



GUIDE TO EMPLOYEE BENEFITS

2023-2024





YOU ARE FLVS.

We're committed to making sure your benefits package is right for both you and your family.

Open Enrollment is your chance to ensure that your benefits package is right for you. Medical coverage, dental and vision care, and financial protection options are built around you and created to keep you in great shape, physically and financially.

Please take the time to understand all the options available to you. As a whole, we think we've created a benefit package that gives you the support you need whether you're at work, at home or even on vacation.

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 38 for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies themselves must be read for those details. The intent of this document is to provide you with general information about your employee benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be directed to your Human Resources/Benefits Department. This guide is meant to serve as a summary. If there are differences between this guide and the carrier contract, the contract will govern.

MAKING YOUR SELECTIONS

CHOOSING YOUR BENEFITS

There are limited opportunities to enroll and/or make changes to your benefit elections throughout the year. Make your selections carefully! The choices you make now will be effective July 1, 2023 through June 30, 2024.



When you're first hired

Your coverage begins on your **benefit eligibility date**, which is the first day of the month following 30 days of full-time employment.

You may elect your benefits starting **7 days** after your date of hire; check your Workday Inbox for your enrollment task.

Details about your benefit offerings are in this guide and online. Please be sure to select **and submit** your benefits by the deadline noted in your welcome email.



At Open Enrollment

Open Enrollment is your opportunity once each year to evaluate your benefit options and make selections for the following plan year.

Benefits selected at Open Enrollment are effective **July** through **June**.

Open Enrollment is May 10 – May 31, with benefits effective July 1, 2023.

All full-time, benefit-eligible employees must log in and submit benefit elections during this time period in order to have coverage on July 1.



If you have a life event

Certain life events may allow you to change your coverage during the year.

You have **30 days** from the date of the event to request applicable changes to your benefits and provide required documentation.

Some common life events and required documentation:

Birth or Adoption	A copy of your child's birth certificate or adoption papers
Marriage	A copy of the marriage certificate or front page of taxes. Step children require birth certificates.
Divorce	A copy of the final divorce decree
Benefit Eligibility Change	A statement on the company's letterhead stating the changes with a beginning and end date.





How to access your online benefit information and make your choices

ENROLLING/MAKING YOUR BENEFITS ELECTIONS

Open Enrollment will be completed by using the Workday app.

Announcements

 **Workday Training Guide & FAQs**
Attention, Staff! FLVS has a Workday Training Guide & FAQs t...








 **Open Enrollment Has Started!**
Open Enrollment has started and will run through Wednesday, May ...







Benefits

\$150.70
Projected Bi-weekly 12 month Cost

Health Care and Accounts

 Medical \$48.41 Blue Cross Blue Shield of Florida PP...	 Health Reimburse... Enroll
 Dental \$10.23 Met Life PPO - High Dental	 Vision \$3.00 Humana PPO Vision
 Accident \$5.42 Met Life	 Health Care Spendin... \$20.83 AmeriFlex
 Dependent Care Spe... Enroll	

Insurance

 Basic Life Included Lincoln Financial (Employee)	 Basic AD&D Included Lincoln Financial (Employee)
 Voluntary Employee... \$30.92	 Voluntary Spouse Life \$1.19

[View Summary](#)

MEDICAL INSURANCE

YOUR FLORIDA BLUE MEDICAL PLANS

	HRA BLUE OPTIONS		BLUE OPTIONS		
Your deductible and out-of-pocket maximum runs January through December.	In-Network Coverage				
	Your deductible (DED)	\$2,000 per person \$6,000 family max		\$500 / \$1,000	
Labs done at a hospital will cost the same as Outpatient Hospital Services.	Coinsurance (your share)	20% after DED		20% after DED	
	Out-of-Pocket Maximum	\$5,000 per person \$10,000 family max		\$4,000 per person \$8,000 family max	
Teladoc offers virtual health care 24 / 7. See page 7 for details.	Preventive Care	Covered 100% in-network		Covered 100% in-network	
	Primary Doctor Visit	\$25 copay		\$25 copay	
Convenience clinics are usually located in drugstores like Walgreens or CVS.	Specialist Doctor Visit	\$50 copay		\$50 copay	
	Labwork (independent lab)	100% covered		100% covered	
	Imaging: X-Ray	Imaging Center: \$50 copay Outpatient Hospital: DED then 20%		Imaging Center: \$50 copay Outpatient Hospital (opt. 1): \$500 copay	
	Imaging: MRI / CT / PET	Imaging Center: \$450 copay Outpatient Hospital: DED then 20%		Imaging Center: \$150 copay Outpatient Hospital DED then 20%	
	Teladoc Visit	\$25 copay		\$25 copay	
	Convenience Clinic	\$25 copay		\$25 copay	
	Urgent Care Center	\$50 copay		\$50 copay	
	Emergency Room	DED then 20%		\$300 copay	
	Inpatient Hospitalization	DED then 20%		DED then 20%	
	Outpatient Hospital Services	DED then 20%		DED then 20%	
	Ambulatory Surgical Center	DED then 20%		\$150 copay	
	Pharmacy coverage	30 day supply	90 day supply	30 day supply	90 day supply
	Generic	\$10 copay	\$20 copay	\$10 copay	\$20 copay
	Brand Name	\$50 copay	\$100 copay	\$50 copay	\$100 copay
	Non-Preferred	\$80 copay	\$160 copay	\$80 copay	\$160 copay
	Specialty	\$150 copay	Retail Only	\$150 copay	Retail Only
Your deductible and out-of-pocket maximum runs January through December.	Out-of-Network Coverage (plus balance billing charges by the provider)				
	Your deductible (DED)	\$4,000 per person \$12,000 family max		\$1,000 per person \$3,000 family max	
	Coinsurance (your share)	40% after DED		40% after DED	
	Out-of-Pocket Maximum	\$8,000 per person \$16,000 family max		\$7,500 per person \$23,500 family max	



Connecting with a doctor within minutes is easy.

Teladoc provides 24/7 virtual access to U.S. board certified doctors by phone or video for many non-emergency illnesses and avoid long wait times and added costs of Urgent Care or the Emergency Room:

- Cold / flu
- Sinus issues
- Sore Throat
- Rash
- Nausea
- Seasonal allergies, and more

Treating physicians can write prescriptions (i.e. antibiotics) as medically necessary and appropriate.

Whenever you feel unwell, you can receive convenient, quality care from a variety of licensed healthcare professionals – for just a **\$25 copay** when you are enrolled in a medical plan through FLVS.

Reach out to get care:



Three simple steps to care:

1 Create an account

Setting up your Teladoc® account through the mobile app only takes a few minutes. After downloading the app, you'll provide medical history to give doctors the information they need to provide you with quality medical care. You can also add family members to give them around-the-clock care.

You can pay for care with your FSA card, credit card, prepaid debit card, or by PayPal.

2 Talk with a doctor now – available 24 / 7 / 365

Log in to your account online or via the app and click **Request a Consult**. You can also request a visit by calling the number below.

Speak with the first available Teladoc doctor or schedule an appointment. Within minutes, a doctor will call ready to listen, diagnose and prescribe medication, if medically necessary. After your consult, you can choose to share the results with your primary



Teladoc doctors are licensed internists, family doctors, and pediatricians. They average 20 years of experience and are licensed to practice in your state.

3 Pick up your prescription

If medically necessary, a prescription can be sent to your local pharmacy. Search for nearby pharmacies or use one of your favorites.

CHOOSING YOUR MEDICAL PLAN



HELPFUL INSURANCE TERMS

Copay – a flat fee you pay whenever you use certain medical services, like a doctor visit.

Deductible – the amount you pay in a *calendar year* before your medical insurance begins paying deductible-eligible claims.

Coinsurance – the percentage of covered medical expenses you continue to pay after you’ve met your deductible and before you reach your out-of-pocket maximum for the *calendar year*.

Out-of-pocket maximum – the most you will pay during the *calendar year* for covered expenses. This includes copays, deductibles, coinsurance and prescription drugs.

Balance billing – the amount you are billed *by out-of-network providers* to make up the difference between the amount they charge and what insurance reimburses. *This amount is in addition to and does not count toward your out-of-pocket maximum.*

There’s more to a medical plan than your paycheck deductions. Consider: which services are covered before you meet your deductible, how you pay for care, the most you’ll pay for care in a calendar year (your out-of-pocket maximum) and FLVS’ funding of expenses (HRA BlueOptions plan).

Medical Plan Features at-a-glance

	HRA BLUE OPTIONS	BLUE OPTIONS
Your cost each paycheck		
Deductible		
Maximum cost of care		
Paying for Care	Some copays, some deductible then coinsurance	Mostly copays
Network Name	BlueOptions	BlueOptions
Health Account Eligibility	HRA (<i>FLVS-funded</i>) Health FSA	Health FSA

FLORIDA BLUE

Group: 63490

Download Florida Blue’s mobile app for claims information, to access your ID card, find a doctor and more!





YOUR COST FOR COVERAGE

12 MONTH EMPLOYEES (24 DEDUCTIONS PER YEAR)

Per Paycheck Cost	HRA BLUE OPTIONS	BLUE OPTIONS
Employee Only	\$30.76	\$52.35
Employee + Spouse	\$122.05	\$177.13
Employee + Child(ren)	\$110.86	\$165.95
Employee + Family	\$187.21	\$248.75

The HRA BlueOptions plan includes a contribution from FLVS to help you pay for eligible health expenses. See page 11 for more information.

10 MONTH EMPLOYEES (20 DEDUCTIONS PER YEAR)

Per Paycheck Cost	HRA BLUE OPTIONS	BLUE OPTIONS
Employee Only	\$36.91	\$62.82
Employee + Spouse	\$146.46	\$212.55
Employee + Child(ren)	\$133.03	\$199.13
Employee + Family	\$224.65	\$298.49



As a new hire and each year during Open Enrollment, you must certify your tobacco use status.

Tobacco users: A cessation program is available; notify the Benefits Department if you wish to participate. If you use tobacco products and do not enroll in the cessation program, you will pay a surcharge for our medical plan. These rates are found in Workday during your enrollment session.

GREAT CARE AT A LOWER COST

There are many ways to save money **and** get the best care using your FLVS Medical Plan.



STAY IN THE NETWORK

The easiest way to save!
Visit floridablue.com to find an in-network provider.
(Outside Florida: search provider.bcbs.com)



USE IN-NETWORK LABS

Stay in-network to receive the same quality service as a smaller lab with big savings.
Visit floridablue.com to locate an in-network lab.



CHECK THE PRICE

If you need elective surgery or a complex scan (MRI or CT), research your provider and cost options first at floridablue.com.
Tip: Option 1 hospitals cost less than Option 2!



USE OUTPATIENT FACILITIES

Freestanding outpatient facilities are often your lowest-cost choice for a variety of imaging services such as MRIs and CT scans, and outpatient procedures like a colonoscopy or GI endoscopy.

WHEN YOU NEED CARE QUICKLY:

CONSIDER TELADOC FOR:

- Cold or flu
- Sinus / allergies
- Ear infection
- Pinkeye
- UTI

\$25
COPAY ALL PLANS

- 15 minutes or less
- your smartphone (app) or computer (Teladoc.com)
- available 24 / 7 / 365

CONSIDER A CONVENIENCE CLINIC FOR:

- Cold, flu, allergies
- Sinus or ear infection
- Minor injuries
- Pinkeye
- UTI

\$25

- 30 minutes
- usually inside grocery stores or drugstores
- most have evening and weekend hours

CONSIDER URGENT CARE FOR:

- Sprains
- Broken bones
- Severe cough
- Stitches
- Vomiting or diarrhea

\$50
COPAY ALL PLANS

- 60 minutes
- freestanding building
- most have evening and weekend hours

SAVE THE EMERGENCY ROOM FOR EMERGENCIES

If it's life-threatening:
stroke, heart attack, head or spinal injuries, trauma, asthma attack, allergic reactions, etc.

\$300
TO WELL OVER
\$1,000

- depends on severity
- red EMERGENCY lettering on the building
- available 24 / 7 / 365

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)



The **HRA BlueOptions** plan includes a contribution from FLVS to help you pay for eligible health expenses. **If you also contribute to a Health Care Flexible Spending Account (FSA)**, HRA funds will be available after your health care FSA funds have been exhausted.

Use HRA funds to help with your medical deductible, pay for glasses or braces, lessen the financial impact of an unexpected medical event or pay for prescription drug expenses and physician's office copays.



FLVS funds **\$1,200** (*prorated for new hires*)



Use your funds for eligible medical, pharmacy, dental, and vision expenses



Claims must occur between **July 1, 2023 – June 30, 2024** and be submitted for reimbursement by **September 30, 2024**



Unused funds do not roll over to the next plan year

When you have an eligible expense, you may either:

- use your Ameriflex **debit card**, or
- pay for your care out-of-pocket and **submit for reimbursement**

Whichever method you choose, please keep your receipt and other documentation (i.e. Explanation of Benefits) for substantiation as required by the IRS and Ameriflex.

AMERIFLEX

Download the Ameriflex mobile app for real-time access to your HRA and FSAs wherever you are.



DENTAL INSURANCE

NEW DENTAL CARRIER, HUMANA AS OF 7/1/2023



Our dental plans allow you to visit any licensed dentist you like -but choose a **Humana PPO/Traditional Preferred** dentist and you'll make the most of your plan by enjoying:



QUALITY ASSURANCE

Humana PPO/Traditional Preferred dentists are monitored for proper licensing, cleanliness and safety.



NO PRE-PAYMENT

You'll pay only your portion of the bill – Humana pays your dentist directly.



NO BALANCE BILLING

You won't be charged more than the contracted rate.



LOWER PRICES

Through reduced fees

Locate an in-network dentist on www.humana.com. Click "Find a dentist", enter your zip code and choose "PPO/Traditional Preferred" for the network.

HUMANA

Group: #861934

Download the MyHumana mobile app for access to your claims, ID card, to find a provider, and more!



YOUR PLAN OPTIONS

	LOW PLAN		HIGH PLAN
Calendar Year Annual Deductible (DED)	\$50 per person; \$150 family maximum		\$50 per person; \$150 family maximum
Calendar Year Annual Benefit	\$1,500 per person		\$2,000 per person
	In-Network	Out-of-Network	In- and Out-of-Network
Preventive Care <i>X-rays (12 months)</i> <i>Exams & cleanings (2 per year)</i>	100% Covered (no deductible)	DED then 20% plus balance billing	100% of reasonable and customary covered (deductible waived)
Basic Care <i>Fillings, Endodontics</i>	DED then 20%	DED then 40% plus balance billing	DED then 20% of reasonable and customary
Major Care <i>Crowns, Dentures, Bridges, Implants and TMJ</i>	DED then 75%	DED then 75% plus balance billing	DED then 50% of reasonable and customary
Child & Adult Orthodontia	Not covered		65% of reasonable and customary \$1,500 lifetime benefit per person Benefit payable on a quarterly basis.

Balance Billing applies to dental insurance too! When you use a non-network provider, you will likely be billed for the difference between what your provider charges and what Humana pays.

Extended Annual Maximum provides additional coverage when the member has exhausted the annual out of pocket maximum. Upon unexpected dental services needed during that plan year, Humana will pay 30% co-insurance towards the cost; therefore, providing an additional benefit. There is no limitation to the extended annual maximum; therefore, the member can take advantage of the benefit as needed.

The Extended Annual Maximum benefit does not apply to orthodontia services.

YOUR COST FOR COVERAGE

	LOW PLAN		HIGH PLAN	
Per Paycheck Cost	12-month (24 deductions)	10-month (20 deductions)	12-month (24 deductions)	10-month (20 deductions)
Employee Only	\$0.00	\$0.00	\$10.33	\$12.39
Employee + Spouse	\$10.92	\$13.10	\$31.42	\$37.70
Employee + Child(ren)	\$14.30	\$17.16	\$39.88	\$47.86
Employee + Family	\$25.09	\$30.10	\$60.99	\$73.19



MORE PLAN INFORMATION



FREQUENTLY ASKED QUESTIONS

How often can I get my teeth cleaned?

Two routine cleanings are available per calendar year they do not have to be 6 months apart.

How do I estimate my costs before getting dental care?

If you or your dentist is anticipating a costly procedure, you may always request a pretreatment estimate. This is a standard request that your dentist (general or specialist) can send to Humana with a treatment plan to estimate your cost for care.

I also have dental coverage through my spouse or Tricare, how does that work with my FLVS dental insurance?

When you have more than one insurance plan to cover the same thing (i.e. two dental plans), the plans coordinate to ensure that all benefits are properly paid. The actual amount that Humana pays will depend on a few factors such as whether they're the primary coverage or secondary plan, the coverage level of your other dental plan, and the service that's being covered. In many cases, your final dental benefit will be the richer of your two plans for the services you received. A pretreatment estimate can generally help you estimate your costs when you have two dental plans.

ID CARDS

Humana will issue ID cards. Your Dentist will contact Humana directly to verify coverage using your Humana ID number.



MyHumana

Your dental plan at your fingertips

Your personal MyHumana account gives you quick, convenient and secure access to your Humana dental plan information. It's available anytime, anywhere.



Get quick access to your dental plan

View, print and email ID cards
ID cards are mailed within 10 days of enrollment. If you need to see a provider before you receive your ID card in the mail, follow the "Registering is easy" instructions below.

Check your claim status

Review deductibles, coverage levels and limits

The screenshot shows the MyHumana web dashboard. At the top, there's a navigation bar with the MyHumana logo, a search bar, and a 'Sign Out' button. Below the navigation bar are tabs for 'Coverage', 'Claims', 'MyHealth', and 'Account'. The main content area is titled 'Dental' and includes a section for 'Nikole's DENTAL PPO (HUMANA INC.)' with links to 'View coverage details' and 'View ID card'. There's a 'Looking for a dentist?' section with a 'Provider finder' link. Below that is a 'Dental claims' table with one entry: '07/13/2021 JOHN SMITH' with a 'Your share \$116.00' and a 'See all claims' link. There are also sections for 'Deductibles & maximums' (showing \$50.00 left), 'Spending Accounts' (with a 'HumanaAccess.com' link), and 'In your network' (with a 'Find a dentist' link). A 'Chat with us' button is located at the bottom right of the dashboard.

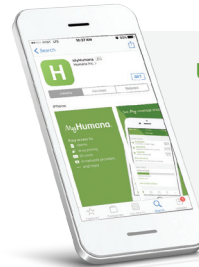
A dashboard that puts all your information in one spot

Chat with a representative about any of your dental plan questions

Find a dentist near you

Registering is easy

1. Go to [Humana.com](https://www.humana.com)/Register and "Start activation now".
2. Confirm member information. Enter your member ID number (or Social Security number), date of birth, and ZIP code.
3. Create a username, password and security prompt and choose "Next" to finish.



Use MyHumana anywhere

Download the MyHumana mobile app from your app store. You can also sign up for text message alerts at [Humana.com](https://www.humana.com).*



Humana

* Message and data rates may apply.

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VISION INSURANCE

Keep your vision clear and eyes healthy with vision insurance offered through Humana. You'll get your greatest benefit when you use an **in-network provider**. In most cases, you can get your eye exam and materials for just your copay – all at the same place (cosmetic options will include additional charges).

To find an in-network provider in your area:

- Go to www.humana.com
- Select "find a doctor" and choose "vision"
- Select "Humana Vision (Humana Insight Network)"

If you choose an **out-of-network** vision provider, Humana will pay you a set reimbursement amount for each service you receive after you pay the provider their set fees.

Humana Lifestyle Discount Programs are available and include savings on Lasik surgery with LasikPlus. Go to Humana.com/LifestyleDiscounts for more information on these programs.

ID CARDS

The first time you enroll in vision coverage, you will receive a vision ID card. If you currently have Humana vision coverage through FLVS, you will not receive a new vision ID card.

To request a replacement card, visit www.humana.com or call Humana at 1-800-865-3676.



HUMANA

Group: 861934

Download the MyHumana mobile app for access to your claims, ID card, to find a provider, and more!



YOUR PLAN SUMMARY

	In-Network (you pay)	Out-of-Network (reimbursement)
Eye Exam	\$10 copay	Up to \$30
Materials copay (lenses and/or frames)	\$20 copay	Not applicable
Lenses: Single / Bifocal / Trifocal (every 12 months)	Covered after material copay	Up to: \$25 / \$40 / \$60
Frames (every 24 months)	\$120 retail allowance after copay 20% off balance over \$120	Up to \$50
Elective Contact Lenses (every 12 months)	\$105 allowance <i>In lieu of lenses and frames</i>	Up to \$80 <i>In lieu of lenses and frames</i>
Medically necessary contact lenses	100% covered	Up to \$200

YOUR COST FOR COVERAGE

Per Paycheck Cost	12-month (24 deductions)	10-month (20 deductions)
Employee Only	\$3.00	\$3.59
Employee + Spouse	\$5.96	\$7.15
Employee + Child(ren)	\$5.66	\$6.79
Employee + Family	\$8.89	\$10.66

FLEXIBLE SPENDING ACCOUNTS (FSA)

HEALTH CARE FSA

Pay for eligible health-related expenses with **pre-tax money** deducted from each paycheck. Use your FSA debit card to pay your provider when you receive care.



Medical

deductibles, copays, coinsurance



Pharmacy

prescription drug copays



Dental

dental & orthodontic expenses



Vision

glasses options, contact lenses, copays

NUMBERS AND DATES:

- New Contribution Maximum up to **\$3,050** for the 2023 plan year.
- **Estimate carefully.** Any unused funds at the end of the plan year will be forfeited per IRS requirements.
- Claims must occur between **July 1, 2023 – June 30, 2024** and be submitted for reimbursement by **September 30, 2024**
- Your entire contribution election will be available on July 1, 2023.

The IRS requires substantiation (proof) of all FSA claims. Please **keep your receipts** for all FSA expenses and submit them to Ameriflex upon request to prevent debit card deactivation. Contact Ameriflex at **888-868-3539** with questions or receipt submission issues.



AMERIFLEX

Download the Ameriflex mobile app for real-time access to your HRA and FSAs wherever you are.



DEPENDENT CARE FSA



Pay for eligible dependent-care expenses with **pre-tax money** deducted from your paycheck. Care must be for a qualifying individual while you and your spouse (if applicable) work, look for work or attend school.

ELIGIBLE EXPENSE EXAMPLES

- Before or after school care (not tuition expenses)
- Daycare / nursery school / preschool
- Summer day camp (not overnight)
- Adult day care
- Other expenses specified by the IRS

QUALIFYING INDIVIDUALS INCLUDE

- Dependent child under age 13
- Child over the age of 13 not capable of self care
- Other adult tax dependent (i.e. spouse, dependent parent) not capable of self care

NUMBERS AND DATES:

- Contribute up to **\$5,000** per year (\$2,500 if you're married filing separately)
- Claims must occur between **July 1, 2023 – June 30, 2024** and be submitted for reimbursement by **September 30, 2024**
- Any leftover funds at the end of the year are forfeited per IRS requirements
- Only the amount actually contributed year to date is available for use

AMERIFLEX

Download the Ameriflex mobile app for real-time access to your HRA and FSAs wherever you are.



LIFE AND AD&D INSURANCE

BASIC COVERAGE



LIFE INSURANCE

As a benefit-eligible employee, FLVS provides you with life insurance in the amount of **\$40,000** at no cost to you.

Reductions to your total benefit amount begin at age 65 and reduces to \$10,000 at retirement. Upon termination of employment, this coverage may be converted to an individual policy. Contact **Lincoln Financial Group** as soon as your employment ends to begin this process.



Please be sure you provide a beneficiary designation in Workday at enrollment and review and confirm your beneficiary designations each year during Open Enrollment.

AD&D INSURANCE

FLVS also provides all benefit-eligible employees with \$40,000 in Accidental Death & Dismemberment (AD&D) coverage at no cost to you. AD&D coverage can pay a benefit in one of two ways:

- If your death is caused due to an accident, the AD&D benefit pays in addition to your life insurance and your beneficiary receives both the life insurance amount and the AD&D amount.
- If, as the result of an accident, you either lose a covered body part (such as a limb) or lose the function of a covered body part, you may receive a percentage of the total AD&D benefit depending on the functions that have been lost.

LINCOLN FINANCIAL GROUP

Please access Workday or contact the benefits department for coverage or claim questions


ADDITIONAL COVERAGE

Additional life insurance protection for you and your family is available for purchase through Lincoln Financial Group.

Your cost for coverage depends on your age and selected coverage level, and is available when you enroll through Workday.


You must cover yourself to purchase coverage for your dependents. A dependent can only be covered once.

EMPLOYEE COVERAGE

Available increments	\$10,000
Coverage maximum	5 times your salary to \$500,000
Guarantee Issue Amount	 5 times your salary to \$200,000
Open Enrollment increase opportunity <small>(answering medical questions is not required unless you have been previously denied coverage or your application is currently pending)</small>	Two increments (\$20,000)

SPOUSE COVERAGE

If your spouse also works for FLVS, you cannot cover each other on spouse life insurance.

Available increments	\$5,000
Coverage maximum	50% of employee amount to \$100,000
Guarantee Issue Amount	 \$50,000
Open Enrollment increase opportunity <small>(answering medical questions is not required unless your spouse has been previously denied coverage or their application is currently pending)</small>	Two increments (\$10,000)

CHILD COVERAGE

If both parents work for FLVS, only one parent can elect child coverage. A dependent child can only be covered under one policy.

Benefit options	\$5,000 or \$10,000 <i>(age 14 days to 6 months: \$250 benefit)</i>
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As a **newly eligible employee**, you may elect up to the Guarantee Issue Amount with no medical questions required. Requests to increase coverage or enroll at a later date will be subject to medical questions and insurance company approval.



Evidence of Insurability (EOI) Instructions during Open Enrollment and New Hire Elections:

If underwriting is required for your coverage election visit www.MyLincolnPortal.com Create an account using the employer code: **FLVIRTUAL2** Select "Complete Evidence of Insurability" and follow the prompts to answer all required questions. If further medical information is necessary you'll receive a letter by mail. The acceptance or denial of the additional coverage will be provided in writing. You can see the status of your coverage application at www.MyLincolnPortal.com

Note: Payroll deductions for the amount subject to underwriting will not begin until you have been approved for coverage.

DISABILITY INSURANCE

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability insurance is designed to provide you with income protection in the event of a disability period in which you are unable to work.

Base coverage is provided by FLVS at no cost to you with the option to purchase **additional / buy-up** coverage to further supplement your income.

You must exhaust all of your paid time off before this benefit will begin to pay.

BASE COVERAGE (PROVIDED BY FLVS)

Benefits begin: <i>Injury/accident</i> <i>Illness</i>	On the first day of inability to work On the 8th day of inability to work
Benefit amount	66 2/3% of your income to \$250 per week
Payments last	Up to 26 weeks if you remain unable to work

ADDITIONAL / BUY-UP STD COVERAGE OPTION

Your cost for coverage is dependent on your salary and is available when you enroll in Workday.

Benefit amount:

66 2/3% of your income to a maximum of \$1,000 per week



This plan has a **pre-existing condition limitation** which means that conditions you received treatment for during the **three months** prior to the start of the coverage are excluded for the first **six months** of coverage.

You may purchase the additional / buy-up option as a **newly eligible employee** with **no underwriting required**. If you decline and then choose to purchase the additional buy-up plan option at a later date, underwriting and approval by Lincoln Financial Group will be required.

LINCOLN FINANCIAL GROUP

Please access Workday or contact the benefits department for coverage or claim questions



LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance is designed to provide you with lasting income protection in the event you're unable to return to work. FLVS provides this coverage through Lincoln Financial Group at no cost to you.

Benefits begin	After your Short-Term Disability benefits end (after 180 days of inability to work)			
Benefit amount	60% of your income to a maximum of \$6,000 per month			
Payments last	If you're unable to perform the duties of any job, until the later of your Social Security Normal Retirement Age (SSNRA) or the maximum benefit period listed below:			
	Age When Disability Begins	Maximum Benefit Period	Age When Disability Begins	Maximum Benefit Period
	Less than 60	To Age 65	65	24 months
	60	60 months	66	21 months
	61	48 months	67	18 months
	62	42 months	68	15 months
	63	36 months	69 and Over	12 months
	64	30 months		
	<i>SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date</i>			

This plan has a **pre-existing condition limitation** which means that conditions you received treatment for during the **three months** prior to the start of the coverage are excluded for the first **12 months** of coverage.

LINCOLN FINANCIAL GROUP

Please access Workday or contact the benefits department for coverage or claim questions

ACCIDENT INSURANCE



Accident coverage through MetLife pays you a benefit if you are injured in a covered accident on- or off-the-job. Benefits are paid for:

INJURIES

Fractures or dislocations
 Second and third degree burns
 Concussions
 Cuts / lacerations
 Eye injuries

MEDICAL SERVICES & TREATMENT

Ambulance
 Emergency and non-emergency care
 Physician follow-up
 Therapy services (including physical therapy)
 Medical testing and appliances
 Inpatient surgery

HOSPITALIZATION

Admission
 Confinement
 Inpatient Rehab

ACCIDENTAL DEATH / DISMEMBERMENT

Accidental Death
 Dismemberment, Loss & Paralysis

YOUR COST FOR COVERAGE

Per Paycheck Cost	12-month (24 deductions)	10-month (20 deductions)
Employee Only	\$5.42	\$6.50
Employee + Spouse	\$8.21	\$9.85
Employee + Child(ren)	\$10.42	\$12.50
Employee + Family	\$13.59	\$16.30

METLIFE

Group: 160727

CRITICAL ILLNESS COVERAGE INCLUDING CANCER



Critical Illness coverage through **MetLife** is available for purchase. Critical illness coverage helps provide financial support if you are diagnosed with a covered critical illness.

You choose either a **\$15,000** or **\$30,000** benefit to protect yourself and any family members upon diagnosis of a covered critical illness. The plan pays a cash benefit based on the percentage payable for the diagnosed condition. A \$50 per person annual **wellness benefit** is also payable when you receive a covered preventive test.

Covered diagnoses include:

- Heart attack
- Stroke
- Heart transplant
- Cancer
- Cancer-Non Invasive (25%)
- Coronary Artery Bypass Surgery
- Major organ transplant
- Paralysis
- End Stage Renal Failure
- Alzheimer's Disease

Family coverage is available when you make your coverage elections in Workday. Your **cost for coverage** varies by age, your coverage amount, and who you choose to cover. Cost information will be available when you enroll in Workday. Eligible dependents will receive 50% of the benefit amount you elect.

This coverage is available with no medical underwriting required.

SUPPLEMENTAL HEALTH/HOSPITAL INDEMNITY PLAN OPTIONS

Supplemental Health coverage through **MetLife** is available for purchase. This coverage pays you a cash benefit for hospital confinements that are due to an accident or sickness which can help keep you from withdrawing money from your personal bank account for hospital-related expenses. Family coverage is available.

BENEFITS INCLUDE:

Initial hospital confinement (once per year)	\$1,000
Daily hospital confinement (15 days per year)	\$200 per day
Hospital Intensive Care	\$200 per day

YOUR COST FOR COVERAGE

Per Paycheck Cost	12-month (24 deductions)	10-month (20 deductions)
Employee Only	\$6.28	\$7.54
Employee + Spouse	\$11.78	\$14.14
Employee + Child(ren)	\$12.02	\$14.42
Employee + Family	\$17.52	\$21.02

This coverage is available with no medical underwriting required.





LEGAL AND IDENTITY THEFT PROTECTION

Legal and Identity Theft Protection through **US Legal** is available for purchase to help you and your family with legal and identity theft protection expenses.

This plan offers assistance with:

- Legal consultation in the office or over the phone
- Will preparation and review
- Lawsuits as a plaintiff or defendant
- Adoptions
- Traffic violations
- Purchase or sale of your home
- Landlord or tenant law
- Chapter 7 bankruptcy
- Criminal law
- Family law
- Child support and custody
- Consumer law
- Elder law
- IRS audit protection
- IRS audit defense

Legal + ID: Optional identity theft protection coverage is also available.

YOUR COST FOR COVERAGE

Per Paycheck Cost	LEGAL ONLY	LEGAL + ID
12-month employees (24 deductions)	\$9.38	\$14.35
10-month employees (20 deductions)	\$11.25	\$17.22

US LEGAL

Download the U.S. Legal Services app to view your account information, see cases, request assistance, and more!



FLVS WELLNESS PROGRAM

WITH INCENTIVES FOR PARTICIPATION!

STARTING AUGUST 1, 2023



All employees are eligible to earn rewards, even if you do not participate in our Florida Blue medical plan.

LOGIN

FLORIDA BLUE MEMBER

Online

1. Log in to your Florida Blue online account at floridablue.com. Click Health & Wellness, then BetterYou Strides. If this is your first time, you will be prompted to create a username and password. Follow the directions on the screen to create your BetterYou Strides account.
2. Read and accept the terms of service. Choose your communications preferences

Mobile App

1. Download the AlwaysOn mobile app from the Apple App store or Google Play.
2. Log in with your username and password, or follow the directions on the screen to create your BetterYou Strides account.

NON-FLORIDA BLUE MEMBER

Online

Visit login.onlifehealth.com/Home/Login Then click Get Started.

Mobile App

1. Download the AlwaysOn mobile app from the Apple App store or Google Play. Click Register now and enter 63490.
2. Follow the directions on the screen to create your BetterYou Strides account.

LET'S GET STARTED.

Complete your online Health Assessment and participate in wellness activities to earn wellness points. Earn 250 points between August 1, 2023 and June 30, 2024, and receive a \$25 gift card. Earn 500 points between August 1, 2023 and June 30, 2024, and receive a \$50 gift card. Earn 1,000 points or more between August 1, 2023 and June 30, 2024, and receive a \$100 gift card. Visit the allowable activities page to see which activities are worth points. All gift cards earned will be distributed between July and August of 2024. Please note, you may only earn one of the three possible gift card amounts and you must be an active employee at time it is awarded.



Get rewarded! Log on and follow the link to view eligible incentivized activities in the program.

Need Help? Have Questions?

Members Call: 800-352-2583

Non-Members Call: 866-560-9355

Email: hrbenefits@flvs.net

FINANCIAL WELLBEING WORKSHOPS

DID YOU KNOW THAT FLVS PARTNERS WITH METLIFE TO OFFER YOU FINANCIAL EDUCATION WORKSHOPS?



FLVS offers Financial Wellness Workshops throughout the year in partnership with MetLife. The Workshop offerings are announced in the Weekly Download and on the Benefits SharePoint.

- Workshop Topics include:
- Smart Money Moves in Your 20s and 30s
- Investing 101
- Understanding Life and Disability Income Insurance
- Estate Planning
- Investing 201
- Planning for College
- Tax Strategies: The Basics and Beyond
- Preparing to Care for an Aging Parent
- Smart Money Moves in Your 40s, 50s, 60s, and Beyond
- A Parent's Guide to Kids and Money: Toddlers to Teens
- Women and Investing

Be on the lookout for more information on upcoming workshops for employees of all ages and career stages.

EMPLOYEE ASSISTANCE PROGRAM



Sometimes balancing work, home, family, finances, health and wellbeing can seem challenging, and we want to make sure that you have access to the advice and support that you need. Our **EmployeeConnect** EAP through ComPsych offers someone to talk to and resources to consult whenever and wherever you need them.

As an employee of FLVS, you and any immediate family members living in your home can access our EAP for a variety of needs at no cost to you:

- Legal and financial concerns
- Grief, depression, substance use / abuse
- Emotional support
- Relationship struggles
- Parenting challenges
- Anxiety, stress, work / life balance

You and your household members have five face-to-face counseling sessions available – just call to request a referral.

Support is available 24 hours a day, 7 days a week, 365 days a year.

LINCOLN: EMPLOYEECONNECT

24/7 Care: 1-888-628-4824 | www.guidanceresources.com

Username: LFGsupport
Password: LFGsupport1

IMPORTANT CONTACTS



MEDICAL & PHARMACY

FLORIDA BLUE

www.floridablue.com

Customer Service – 800-664-5295

Health Dialog: 1-877-789-2583

Care Consultants: 1-888-476-2227

Mail Order Prescription: 1-855-965-7539

TELADOC

TELADOC

www.teladoc.com

1-800-Teladoc (835-2362)

DENTAL COVERAGE

HUMANA

www.humana.com

1-800-233-4013

VISION COVERAGE

HUMANA

www.humanavisioncare.com

1-800-865-3676

OTHER COVERAGES

METLIFE

www.metlife.com

Accident plan: 1-800-438-6388

HRA & SPENDING ACCOUNTS

AMERIFLEX

www.myameriflex.com

1-888-868-3539

LIFE & DISABILITY INSURANCE

LINCOLN FINANCIAL GROUP

www.lfg.com

Report a disability claim: 1-800-423-2765

(Group ID: FLVIRTUAL2)

EAP: EMPLOYEECONNECT

LINCOLN FINANCIAL / COMPSYCH

www.guidanceresources.com

24/7 Care: 1-888-628-4824

username: LFGsupport

password: LFGsupport1

FLORIDA VIRTUAL SCHOOL

Benefits Department

(407) 513-3587 x5341

hrbenefits@flvs.net

Missy Schneider, *Senior Benefits Specialist*

(407) 513-3690

aschneider@flvs.net

Catherine Jackson, *Benefits Technician*

(407) 640-6389

cajackson@flvs.net

Christina Elders, *Senior Manager, Benefits and Compensation*

(407) 513-3374

celders@flvs.net

WORKDAY (ONLINE ENROLLMENT)

<https://www.myworkday.com/flvs/d/home.html>



ANNUAL RIGHTS AND NOTICES

This section contains important information about your benefits and rights. Please read the following pages carefully and contact your Benefits Department at HRBenefits@flvs.net 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 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).

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

To request special enrollment or obtain more information, contact your Benefits or HR Administrator.

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.

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 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).

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.

CONTINUED

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.

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).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your state for more information on eligibility.

CHIP STATE CONTACT INFORMATION

ALABAMA – Medicaid
http://myalhipp.com 855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ 866-251-4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP 855-692-7447
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800-221-3943 State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800-359-1991 State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855-692-6442
FLORIDA – Medicaid
www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html 877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678-564-1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ 877-438-4479 All other Medicaid https://www.in.gov/medicaid/ 800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members 800-338-8366 Hawki: http://dhs.iowa.gov/Hawki 800-257-8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp 888-346-9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800-792-4884 HIPP Phone: 800-766-9012
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855-459-6328 KIHIP.PPROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx 877-524-4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888-342-6207 (Medicaid hotline) or 855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800-862-4840 TTY: 617-886-8102
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800-657-3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573-751-2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800-694-3084 Email: HSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

CHIP STATE CONTACT INFORMATION, CONTINUED

NEVADA – Medicaid
http://dhcfnv.gov 800-992-0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603-271-5218 Toll free number for the HIPP program: 800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609-631-2392 CHIP: http://www.njfamilycare.org/index.html 800-701-0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800-541-2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919-855-4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844-854-4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888-365-3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800-699-9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855-697-4347 or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888-549-0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888-828-0059
TEXAS – Medicaid
http://gethipptexas.com 800-440-0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877-543-7669
VERMONT – Medicaid
http://www.greenmountaincare.org Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access 800-250-8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800-432-5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800-562-3022
WEST VIRGINIA – Medicaid
https://dhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304-558-1700 CHIP Toll-free: 855.MyWVHIPP 855-699-8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800-362-3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800-251-1269

CHIP STATE CONTACT INFORMATION, CONTINUED

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

HEALTH INSURANCE MARKETPLACE

PART A: General Information

When key parts of the health care law took effect 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly insurance premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money or lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Premium Savings through the Marketplace?

Yes. If the health coverage from your employer 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 9.5% 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.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, you will lose the employer contribution 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.

How Can I Get More Information?

For more information about the coverage offered by your employer, please check your Summary Plan Description or contact your Benefits Administrator. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. 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.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. The information below is numbered to correspond to the Marketplace application.

3. Employer Name: Florida Virtual School		4. Employer Identification Number: 59-3721320	
5. Employer Address: 5422 Carrier Drive, Suite 201		6. Employer Phone Number: 407-513-3374	
7. City: Orlando	8. State FL	9. Zip Code 32819	
10. Who can we contact about associate health coverage at this job? Christina Elders, Senior Manager, Benefits and Compensation			
11. Phone Number: 407-513-3374		12. Email Address: celders@flvs.net	
<ul style="list-style-type: none"> As your employer, we offer a health plan to some employees. Eligible Employees are full-time, active employees normally scheduled to work a minimum of 30 hours per week, on the regular payroll of the Company, and in a class of employees eligible for coverage. With respect to dependents, we do offer coverage. Eligible dependents are defined as the Covered Employee’s spouse under a legally valid existing marriage as defined by Florida Law, dependent child(ren) up to age 26 and the newborn child of a covered dependent child up to 18 months. This coverage meets the minimum value standard, and the cost to you is intended to be affordable, based on employee wages. 			

¹ An employer-sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE

Important Notice About Your Prescription Drug Coverage & 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 Virtual School 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:

- 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.
- Florida Virtual School has determined that the prescription drug coverage offered by the group medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 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 Virtual School coverage will be affected. You cannot keep your coverage with the Florida Virtual School plan if you elect Part D coverage. If you decide to join a Medicare drug plan and drop your current coverage under the Florida Virtual School Medical Plan, be aware that you and your dependents will not be able to get this coverage back. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

This Notice should be shared with your Medicare eligible dependents and spouse as this information could impact your decision to enroll in Medicare part D.

MEDICARE PART D NOTICE OF CREDITABLE COVERAGE, CONTINUED

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Florida Virtual School changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

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

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

Date: July 1, 2023
Name of Entity / Sender: Florida Virtual School
Address: 5422 Carrier Drive, Suite 201, Orlando, FL 32819
Phone Number: 407-513-3374

NOTICE OF PRIVACY PRACTICES

Understanding Your Health Record/Information

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Unless otherwise required by law, your health record is the physical property of the health plan that compiled it. However, you have certain rights with respect to the information. You have the right to:

- Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.

- Request restrictions on our uses and disclosures of your protected health information for treatment, payment and health care operations. We reserve the right not to agree to a given requested restriction.
- Request to receive communications of protected health information in confidence.
- Inspect and obtain a copy of the protected health information contained in your medical or billing records and in any other of the organization's health records used by us to make decisions about you.
- Request an amendment to your protected health information. However, we may deny your request for an amendment if we determine that the protected health information or record that is the subject of the request: was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment; is not part of your medical or billing records; is not available for inspection as set forth above; or is accurate and complete. In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.

- Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures: to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; to correctional institutions or law enforcement officials as provided by law; for national security or intelligence purposes; that occurred prior to the date of compliance with privacy standards (April 14, 2003 or April 14, 2004 for small health plans); incidental to other permissible uses or disclosures; that are part of a limited data set (does not contain protected health information that directly identifies individuals); made to plan participant or covered person or their personal representatives; for which a written authorization form from the plan participant or covered person has been received.
- Revoke your authorization to use or disclose health information except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
- Receive notification if affected by a breach of unsecured PHI.

How Medical Information About You May Be Used and Disclosed

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use or disclose your health information without your permission for health care providers to provide you with treatment.

Payment: We may use or disclose your health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. Such functions may include reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.

To Carry Out Certain Operations Relating to Your Benefit Plan: We may use or disclose your protected health information without your permission to carry out certain limited activities relating to your health insurance benefits, including reviewing the competence or qualifications of health care professionals, placing contracts for stop-loss insurance and conducting quality assessment activities.

NOTICE OF PRIVACY PRACTICES, CONTINUED

To Plan Sponsor: Your protected health information may be disclosed to the plan sponsor as necessary for the administration of this health benefit plan pursuant to the restrictions imposed on plan sponsors in the plan documents. These restrictions prevent the misuse of your information for other purposes.

Health-Related Benefits and Services: We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your protected health information for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing health plan coverage, and about health-related products and services that may add value to your existing health plan.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. An example might include a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Limited Data Sets: We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets. These circumstances include public health, research, and health care operations purposes.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example: in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized bylaw.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

NOTICE OF PRIVACY PRACTICES, CONTINUED

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purposes such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

For Purposes For Which We Have Obtained Your Written Permission: All other uses or disclosures of your protected health information will be made only with your written permission, and any permission that you give us may be revoked by you at any time.

Information We Collect About You

We collect the following categories of information about you from the following sources:

- Information that we obtain directly from you, in conversations or on applications or other forms that you fill out.
- Information that we obtain as a result of our transactions with you.
- Information that we obtain from your medical records or from medical professionals.
- Information that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other insurance-related needs.

Genetic Information

We will not use or disclose genetic information or results from genetic services for underwriting purposes, such as:

- Rules for eligibility or benefits under the health plan.
- The determination of premium or contribution amounts under the health plan.
- The application of any pre-existing condition exclusion under the health plan.
- Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

Our Responsibilities

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed upon request to the address on record. If we maintain a website that provides information about our services or benefits, the new notice will be posted on that website. Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at anytime.

Our Practice Regarding Confidentiality And Security

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

NOTICE OF PRIVACY PRACTICES, CONTINUED

Our Practice Regarding Confidentiality And Security For E-Mail Communication

If you choose to communicate with us via e-mail, please be aware of the following due to the nature of e-mail communication: (i) privacy and security of e-mail messages are not guaranteed (ii) we are not responsible for loss due to technical failures and (iii) e-mail communication should not be used for emergencies or time and content sensitive issues.

Potential Impact Of State Law

In some circumstances, the privacy laws of a particular state, or other federal laws, provide individuals with greater privacy protections than those provided for in the HIPAA Privacy Regulations. In those instances, we are required to follow the more stringent state or federal laws as they afford the individual greater privacy protections. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights.

Notice Of Privacy Practices Availability

You will be provided a hard copy for review at the time of enrollment (or by the Privacy compliance date for this health plan). Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's website (if applicable website exists) for downloading.

For More Information Or To Report A Problem

If you have questions about this notice or would like additional information, you may contact our HIPAA Privacy Officer at the telephone number or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services at the telephone number or address listed below. We will take no retaliatory action against you if you make such complaints.

U.S. Department of Health and Human Services

Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: 202-619-0257
Toll Free: 1-877-696-6775
<http://www.hhs.gov/contacts>

Florida Virtual School Self-Funded Medical Plan

Christina Elders
Privacy Officer
5422 Carrier Drive, Suite 201
Orlando, FL 32819
407-513-3374

This benefit summary prepared by



Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.