Acentria Insurance

Benefits Guide

Plan Year: 2025 - 2026

GRACECITY CHURCH

CONTACT INFORMATION

BROKER

PROVIDER NAME	ACENTRIA INSURANCE – LAKELAND OFFICE
ACCOUNT PRODUCER	RICKY LEE
BENEFITS ACCOUNT MANAGER	MICHELE LOPEZ
E-MAIL ADDRESS	Michele.Lopez@Acentria.com
PHONE NUMBER	863-688-1751

MEDICAL

PROVIDER NAME	FLORIDA BLUE
PROVIDER PHONE NUMBER	1-800-FLA-BLUE
PROVIDER WEB ADDRESS	WWW.FLORIDABLUE.COM
GROUP NUMBER	J3843

DENTAL & VISION

GROUP NUMBER: 00552325

DENTAL PROVIDER NAME	GUARDIAN
PROVIDER PHONE NUMBER	1-888-600-1600
DENTAL WEB ADDRESS	WWW.GUARDIANLIFE.COM

VISION PROVIDER NAME	GUARDIAN
PROVIDER PHONE NUMBER	888-600-1600
VISION WEB ADDRESS	WWW.GUARDIANLIFE.COM

PICK THE BEST BENEFITS FOR YOU AND YOUR FAMILY

Grace City Church strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all the different benefits offers, so you can identify which offerings are best for you and your family.

If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

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WHO IS ELIGIBLE?

If you're a full-time employee, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work ***25 or more hours per week***. In addition, the following family members are eligible for medical, dental and vision coverage:

- Your legal spouse; or your natural, step, adopted, and foster child, as well as, a child you have legal guardianship for, who is dependent upon you for support, may be covered on the medical and dental plans. Dependent children can be covered to the end of the calendar year in which they turn 30 for medical and 26 for dental.
- Dependent children age 26 or older who are incapable of sustaining employment by reason of mental deficiency or physical handicap; and are chiefly dependent upon you for support and maintenance. This dependent must be primarily dependent upon you for financial support and maintenance on a continuous basis.

WAITING PERIOD

You are eligible for benefits the *First of the Month following your hire date*.

HOW TO ENROLL

Grace City Church will continue to use the Online Enrollment System – Employee Navigator!

Are you ready to enroll?

The first step is to follow the directions on ***Page 5*** and get registered – you can either go to www.employeenavigator.com or scan the QR Code to get started. Your Company Identifier is - ***GCCOF***

The second step will be to verify all your personal information and make any necessary changes. Did you move recently or get married?.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

HOW TO MAKE CHANGES

Unless you experience a life-changing qualifying event, you **cannot** make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence which affects eligibility for coverage (moving outside the plan service area)
- Change in employment status or a change in coverage under another employer-sponsored plan

*If you have a qualifying change in status, you can make changes to your benefits by providing Human Resources with any applicable documentation within **30 days of the change**.*

EMPLOYEE NAVIGATOR: ENROLLMENT GUIDE

HOW TO ACCESS EMPLOYEE NAVIGATOR

COMPANY IDENTIFIER: GCCOF

NEW USERS

1. First time users: Visit the Employee Navigator website www.employeenavigator.com to register or scan the QR code.
2. Register as a new user by entering personal information and the company identifier.
3. Complete any assigned tasks, confirm, or update personal information.
4. Elect or waive each line of coverage and click 'Agree' to complete enrollment.

Tip: Have dependent details ready for enrolling them in coverage.

Returning Users

RETURNING USERS

Go to www.employeenavigator.com and click **Login**

1. **Returning users:** Log in with your current username and password.
2. **Forgot** your password or username? Click Forgot Password? to reset both password and username, if needed
3. Complete any assigned tasks, confirm, or update personal information.
4. Elect or waive each line of coverage and click 'Agree' to complete enrollment.

*Tip: If you miss a step, you will see **Enrollment Not Complete!** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.*

CONGRATULATIONS!: You have successfully completed your enrollment! You will have the remainder for your Open Enrollment Window or New Hire Enrollment Window to come back and make updates to plans

Health Insurance

Medical and Prescription Drugs - Effective 5/01/2025

Benefits	Blue Options Plan 14054
Network Used	Blue Options
Deductible (Individual / Family)	$1,500 / $3,000
Coinsurance	80% / 20%
Out-of-Pocket Max	$4,800 / $9,600
Office Services	
Preventative Care	No Charge
Primary Care Physician's Office Visit	Value Choice Provider: No Charge or Regular Primary Care Provider $10 Copay per Visit
Specialist Physician's Office Visit	Value Choice Specialist $20 Copay per Visit or Regular Specialist $40 Copay per Visit
Hospital Services	
Inpatient Hospital	After Deductible / then 20%
Outpatient Surgery	Ambulatory Surgical Ctr: 20% Coins / Hospital: Ded + 20% Coins
Diagnostic Services	
Lab Work/X-Rays	Independent Clinical Lab – No Charge; Value Choice Specialist $20 Copay – Independent Diagnostic Testing Cntr $50 Copay
Advanced Imaging Services (CT, PET Scan, MRI, etc.)	Physician Office $40 Copay – Ind Diag Testing Cntr $300 Copay per Visit
Emergency Services	
Urgent Care Center	Value Choice Provider – No Charge for visits 1 and 2, then $55 Co-pay ; Regular Urgent Care Visits $55 Copay per Visit
Emergency Room	Physician Services – No Charge / Facility $200 Copay per Visit
Ambulance	Deductible / then 20%
Prescription Drugs	
Tier 1 Generic	Condition Care $4 Copay – All other Generics $10 Copay
Tier 2 Preferred Brand	Condition Care $15 – All other Pref Brand $30 Copay
Tier 3 Non-Preferred Brand	$50 Copay
Tier 4 Highest Cost	$150 Copay
Out of Network Benefits	
Deductible	$3,000 / $6,000
Coinsurance	50% / 50%
Out-of-Pocket Max	$9,600 / $19,200
Emergency Services	Paid as In-Network
See your contract for complete plan details. If there is a discrepancy between this plan summary and the actual contract, the contract will always prevail.	

Florida Blue
In the pursuit of health

When You Don't Have Time to Wait, You've Got Teladoc!

Provides 24/7 Access to Care

When you or a family member don't feel well and your primary care doctor or your child's pediatrician can't see you right away, you can now get care within minutes without leaving home with Teladoc.

For a cost that's less than an urgent care or ER visit, Teladoc gives you 24/7/365 access to U.S. board-certified doctors by web, phone or mobile app. It's a more convenient and affordable option for quality medical care. And there's no obligation or extra monthly fee.

Getting Started

Set up your account today—so when you need care, a Teladoc doctor is a just a call or click away.

How Does Teladoc Work?

1. **Register**
   3 easy ways: download the mobile app, visit the Teladoc website or call the number below.
2. **Provide Medical History**
   Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.
3. **Request a Visit**
   That's it! The next time you need immediate care for a non-emergency illness, you have another option.

The Teladoc Difference

Teladoc can help with many non-emergency illnesses, including:

- Sinus infection
- Flu
- Cough
- Sore throat
- Rash
- Allergies
- Upset stomach
- Nausea
- Other minor health issues and more

TELADOC®

Talk to a doctor anytime.

Call today 1-800-Teladoc (835-2362) or visit Teladoc.com

How to set up your **Teladoc account**

Simply download the Teladoc app and follow the four steps you see below.

1 Confirm benefits

Provide some information about yourself to confirm your eligibility.

2 Benefit confirmation

We'll confirm that we found your benefits so you can finish creating your account.

3 Create account

Provide your contact information and preferred language.

4 Complete account

Create a username, password and pick security questions to ensure your account is secure.

Set up your Teladoc account today

Visit Teladoc.com

Call 1-800-TELADOC (835-2362) | Download the app

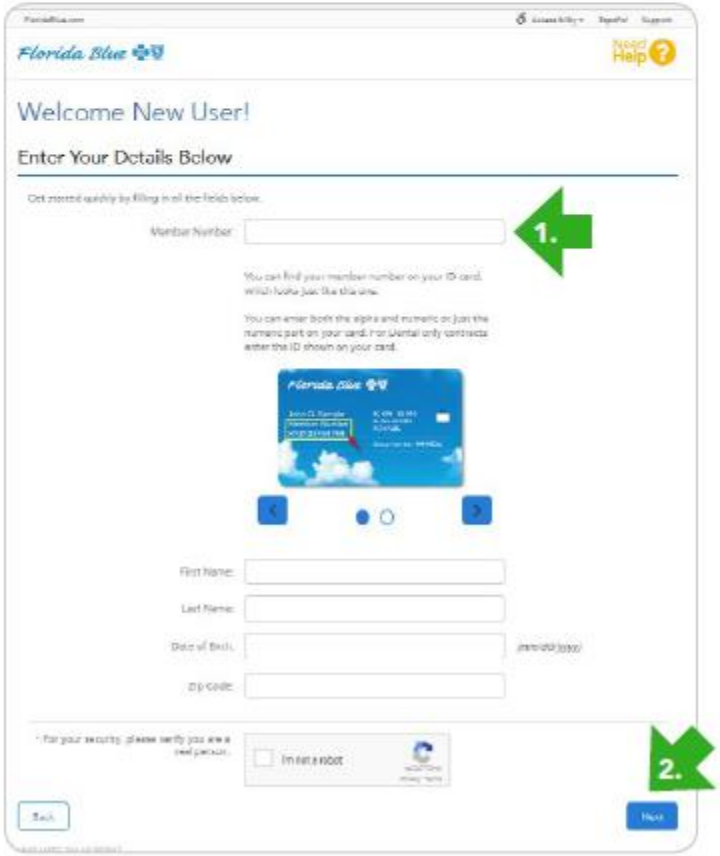
Visit FloridaBlue.com to Sign Up and Log In

Florida Blue
In the pursuit of health®

If you are already signed up for an account, simply enter your **User ID** and **Password** to log in. If you forgot these, click Forgot your User ID or Password. You'll need your Florida Blue Member ID to recover your User ID.

If you have trouble logging in, call 800-352-2583 for help.

New User Sign Up

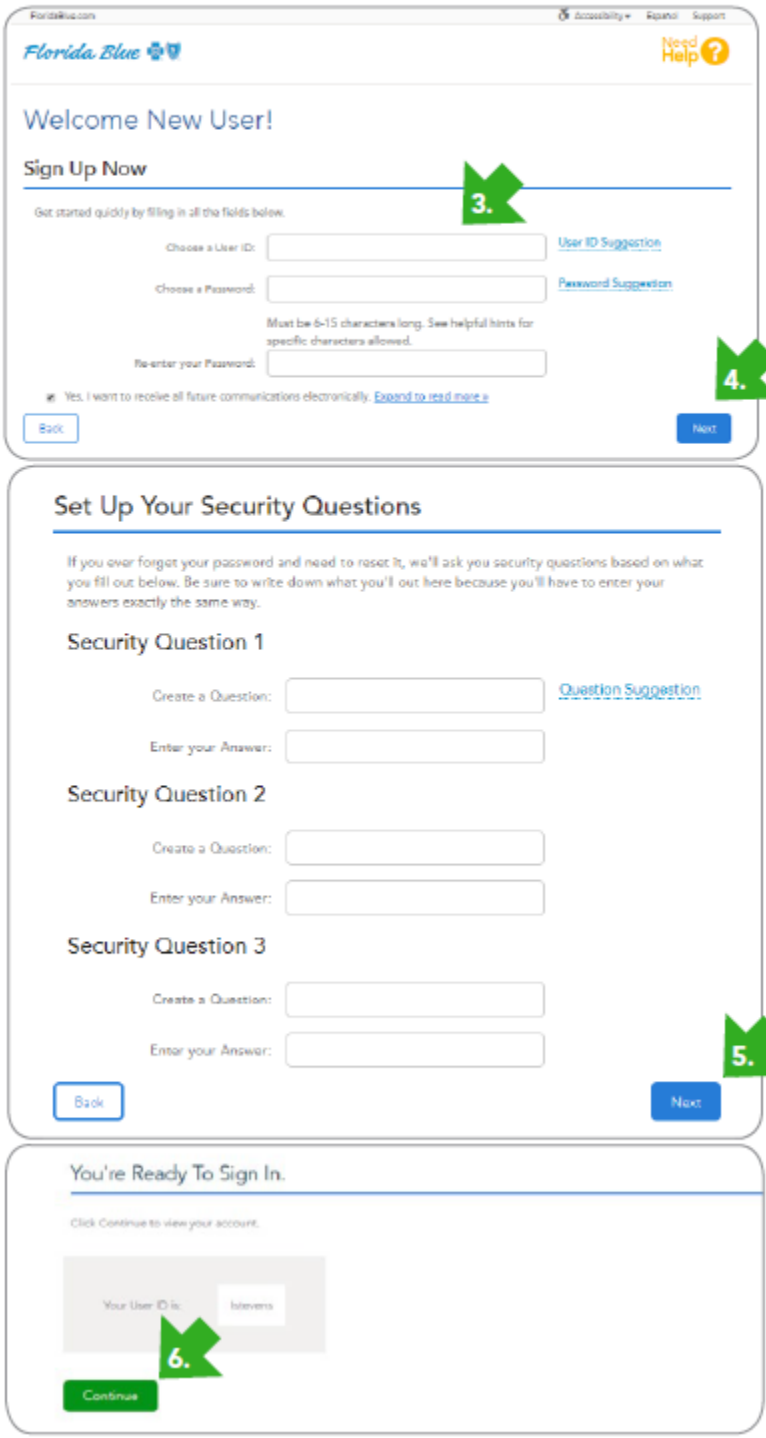


Step 1: To Sign up for your Member Account, you'll need your **Member Number** (shown on your ID card).

Step 2: Fill in all of the boxes, and click **Next**.

(continued next page)

New User Sign Up (continued)



Step 3: Choose and type in a User ID (click on User ID suggestion for help on User IDs).

Step 4: Choose and type in a Password. The Password must be typed in twice for security purposes. Click **Next**.

*If you opt-in for electronic communications, a screen for **email address** will also appear on this screen. If so, enter your email address twice, and click **Next**. (not applicable for everyone)*

***Note**: Write down your User ID and Password in case you forget them later.*

Step 5: Type three different security questions and type an answer to each. Click **Next**.

***Note**: The security questions will be used if you forget your **User ID** or **Password**.*

Step 6: Click **Continue**, and you'll be taken to the member website homepage.

How Does Health Insurance Work?

Your health insurance plan protects you from the unexpected; when you get sick or have to go to the hospital.

To help you better understand your plan, we've defined five key health insurance terms you should know:

Copay
A flat fee (e.g., $15) you pay for covered health services, such as a x-ray.

Deductible
The dollar amount you must pay each calendar year before insurance begins to pay for certain health services. You pay the plan deductible first then coinsurance (%) may apply.

Coinsurance
The percentage (%) you may pay for services after you meet the plan deductible. It's also known as "cost sharing."

Out-of-Pocket Maximum
The most you pay for covered health care services during your plan's calendar year. All of your covered expenses go toward this maximum. Once you reach the maximum, your health care plan pays 100% toward covered services and you don't pay anything.

YOUR COST IN 2025

Below are the deductions for medical based on *26 pay periods*.

	Florida Blue – Blue Options Plan 14054
Employee Only	$0.00
Employee + Spouse	$395.16
Employee + Child(ren)	$335.88
Family	$731.04

REMEMBER: Under the Affordable Care Act, the requirement that individuals obtain health coverage or pay a penalty no longer applies; however, individuals who go to the marketplace in lieu of choosing health through your employer may not be able to take advantage of tax credits afforded under this Act.

DENTAL AND VISION INSURANCE

Dental and Vision - Effective 5/01/2025

GRACE CITY CHURCH OF FLORIDA, INC.

Dental Benefit Summary

Group Number: 00552325

A Dental insurance plan through Guardian:

- Provides coverage for key preventive services such as regular checkups and cleanings to keep you and your family healthy
- Helps offset potentially expensive dental procedures, such as crowns and fillings
- Gives you access to one of the nation's largest dental networks so care is convenient to you
- Makes it easy to find a high quality certified network dentist by accessing guardiananytime.com or Guardian's find a provider mobile app
- Fast and easy claim payments

About Your Benefits:

PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**PPO**	
Your Network is	DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$50	$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%
Basic Care	100%	80%
Major Care	60%	50%
Orthodontia	Not Covered (applies to all levels)	
Annual Maximum Benefit	$2000	$2000
Maximum Rollover	Yes	
Rollover Threshold	$800	
Rollover Amount	$400	
Rollover In-network Amount	$600	
Rollover Account Limit	$1500	
Lifetime Orthodontia Maximum	Not Applicable	
Dependent Age Limits(Non-Student/Student)	20/26 *	

***Family coverage** for spouse and children if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 19	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	100%	80%
	Fillings‡	100%	80%
	Perio Surgery	100%	80%
	Periodontal Maintenance	100%	80%
	Frequency:	Once Every 6 Months	
	Root Canal	100%	80%
	Scaling & Root Planing (per quadrant)	100%	80%
	Simple Extractions	100%	80%
Major Care	Bridges and Dentures	60%	50%
	Dental Implants	60%	50%
	Inlays, Onlays, Veneers**	60%	50%
	Repair & Maintenance of Crowns, Bridges & Dentures	60%	50%
	Single Crowns	60%	50%
	Surgical Extractions	60%	50%

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.
- **PPO and or Indemnity Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Guardian

Guardian

GRACE CITY CHURCH OF FLORIDA, INC.

Vision Benefit Summary

Group Number: 00552325

Why choose Guardian for your Vision insurance:
For just a few dollars a month, this coverage saves you money on optical wellness, as well as providing discounts on eyewear, contacts, and corrective vision services

- Extensive network of vision specialists and medical professionals
- Affordable coverage
- Quick and easy claim payments

About Your Benefits:

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of VSP's network locations, including one of the largest private practice provider networks, Visionworks and contracted Pearle Vision locations.

Your Vision Plan	**Full Feature**	
Your Network is	VSP Choice Network	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 25	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $39
Single Vision Lenses	$0	Amount over $23
Lined Bifocal Lenses	$0	Amount over $37
Lined Trifocal Lenses	$0	Amount over $49
Lenticular Lenses	$0	Amount over $64
Frames	80% of amount over $130[1]	Amount over $46
Costco Frame Allowance	Amount over $70	
Contact Lenses *(Elective)*	Amount over $130	Amount over $100
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Contact Lenses *(Evaluation and fitting)*	Up to $60	Not Applicable
Cosmetic Extras	Avg. 20-25% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	20% off retail price**	No discounts
Laser Correction Surgery Discount	Up to 15% off the usual charge or 5% off promotional price	No discounts

VSP

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Family coverage for spouse and children if the child is dependent upon the employee for support and is: (i) living in the employee's household; or (ii) a full-time or part-time student.
- ** For the discount to apply your purchase must be made within 12 months of the eye exam.

- Charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. The only exception would be if a member purchases contact lenses from an out of network provider, members can use the balance towards additional contact lenses within the same benefit period.
- [1]Extra $20 on select brands
- Members can use their in network benefits on line at Eyeconic.com.
- ###.*The VSP system considers contact lenses to be the equivalent of a full pair of eyeglasses (lenses and frames) so while the member can obtain contact lenses one year and standard eyeglass lenses the next year, the frames benefit would not be available until 24 months or two calendar years, depending on the plan design, after the date the member obtained the contact lenses.*

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00552325.
Please call the Guardian Helpline if you need to use your benefits within 30 days of plan effective date. Please note, self-serve options over the phone or online at Guardian Anytime are not available until the case is fully implemented, please wait to speak to a live agent when calling the Guardian Helpline.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-VSN-96-VIS et al.

Laser Correction Surgery:

Discounts on average of 10-20% off usual and customary charge or 5% off promotional price for vision laser Surgery. Members out-of-pocket costs are limited to $1,800 per eye for LASIK or $1,500 per eye for PRK or $2300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK.

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

YOUR COST IN 2025

DENTAL ---- EMPLOYEE DEDUCTIONS PER 26 PAY PERIODS	
Guardian	Dental – PPO Plan W1
Employee Only	$0.00
Employee + Spouse	$14.48
Employee + Child(ren)	$19.25
Family	$36.69

VISION ----- EMPLOYEE DEDUCTIONS PER 26 PAY PERIODS	
Guardian	Vision – VSP Plan
Employee Only	$3.62
Employee + Spouse	$6.09
Employee + Child(ren)	$6.21
Family	$9.82

SECTION 125

Grace City Church allows you the opportunity to pre-tax your benefits. This means you pay for your insurance premiums with pre-tax dollars. You must elect this when completing the necessary paperwork. Certain limitations apply regarding dependent status changes if you choose to pre-tax your benefits.

If you decline to participate in the benefit program, you may not enroll until the next open enrollment period. The open enrollment period occurs annually, prior to the plan anniversary dates. You will be advised of the opportunity to enroll during annual open enrollment.

If you pre-tax your benefits, IRS Section 125 guidelines mandate that coverage may not be cancelled without a qualifying event. Once coverage is cancelled, you may not re-enroll until the following open enrollment period.

Your contributions through payroll deduction for Medical, Dental, Vision, the first $50,000 of Term Life, and Supplemental Health (including Hospital Indemnity) are covered under the IRS Section 125 Premium Payment Plan. This plan allows this contribution to be taken out of your paycheck ***before taxes are applied.*** The example below illustrates what this means to an employee earning $25,000 per year, filing single with zero exemptions. Keep in mind that the tax savings include both federal income tax and social security tax. The example assumes Employee only coverage at a weekly cost of $20.00 and an annual cost of $1,040.00.

	No Plan	With Plan
Gross income	$25,000	$25,000
Insurance Premium	N/A	$ 1,040
Taxable income	$25,000	$23,960
Federal Income & Social Security Taxes	$4,970	$4,734
Sub-Total	$20,030	$19,226
Insurance Premiums (after Tax)	$1,040	N/A
Take Home Pay	**$18,990**	**$19,226**

TOTAL AVERAGE SAVINGS OF $236

Required Annual Employee Disclosure Notices

Your Right to Documentation of Health Coverage

Recent changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, pre-existing condition exclusions generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without pre-existing condition exclusions. Contact your state insurance department for further information.

For employer group health plans, these changes generally take effect at the beginning of the first plan year starting after June 30, 1997. For example, if your employer's plan year begins on January 1, 1998, the plan is not required to give you credit for your prior coverage until January 1, 1998.

You have the right to receive a certificate of prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your insurance carrier to see if your plan excludes coverage for pre-existing conditions or if you need to provide a certificate or other documentation of your previous coverage.

The Women's Health and Cancer Rights Act Of 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires all health plans to cover reconstructive surgery following a mastectomy. Your health program currently covers such reconstructive surgery. This law also requires that we provide you with this notice.

Coverage for Reconstructive Surgery Following Mastectomy

When a covered individual receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the health plan must cover:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- prosthesis and treatment of physical complications in all stages of mastectomy, including lymph edema.

This coverage must be the same as for any other benefit under the plan.

Genetic Information Non-Discrimination Act of 2008 (GINA)

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Important Notice about Your Prescription Drug Coverage & Medicare

As part of the Medicare Part D regulations under the Medicare Modernization Act of 2003 (MMA), employer groups are required to notify all Medicare-eligible individuals covered under their plan, annually and at other specific times, if their pharmacy coverage meets the "creditable coverage" requirements of the Medicare Part D regulations. A pharmacy plan is considered creditable if its benefits are equal to, or better than, a Medicare Part D plan.

This required notice of creditable coverage is intended to assist Medicare-eligible individuals in determining whether they should enroll in a Medicare Part D plan at their initial enrollment period (IEP), or later. For those individuals who do not enroll during the initial enrollment period and do not have creditable coverage under another pharmacy plan (e.g., their employer's coverage), a late enrollment penalty fee (assessed as part of the premium) accrues monthly for each month that the individual delays enrollment in a Medicare Part D plan. If an individual has creditable coverage and enrolls in a Medicare Part D plan later, there are three important things to remember:

1. Medicare Part D Prescription Drug coverage is not automatic. You must join for coverage to begin. If you miss the enrollment period, for example October 15th - December 7th, you cannot enroll until the next Annual Election period, which begins in November of the following year.

   If you become eligible for Medicare Part D between annual election periods, you may enroll anytime during the month you become eligible or within the three months that precede or follow this month.

2. You must be eligible to enroll in a Medicare Part D Prescription Drug Plan. To be eligible you must reside in the service area of the Part D plan, be entitled to Medicare benefits under Part A and/or enrolled in Part B, continue to pay the Part B premium -- if not otherwise paid for under Medicaid or by another third party -- and enroll during the initial, special or annual election periods.

3. Medicare Part D is not free, and you could pay a penalty if you delay enrollment. If you choose to enroll in a plan without a delay in your enrollment window, you will pay the plan's applicable monthly premium. Should you delay enrollment in a plan, you could pay a government-imposed penalty of 1% of the national base beneficiary premium for every month you remain without effective coverage.

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (NMHPA) was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section.

In October 2008, final regulations relating to the NMHPA were jointly issued by the Internal Revenue Service (IRS), Department of Labor (DOL) and Department of Health and Human Services (HHS). The final regulations are effective for plan years beginning on or after Jan. 1, 2009.

Coverage Requirements

The NMHPA sets limits on benefits that are provided for hospital stays after childbirth. However, nothing in the law or regulations requires a mother to give birth in a hospital or stay in the hospital for a specific period after giving birth. Also, group health plans may not be required to provide any benefits for hospital stays related to childbirth. However, if the plan provides these benefits, it must comply with the NMHPA's minimum requirements.

Hospital Length of Stay

The final regulations clarify when a hospital stay connected with childbirth begins.

- When a delivery occurs in the hospital, the stay begins at the time of delivery, not at the time of admission or beginning of labor.
- If there are multiple births, the stay begins at the time of the last delivery.
- For deliveries that occur outside of the hospital, the stay begins at the time the mother or newborn is admitted.

The decision of whether a hospital stay relates to childbirth is a medical decision to be made by the attending provider.

Medicaid and the Children's Health Insurance Program (Chip)

Offers Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can 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, you can 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, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that 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 feel you may be eligible for assistance paying your employer health plan premiums contact your state Medicaid office.

The following is for the state of Florida:

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

To see other states or for more information on special enrollment rights, you can contact either:

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

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

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

When key parts of the health care law took effect in 2014, a new way to buy health insurance was introduced: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the 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 premium right away.

Open enrollment for health insurance coverage through the Marketplace runs from November 1, 2024 to December 15, 2024, for coverage starting January 1, 2025. After Jan. 1, 2025, you can get coverage through the Marketplace for 2023 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. 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 9.02 % for 2025 (for plan years beginning in 2024, the applicable percentage is 8.39%) 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. (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.)

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.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact *your Human Resources Department*.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

NOTES:

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.