ACV

ADVENT CHRISTIAN VILLAGE
AT DOWLING PARK

2025 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.

Table of Contents

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 19-20 for more details.

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 7/1/2025 – 6/30/2026.

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, 2026.**

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.

Important information for this upcoming Open Enrollment:

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.

For Enrollment and Benefit Information:

Please go to: https://ACVillage.mybenefitsinfo.com

or scan this QR code:

What to expect during my call:

Your call with the Benefits Specialist will take on average about 15/20 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 **Monday – Friday, June 2nd – June 13th from 9am to 8pm EST.** Please call (321) 249.3211 to speak with a benefit specialist and enroll in your benefits.

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, 2026. The enrollment will take place through our benefit call center with a benefits specialist. Please call (321) 249.3211 **Monday – Friday, 9am to 8pm EST**, to speak with a benefit specialist and enroll in your benefits.

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 Florida Blue, 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.**

Comparison	Base Plan	Buy Up Plan
	Blue Options HSA 5192/5193	**Blue Options 3766**
	Nationwide Florida Blue Choice Plus Network	**Nationwide Florida Blue Choice Plus Network**
	Base Plan Lower paycheck premiums	Buy Up Plan Higher paycheck premiums
	Higher maximum out-of-pocket costs	Lower maximum out-of-pocket costs
	Preventive Care covered 100%	Preventive Care covered 100%
	Traditional Plan with in- and-out-of-network coverage	Florida Blue group number for ACV: 49594. Group Customer Service number: 800.352.2583. www.FloridaBlue.com

Florida Blue

Website: www.floridablue.com/

Phone: 800.352.2583

Policy Number:

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 Florida Blue. 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.

Medical Plan Summaries

	Blue Options 5192/5193		Blue Options Plan 3766	
In-Network Coverage	**BASE PLAN**		**BUY UP PLAN**	
Deductible DED	Individual: $2,500 Family: $5,000		N/A	
Coinsurance *(your share)*	20% after DED		20%	
Out-of-Pocket Maximum	Individual: $6,850 Family: $11,600		Individual: $2,500 Family: $5,000	
Preventive Care *(Physician Office)*	100% covered		100% covered	
E-Visit / Primary Doctor Visit	DED then 20%		$20 Primary/ $0 E-Visit	
E-Visit / Specialist Doctor Visit	DED then 20%		$40	
Independent Lab	No Charge after Deductible		$0	
Independent X-Ray	DED then 20%		$50	
Complex / Advanced Imaging *(MRI, CT, PET, etc.)*	DED then 20%		$150	
Urgent Care Center	DED then 20%		$45	
Emergency Room	DED then 20%		$100	
Inpatient Hospitalization	DED then 20%		$600 Copay per Admission	
Outpatient Surgery / Services	DED then 20%		ASC $100 Copay per Visit/ Hospital: $200 Copay per Visit	
Out-of-Network Coverage *(plus balance billing)*				
Deductible DED	$5,000 | $10,000		$500-$1,500	
Coinsurance *(your share)*	40% after DED		50%	
Out-of-Pocket Maximum	$11,600 | $23,200 *(plus balance billing)*		Out-Of-Network: $5,000 Per Person/$10,000 Family.	
Prescription Drugs *(in-network)*	Retail	Mail Order	Retail	Mail Order
Generic	DED then $10	DED then $25	$10	$25
Preferred Brand	DED then $50	DED then $125	$30	$75
Non-Preferred Brand	DED then $80	DED then $200	$50	$125

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 are eligible to open an HSA if: • You enroll in one of the high deductible health plans (HDHP): Please remember that you will need to enroll in our Florida Blue Choice Plus Plan HSA 5192/5193 or Florida Blue Plan 3766. 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: • $4,300 if enrolled in employee only medical coverage • $8,550 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 **Florida BlueOptions Plan 5192/5193**, 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**
$4,300 2025 IRS maximum	**$8,550** 2025 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:

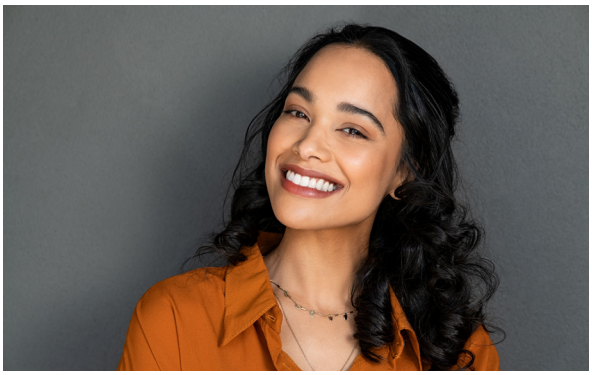
If you are eligible to contribute to a Health Savings Account you will need to open a Health Savings Account (HSA) at First Federal Bank of Florida. Once the account is opened, you will need to provide HR with the Account Number and per pay period contribution amount.

First Federal Bank of Florida

Website: www.ffbf.com

Phone: 386.362.3433 ext. 1985

The HSA Advantage



Jill has an individual HSA

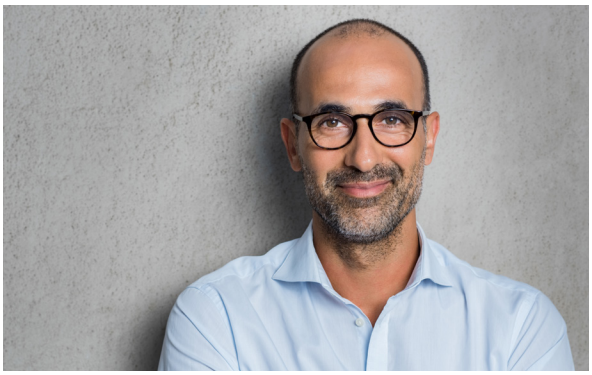
She saves directly from her paycheck into her HSA

$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 Florida BlueOptions Plan 5192/5193 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.

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).*

PLAN ONE

Medical Plan Premiums		
Coverage Level	**Base Plan HSA 5192/5193**	**Blue Option Plan 3766**
Employee Only	$91.31	$202.36
Employee + Spouse	$743.53	$996.73
Employee + Child(ren)	$652.22	$874.32
Employee + Family	$1,043.56	$1,398.91

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 March 17, 2025. 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: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/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/health-care-coverage/ 800.657.3672
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. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 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 March 17, 2025, 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 7/1/2025

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

10680 Dowling Park Drive, Live Oak, FL 32060

386.658.5592

psmythe@acvillage.net

MEDICARE PART D DISCLOSURES

Medicare Part D Creditable Coverage Disclosure for Florida Blue 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.

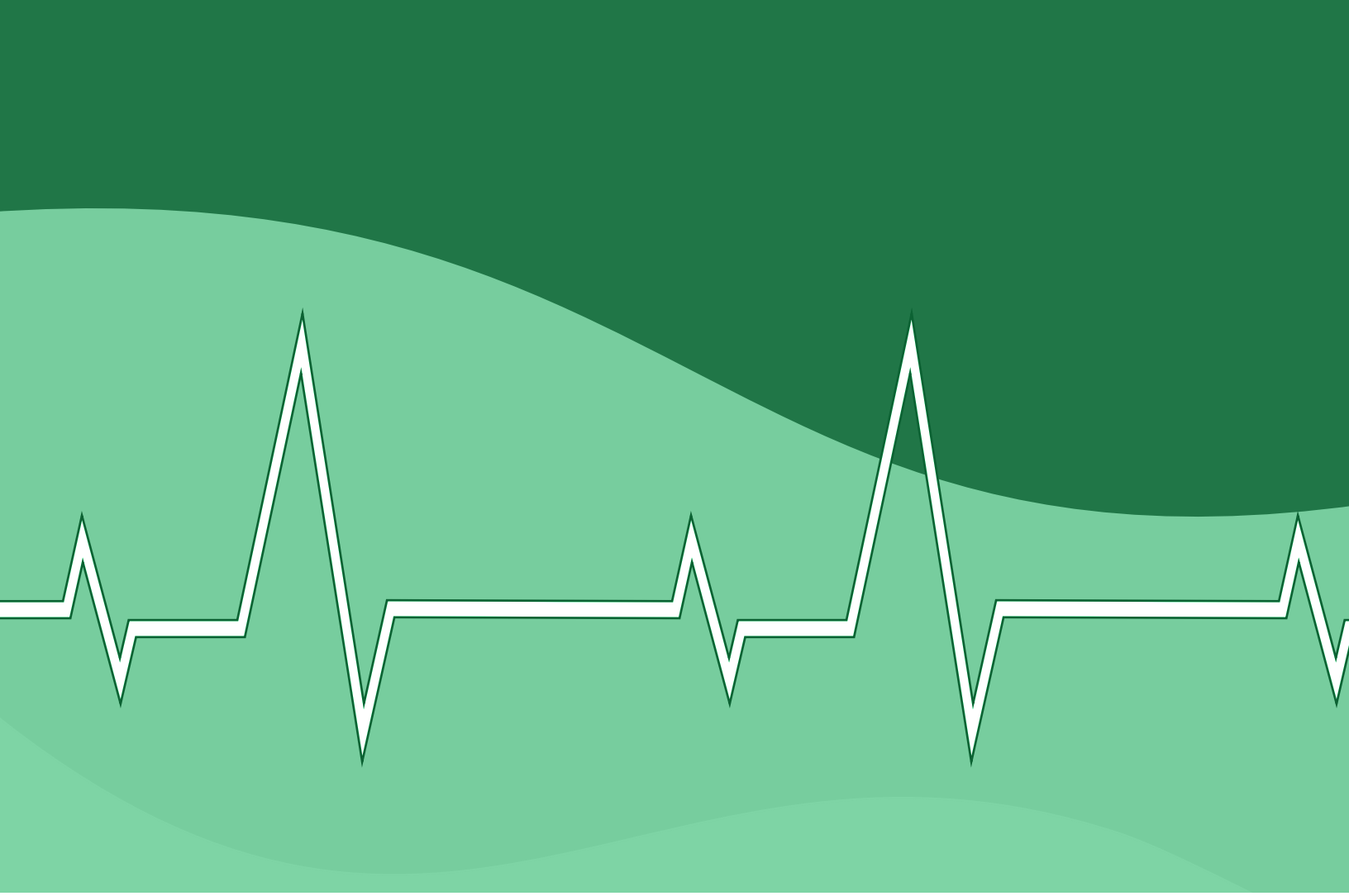
For More Information About Medicare Prescription Drug Coverage:

- 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:	7/1/2025
Name of Entity/Sender:	Advent Christian Village
Contact--Position/Office:	Pam Smythe, Human Resources Director
Address:	10680 Dowling Park Drive, Live Oak, FL 32060
Phone Number:	386.658.5592



This benefit summary prepared by

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Insurance | Risk Management | Consulting

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