ACV

ADVENT CHRISTIAN VILLAGE
AT DOWLING PARK

2024 Benefits Guide

PRN Edition

Benefits For Life

We're committed to making sure you get the benefits package that's right for you and your family.

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

We are offering Group Aflac Voluntary Benefits again this year, including: Short-Term Disability, Accident Insurance, Critical Illness, Hospital Indemnity Plan and Whole Life Insurance. Please consider the convenience and affordability of the Group Aflac voluntary benefits.

Please take the time to read through this booklet and understand all the options available to you. As a whole, we think we've created a benefit package that gives you outstanding support, 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 pages 30-31 for more details.

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 Department.

First Things First

Choosing Your Benefits

During the year, you have limited opportunities to make your benefit choices. **Make your selections carefully!** The choices you make now will be effective 7/1/2024 – 6/30/2025.

When you're first hired

When you are first hired, your coverage begins on your **benefit eligibility date:** the first day of the month following your 60th day of full-time employment.

The choices you make as a new hire will be in effect through **June 30, 2025.**

At Annual Enrollment

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

Benefits selected at Annual Enrollment are effective **July 1 through June 30.**

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 contact Human Resources and request applicable changes to your benefits.

Life events include: marriage or divorce, adopting a child, custody status change of a child, a change in Medicare or Medicaid eligibility, or a change in your or your spouse's work affecting benefits eligibility.

Covering Your Family

Your Spouse

You may cover your legal spouse on your benefit plans, including medical, dental, vision and voluntary benefits, including; supplemental life, accident, critical illness, hospital indemnity and whole life insurance.

Your Children

Your natural, adopted, foster, step children and children in your custody due to a court order are eligible for benefits with Advent Christian Village:

Medical	*Through the end of the* **calendar year** *when they reach* **age 26.**
Dental and Vision	*Through the end of the* **month** *when they reach* **age 26.**
Child Life	*To* **age 20** *if unmarried, or* **age 26** *if also a full-time student.*

Disabled dependents: children who became disabled before age 26 and rely on you for support are also eligible for health coverage. Contact Human Resources for coverage information.

Online Enrollment

Important information for this upcoming Open Enrollment:

Last year we installed a new Benefits Administration system to manage ALL benefit functions throughout the year. Once again, we are partnering with U.S. Enrollment Services to assist in our Open Enrollment and have contracted for their Call Center and Co-Browsing support. **All benefit eligible employees will need to enroll in their benefits via the call center.** The benefits specialist will be trained on all benefit programs available to benefit eligible employees and will be able to answer questions regarding your programs. They will review your current elections and will assist you in making changes or modifications to benefit programs for the upcoming Plan Year. You will simply make an appointment online to set a convenient time to speak to the representative.

How to set up my appointment with a Benefits Specialist

To schedule your appointment, go to: https://ACVillage.mybenefitsinfo.com

or scan this QR Code –

Please call 800.735.0080 for assistance.

Once you schedule your appointment time, you will receive a confirmation email and a reminder email the day prior to your appointment.

What to expect during my appointment:

Your appointment with the Benefits Specialist is scheduled for 30 minutes. During this time, they will verify all demographic and dependent information, as well as discuss each benefit program with you. This is your annual opportunity to review and ask questions regarding any of your benefit programs.

The Call Center will be open **Tuesday, June 4th – Friday, June 7th and Monday, June 10th – Friday, June 14th from 9am to 6pm EST**. The benefit specialist will call you on the date and time of your appointment.

If you are at a computer or mobile device with internet access, the Benefit Specialist can share their screen (Co-browse) as they walk through the enrollment system. They will provide instructions at the time of your call.

If you are a New Hire

When you are first hired, your coverage begins on your benefit eligibility date: the first day of the month following your 60th day of full-time employment. The choices you make as a new hire will be in effect through June 30, 2025. Enrollment will take place on the third Monday of the month prior to your benefit eligibility date. The enrollment will take place through our benefit call center with a benefits specialist.

To schedule your appointment, go to: https://ACVillage.mybenefitsinfo.com

or scan this QR Code –

Please call 800.735.0080 for assistance.

Once you schedule your appointment time, you will receive a confirmation email and a reminder email the day prior to your appointment.

Medical Insurance

Overview of Options

Coverage, choice, cost and convenience are important factors each of us considers when selecting a medical plan. You may choose from the three medical plans offered through UnitedHealthcare, or you may choose to opt out of coverage.

Choose between three medical plans to best meet your needs. The difference between the plans is how services are covered and the amount you are required to contribute each pay period toward the premium. **Preventive care (wellness visits) are covered 100% on all medical plans when you stay in the network.**

	Base Plan	Buy Up Plan	Buy Up Plan
	Choice Plus Plan DU9V-MOD HDHP HSA (formerly DB7U-M)	**Choice Plus Plan DU94-MOD HDHP HSA (formerly DEOA-M)**	**Surest Plan A4000 with Navitus Pharmacy**
	Nationwide UnitedHealthcare Choice Plus Network	**Nationwide UnitedHealthcare Choice Plus Network**	**Nationwide UnitedHealthcare Choice Plus Network**
Comparison	Base Plan Lower paycheck premiums	Buy Up Plan Higher paycheck premiums	Buy Up Plan Higher paycheck premiums
	Higher maximum out-of-pocket costs	Lower maximum out-of-pocket costs	Lower maximum out-of-pocket costs
	Preventive Care covered 100%	Preventive Care covered 100%	Preventive Care covered 100%
	Traditional Plan with in-and-out-of-network coverage	Traditional Plan with in-and-out-of-network coverage	Digital Plan experience with in-and-out-of-network coverage. Download the Surest app to find coverage options before selecting a provider.

UnitedHealthcare

Website: www.myuhc.com
Phone: 800.842.5658
Policy Number: 931814

Surest

Website: www.Benefits.Surest.com
Phone: 866.683.6440
Policy Number: 1517840

Helpful Coverage Terms

Copay

A flat fee you pay whenever you use certain medical services, like a doctor visit. *Goes toward your out-of-pocket maximum*.

Deductible

The annual dollar amount you pay before your insurance begins paying deductible-eligible claims. *Goes toward your out-of-pocket maximum.*

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. *Goes toward your out-of-pocket maximum.*

Out-of-Pocket Maximum

The most you will pay during the calendar year for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Network

A specific group of doctors, facilities, hospitals, and providers who contract with UnitedHealthcare. Your specific network depends on the plan you choose. In-network providers are your lowest cost for care.

Balance Billing

The amount you are billed to make up the difference between what your out-of-network provider charges and what insurance reimburses. This amount is in addition to, and does not count toward your out-of-pocket maximum.

Maintenance Medication

Prescription medication you take daily or on a regular basis; these scripts are usually written for 90 days instead of 30. You generally pay less for maintenance medication when you use mail order instead of a local retail pharmacy.

For UnitedHealthcare Plan Members

Health and Wellness Resources for Care

UnitedHealthcare has a wealth of resources available to you and your family when you enroll in our medical plan.

UnitedHealthcare app

- Find nearby care options in your network.
- See your claim details and view progress toward your deductible.
- View and share your health plan ID card.
- Video chat with a doctor – without leaving the app.

Virtual Visits

- See a doctor whenever, wherever.
- At myuhc.com/virtualvisits you can talk with nurses to walk you through the steps for a healthy pregnancy, birth and baby, along with free educational materials and gifts. Call 800.955.7635 (option 6) to learn more.

Rally®

- A program to help you move more and eat better. It even rewards you for your progress. Take a health survey, pick your focus and earn rewards while improving your health.

Real Appeal®

- A program designed to help with simple steps and support along the way for lasting weight loss.

Quit For Life

- Is just like having a coach right at your fingertips anytime you need support and at no cost to you. Enroll today at myuhc.com.

Decision Support

- For when a health question comes up, you can talk with a registered nurse any time, day or night.

Maternity Support Program

- Get support throughout your pregnancy.

Extra Care Support

- Emotional support when you need it. Your behavioral health benefit provides confidential support.

Cancer Support Program

- Dedicated cancer nurses will help you find information and emotional support for you and your family.

Medical Plan Summaries

	Choice Plus Plan DU9V-MOD HDHP HSA (formerly DB7U-M)		Choice Plus Plan DU94-MOD HDHP HSA (formerly DEOA-M)		Surest Plan A4000 Download app or go to Benefits.Surest.com to compare network provider costs	
In-Network Coverage	**BASE PLAN**		**BUY UP PLAN**		**BUY UP PLAN**	
Deductible DED	Individual: $5,000 Family: $10,000		Individual: $2,000 Family: $6,000		N/A	
Coinsurance *(your share)*	40% after DED		20% after DED		0%	
Out-of-Pocket Maximum	Individual: $7,500 Family: $15,000		Individual: $4,000 Family: $8,000		Individual: $4,000 Family: $8,000	
Preventive Care *(Physician Office)*	100% covered		100% covered		100% covered	
E-Visit / Primary Doctor Visit	DED then 40%		DED then 20%		$5 to $40	
E-Visit / Specialist Doctor Visit	DED then 40%		DED then 20%		$5 to $40	
Independent Lab	DED then 40%		DED then 20%		$0	
Independent X-Ray	DED then 40%		DED then 20%		$0	
Complex / Advanced Imaging *(MRI, CT, PET, etc.)*	DED then 40%		DED then 20%		$50 to $310	
Urgent Care Center	DED then 40%		DED then 20%		$15	
Emergency Room	DED then 40%		DED then 20%		$170	
Inpatient Hospitalization	DED then 40%		DED then 20%		$1,000	
Outpatient Surgery / Services	DED then 40%		DED then 20%		$50 to $300	
Out-of-Network Coverage *(plus balance billing)*						
Deductible DED	$10,000 | $20,000		$4,000 | $8,000		N/A	
Coinsurance *(your share)*	50% after DED		40% after DED		0%	
Out-of-Pocket Maximum	$15,000 | $30,000 *(plus balance billing)*		$6,250 | $12,500 *(plus balance billing)*		$8,000 | $16,000 *(plus balance billing)*	
Prescription Drugs *(in-network)*	Retail	Mail Order	Retail	Mail Order	Retail	Mail Order
Generic	DED then $10	DED then $25	DED then $10	DED then $25	$5 pref/ $10 non	$25
Preferred Brand	DED then $35	DED then $87.50	DED then $53	DED then $87.50	$35	$87.50
Non-Preferred Brand	DED then $70	DED then $175	DED then $70	DED then $175	$70	$175

Health Saving Account (HSA)

FOR THOSE ENROLLED IN THE HSA PLANS

Employees who participate in Advent Christian Village's High Deductible HSA Plans may establish a Health Savings Account with First Federal Bank of Florida to pay out-of-pocket medical expenses. First Federal Bank of Florida has agreed to waive the HSA banking fees for Advent Christian Village Employees. Employees participating in either of the HSA plans will be issued a debit card. To pay for qualified medical expenses with your HSA funds, simply swipe the card at the time of service. Manual claim forms may also be submitted for reimbursement. You may contact the HR department for a new account form or contact your local First Federal Bank of Florida Branch. You are welcome to use another banking institution for your Health Savings Account.

What is an HSA?	A Health Savings Account (HSA) is a tax-free account you can use to pay for current and future medical expenses (even medical expenses during retirement). An HSA has triple tax benefits: • The money goes in tax-free. • The money grows tax-free. • Your withdrawals for qualified medical expenses, including any earnings, are tax-free.
Who is eligible?	You are eligible to open an HSA if: • You enroll in one of the high deductible health plans (HDHP): Base Plan DU9V-MOD or Buy Up Plan DU94-MOD. Your only coverage is a HDHP and you have not signed up for Medicare coverage or are a dependent on someone else's tax return. . • If you're covered under your spouse's plan and that plan is not a high-deductible plan, or your spouse contributes to a healthcare FSA, then you are not eligible to contribute to an HSA.
Rollover	100% of unused funds roll over each year. No exceptions
Maximum Annual Contributions	You decide how much you want to contribute. Below are the IRS defined limits, including both employee and employer combined contributions: • $4,150 if enrolled in employee only medical coverage • $8,300 if enrolled in family coverage (family includes one or more covered dependents) • $1,000 additional if you are age 55 or older If you are not enrolled in the HDHP for the full year, you will not be able to make the full contribution to your HSA. You will need to pro-rate your contribution for that year. Count only those months for which you had HSA-qualified coverage on the first day of the month.
Pay Healthcare Expenses	Each time you have a qualified expense, you decide whether to: • Pay out of your pocket and let your HSA grow, earning interest for future eligible expenses (e.g., medical expenses during retirement); or • Pay for certain expenses using a healthcare FSA and let your HSA grow. You can use the FSA to pay for dental and vision expenses. Then after you meet your HSA plan deductible, you can use the FSA to pay for eligible medical expenses; or • Use your HSA to pay for eligible medical expenses, such as your annual deductible and coinsurance. Your HSA can also help pay for vision care, dental care, and prescription drugs (For a complete list of eligible expenses, visit www.irs.gov.)

Health Savings Account (HSA)

What's an HSA?

It's more than just a savings account. A Health Savings Account (HSA) is designed to be paired with a qualified HDHP health plan, like our HDHP plans, and can provide a smart way to save for current and future healthcare needs.

- Make tax-free contributions through payroll deductions to save for current and future expenses.
- Your funds never expire and always belong to you - even if you retire or leave Advent Christian Village.
- Use your funds to pay for eligible medical, pharmacy, dental, and vision expenses.

If you enroll in our **United Healthcare Choice Plus DU9V-MOD Plan** or **United Healthcare Choice Plus DU94-MOD Plan**, an HSA can provide you with tax savings and a nest egg of tax-free funds for health expenses.

Contributions

The amount you can contribute to your HSA is set by the IRS and determined by who you cover on your HDHP plan.

If you cover **Yourself**	If you cover **You + any dependents**
$4,150 2024 IRS maximum	**$8,300** 2024 IRS maximum

Maximums are set by the IRS, include contributions from all sources, and assume 12 months of coverage in a qualifying HDHP plan. Qualifying HDHP coverage lasting less than 12 months generally results in contribution maximums pro-rated on a monthly basis.

Age 55 or older? You may contribute an extra **$1,000** per year in catch-up contributions.

Your funds are available as soon as they are deposited and you can use your money in two ways:

1. **Pay** for out-of-pocket costs when you receive medical, prescription, dental, or vision care
2. **Leave** the money in your account so it will carry over from year to-year and grow tax-free

Next Steps:

If you are eligible to contribute to a Health Savings Account you will need to open a Health Savings Account (HSA) at First Federal Bank of Florida. Once the account is opened, you will need to provide HR with the Account Number and per pay period contribution amount.

First Federal Bank of Florida

Website: www.ffbf.com

Phone: 386.362.3433 ext. 1985

The HSA Advantage

Jill has an individual HSA

She saves directly from her paycheck into her HSA

$1,100 annually ($50.00 per paycheck)

-$0 (No income tax is applied)

$1,100

Tax-free money to cover medical expenses

Clark doesn't have an HSA

He saves for medical expenses from his paycheck

$1,100 annually ($50.00 per paycheck)

- $275 (25% federal income tax)

$825

Post-tax money to cover medical expenses

Triple Tax Advantage:

1. **Contributions** are tax- free (exempt from federal taxes)
2. Any **interest** earned on the account balance is tax-free
3. **Withdrawals** for qualified health expenses are tax- free

HSA Eligibility

Please remember that you will need to enroll in our United Healthcare Choice Plus Plan DU9V-MOD or United Healthcare Choice Plus Plan DU94-MOD plan to have a Health Savings Account with First Federal Bank of Florida. Also, you can't contribute to an HSA if you are enrolled in another medical plan (including a Health Care FSA, Medicare, or TRICARE) or can be claimed as a dependent on someone else's tax return. In these cases, you can still enroll in one of our HDHP plans, but you'll need to opt out of the HSA.

Questions about your eligibility or how an HSA might affect your taxes? Contact your tax professional.

For UnitedHealthcare Plan DU9V-MOD and DU94-MOD Members

Good news—your health plan comes with a new way to earn up to $300. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions—including many things you may already be doing—lead to rewards. The activities you go for are up to you—same goes for ways to spend your earnings. Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Personalize your experience by selecting activities that are right for you—and look for new ways of earning rewards to be added throughout the year.

Earn up to
$300

United Healthcare

continued

For United Healthcare Plan DU9V-MOD and DU94-MOD Members

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select the **Menu** tab and choose **UHC Rewards**
- Activate UHC Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **UHC Rewards**
- Activate UHC Rewards
- Choose reward activities that inspire you—and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $300 and use it however you want

Questions? Call customer service at **1-866-230-2505**

United Healthcare

For Surest Plan Members

surest
A UnitedHealthcare Company

Understanding your pharmacy benefits:

Optum Rx®

Did you know your Surest health plan includes medical benefits and pharmacy coverage for a variety of prescription drugs? The Surest pharmacy benefit manager is OptumRx.

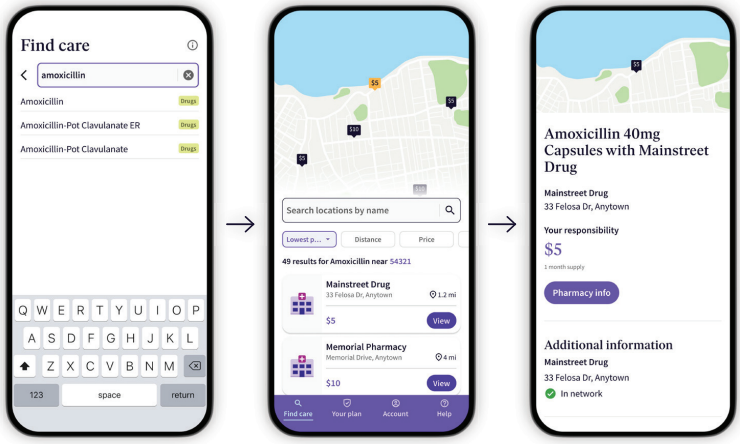
Compare costs

Sign in to your member account on the Surest app or Benefits.Surest.com.

You can:

- Search for prescriptions by name to see coverage details.
- Check prices (copays) for your covered prescriptions.
- Choose from pharmacies in the broad, national OptumRx network of retail pharmacies or Optum Home Delivery for mail orders.

Shopping around is part of the intuitive Surest plan design. When you can check prices in advance and compare options, you may even find opportunities to save. *If the cost at the pharmacy is less than the assigned copay, you'll pay the lower cost.*



Illustrative example only. Cost and coverage may vary.

For Surest Plan Members

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A UnitedHealthcare Company

Formulary tiers: Standard and specialty (complex) drugs

The point of tiers is that high costs can sometimes be avoided when an equally effective generic alternative exists. This lowest-net-cost philosophy can help drive down costs.

1. Tier 1/Specialty Tier 1: Preferred generics and some lower-cost brand products (typically the least costly at the pharmacy)
2. Tier 2/Specialty Tier 2: Preferred brand-name drugs that are typically less costly and some higher-cost non-preferred generics
3. Tier 3/Specialty Tier 3: Non-preferred products, may include some higher-cost non-preferred generics

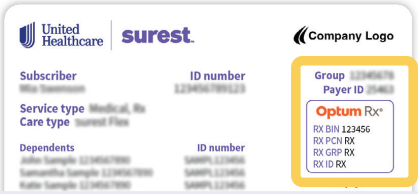
Optum Home Delivery

Receive a 3-month supply of ongoing maintenance medications, with free standard shipping, mailed to your home.

There are 3 ways to get your medications mailed:

1. Go to OptumRx.com.
2. Call a health care advisor at 800-357-1371.
3. Ask your doctor to send a prescription to OptumRx.

Sign up for automatic refills at no additional cost.
You'll receive a notification when it's time to refill your 3-month supply, with orders charged to your account.



Helpful tip

When you fill your prescription at the pharmacy, show them your Surest ID card. This card has the details needed to send your pharmacy claims to Surest.

Card is for illustrative purposes only.

90-day supply

Get a 90-day supply of non-specialty medications at in-network retail pharmacies at the same copay as mail order.

Specialty pharmacy

Some medications are considered specialty drugs that may require special handling or administration, available only in 30-day supplies. Specialty prescriptions must be filled through Optum Specialty by calling 855-427-4682.

Still have questions?

Call Surest Member Services at **866-683-6440, Monday–Friday, 6 am–9 pm CT**.

For Surest Plan Members

Clear answers about your costs, your coverage, your options.

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GENERAL PLAN DETAILS

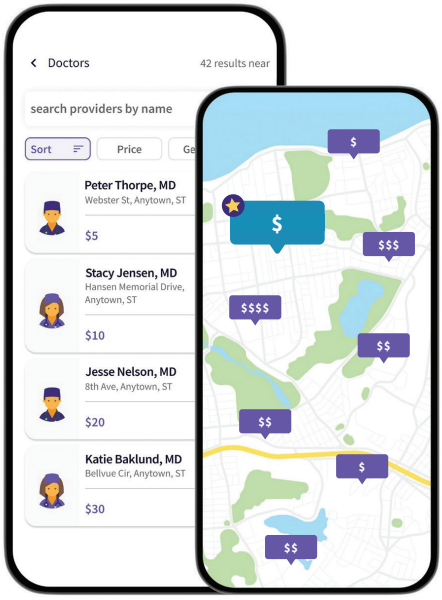
Deductible	$0
Out-of-pocket limit	
Employee	$4,000
Family	$8,000
Prescription drugs – 30-day	
Preventive drugs	$0
Tier 1	$10
Tier 2	$35
Tier 3	$70

YOUR COPAYS

Preventive visit	$0
Office visit	$5 – $40
Virtual visit (primary & urgent)	$0 – $40
Physical therapy*	$5 – $25
Mental health office visit	$5
Urgent care visit	$20
Emergency room visit	$180
Basic diagnostic lab tests, X-rays and ultrasounds	$0
Maternity labor and delivery	$350 – $1,000

"Everything is just **easy and affordable.** I feel in control of my health plan for the first time."

Jaime A., Surest member



Providers, locations, and prices are fictional. Prices are representative of member copays, no deductible.

See how powerful simple can be.

Get started
surest.com/plan?accesscode=FIFL24245Alt1

*See plan for visit limit details. In-network costs only. For out-of-network costs, exclusions and limitations, see website. Administrative services provided by Bind Benefits, Inc. d/b/a Surest, its affiliate United

Insurance coverage is provided by All Savers Insurance Company (for FL, GA, OH, UT and VA), by UnitedHealthcare Insurance Company of IL (for IL), by United Healthcare of Kentucky, Ltd. (for KY), or by UnitedHealthcare Insurance Company (for AL, AR, AZ, CO, DC, DE, GA, IA, ID, IL, IN, KS, KY, LA, MI, MN, MO, MS, MT, NC, NE, NH, NV, OH, OK, PA, RI, SC, SD, TN, TX, UT, VA, WI, WV, and WY). These policies have exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact either your broker or the insuring company. Administrative services provided by Bind Benefits, Inc. d/b/a Surest, its affiliate UnitedHealthCare Services, Inc., or by Bind Benefits, Inc. d/b/a Surest Administrators Services, in CA.B2C_23-AI-615484_0424

For Surest Plan Members

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A UnitedHealthcare Company

Information at your fingertips.

Use the Surest app to search for care, and so much more. You can also:

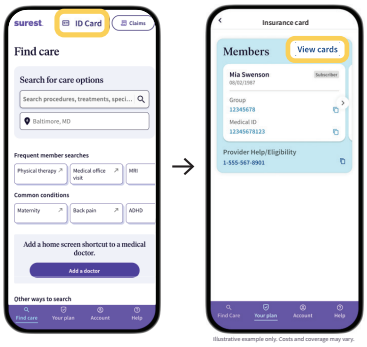
1

Conveniently access your digital ID card.

From the “Find care” screen, click on **“ID card”** and **“View cards”** to pull up your member ID card.

If your provider isn’t familiar with Surest:

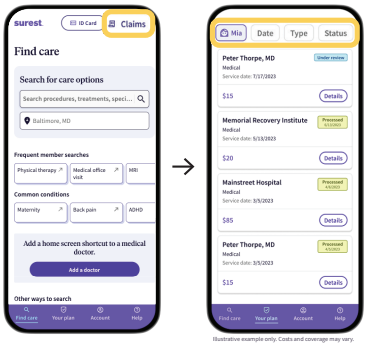
Within the insurance card screen, scroll down to “Having trouble using Surest with your provider?” and “Learn more” to pull up some helpful tips.



2

View claims.

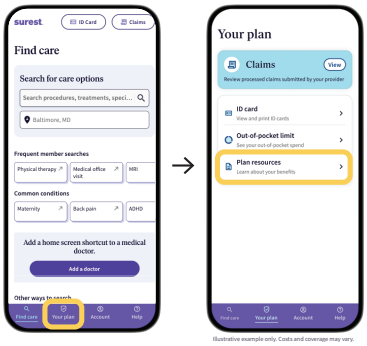
From the “Find care” screen, click on **“Claims.”** Filter by date, type (medical or pharmacy), or status to see medical claims that are processed or under review.



3

Find forms and resources.

From the “Find care” screen, click on **“Your plan”** and then **“Plan resources.”**

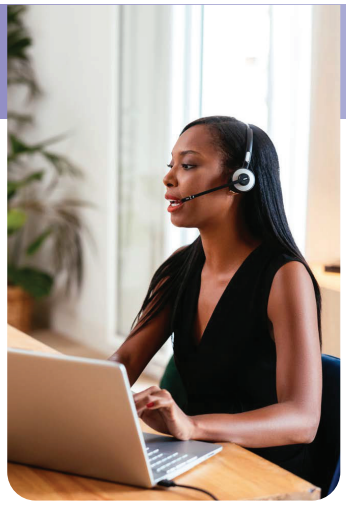


Questions?

You don’t have to leave the app to get answers! Member Services is available directly from the app via chat and email or by calling the number on the back of your Surest member ID card.

For Surest Plan Members

surest



The Surest Member Services team is here to help

Manual Transition of Care

When your new Surest member or existing member needs help and additional time to speak with their physician about switching to a preferred or covered alternative medication and/or satisfying their drug's clinical program requirements, the manual Transition of Care process (TOC) can help.

- Manual TOC allows Surest Member Services to approve a one-time, one-month override on certain medications that are strategically excluded or have clinical review requirements (e.g. Prior Authorization, Step Therapy) when the member is new to Surest pharmacy benefits or the member is impacted by a Prescription Drug List (PDL) Cycle change.
- Manual TOC applies to both new and existing members
- Members simply call the number on the back of their ID card to request a TOC override.
- Surest Member Services will work with your member to determine if their drug is eligible for a Transition of Care override.
- For existing members to be eligible, they must also have a paid claim within the last 120 days in their history. The override is not available for new medications.
  - Existing members should have a denied claim in their history for the drug under review in order to help streamline the process.

Contact your Surest representative for more information.

Surest Plan FAQ's

With Surest, employees can search for their condition and see different treatment options and providers – with exact prices – so they can make more informed decisions. And Surest has made it so there is no compromise between cost and quality – high-quality treatments and providers cost less.

That's a win for employees and employers."

What is Surest?

Surest is a health plan offering consumers choice and clarity. Decision-making is straightforward. Consumers compare and see treatment options and costs in advance of treatment and provider selection. Consumers can make informed decisions. Surest plan members don't have to pay down a deductible before their plan contributes. Prices for cost-effective treatments, doctors and clinics are typically priced lower.

Freedom from barriers: We removed deductibles and coinsurance. Members have access to a broad network of doctors, clinics and hospitals locally and nationally.

Opportunities to save: With Surest, you see clear prices for treatments, doctors and prescription drugs so you can decide how much to spend based on provider quality ratings.

How does the Surest plan work?

The Surest plan is simple. No deductible. No coinsurance. Without a deductible, the plan starts contributing whenever people use it. Without coinsurance, there's no confusing cost-sharing math percentages to figure out.

The Surest plan provides coverage for numerous common conditions – from preventive to emergency, from colds to cancer treatment.

Does the Surest experience differ from other health plans?

Yes. The Surest health plan makes people the center of our design, not doctors, clinics and prescription drugs. With Surest, people shape their cost and coverage around their own health needs, making the health care marketplace their marketplace. You know costs before you seek care, not weeks later. You can see savings opportunities by comparing options. Health needs differ from person to person, and day to day.

Providers with lower direct costs, lower risks of complications and higher rates of effectiveness are listed as more cost-effective options.

Is it true I don't have a deductible? Or coinsurance? Ever?

Yes, it's true. Health insurance was intended to be a benefit – we redesigned it so it is. The Surest plan has no deductible and no coinsurance – your benefit starts working for you when you need it. With the Surest plan, you get clear, on-the-go cost and coverage answers through the Surest app, logging in to Benefits.Surest.com or calling Surest Member Services. Find out what things may cost and explore your options before you step foot in the doctor's office.

Is the Surest plan compatible with – and can I submit expenses to my flexible spending account (FSA) or health savings account (HSA)?

Yes, you can submit expenses to your FSA for reimbursement. You can continue using funds in an existing HSA if you accumulated earnings while on another plan. Because the Surest plan does not have a high deductible (or any deductible) – a requirement of contributing to an HSA – Surest members are not eligible to contribute to an HSA.

How does your no-deductible plan have a cheaper monthly price than a plan with a health savings account (HSA)?

Modeled after other consumer services, the Surest plan provides transparent prices across treatments, settings and providers – in advance. Members can typically see their full cost before they see the doctor or fill a prescription. Prices for cost-effective treatments, doctors and clinics are typically priced lower. Members can easily compare provider quality ratings for many providers. And they can map-view prices of lower-cost pharmacies across the street or across town.

I can't find my condition, treatment or provider using the Surest app or on the Benefits.Surest.com website. Does that mean it isn't covered?

Not necessarily. Contact Surest Member Services for more support by calling the number on the back of your Surest member ID card.

Does the Surest plan cover pre-existing conditions?

Yes. The Surest plan offers you coverage regardless of pre-existing medical conditions you may have. Whatever your health care needs, use our search tool on the Surest app or on Benefits.Surest.com to compare map-view prices of treatments and pharmacies in your general area.

If I was previously on a different health insurance plan and switched to the Surest plan, do I need new prior authorization for medical care or prescriptions?

Probably, yes. Unfortunately, we are not able to transfer your existing prior authorization. We encourage you to fill prescriptions before the end of the plan year to allow time for your provider to submit a new prior authorization. Once you receive your Surest member ID card, call the number on the back of your member ID card to discuss prior authorizations.

Is my provider or pharmacy in-network?

You can verify whether your provider or pharmacy is in-network through the Surest app or by logging in to Benefits.Surest.com. You can also reach Surest Member Services by calling the number on the back of your Surest member ID card.

What does the Surest plan cover?

The Surest plan covers basic health care needs—expected and unexpected, including:

- Preventive care
- Primary and specialty care
- Hospital care
- Urgent and emergency care
- Unexpected care
- Chronic care
- Pharmacy
- Maternity care

For complete details on the services included in your coverage, refer to your plan materials on the Surest app or on Benefits.Surest.com.

Can I keep my same primary care doctor? Am I required to have a primary care provider?

With the Surest plan, it's highly likely that you'll be able to keep your doctor, although you're not required to designate a primary doctor. We have access to the broad, nationwide UnitedHealthcare Choice Plus provider network. Use our search tool on Benefits.Surest.com or in the Surest app to find in-network doctors who meet your needs.

If you see a provider who is not in-network, you may have higher out-of-pocket costs. Out-of-network prices tend to be higher than staying in-network.

Do I need a referral to see a specialist?

No specialist referrals are needed.

What happens if my provider is out-of-network?

The Surest plan includes in-network preventive care; primary and specialty care; urgent, emergency and hospital care; chronic care for long-term and recurring illnesses; and pharmacy.

Treatment from out-of-network providers may cost members significantly more due to often higher out-of-network prices, compared to staying in-network—and some Surest plans don't include any out-of-network coverage for services. Use our search tool on Benefits.Surest.com or in the Surest app for cost comparisons.

Can I access the Surest plan from my cell phone? Is there an app?

Absolutely! We designed the digital Surest plan experience to fit your lifestyle. Download the Surest app (or if you'd rather use your laptop or phone, check out the website or call Surest Member Services) to see what coverage options are available for your specific need before you select your provider. You can also find support information for chronic conditions, see resources for your condition and compare side-by-side options.

Are my dependents covered if they live in different state than I live?

Yes. Surest partners with national and regional provider networks to give you broad access to doctors, clinics, hospitals and pharmacies – including those in different states. Simply change your location within our search tool to find network providers across the country, wherever your family may be.

What's a virtual visit?

Virtual visits are convenient, easy-to-use online or phone visits with treating providers. Virtual visits are performed as a standalone service, not to be confused with a follow-up or related service your treating provider may complete with you online or by phone in tandem with an office visit.

What's a retail clinic?

Retail clinics are clinics located within a retail setting or store such as a drug store or "big box" store. Retail clinics, also known as convenience care clinics, provide a select set of primary care services.

How does the Surest plan work for members who are already sick?

At Surest, we believe individuals with multiple care needs should have the same or greater financial protection as they do under a traditional plan. Under the Surest plan, members enjoy cost clarity. Straightforward prices are presented for critical treatments and procedures, including high-risk birth, cancer treatment and chronic care.

What provider networks do you use?

The Surest plan is powered by the broad, nationwide UnitedHealthcare Choice Plus network.

How does this work with other health insurance?

If you have other existing insurance, call us to discuss how the Surest plan works with that coverage. Each insurance plan has its own design, and we can help you understand how the two plans might work together.

How do I pay for Surest?

You pay for your health insurance coverage through a paycheck deduction that comes out of each paycheck each pay period (referred to as a premium in some plans). You also pay prices for services at the time of use (referred to as a copayment in some plans). You'll know these costs in advance, so you can choose what is best for you. Members often choose the most cost-effective options when they have the ability to see and compare prices up front.

How much do I pay for the care I receive?

Providers charge different amounts. With the Surest plan, you can pay less for doctors with lower direct costs, lower complications and proven effectiveness. Search in the Surest app to find your costs.

What medications are covered and how much do they cost?

Use the Surest app to determine cost and coverage information for medications and see savings opportunities among pharmacy locations.

Does the Surest plan have an out-of-pocket limit? What does it include?

Yes, the Surest plan has an out-of-pocket limit that provides you with a safety net. All prices (sometimes referred to as copays in other plans) for in-network covered services, including routine care, inpatient, outpatient, coverages available with activation, etc., toward your out-of-pocket limit. Your paycheck deductions and costs for non-covered services do not count toward your out-of-pocket limit.

Is there an out-of-pocket limit if I choose out-of-network providers?

Yes. Prices covered for out-of-network services count toward your out-of-network out-of-pocket limit, a separate accumulator from your in-network, out-of-pocket limit.

What happens if I reach my out-of-pocket limit?

Your out-of-pocket limit is the most money you'll pay in a given year for the health care benefits your plan covers. Once you hit this number, we pick up the full cost for covered services the remainder of the plan year.

Your Cost For Coverage

Your Per-Paycheck Cost for Coverage

We do our very best to get the most competitive prices while getting you the best possible coverage. These premiums are the amount you pay for your insurance each paycheck (26 paychecks per year). Remember that they come out before taxes, which lowers your taxable income *(unless you direct otherwise on your signed Enrollment Summary).*

PRN ONE

Medical Plan Premiums			Buy Up Plan Surest
Coverage Level	**Base Plan DU9V-MOD**	**Buy Up Plan DU94-MOD**	**A4000**
Employee Only	$95.50	$417.50	$460.50
Employee + Spouse	$815.50	$995.50	$1,095.50
Employee + Child(ren)	$630.50	$768.00	$847.00
Employee + Family	$1,068.50	$1,301.50	$1,435.50

Annual Notices

This section contains important information about your benefits and rights. Please read the following pages carefully and contact Human Resources with any questions you have.

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 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 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, 2024. Contact your state for more information on eligibility.

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.mycohibi.com/ HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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: 800.967.4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
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: 711| Email: masspremassistance@accenture.com
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: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.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://dma.ncdhhs.gov 919.855.4100

NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 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 RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.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

To see if any other states have added a premium assistance program since January 31, 2024, 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)

Summary of Benefits and Coverage: Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about your health plan option(s). This summary is in a standard format, as regulated by the Patient Protection and Affordable Care Act, to help you compare options. The standard format enables readers to conduct an apples-to-apples comparison.

We are pleased to provide you with the Summary of Benefits and Coverage (SBC) for your plan(s) along with the Health and Human Services uniform glossary that is to be paired with the SBC when distributed to employees.

The SBC(s) are available on the Home Page of: www.EmployeeNavigator.com. The glossary can be found here:
https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf

A complimentary paper copy is available upon request by calling Human Resources 386.658.5592. Participants and beneficiaries may request an electronic SBC from their employer.

The Summary of Benefits and Coverage (SBC) may not be all-inclusive. Arthur J. Gallagher & Co. and Gallagher Benefit Services strives to provide our customers with accurate SBCs but rely on the issuer for accuracy. It is ultimately the responsibility of the issuer and employer to ensure accuracy and furnish to their employees in accordance with the SBC regulations.

Notice of Availability of HIPAA Privacy Notice

Advent Christian Village Health Plan

Protecting Your Health Information Privacy Rights 7/1/2024

Advent Christian Village is committed to the privacy of your health information. The administrators of the Advent Christian Village Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting 386.658.5592.

HIPAA Notice of 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 towards 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). You will be required to submit a signed statement when other coverage is the reason for waiving enrollment originally.

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.

In addition if you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan.

However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or obtain more information, contact Human Resources at 386.658.5592 or psmythe@acvillage.net.

Newborn's and Mother's Health Protection Act: Statement of Protection

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

Notice of Continuation Coverage Rights under COBRA: (Initial or General Notice)

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

When is COBRA continuation coverage available?

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources at 386.658.5592.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Advent Christian Village Health Plan

Pam Smythe, Human Resources Director

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MEDICARE PART D DISCLOSURES

Medicare Part D Creditable Coverage Disclosure for UnitedHealthcare plans DB7U-m, DEOA-M and Surest Plan A4000

Important Notice from Advent Christian Village about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Advent Christian Village and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Advent Christian Village has determined that the prescription drug coverage offered by the Advent Christian Village Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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 Advent Christian Village coverage may be affected. You can keep your coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Advent Christian Village coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Advent Christian Village 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 or call the number on the back of your ID card.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

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:	7/1/2024
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This benefit summary prepared by

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