Benefits Guide

Plan Year: 2023 - 2024

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

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

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all your personal information and make any necessary changes.

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**.*

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, 2022 to December 15, 2022, for coverage starting January 1, 2023. After Jan. 1, 2023, 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 9.12% for 2023 (for plan years beginning in 2022, the applicable percentage is 9.61%) 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 HR 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.

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.