FCM
ECW
Florida Custom Mold

2022-2023 EMPLOYEE BENEFITS

Effective December 1, 2022 through November 30, 2023

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GET READY!

New Benefits Choices Are Coming Your Way

Florida Custom Mold is pleased to offer its employees an excellent benefits program. These benefits are designed to protect you and your family while you are an active employee. The benefit choices you make should be tailored to your personal needs. After the open enrollment period ends, you may not add, delete, or change the coverage you have selected for yourself or your dependents until the next open enrollment period. **Make sure to review this guide to learn about your options.**

Outside of open enrollment, changes to insurance coverage can only be made within 30 days of a Qualifying Family Status Change, which are as follows:

- Marriage
- Birth or adoption of a dependent child
- Change in custody of a dependent child
- Death of a spouse or dependent child
- Your spouse has a change of employment or status affecting benefits coverage
- Your change of employment status
- You experience an involuntary loss of other group benefits coverage
- Or within 60 days if the Qualifying Event is relative to Medicaid or CHIP Eligibility
- Employees or Dependents become eligible or lose eligibility with state Medicaid or CHIP subsidies (Special Enrollment Rights Offered)

PRE- TAX ADVANTAGE

One of the advantages of your Employee Benefit Program is that your premium contributions are deducted from your paycheck on a pre-tax basis. When you pay for your premiums with pre-tax dollars, you are actually reducing your taxable income. Instead of paying taxes on your total income, you now pay on your income minus pre-tax deductions.

ELIGIBILITY

Eligibility: You are eligible for benefits if you are classified as an active, full-time employee working 30 hours a week or more. Your coverage is effective the **first of the month following 60 days from hire**.

Dependent Eligibility: If you wish, your dependents may also be covered under the medical, dental, vision and voluntary life plans. Newborns must be enrolled within 30 days from the date of birth.

Eligible Dependents include:
- Legal spouse, as defined by the Federal Law;
- Dependent children

MEDICAL - Your children up to the end of the calendar year in which they turn age 26, regardless of marital status, financial dependency, residency with the Eligible Employee, student status, employment status, or eligibility for other coverage.

CLARIFICATION ON ELIGIBILITY FOR DEPENDENT COVERAGE

Plans that offer dependent coverage must offer coverage to enrollees' adult children until age 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, is no longer a student, or is married.

Additionally in the State of Florida: In the event that the Subscriber has a Dependent who meets the following requirements, extended coverage may be eligible for that Dependent **up to the end of the calendar month in which the dependent reaches the age of 30**.

To be eligible for extended coverage, a Dependent must:
- Be unmarried and not have dependent of his or her own;
- Is a resident of Florida or a Student, AND
- Not have coverage as a named subscriber, insured, enrollee or covered person under any other group, blanket or franchise health insurance policy or individual health benefits plan, or is not entitled to benefits under Medicare.
- The Dependent child is not eligible to be covered unless the Dependent child was continuously covered by Creditable Coverage without a gap in coverage of more than 63 days

DENTAL – Dependent children are eligible until the end of the calendar month in which they turn 26.

VISION – Dependent children are eligible until the end of the calendar month in which they turn 26.

COBRA Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, (medical, dental or vision) you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

THINGS TO THINK ABOUT BEFORE YOU ENROLL

HOW CAN I SAVE MONEY ON MY HEALTH CARE?

What you pay for in healthcare expenses made up of two parts

1. Contributions – The amount that comes out each paycheck that pays for your share of health care premiums.
2. Out-of-Pocket Costs – Your share of coverage when you get care, like your deductible and coinsurance amount.

DO YOUR HOMEWORK

- Review your health care expenses
- Take a look at each plan cost per pay period. Would you rather pay less out of each paycheck or less at the time of receiving care?
- Gather a list of your doctors and check to see if they are in-network
- Make a list of any medications you routinely take and check to see if they are covered and at what cost
- Consider all of your options (i.e. review your spouse's plan)

RESEARCH BEFORE YOU RECEIVE CARE

- Use your in-network providers
- Contribute to tax-advantaged accounts
- Don't be afraid to ask your healthcare provider questions so you can avoid unnecessary testing or procedures. There may be better alternatives available that can save you money.
- Use virtual visits, convenience care clinics or urgent care centers before going to the ER if you re not having a true emergency.

ORGANIZE YOUR HEALTH CARE INFORMATION

- Create a safe place or folder with all your health care information so you have it handy when needed. Include items such as Summary Plan Descriptions (SPD), Explanation of Benefits (EOB, bills and receipts.

TAKE CHARGE OF YOUR HEALTH

- Practice preventive care. It is covered at 100% when you utilize an in-network provider.

MEDICAL BENEFITS

You have a choice of four medical plans through UnitedHealthcare. To find a doctor, visit www.uhc.com and click on **Find a Doctor.** Search the **General Directory Provider List** and click under **Medical Directory.** Then select **Employers and Individual Plans and** click on **NHP HMO/POS ACCESS for CRU7 & CRV5. A PCP must be selected at the time of enrollment along with their 14 digit Provider ID#.** The benefits are as follows:

STAHL & ASSOCIATES INSURANCE	UnitedHealthcare	
	NHP CRU7 – Plan 1	NHP CRV5 – Plan 2
PHYSICIANS SERVICES	**In Network Only**	**In Network Only**
Preventive Care	Covered at 100%	Covered at 100%
Primary Physician Services	$30	$40
Specialist Physician Services	$55	$65
Hospital / Other	30% after ded.	30% after ded.
OUTPATIENT SERVICES		
Emergency Room Services	$350	$350
Urgent Care	$60	$85
Diagnostic Lab & X-Ray (Quest or LabCorp)	30% after ded.	$0 – Lab –physician office/freestanding $65 – X-ray (Lab/X-ray – 30% after ded. – Hospital/Outpatient Facility)
Diagnostic - CT & Pet Scan/ MRI	30% after ded. – Designated Network 50% after ded. – Network	$200 - Designated Network $750 –Network
PRESCRIPTIONS	**RX Deductible - $1,500/$3,000**	
RX	$10 – Tier 1 No Ded. 50% after ded, - Tier - 2,3,4	$10/$60/$100 Specialty RX - $10/$150/$500
Mail Order Prescriptions (90 Days)	50% after ded. – Tier – 2,3,4	2.5 x Retail
HOSPITALIZATION		
In Patient Hospital Facility Charge	30% after ded.	30% after ded.
OUTPATIENT SERVICES		
Outpatient Surgery Facility Charge	30% after ded.	30% after ded. - Amb Surgical CTR 40% after ded. – Hospital-based Surgical CTR
BENEFIT HIGHLIGHTS		
Calendar Year Deductible (Individual/Family)	$6,000/$12,000	$1,500/$3,000
Co-Insurance Percentage	70%	70%
Max Out of Pocket Including Deductible, CoInsurance & Copays (Individual/Family)	$8,700/$17,400	$6,500/$13,000
Lifetime Maximum	Unlimited	Unlimited

COST PER PAY PERIOD (52 weeks)		
Coverage Tier	**NHP CRU7 – Plan 1**	**NHP CRV5 – Plan 2**
Employee	$11.08	$13.05
Employee + Spouse	$168.41	$198.31
Employee + Child(ren)	$100.38	$118.21
Employee + Family	$269.41	$317.24

MEDICAL BENEFITS

To find a doctor, visit www.uhc.com and click on **Find a Doctor.** Search the **General Directory Provider List** and click under **Medical Directory.** Then select **Employers and Individual Plans and** click on **Choice for the CRXQ & CHYZ plans. PCP Does NOT need to be selected.** The benefits are as follows:

STAHL & ASSOCIATES INSURANCE	UnitedHealthcare	
	Choice – CRXQ – Plan 3	**Choice CHYZ – Plan 4**
PHYSICIANS SERVICES	**In Network Only**	**In Network Only**
Preventive Care	Covered at 100%	Covered at 100%
Primary Physician Services	$0	$25
Specialist Physician Services	$100	$80
Hospital / Other	20% after ded.	20% after ded.
OUTPATIENT SERVICES		
Emergency Room Services	$750	$500
Urgent Care	$75	$75
Diagnostic Lab & X-Ray (Quest or LabCorp)	$25 – Lab/X-ray- Designated Network 50% - Network	$0 – Lab/X-ray – Designated Network 50% - Network
Diagnostic - CT & Pet Scan/ MRI	$400 – Designated Network $750 - Network	$400 - Designated Network $750 - Network
PRESCRIPTIONS	**RX Deductible - $1,500/$3,000**	
RX	$10 – Tier 1 No Ded. $35/$70/$150 after ded. Tier - 2,3,4 Specialty RX - $10 Tier 1 No Ded $150/$350/$500 after ded. – Tier 2,3,4	$10/$60/$100 Specialty - $10/$150/$500
Mail Order Prescriptions (90 Days)	2.5 x Retail – Tier – 1	2.5 x Retail
HOSPITALIZATION		
In Patient Hospital Facility Charge	20% after ded.	20% after ded.
OUTPATIENT SERVICES		
Outpatient Surgery Facility Charge	20% after ded.	$500
BENEFIT HIGHLIGHTS		
Calendar Year Deductible (Individual/Family)	$6,000/$12,000	$1,500/$3,000
Co-Insurance Percentage	80%	80%
Max Out of Pocket Including Deductible, Colnsurance & Copays (Individual/Family)	$8,700/$17,400	$6,500/$13,000
Lifetime Maximum	Unlimited	Unlimited

COST PER PAY PERIOD (52 weeks)		
Coverage Tier	**Choice – CRXQ –Plan 3**	**Choice CHYZ – Plan 4**
Employee	$14.25	$15.86
Employee + Spouse	$216.61	$241.08
Employee + Child(ren)	$129.11	$143.70
Employee + Family	$346.51	$385.66

MEDICAL PLAN HIGHLIGHTS

IT PAYS TO STAY IN-NETWORK

You should know that if your doctor sends you for an x-ray, CT scan, or MRI, it will generally cost less at an independent, or "freestanding", in-network imaging center – rather than an outpatient hospital.

Find in-network physicians, facilities, and hospitals at **www.uhc.com** and click on **Find a Doctor.** Next click on Search **General Directory Provider List and click on Medical Directory**. Then select the **NHP HMO/POS for the CRU7 & CRV5 plans. Select the Choice network for the CRXQ & CHYZ plans.**

PREVENTIVE CARE

Preventive care services include routine wellness exams, well-child exams, physicals, mammograms, flu shots and other immunizations. Visit **www.uhc.com** to access age and gender specific preventive care recommendations that will help you manage your health.

ACCESS YOUR INFORMATION ON THE GO

United Healthcare offers several easy and convenient tools to help you understand your health benefits. Online at uhc.com you can:

- Review you plan benefits and check claims
- Get up to date information on your out of pocket expenses
- Request an ID card
- View health videos and read blogs
- Research your symptoms and conditions with easy-to-understand health content

PERSONALIZED CARE

- **Nurseline** is available 24/7 for general health and prevention questions or for education and support on medical issues. Contact Nurseline at **1-877-440-0547**

WHERE TO GO FOR CARE

When you need care, choosing the right treatment option can help you avoid needless worry, higher expenses, and hours of unnecessary waiting. Your primary care provider should be you first line of defense when seeking care. Your primary care provider can treat common illnesses, minor injuries and can conduct routine exams, vaccinations and screenings.

Use the chart below as a guide to help you make the right decisions when you can't see your primary care provider.

VIRTUAL VISITS - $0 – Designated Virtual Network Provider

Virtual Visit doctors are available via phone or video 24/7, 365 days a year. To get started go to www.uhc.com/virtualvisits or call 1-855-615-8335

Use Virtual Visits for conditions like:

- Upper respiratory infection
- Sinus infection
- Urinary tract infection
- Common cold
- Cough
- Flu

URGENT CARE CLINIC

Urgent care centers are less expensive than ERs and often have shorter wait times.

Visit an urgent care center for conditions like:

- Cold, flu and fever
- Strains, sprains and/or breaks
- Infections
- Mild burns

EMERGENCY ROOM

Going to an ER for an issue that is not life threatening often results in long wait times and high medical bills.

Examples of symptoms that require emergency room care:

- Severe chest pain (a possible heart attack)
- Signs of a possible stroke
- Severe or sudden shortness of breath
- Sudden or unexplained loss of consciousness

PRESCRIPTION BENEFITS

You can save time and money by understanding important features of your prescription drug benefits.

GO GENERIC WHEN POSSIBLE.
Generic medications are as safe and effective as their brand name counterparts, and are usually considerably less expensive.

REASONS TO CHOOSE GENERICS

- **They're safe.** Generic medications are tested and approved by the FDA, and they're manufactured in FDA-inspected facilities.
- **They're effective**. Generics are required to have the same active ingredients and must work the same as their brand-name counterparts to obtain FDA approval.
- **They can save you money.** Choosing a generic equivalent could save you a significant amount of money over a brand-name counterpart.
- **It's easy to switch to a generic.** Ask your doctor to prescribe a generic alternative or ask your pharmacist to contact your physician.

WHAT SHOULD I CONSIDER BEFORE FILLING A PRESCRIPTION?

- Use a pharmacy that is in your plan's network and generic drugs (when available) to lower your cost. Using home delivery for ongoing maintenance medication may also save you money.
- Some drugs may require your doctor to submit a prior authorization before they're covered. You can check online at www.uhc.com and view the Medication Guide to see what drugs may require Prior Authorization.
- For plans that cover brand name drugs, certain brand name drugs may not be covered or will cost you more unless you have tried the generic alternative first.

MAIL-ORDER SERVICES
Use United Healthcare's mail order pharmacy, for up to a 90-day supply of medication. If you take medication to treat chronic conditions or diseases, such as arthritis, asthma, high cholesterol, hypertension, or heart conditions – it's a great way to save time and money. You'll get:

- A 90 day supply of medication for 2.5 times the cost of a 30-day supply
- Prescriptions delivered anywhere in the U.S. and free shipping.
- A pharmacist you can talk to any day, any time
- Easy ways to request refills online or by phone.

MAIL ORDER PRESCRIPTION PROTOCOL
OptumRx makes it easy to move to home delivery. Get started with only a few quick steps. They can even contact your doctor to move your prescription. Begin using home delivery today.

- **ePrescribe –** ask your doctor to send an electronic prescription to OptumRx
- **Online –** set up your account at www.optumrx.com and choose which medication you want to move to home delivery. Or use the OptumRx App on your smart phone or tablet.
- **Phone –** call OptumRx toll-free at 1-888-658-0539 (TTY711) any day, anytime.
- **Mail –** complete an order form found on www.optumrx.com and mail it with your written prescriptions to OptumRx.

HOW TO TRANSFER CURRENT PRESCRIPTIONS
Call OptumRx at 1-888-658-0539. All you'll need is the Member Number found on your ID card, your prescription information, your doctor's name and phone number.

HOW TO REFILL MEDICATION
Call OptumRx at 1-888-658-0539 and enter your prescription number. Or login at www.optumrx.com.

COMPARE DRUG PRICES BASED ON YOUR PLAN
Login to **www.optumrx.com** to find medication and lower costs alternatives covered by your plan.

DENTAL BENEFITS

Dental Coverage will continue to be offered through Guardian with a choice of two plans. Under the DHMO plan, you will need to elect a primary dentist. All services must be provided by or referred by that dentist. Under the PPO plan you have the option of seeing a dentist in the Guardian network or going to a dentist of your choice. To find a provider visit www.guardianlife.com.The DHMO plan is under the **Managed DentalGuard network** and the PPO plan is under the **DentalGuard Preferred network**.

STAHL & ASSOCIATES INSURANCE	Guardian		
	DHMO Plan	PPO Plan	
Benefits	**In-Network Only**	**In-Network**	**Out-of-Network**
Office Visit Copay	$5 in addition to copay(s) for services received	None	None
Annual Deductible *(Individual/Family)*	No Deductible	$50 / $150	$100 / $300
Waived for Preventive	No Deductible	Yes	No
Calendar Year Maximum	Unlimited	$1,200 per person	
Preventive - Cleanings & X-Rays	Covered at 100%	100%	80%
Basic - Fillings & Extractions	Various Copays	80%	70%
Major Services - Crowns, Root Canals, Scaling	Various Copays	50%	40%
Waiting Periods	None	12 months for major services	
Orthodontia	Various Copays	Not Covered	

For services other than preventive, it is recommended to get a pre-determination to review what your cost will be prior to services.

COST PER PAY PERIOD (52 weeks)		
Coverage Tier	**DHMO Plan**	**PPO Plan**
Employee	$6.90	$5.22
Employee + Spouse	$13.42	$11.72
Employee + Child(ren)	$12.63	$12.21
Employee + Family	$20.49	$18.70

VISION BENEFITS

STAHL & ASSOCIATES INSURANCE	Guardian Vision Plan	
BENEFIT HIGHLIGHTS	**In-Network**	**Out-of-Network**
Exams	$10	Reimbursement up to $3
Lenses		
Single Vision	$15	Reimbursement up to $23
Bi-Focal	$15	Reimbursement up to $37
Tri-Focal	$15	Reimbursement up to $49
Lenticular	$15	Reimbursement up to $64
Frames	$130 Retail Allowance + 20% off balance $70 retail max. – Costco, Walmart, SamsClub	Reimbursement up to $65
Contact Lenses		
Exam/Contact Lense Fit	Included in contact lens allowance – 15% discount	Included in contact lens allowance
Elective (in lieu of Eye Glasses)	$130 Retail Allowance	Reimbursement up to $100
Medically Necessary (in lieu of Eye Glasses)	Covered in Full after copay	Reimbursement up to $210
Laser Vision Correction		
Lasik or PRK	Discount Available	No Discount
FREQUENCY OF BENEFITS		
Exams/Frames/Lenses	12,24,12	

Coverage Tier	COST PER PAY PERIOD (52 weeks)
Employee	$1.23
Employee + Spouse	$2.33
Employee + Child(ren)	$2.38
Employee + Family	$3.76

FINDING A PROVIDER:

Voluntary vision insurance will be offered through Guardian. To find a provider in your area, go to www.guardianlife.com and click on Find a Vision or dental Provider at the bottom of the page. The vision network is VSP.

LIFE INSURANCE BENEFITS

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

All employees are provided with a company sponsored Life and Accidental Death Insurance benefit *at no cost to you*. This benefit is $25,000 for employees, $2,000 for spouses and $500 for child(ren). In the event of your death, this benefit is paid to your designated beneficiary. It is important to name a beneficiary for this benefit and review those beneficiaries on an annual basis. The benefit is provided through Guardian.

VOLUNTARY TERM LIFE INSURANCE AND AD&D

In addition to your company paid Life Insurance, you may purchase additional coverage through Guardian for yourself and for your dependents. **If you do not currently have voluntary life coverage for you and/or your dependents and you wish to elect coverage at this time you will need to complete an Evidence of Insurability form and go through an underwriting process. In addition, if you do have voluntary life coverage and wish to elect additional coverage you will need to complete an Evidence of Insurability form and go through an underwriting process. If approved by Guardian, coverage will be effective the first of the month following Guardian's approval.**

Employees can choose amounts in increments of $25,000 to a maximum of $150,000. The guarantee issue amount for employees who elect coverage when first eligible is $100,000. Spouses can elect coverage up to 50% of the employee amount to a maximum of $75,000. The guarantee issue amount for spouses who elect coverage when first eligible **is $50,000**. **Benefits reduce by 35% of the original amount at age 65; by 60% at age 70; by 75% at age 75; and by 85% at age 80.** Spouse coverage ends at age 70. The child benefit is in increments of $2,500 to a maximum of $10,000.

EVIDENCE OF INSURABILITY

Evidence of Insurability (EOI) will be required for either you, your spouse, or child under the following circumstances:

- If you previously waived voluntary term life insurance and wish to elect coverage this plan year.
- If you currently have voluntary term life insurance and wish to elect additional coverage for this plan year.
- For any amount elected over the guaranteed issue amount.
- For questions regarding Evidence of Insurability, please contact Human Resources.

***Cost for Employee or Spouse Voluntary Life is based on Employee's Age as follows*:**

MONTHLY RATE PER $1,000 OF BENEFIT	
29 & Under	$0.05
30 – 34	$0.07
35- 39	$0.10
40 - 44	$0.16
45 - 49	$0.28
50 - 54	$0.49
55 - 59	$0.83
60 - 64	$1.39
65 - 69	$2.19
70 – 74	$3.21
75 – 79	$5.87
80 – 84	$8.97
85 – 89	$16.41
Child Rate per $1,000 of benefit	$.170

PREMIUM CALCULATION EXAMPLE:

For a 44 - year-old employee who wants to buy $50,000 of voluntary life, the cost would be $8.00 per month or $1.85 per paycheck.

($0.16 x $50,000/$1,000 = $8.00, $8.00*12/52= $1.85)

DISABILITY BENEFITS

VOLUNTARY SHORT TERM DISABILITY

Voluntary short term disability coverage will continue to be offered through Guardian. **If you do not currently have short term disability coverage and you wish to elect coverage at this time you will need to complete an Evidence of Insurability form and go through an underwriting process. If approved by Guardian, coverage will be effective the first of the month following Guardian's approval.**

Benefit Percentage:	66.7% of pre-disability earnings
Weekly Max Benefit:	$1,000
Benefits Begin:	1st day for accident or 8th day for illness
Benefit Duration:	52 weeks
Pre-Existing Condition:	Disabilities that occur during the first 12 months after your effective date are not covered if you were treated, diagnosed, or sought consultation for that condition during the three months prior to the effective date.

MONTHLY RATE PER $10 OF BENEFIT	$0.96

SHORT TERM DISABILITY PREMIUM CALCULATION EXAMPLE:

$ 25,000 / 52 = $ 480.77 x .667 = $ 320.67 / 10 x $0.96 x 12 / 52 = $ 7.10

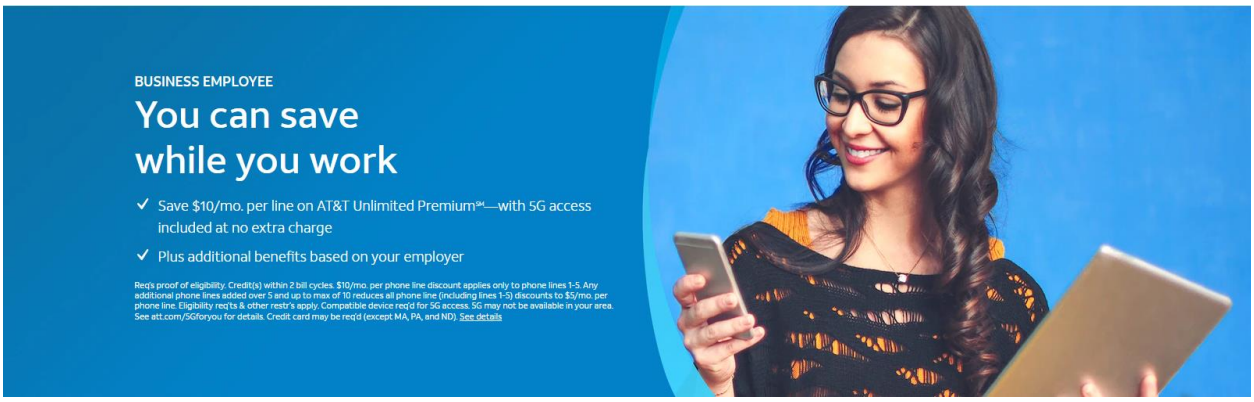
Annual Salary | *Per Pay Period Salary* | *Per Pay Period Benefit* | *Per Pay Period Cost*

AFLAC INSURANCE PLANS

Florida Custom Mold offers group indemnity products through AFLAC. There are five separate products to choose from: Medical Bridge, Accident, Critical Illness, Cancer and Whole Life.

These products can help you fill in some of the gaps caused by deductibles, copayments, and out-of-pocket costs related to illness and/or accidental injury. You do not need to be enrolled in any of the group health insurance plans offered through Florida Custom Mold to elect any of these coverages.

If you are interested in enrolling in any of these coverages, an AFLAC representative will be available to discuss the benefits and assist you with completing the application.



Florida Custom Mold has partnered with AT&T to be able to offer discounts to their employees. All you need to do to sign up is go to any AT&T retailer and provide the representative the following detail upon opening a new account or if an employee already has active service.

Restrictions apply. The employee must be the register account number for the discounts to be applied to the account.

There are several discounts available and may vary depending on the plan you select on your account.

Should you have any questions, please contact Christy Justi in Human Resources. 813-343-5076

Florida Custom Mold

1806 Gunn Highway, Odessa, FL 33556

Foundation Account Code: 03033875

Access Your Employee Perks Program Today!

working ADVANTAGE

More perks. More savings. More of what makes you happy.

We're here to support your personal and financial well-being through exclusive deals and limited-time offers on the products, services and experiences you need and love.

START SAVING ON

Electronics • Appliances • Apparel • Cars • Flowers • Fitness Memberships
Gift Cards • Groceries • Hotels • Movie Tickets • Rental Cars • Special Events
Theme Parks • And More!

New to Working Advantage? Getting Started is Easy.

Maximize your time away from the workplace and start saving today!

1. Visit WorkingAdvantage.com
2. Click *Become a Member*
3. Enter your company code or work email to create an account

YOUR COMPANY CODE

FLORIDACUSTOMFUN

SCAN ME

NEED HELP? EMAIL US: CUSTOMERSERVICE@WORKINGADVANTAGE.COM

Pet insurance from Nationwide®

Fetch the best health coverage for your pet this open enrollment. With two budget-friendly options, there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

- **Get cash back on eligible vet bills:** Choose 50% or 70% reimbursement[1]
- **Just for employees:** Preferred pricing offered only through your company
- **Use any vet, anywhere:** No networks, no pre-approvals

Did you know? Nationwide is the only insurer with coverage plans for birds and exotic pets. To enroll your bird, rabbit, reptile or other exotic pet, call 877-738-7874.

How to use your pet insurance plan

1 Visit any vet, anywhere.

2 Submit claim.

3 Get reimbursed for eligible expenses.

Get a quote at https://benefits.petinsurance.com/floridacustommold • 877-738-7874

[1] Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states.

Nationwide®

USF Federal Credit Union

Bank Where You Work, Travel & Live

- **More than 5,600 Nationwide Branches***
- **More than 30,000 Surcharge-Free ATMs***
- Free online and mobile banking
- Great rates on home loans and auto loans
- Dividend checking and savings accounts

*Through CO-OP Network

Odessa Branch
16032 Preserve
Marketplace Blvd.
Odessa, FL 33556

Join Online: usffcu.com/join

or you can call John Willis 813-437-8043 to join. Tell him you work for FCM.

USF FEDERAL CREDIT UNION

Delivering financial solutions to improve members' lives.

Federally Insured by NCUA

EQUAL HOUSING LENDER

ENROLLING IN BENEFITS

Florida Custom Mold will utilize the benefit enrollment online at www.benefitsconnect.net/floridacustom
Online enrollment is simple, secure and can be done within a few minutes from any computer with internet access. After enrolling online, you will have access to your benefit information at any time.

GETTING STARTED

During the enrollment process you will be asked to provide the following information:

- Your social security number
- Your dependent's social security numbers and birth dates

USERNAME AND PASSWORD

Initially your username and password are defaulted to a standard format. Upon completing your first login you will be prompted to change your password. Your user name is made up of the **first six letters of your last name**, followed by your **first initial** and **the last four numbers of your social security number**. The **initial password** for the system is your **social security number** (without dashes). Note: If your last name is not six letters please use your entire last name, first initial and last four of our social security number as your username.

EXAMPLE

Employee Name: Matt Sample
User Name: samplem1234
Social Security Number: 949-12-1234 **Password:** 949121234

After your initial login, the system will take you to the Personal Information section. Please complete all the fields (bolded fields are required) then click ***Save & Continue***.

ENTERING DEPENDENT INFORMATION

- To enter a spouse, click the icon under Spouse, enter information, and click ***Save***.
- To enter a child, click the icon under Children, enter information, and click ***Save***.
- To edit a dependent, click on the pencil icon next to the dependent you want to edit, make changes, and click ***Save***
- When you are finished entering dependents, click ***Save & Continue***.

MAKING BENEFIT ELECTIONS

Next , the system will take you to the Benefit Plan Enrollment Section. Each benefit and your options will be displayed one by one.

- To enroll in a plan, check next to the plan, and check any dependents you want to cover. If applicable, indicate the amount for which you would like to enroll.
- To waive coverage, check next to ***I waive enrollment.***
- Click ***Save & Continue*** after each benefit selection.

COMPLETING YOUR ENROLLMENT

- Once you have gone through enrollment, the system will take you to the consolidated enrollment form page. This screen will show you a summary of the information you entered and benefit elections you made.
- To completed the enrolled process click ***Finished.***
- Always make sure to log out upon completing any action on the system.
- **For Technical Assistance – Please call GIS Benefits of Florida at 866-400-7771. (Online Technical Assistance) and we will be able to assist you. The office is open Monday through Friday from 8:30 am to 5 pm EST.**

IMPORTANT DISCLOSURES

AVAILABILITY OF SUMMARY HEALTH INFORMATION – HEALTH CARE REFORM

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

NOTICE OF HEALTH INSURANCE EXCHANGES

The Health Insurance Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace helps you to find and compare private health insurance options. You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer offered coverage. Also, this employer contribution as well as your employee contribution to employer offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Human Resources and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

HIPAA SPECIAL ENROLLMENT RIGHTS

LOSS OF OTHER COVERAGE

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 your or your dependents' other coverage). However, you must request enrollment within *30 days* after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

NEW DEPENDENT AS A RESULT OF MARRIAGE, BIRTH, ADOPTION OR PLACEMENT FOR ADOPTION

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 within30 days after the marriage, birth, adoption, or placement for adoption.

TERMINATION OF MEDICAID OR CHIP COVERAGE OR ELIGIBILITY FOR PREMIUM ASSITANCE UNDER MEDICAID OR CHIP

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Human Resources.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans must provide this coverage.

If you receive benefits for medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you will also be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymphedema

IMPORTANT DISCLOSURES

IMPORTANT NOTICE FROM FLORIDA CUSTOM MOLD ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Florida Custom Mold 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. Florida Custom Mold has determined that the prescription drug coverage offered by the UnitedHealthcare CRV5 & CHYZ medical plan 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. The UnitedHealthcare CRU7 & CRXQ Base medical plan is Not-Creditable coverage.

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 15th to December 7th.

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 Florida Custom Mold coverage will not be affected.

- **CRV5 & CHYZ - $10/$60/$100 Specialty - $10/$150/$500 – Creditable Coverage**
- **CRXQ - RX deductible - $1,500 (individual) $3,000 (Family) for Tier 2,3,4. Tier 1 - $10 copay Tier 1 & $35/$70/$150 after ded. Tier 2,3,4 - INot Creditible Coverage**
- **CRU7 Plan 1 – RX deductible - $1,500 (individual) $3,000 (Family) for Tier 2,3,4. Tier 1 - $10 copay Tier 1/50% after ded. Tier 2,3,4 – Not Creditible Coverage**

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 Florida Custom Mold 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 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).

IMPORTANT DISCLOSURES

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

OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

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 on the next page, 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).

If you live in one of the states on the following page, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility – To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

STATE
ALABAMA – Medicaid **Website:** http://myalhipp.com/ **Phone:** 1-855-692-5447
ALASKA – Medicaid **Website:** http://myakhipp.com/ **Email:** CustomerService@MyAKHIPP.com **Phone:** 1-866-251-4861
ARKANSAS – Medicaid **Website:** http://myarhipp.com/ **Phone**: 1-855-692-7447
CALIFORNIA – Medicaid **Website:** https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx **Phone:** 1-800-541-5555
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) **Website:** https://www.healthfirstcolorado.com/ **Website:** https://www.colorado.gov/pacific/hcpf/child-health-plan-plus **Phone:** 1-800-221-3943/State relay 711 1-800-359-1991/ State Relay 711
FLORIDA – Medicaid **Website:** http://flmedicaidtplrecovery.com/hipp/ **Phone:** 1-877-357-3268
GEORGIA – Medicaid **Website:** https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **Phone:** 1-678-564-1162 ext. 2131
INDIANA – Medicaid **Website:** http://www.in.gov/fssa/hip/ http://www.indianamedicaid.com **Phone:** 1-877-438-4479 or 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki) **Website:** http://dhs.iowa.gove/ime/members http://dhs.iowa.gov/Hawki **Phone:** 1-800-338-8366 or 1-800-257-8563
KANSAS – Medicaid **Website:** http://www.kdheks.gov/hcf/default.htm **Phone:** 1-800-792-4884
KENTUCKY – Medicaid **Website:** http://chfs.ky.gov/agencies/dms/members/Pages/kihipp.aspx **Email:** KIHIPP.PROGRAM@ky.gov https://kidshealth.ky.gov/Pages/index.aspx https://chfs.ky.gov **Phone:** 1-855-459-6328 or 1-877-524-4718
LOUISIANA – Medicaid **Website:** www.medicaid.la.gov www.ldh.la.gov/lahipp **Phone:** 1-888-342-6207 or 1-855-618-5488
MAINE – Medicaid **Website:** http://www.maine.gov/dhhs/ofi/public-assistance/index.html **Phone:** 1-800-442-6003
MASSACHUSETTS – Medicaid and CHIP **Website:** http://www.mass.gov/eohhs/gov/departments/masshealth/ **Phone:** 1-800-862-4840
MINNESOTA – Medicaid **Website:** https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp **Phone:** 1-800-657-3739
MISSOURI – Medicaid **Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
MONTANA – Medicaid **Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084
NEBRASKA – Medicaid **Website:** http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 or 1-402-473-7000 or 1-402-595-1178

IMPORTANT DISCLOSURES

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) CONTINUED

STATE
NEVADA – Medicaid **Website:** https://dhcfp.nv.gov/ **Phone:** 1-800-992-0900
NEW HAMPSHIRE – Medicaid **Website:** http://www.dhhs.nh.gov/oii/hipp.htm **Phone:** 1-603-271-5218
NEW JERSEY – Medicaid and CHIP **Website:**http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ http://www.njfamilycare.org/index.html **Phone:** 1-609-631-2392 or 1-800-701-0710
NEW YORK – Medicaid **Website:** http://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831
NORTH CAROLINA – Medicaid **Website:** http://www.medicaid.ncdhhs.gov **Phone:** 1-919-855-4100
NORTH DAKOTA – Medicaid **Website:** http://www.nd.gov/dhs/services/medicalserv/medicaid/ **Phone:** 1-844-854-4825
OKLAHOMA – Medicaid and CHIP **Website:** http://www.insureoklahoma.org/ **Phone:** 1-888-365-3742
OREGON – Medicaid **Website:** http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html **Phone:** 1-800-699-9075
PENNSYLVANIA – Medicaid **Website :**http://www.dhs.pa.gov/Providers/Pages/Medical/HIPP-Program.com **Phone:** 1-800-692-7462
RHODE ISLAND – Medicaid **Website:** http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347 or 1-401-462-0311
SOUTH CAROLINA – Medicaid **Website:** http://www.scdhhs.gov **Phone:** 1-888-549-0820
SOUTH DAKOTA – Medicaid **Website:** http://dss.sd.gov **Phone:** 1-888-828-0059
TEXAS – Medicaid **Website:** http://gethipptexas.com/ **Phone:** 1-800-440-0493
UTAH – Medicaid and CHIP **Website:** http://Medicaid.utah.gov/ http://health.utah.gov/chip **Phone:** 1-877-543-7669
VERMONT– Medicaid **Website:** http://www.greenmountaincare.org/ **Phone:** 1-800-250-8427
VIRGINIA – Medicaid and CHIP **Website:** http://www.coverva.org/hipp/ **Phone:** 1-800-432-5924 or 1-855-242-8282
WASHINGTON – Medicaid **Website:** http://www.hca.wa.gov/ **Phone:** 1-800-562-3022
WEST VIRGINIA – Medicaid **Website:** http://mywvhipp.com **Phone:** 1-855-699-8447
WISCONSIN – Medicaid and CHIP **Website:** https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf **Phone:** 1-800-362-3002
WYOMING – Medicaid **Website:** https://wyequalitycare.acs-inc.com/ **Phone:** 1-307-777-7531

NEWBORNS' AND MOTHERS' HEALTH PROTECTION 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 to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean 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).

OPEN ENROLLMENT CHECKLIST

BEFORE ENROLLMENT

- ❑ Review this Open Enrollment guide
- ❑ Attend an Open Enrollment meeting
- ❑ Collect a list of doctors and medical facilities you use
- ❑ Collect a list of current prescriptions you take
- ❑ Review the Open Enrollment FAQs

DURING ENROLLMENT

- ❑ If you are enrolling dependents, have their information handy (i.e. SSN and date of birth)
- ❑ Review and/or update your beneficiaries

AFTER ENROLLMENT

- ❑ Submit Evidence of Insurability (EOI), if applicable
- ❑ Be on the lookout for your ID cards no later than December 1, 2022.
- ❑ Check your first paystub after December 1, 2022 and confirm your deductions are correct.

FREQUENTLY ASKED QUESTIONS

Q: WHO IS ELIGIBLE FOR BENEFITS?

A: You are eligible for benefits if you are classified as an active, full-time employee working 30 hours a week or more.

Q: WHEN IS MY COVERAGE EFFECTIVE?

A: For new hire employees, your coverage is effective the 1st of the month following 60 days from hire.

For Open Enrollment, all coverage changes will be effective December 1, 2022.

Q: WHAT BENEFITS REQUIRE RE-ELECTION?

A: All benefits require re-election. All employees are required to complete an open enrollment form or utilize the BenefitsConnect system.

FREQUENTLY ASKED QUESTIONS

Q: WHAT IF I DO NOT MAKE CHANGES TO MY CURRENT ELECTIONS?

A: All benefit eligible employees must complete their benefit elections even if they do not want to make any benefit changes.

Q: WHAT IF I WANT TO CHANGE MY ELECTIONS OR I AM ENROLLING FOR THE FIRST TIME?

A: New employees may elect coverage for the first time after satisfying the new hire waiting period. Once elections are made, they can only be changed once annually during Open Enrollment, unless you experience a qualifying event.

Q: WHAT IF I EXPERIENCE AN APPROVED QUALIFYING EVENT?

A: If you experience a qualifying event, you can submit the qualifying event along with any benefit changes you would like to make HR for approval.

Q:WHAT HAPPENS IF I DO NOT ENROLL?

A: Please note if you do not actively enroll during Open Enrollment you, WILL NOT have coverage for the 2022 plan year. Be sure to enroll so that you can choose what best fits you and your family member's needs this year.

After Open Enrollment ends, you will not be able to make changes to your 2022 benefit elections until the next Open Enrollment period unless you have a qualifying event.

USEFUL TERMS

Health insurance can be overwhelming and confusing. Here are some terms to make it easier for you to understand:

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

Certificate of Coverage: A description of the benefits included in your plan. In this guide, we refer to this as "benefit plan documents."

Coinsurance: The money you have to pay for health services after you have paid any applicable deductible.

Copayments: The fee paid for a doctor visit, hospital stay and other service.

Deductible: The amount of money you pay before your insurance starts to pay, if applicable to your plan.

Generic: A drug approved by the FDA for the same effectiveness, quality, safety and strength as a brand name drug.

Guaranteed Issue: The maximum amount of life insurance you can purchase without submitting an Evidence of Insurability form.

Health care: When doctors and other specialists help you when you are ill or need treatment or provider service for your annual check ups and preventive care visits.

Health plan ID card: The card issued to you by your medical insurance carrier that includes your name, group and policy information, and important phone numbers.

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

Initial Enrollment: Period when newly hired employees may elect benefits.

Network provider: All doctors, hospitals, nursing homes, and laboratories that have contracts with an insurance company. Sometimes called "in-network provider" or "participating network provider."

Open Enrollment: Annual period when current employees elect new benefits or make changes to existing elections.

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

Out-of-pocket maximum: The most you have to pay in deductibles and coinsurance for covered health services during the plan year. Depending on your plan design, the out- of-pocket maximum may also include copayment amounts.

Non-network provider: Doctors, hospitals, and other health care professionals who do not participate in our network. They may provide services at a higher cost; Sometimes called "out-of-network provider," or "non-participating network provider."

Preventive care: Services that help you stay healthy such as annual preventive visits, immunizations, and routine screenings.

Primary care provider: A doctor who you go to first when you are not feeling well, sometimes called a "primary care physician."

Qualified expense: The amount eligible to be paid for a covered health benefit under your insurance plan.

IMPORTANT CONTACTS

QUESTIONS ABOUT BENEFITS?

IMPORTANT CONTACTS			
Benefits	**Company**	**Phone Number**	**Website/Email**
Human Resources	Florida Custom Mold Christy Justi – HR Manager	1-813-343-5080 ext.238	Cjusti@fla-mold.com
Benefits – Enrollment and General Benefit Questions	**Stahl & Associates Insurance, Jim Sullivan**	**727-391-9791**	**Jim.Sullivan@stahlinsurance.com**
Benefits – Enrollment and General Benefit Questions	**Stahl & Associates Insurance Tracy Becker**	**727-489-0565**	**Tracy.Becker@stahlinsurance.com**
Medical	UnitedHealthcare	1-866-633-2446	www.uhc.com
Optum RX	UnitedHealthcare	1- 888-223-2759	www.uhc.com
Dental	Guardian	1-800-541-7846	www.guardiananytime.com
Vision	Guardian	1-800-541-7846	www.guardiananytime.com
Life & Disability	Guardian	1-800-268-2525	www.guardiananytime.com
AFLAC	AFLAC – John Domeier	727-894-5590	jdome1104@gmail.com