Life Group	1-800-732-8939
Lincoln Investment Planning	1-800-242-1421
*Oppenheimer Funds	1-800-525-7040
*Plan Member Services	1-800-874-6910
Security Benefit Group	1-800-222-3003

*Also offer ROTH 403(b)

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.

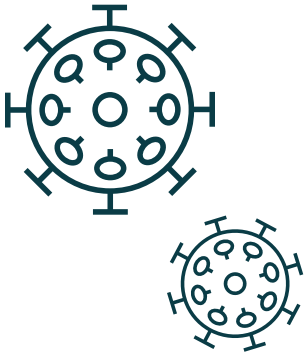
FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

Effective April 1, 2020 through December 31, 2020. The act entitles disctrict employees with expanded family and medical leave for specified reasons related to COVID-19 including an expanded FMLA leave provision and Emergency Paid Sick Leave.

An eligible SDOC employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to telework, because the employee:

1. Is subject to Federal, State, or local quarantine or isolation order related to COVID-19
2. Has been advised by a health care provider to self-quarantine related to COVID-19;
3. Is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. Is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. Is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. Is experiencing any other substantially-similar condition specified by the U.S Department of Health and Human Services.

Under the FFCRA, the following paid leave options are available:



- **Expanded FMLA**

  For Option 5 as listed above: The first 10 days of this leave are unpaid, however, you may substitute accrued available time off or the Emergency Paid Sick Leave Act described below. After the initial 10 days, employees will be paid two-thirds of your regular rate of pay up to $200 a day or $10,000 total for the remainder (10 weeks) of the FMLA (not to exceed 12 weeks of FMLA in a rolling year).

- Emergency Paid Sick Leave Act

  For Options 1, 2 and 3 as described above: Regular rate of pay for 10 days capped at $511/day or $5,110 total.

  For Options 4, 5 and 6 as described above: Two-thirds of your regular rate of pay for 10 days up to $200 a day or $2,000 total.

If you would like to apply for this expanded leave, please contact Risk and Benefits Management at 407-870-4899 or insurance osceolaschools.net to begin the process.

COBRA CONTINUATION OF COVERAGE

An employee's coverage ceases on the last day worked for the District. The District's COBRA administrator, Aither Health, 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.

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, 2021. 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, 2021. 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 as follows:

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. Insurance 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 **www.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 www.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 **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Florida Medicaid
Website: **www.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: **www.flmedicaidtplrecovery.com**
Phone: **1-866-444-EBSA (3272)**

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
Website: **www.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).

NOTICE TO ENROLLEES IN A SELF-FUNDED NONFEDERAL GOVERNMENTAL GROUP HEALTH PLAN

Group health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, these employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. The School Board of Osceola County Health and Life Trust Fund has elected to exempt all medical plans administered by Aither Health from the following requirement:

Continued coverage for up to one year for a dependent child

who is covered as a dependent under the plan solely based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the 2020-21 plan year beginning 10/1/20 and ending 9/30/21. The election may be renewed for subsequent plan years.

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 http://osceolaschools.net/departments/risk_and_benefits_management 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.

KEY CONTACTS

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

Health Insurance		
MAP Nurse Advocates	Medical Advocacy Program	888-289-0700 http://mapmember.com
Custom Provider Network	Evolutions Healthcare Systems	800-308-2749 https://www.ehsppo.com/
Health Insurance Third Party Administrator (claims and programs)	Aither Health	1-833-575-0724 www.myaitherhealth.com
Center for Employee Health	RosenCare	407-483-5757 SDOCEmployeeHealthCenter.net
Open Enrollment	Explain My Benefits	888-734-6937, prompt 2 service@explainmybenefits.com
Dental **Group ID 830049**	Humana	1-800-233-4013 www.humana.com
Vision **Group ID 1012310**	EyeMed	1-866-800-5457 www.eyemed.com
Life and AD&D **Group ID 145776**	MetLife	1-800-638-6420 www.metlife.com/mybenefits
Universal LifeEvents Accident Insurance Hospital StayPay	Trustmark	1-800-918-8877 www.trustmarkins.com
Critical Illness Disability **Group ID OSCEOLACTY**	Lincoln	1-800-423-2765, prompt 1 www.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

Visit the Benefits Enrollment System at
http://osceolaschools.net/benefits

Risk and Benefits Management	t: 407-870-4899 f: 407-943-7749 http://osceolaschools.net/benefits
Aither Benefits Champion	t: 407-870-4900; Internal Extension 67559

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