



Benefits Staff



2026



CHRIST FELLOWSHIP
Staff





Dear valued employee,

We are happy to provide you with this Benefit Guide to summarize your employee benefits for the 2026 plan year.

Christ Fellowship Church recognizes that benefits are an important part of your life as an employee. Our benefits program will help you choose what works best for your needs and your budget.

This document is not just an enrollment guide; it is a resource for you and your family to use throughout the year. Inside you will find a summary of each benefit plan and helpful tips you may not have known about in the past. This guide is designed to break down the insurance benefits to help you make an informed decision regarding the selection and management of the services and benefits provided to you as an employee of Christ Fellowship Church.

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 36–39 for more details.

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IMPORTANT NOTICE TO EMPLOYEES:

This Benefit Guide provides a general description of the various benefits available to you through the Christ Fellowship Church Employee Benefits program. The details of these plans and policies are contained in the official plan and policy documents.

This guide is meant only to cover the major points of each plan or policy, for illustrative purposes only. It does not contain all of the facts regarding coverage, limitations, or exclusions that are contained in the policy documents. In the event of a conflict between the information in this guide and the formal policy documents, the formal documents will govern.

SUMMARY OF BENEFITS & COVERAGE (SBC) NOTICE

Attached are your Federally Mandated Summary of Benefits and Coverage (SBC) documents for all offered medical plan options. In the following pages you will find simpler formatted, easy to understand plan summaries which provide a general description of the various benefits available to you through the Christ Fellowship Church Employee Benefits Program.

To access your SBCs you may scan or click the QR code below with your phone.



If you would prefer a printed copy, please contact your HR department.

ELIGIBILITY

FOR YOU

All full-time employees working an average of **30 hours** per week are eligible to enroll in benefits. For specific details, please refer to the plan documents.

New full-time employees' benefits for all lines of coverage will begin on the **1st of the month following date of hire.**

FOR YOUR FAMILY

Legislation regulates eligibility requirements for dependent coverage on Medical insurance plans. It is important for everyone to understand what constitutes eligibility and what the implications could be for not following the eligibility guidelines.

Examples of Eligible Dependents includes:

- Legal spouse
- Dependent children
- Disabled children

Healthcare reform legislation restricts a plan or issuer from denying coverage for a child under age 26 based on any of the following factors:

- Financial dependence on the employee
- Residency with the employee
- Student status
- Marital status
- Employment status

DEPENDENT COVERAGE

When you first enroll, and/or if you change coverage mid-year due to a qualifying event, you may be asked to provide the applicable documents from the following list:

Spouse Verification Documentation:

Marriage certificate

Child Verification Documentation:

Birth certificate, court document awarding custody or requiring coverage

You can provide these documents to Human Resources.

The adult child's spouse is not eligible for coverage. In some circumstances and for a limited time period, the newborn of an enrolled adult dependent may be covered. For adult children age 26, the State of Florida has adopted legislation allowing for extended coverage up to age 30, but under more limited conditions such as the child must reside in Florida or be a part-time or full-time student and must be unmarried with no dependent child(ren) of his/her own. In addition, they cannot be covered under another group or franchise plan, student or individual plan, or be Medicare eligible.

HOW TO ENROLL

- » Log into your ADP account
- » Navigate to the "Myself" Tab, then select "Benefits", then "Enrollments"
- » Click the "Start Enrollment" button inside the Open Enrollment box
- » Make your Benefits selections and add dependents under "Manage Dependents" tab
- » Review a summary of your selections, then click "Submit Enrollment"

PLEASE NOTE:

You will continue to have access to the ADP Benefits portal to update your HSA contribution amount and 403b contributions at any time throughout the year.





ENROLLMENT

When can I apply for my benefits?

- During your initial new hire eligibility period
- During the annual open enrollment period
- Within 30 days of a qualified life event

MID-YEAR ENROLLMENT CHANGES – Section 125 Cafeteria Plan

Employees receive the tax benefits of a Section 125 Cafeteria Plan. This plan allows you to pay for your employee benefits on a pre-tax basis to be deducted from your paycheck.

When you elect to pay for these authorized benefits pre-tax, you save because you are paying less in taxes. You do not pay Federal Income or Social Security taxes on these designated benefit dollars. Therefore, you lower your taxable income. This will allow you to take home more of your paycheck, decreasing the net cost of the benefit you are purchasing.



IRS regulations state that benefit choices cannot be changed in the middle of a plan year unless you experience a qualifying life event.

Changes must be reported within 30 days of the actual event.

Some common qualifying events may include:

- Marriage, divorce or death of a spouse or child
- Birth, adoption or change in legal custody of a child
- Gaining or Losing of other coverage including a change in your spouse's employment status affecting benefits
- Change in Medicare or Medicaid entitlement
- FMLA or Military Leave

To determine if any of these apply to you, please check with your Human Resources representative.

PLEASE NOTE:

The IRS does not consider financial hardship a qualifying event to drop coverage.

MEDICAL INSURANCE

CIGNA | Group #00627830 | 866-494-2111 | www.mycigna.com

Scan or Click the QR code to access the carrier's website >>>



IN-NETWORK MEDICAL BENEFITS	SUREFIT HSA	HSA OAP IN
Deductible (Individual / Family)	\$2,500 / \$5,000	\$2,500 / \$5,000
Is Deductible Calendar Year or Policy Year?	Calendar Year	Calendar Year
Is Deductible Embedded or Non Embedded	Non-Embedded	Non-Embedded
Out of Pocket Maximum (Individual / Family)	\$5,000 / \$10,000 (\$6,850 max per family member)**	\$5,000 / \$10,000 (\$6,850 max per family member)
Coinsurance	20%	20%
Prescription Drugs	\$10* / \$50* / \$80* *after Deductible	\$10* / \$50* / \$80* *after Deductible
Mail Order Drugs (90 Day Supply)	\$30* / \$150* / \$240* *after Deductible	\$30* / \$150* / \$240* *after Deductible

PHYSICIAN OFFICE VISITS

Primary Care Physician	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Virtual Visits	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Specialist	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Referral Needed for Specialist?	No	No

PREVENTIVE CARE

Routine Adult Physical Exams	Covered 100%	Covered 100%
Well Woman Exams		
Routine Mammograms and Colonoscopy		
Well Child Exam & Immunizations		

DIAGNOSTIC / LABORATORY

Independent Clinical Lab (Blood Work)	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Independent Diagnostic Testing Facility (X-rays)	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Advanced Imaging (MRI, PET, CT Scan, Nuclear Medicine)	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance

HOSPITALIZATION / OUTPATIENT SERVICES

Inpatient Hospitalization (Facility)	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Outpatient Surgical Care (Hospital Facility)	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Emergency Room	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance
Urgent Care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance

OUT-OF-NETWORK BENEFITS

OUT-OF-NETWORK

OUT-OF-NETWORK

Deductible (Individual / Family)		
Out of Pocket Maximum (Individual / Family)	Emergency Only	Emergency Only
Coinsurance		

EMPLOYEE SEMI-MONTHLY (24) PAYROLL DEDUCTIONS

Employee Only	\$24.72	\$46.14
Employee + Spouse	\$184.13	\$233.20
Employee + Child(ren)	\$119.87	\$157.80
Employee + Family	\$272.12	\$336.46

This information summarizes the Christ Fellowship medical benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

MEDICAL INSURANCE

CIGNA | Group #00627830 | 866-494-2111 | www.mycigna.com

Scan or Click the QR code to
access the carrier's website
>>>



IN-NETWORK MEDICAL BENEFITS	SUREFIT COPAY	OAPIN COPAY	OAP COPAY
Deductible (Individual / Family)	\$4,500 / \$6,500	\$4,500 / \$6,500	\$2,500 / \$5,000
Is Deductible Calendar Year or Policy Year?	Calendar Year	Calendar Year	Calendar Year
Is Deductible Embedded or Non Embedded	Embedded	Embedded	Embedded
Out of Pocket Maximum (Individual / Family)	\$6,350 / \$12,700	\$6,350 / \$12,700	\$5,000 / \$10,000
Coinsurance	30%	30%	20%
Prescription Drugs	\$10 / \$50 / \$80	\$10 / \$50 / \$80	\$10 / \$50 / \$80
Mail Order Drugs (90 Day Supply)	\$30 / \$150 / \$240	\$30 / \$150 / \$240	\$30 / \$150 / \$240
PHYSICIAN OFFICE VISITS			
Primary Care Physician	\$40	\$40	\$35
Virtual Visits	\$10	\$10	\$10
Specialist	\$65	\$65	\$60
Referral Needed for Specialist?	No	No	No
PREVENTIVE CARE			
Routine Adult Physical Exams	Covered 100%	Covered 100%	Covered 100%
Well Woman Exams			
Routine Mammograms and Colonoscopy			
Well Child Exam & Immunizations			
DIAGNOSTIC / LABORATORY			
Independent Clinical Lab (Blood Work)	\$0	\$0	\$0
Independent Diagnostic Testing Facility (X-rays)	\$0	\$0	\$0
Advanced Imaging (MRI, PET, CT Scan, Nuclear Medicine)	\$250	\$250	\$250
HOSPITALIZATION / OUTPATIENT SERVICES			
Inpatient Hospitalization (Facility)	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	Deductible + 20% Coinsurance
Outpatient Surgical Care (Hospital Facility)	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	Deductible + 20% Coinsurance
Emergency Room	\$300	\$300	\$300
Urgent Care	\$65	\$65	\$65
OUT-OF-NETWORK BENEFITS			
Deductible (Individual / Family)	OUT-OF-NETWORK	OUT-OF-NETWORK	OUT-OF-NETWORK
Out of Pocket Maximum (Individual / Family)	Emergency Only	Emergency Only	\$5,000 / \$10,000
Coinsurance			\$10,000 / \$20,000 50%
EMPLOYEE SEMI-MONTHLY (24) PAYROLL DEDUCTIONS			
Employee Only	\$60.40	\$89.00	\$114.00
Employee + Spouse	\$227.11	\$295.17	\$354.69
Employee + Child(ren)	\$161.88	\$214.49	\$260.52
Employee + Family	\$316.50	\$405.74	\$483.77

This information summarizes the Christ Fellowship Medical benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

WELCOME TO CIGNA

Make the most of your plan with this quick guide

Your life is busy, but that doesn't mean it has to be complicated. At Cigna, we want to help. That's why we offer programs and services to help make it easier to be your healthiest – both body and mind.

Get to know your plan. The more you learn, the better prepared you can be to make choices about your health and health spending.



Together, all the way.®



Offered by: Cigna Health and Life Insurance Company.



myCigna

On **myCigna.com** and through the myCigna App, you can:

- › Find in-network doctors and medical services
- › Review coverage
- › Manage and track claims
- › View, print or fax your Cigna ID card
- › See cost estimates for medical procedures and prescription drugs
- › Compare quality-of-care information for doctors and hospitals
- › Compare prescription costs for 30- and 90-day medications and see if a lower-cost drug alternative is available
- › Find retail pharmacies that offer a 90-day supply
- › Access a variety of health and wellness tools and resources, including:
 - Online health assessment
 - Apps & Activities interactive health goal tracking program
 - My Health Assistant digital lifestyle coaching
- › Sign up to receive alerts when new plan documents are available



Cigna One Guide

Combining digital technology with our personalized customer service, your Cigna One Guide team is here to help you:

- › Resolve health care issues
- › Save time and money
- › Get the most out of your plan
- › Find the right hospitals, dentists and other health care providers in your plan's network
- › Get cost estimates
- › Understand your bills
- › Navigate the health care system

Get it all in the way that's most convenient for you.

- › Call the number on your Cigna ID card
- › Access the Cigna One Guide support tool by downloading the myCigna App⁴



Specialty medications

We can help you understand, manage and treat complex conditions that require a specialty medication. Our therapy management teams, made up of health advocates with nursing backgrounds as well as pharmacists, are specially trained to help with your specific needs.

- › Personalized, 24/7 support
- › Condition-specific education on medication therapy and side effects
- › Help with the medication approval process
- › Financial assistance programs, if needed

For more information, call **800.351.3606**.



Preventive care

Getting and staying healthy is important. That's why eligible preventive care services are covered at no additional cost to you when you receive them from a doctor who participates in your plan's network. Covered preventive care services include, but are not limited to:²

- › Screenings for blood pressure, cholesterol and diabetes
- › Clinical breast exams and mammograms
- › Pap tests
- › Testing for colon cancer

Your physical and emotional health are connected. So, when you go for your annual check-up, be sure to talk with your doctor about what you're feeling both physically and emotionally.

Go to **myCigna.com** to see a full list of services covered under preventive care.



Health Information Line

Speak with a clinician who can help you understand and make informed decisions about health issues you are experiencing, at no extra cost.

Get help choosing the right care in the right setting at the right time, whether it's reviewing home treatment options, following up on a doctor's appointment or finding the nearest urgent care center in your plan's network. Just call the number on your Cigna ID card anytime day or night.



Virtual care

Convenient care, where and when it works for you.

With virtual care, you and your covered family members can get medical and behavioral care from the comfort and safety of home via video or phone. And, it's super easy to use.

Right from your phone, tablet or computer, you can:

- › Connect with board-certified doctors and pediatricians for minor medical conditions, such as seasonal allergies, cold and flu, or upper respiratory infections
- › Schedule appointments with licensed therapists or psychiatrists for behavioral or mental health conditions, such as stress and depression
- › Have a prescription sent directly to your pharmacy, if appropriate

Contact your in-network provider or connect 24/7 with an MDLIVE¹ provider on **myCigna.com**.

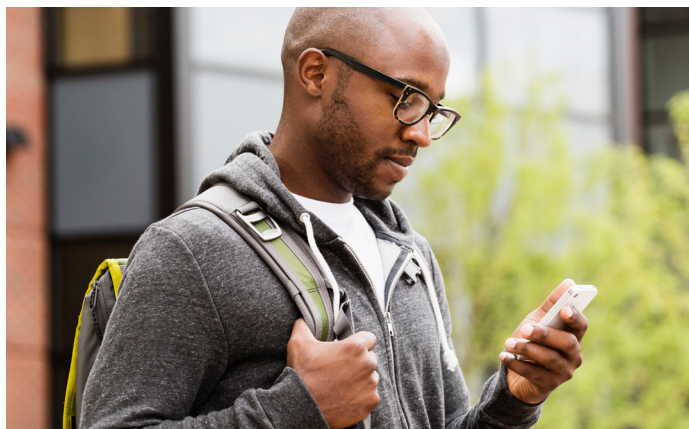
Wellness screenings.

With virtual wellness screenings through MDLIVE, getting your preventive check-up is more convenient than ever. Plus, it's covered at no cost to you, as part of your preventive care benefits through your health plan.²

How it works, step by step:

- › Complete your MDLIVE online health assessment
- › Choose an in-network lab and schedule an appointment⁵
- › Choose an MDLIVE provider and schedule your virtual visit
- › Go to your lab appointment; you'll receive a notification when the results are available in the MDLIVE customer portal
- › Attend your virtual visit; you'll receive a summary of your screening results for your records

Access virtual care through myCigna.com anytime.



Behavioral health - online and in person

For behavioral health and substance use support, get access to quality care that's convenient too. You have access to the Cigna Behavioral Health network of providers. To find online care:

- › Go to **myCigna.com** > Find Care & Cost
- › Search for "Virtual Counselor" under "Doctor by Type"
- › Call to make an appointment with your selected provider

Online visits with Cigna Behavioral Health network providers cost the same as in-office visits. Costs vary by plan.⁶



In-network care

Save money when you use doctors, hospitals and health facilities that are part of your plan's network. Chances are there's a network doctor or facility right in your neighborhood. It's easy to find quality, cost-effective care at **myCigna.com**.



Care management programs

Take advantage of our personal services to help you with your personal health needs. A Cigna case manager, trained as a nurse, can work closely with you and your doctor to check on your progress. You can get help with conditions and illnesses such as cancer, end-stage renal disease, neonatal care and pain management.

You also have access to My Health Assistant on **myCigna.com** to help you:

- › Control stress
- › Lose weight and eat better
- › Enjoy exercise
- › Quit tobacco
- › Manage diabetes, COPD, asthma and other conditions

Enroll online today. Go to **myCigna.com** > Wellness > My Health Assistant - Online Coaching Program.

TIPS TO HELP YOU SAVE MONEY

1

Find where to get prescription drugs

- › Find the complete list of covered medications on **myCigna.com**
- › Remember generics offer the best value
- › Know what brand-name drugs are covered in your plan
- › Ask your doctor about a 90-day supply for your maintenance medication(s) through our home delivery pharmacy service⁶

2

Know where to go for care

- › Use an emergency room for true emergencies
- › Don't wait: Locate an in-network convenience care clinic or urgent care center near you, before you need it
- › Don't be fooled: Some emergency rooms look like urgent care centers, so know what type of facilities are in your area

3

Choose your health care provider

- › Know which providers are in your network by going to **myCigna** > Find Care & Costs
- › Opt to connect with a board-certified doctor, therapist or psychiatrist via video or phone¹
- › Use in-network national labs to help save money

4

Be proactive in your health

- › Use the health improvement tools available to you
- › Get information on the cost of medications and treatments to avoid surprises
- › Use your preventive care benefits, learn your core health numbers and get more information at **Cigna.com/TakeControl**

Find your way to better health.

Get more information on all the programs that are available to you.



Visit **myCigna.com**.



Download the **myCigna App**.⁴



Call the **24/7 customer service number on the back of your ID card**.



1. MDLIVE is an independent company/entity and is not affiliated with Cigna. The services, websites and mobile Apps are provided exclusively by MDLIVE and not by Cigna. Providers are solely responsible for any treatment provided. Video chat may not be available in all areas or with all providers. MDLIVE services are separate from your health plan's provider network and may not be available in all areas. A primary care provider referral is not required for MDLIVE services.

2. Coverage for preventive care may vary, depending on the terms of your specific medical plan. Actual covered services may vary, depending on your age, gender and medical history. Not all preventive care services are covered. For example, immunizations for travel are generally not covered. For a complete list of covered preventive care services, contact your Cigna representative.

3. Not available with all plans.

4. The downloading and use of any mobile App is subject to the terms and conditions of the App and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

5. Limited to labs contracted with MDLIVE for virtual wellness screenings.

6. Plans vary; please check your plan materials for more information on what is covered under your plan.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans have exclusions and limitations. For costs and complete details of coverage, see your plan documents. Providers that participate in the Cigna network are not agents of Cigna and are solely responsible for any treatment provided.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., Tel-Drug, Inc., and Tel-Drug of Pennsylvania, L.L.C. Policy forms: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al., (CHLIC). The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. All pictures are used for illustrative purposes only.

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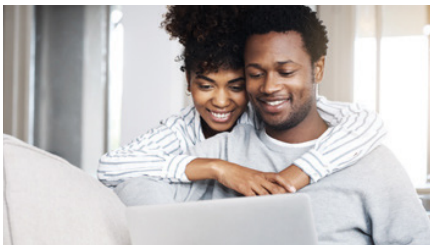


QUALITY CARE. AFFORDABILITY. IT'S ALL RIGHT HERE.

Cigna **SureFit**—South Florida

It's a health plan designed to be more personal and more affordable. Cigna SureFit® is built around a local network of quality doctors and hospitals in your community who work together for your health and well-being, to provide coordinated care and help lower costs.

Finding care in your Cigna SureFit—South Florida network



Choose an in-network PCP

When you enroll in the Cigna SureFit health plan, you and each covered family member must choose an in-network primary care provider (PCP). If you don't, we will assign one to you. You can change your PCP at any time by **calling your Cigna One Guide® team** or visiting **myCigna.com®**.



PCP coordinates care

Your PCP is responsible for coordinating your care and for directing you to an in-network specialist! They will collaborate with in-network specialists and hospitals to deliver whole-health care, as a team. You must stay in-network (except for urgent or emergency care²); otherwise, you may be responsible for the full cost of your care.



Access care

Your local network gives you access to more than 13,000 in-network primary care and specialty providers, hospitals and other facilities.³ To find in-network providers, go to **myCigna.com** or **call your Cigna One Guide team**. During enrollment, go to **Cigna.com**.

[See back for more information.](#)

Together, all the way.®



Offered by: Cigna Health and Life Insurance Company.

Cigna **SureFit**—South Florida offers access to **13,000+** providers,³ including:

Primary Care Physician groups:

- › Baptist Health Quality Network
- › Cleveland Clinic Physician Group
- › Holy Cross Physician Partners
- › Memorial Health Network
- › Orange Accountable Care of South Florida
- › Palm Beach Accountable Care Organization
- › Pediatric Associates
- › PrimeHealth Physicians
- › Sunrise Medical Group
- › Tenet Florida Physicians Services
- › Tenet Health System
- › University of Miami Physician Group

Hospital systems:

- › Associates MD Medical Group
- › Baptist Health South Florida
- › Bethesda Memorial Hospital
- › Boca Raton Regional Hospital
- › Broward Health
- › Cleveland Clinic Florida
- › Coral Gables Hospital
- › Delray Medical Center
- › Good Samaritan Medical Center
- › Hialeah Hospital
- › Holy Cross Hospital
- › Jackson Health System
- › Jupiter Medical Center
- › Martin Health System

- › Medical Specialists of the Palm Beaches
- › Memorial Healthcare System
- › Mount Sinai Medical Center
- › North Shore Medical Center
- › North Shore Medical Center – FMC
- › Palm Beach Gardens Medical Center
- › Palmetto General Hospital
- › St. Mary's Hospital
- › Tenet Hospital
- › University of Miami Health System
- › Wellington Regional Medical Center
- › West Boca Medical Center

24/7/365 VIRTUAL CARE

On-demand access to U.S.-based doctors by phone or video.⁴ Register through myCigna.com.

URGENT AND EMERGENCY CARE

Access to thousands of urgent care facilities,³ and worldwide coverage for emergency care.²

CIGNA ONE GUIDE SERVICE IS HERE TO HELP

Our highly personalized, intelligent support can help you find in-network providers, choose a PCP and understand how to get the most out of your plan.

DURING ENROLLMENT

Call **855.244.6216**
or go to **Cigna.com**

ONCE YOUR PLAN BEGINS

Call the number on
the back of your
ID card

Go to
myCigna.com

Download the
myCigna® App⁵



1. Except to see an in-network OBGYN or for behavioral health services.

2. For emergency and urgent care services as defined by your plan documents.

3. As of April 2021. Subject to change. For the most up-to-date listing of providers and hospitals visit Cigna.com.

4. Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas. A Primary Care Provider referral is not required for this service.

5. The downloading and use of the myCigna app is subject to the terms and conditions of the app and the online store from which it is downloaded. Standard mobile phone carrier and data charges apply.

The providers that participate in the Cigna network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, contact your Cigna representative.

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HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care¹ from MDLIVE.®



It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost² to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities³

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology⁴

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours



3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:



Access MDLIVE by logging into myCigna.com and clicking on “Talk to a doctor.” You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

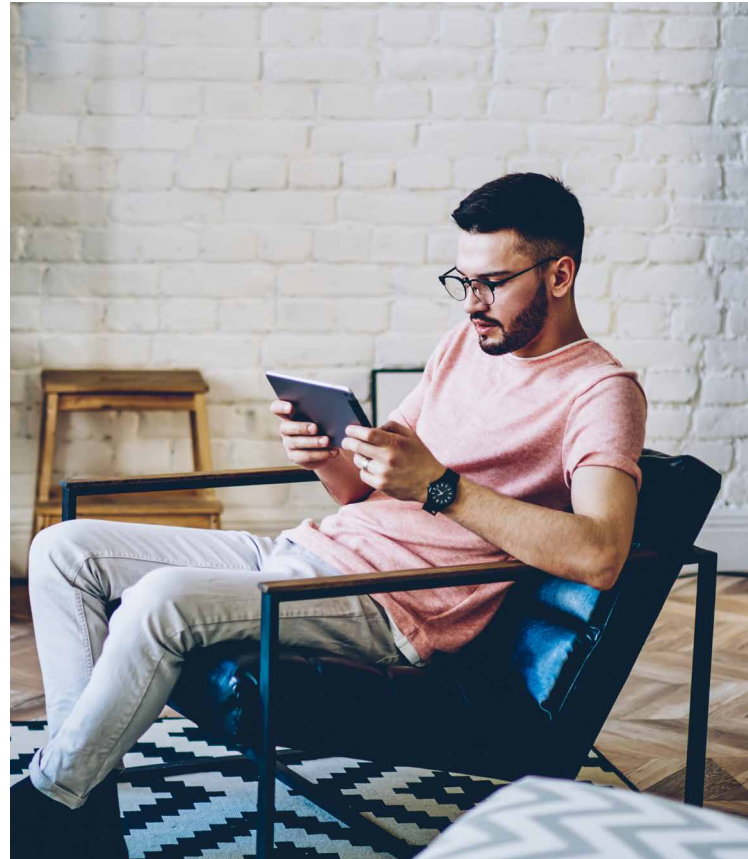


Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE



Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.



Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®



1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost \$0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

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KNOW YOUR OPTIONS

5 Healthcare Options

to help you make the best decision for your medical needs

Virtual Visits \$

24/7/365 access to a doctor through the convenience of phone or video consults

You can receive care for:

Cough, cold & flu • Allergies • Skin problems

• Sinus problems • Minor fevers

Convenience Care Clinic \$

Your condition is not urgent or an emergency

You can receive care for:

Cough, cold & flu • Pink eye • Urinary tract infections

Ear infections • Head lice • Insect bites

Minor burns, cuts, and scrapes • Sprains and strains

Doctor's Office \$\$

Routine care or treatment for a current health issue

You can receive care for:

Routine checkups • Immunizations • Preventive services

Manage medications

Urgent Care Center \$\$\$

You need medical care fast for a non-emergent medical issue

You can receive care for:

Migraines • Severe back pain • Vomiting and diarrhea

Minor broken bones • Asthma attacks • Severe cough

Animal bites • Wounds requiring stitches

Emergency Room \$\$\$\$

For a true medical emergency that results in serious jeopardy to your health, impairment of bodily functions or organs

You can receive care for:

Head trauma or loss of consciousness • Chest pain

Numbness or difficulty speaking • Severe abdominal pain

Coughing or vomiting blood • Severe bleeding and burns





WHAT IS A PREVENTIVE EXAM?

also called a "Physical," "Wellness Exam" or "Annual Exam"

A Preventive Exam is a scheduled medical evaluation of an individual that focuses on preventive care. It includes age and gender-appropriate history, a physical examination, a review of risk factors and plans to reduce them, and the ordering of appropriate immunizations, screening laboratory tests, ultrasound or diagnostic procedures.

What does this mean?

A Preventive Exam is an annual exam covering all prevention and health maintenance issues related to age, sex, and family history; it is a "Well Exam". A Preventive Exam is NOT a follow-up visit or a problem-based visit; it cannot be expected to deal with everything bothering you since your last visit.

A SECOND Service May Be Necessary

If time and the provider's judgment allow, new problems or chronic disease follow-up issues may be addressed as a SECOND service during a Preventive Exam visit.

NOTE: Your insurance plan may require a co-pay or apply charges to your deductible for a SECOND service provided during a Preventive Exam visit.

For more information on Preventive Health such as free services offered to you, visit www.hhs.gov/healthcare/about-the-aca/preventive-care/index



PRESCRIPTIONS RX

There are other sources to help cover the cost of antibiotics, HBP medicine, cholesterol, or supplies for diabetes.



Works with or without insurance

Create an account at [CostPlusDrugs.com](https://www.costplusdrugs.com) and have your prescription from your provider submitted to [CostPlusDrugs.com](https://www.costplusdrugs.com).

The prescription will be sent via mail if it is one they carry. You must determine this before submitting your prescription as availability changes frequently.

A complete list of drugs is available at [CostPlusDrugs.com/medications](https://www.costplusdrugs.com/medications)

Mail order Rx



Works with or without insurance

\$5 per month

(For Prime members only)

You must create an account at [amazon.com](https://www.amazon.com) or use your current Amazon Prime membership. Your provider must submit your prescription to Amazon.

The prescription will be sent via mail if it is one they carry. You must determine this before submitting your prescription as availability changes frequently.

A complete list of drugs is available at [pharmacy.amazon.com/how-it-works](https://www.pharmacy.amazon.com/how-it-works)

Mail order Rx



Outside of Insurance - leverages coupons for your prescription drug up to 50% off.

You must download the app and create an account at [GoodRx.com](https://www.goodrx.com). The app is FREE!

The downfall of GoodRx purchases is they do NOT accumulate toward your deductible or OOP expense as they are not run through the insurance. The upside is you can generally go to local retail merchants that may already have your Rx on file or easily transfer it from another retail pharmacy (e.g. Walgreens to CVS, etc).

A complete list of drugs is available at [goodrx.com](https://www.goodrx.com) or the GoodRx app.

Local Rx

FLEXIBLE SPENDING ACCOUNT (FSA)

WAGE WORKS

Flexible Spending Accounts (FSAs) have become a popular vehicle for reducing rising costs. By contributing pre-tax dollars into an FSA, you can save an average of 30% on eligible expenses every year. You may be eligible to participate in the following spending accounts:

- » **General Purpose Health Care Flexible Spending Account:** Employees use pre-tax dollars to pay for healthcare-related expenses including medical, dental and vision insurance deductibles, co-payments, certain over-the-counter medications, and medical supplies not covered by their insurance plans. Visit the [FSAStore.com](https://www.fsastore.com) for a list of FSA eligible/ineligible expenses.
- » **Dependent Care Flexible Spending Account:** Employees use pre-tax dollars to be reimbursed for work-related day care expenses incurred for you (and your spouse) to work. A qualified dependent includes children up to age 13 or a mentally or physically disabled dependent incapable of self-care and claimed on your taxes.
- » Christ Fellowship provides an HSA contribution in the amount of \$750 per plan year to employees enrolled in an employee-only plan or \$1,500 to employees enrolled in a non-single plan coverage.

MEDICAL FSA vs DEPENDENT CARE FSA

	MEDICAL FSA	DEPENDENT CARE FSA
Contribution limit	\$3,400 per plan year (1/1/2026-12/31/2026)	\$7,500 per calendar year (1/1/2026-12/31/2026) (\$3,750 if you and your spouse file separate tax returns)
Medical plan rules ¹	Pre-tax contributions to a General Purpose Health Care FSA can only be made if you are not enrolled in a high-deductible health plan (HDHP) such as a Health Savings Plan (HSA)	Pre-tax contributions to a Dependent Care FSA can be made no matter what health care coverage you have
Frontloaded	YES You can access your total annual contribution right away	NO Funds are available only as contributed ²
Funds are Use it or Lose it ³	YES You forfeit any unused funds if claims incurred during the plan year are not filed by the deadline	YES You forfeit any unused funds if claims incurred during the calendar year are not filed by the deadline

¹ For a complete list of eligible FSA expenses and guidelines, visit the IRS website at www.irs.gov. Publication 502 includes eligible Medical FSA expenses; Publication 503 includes eligible dependent care FSA expenses.

² Only the amount currently in your dependent care FSA is eligible for reimbursement.

³ Check with your plan administrator to confirm if your FSA plan includes a rollover or grace period and the claims filing deadline.

HEALTH SAVINGS ACCOUNT (HSA)

WAGE WORKS

It's no secret health care costs are getting less affordable every day. And the cost to provide health care coverage continues to escalate. Like many companies, we need to control these costs to stay competitive. At the same time, we want to be sure that our health benefits do what they are intended to do, which is to help you and your family achieve and maintain your health potential.

Fortunately, good health can actually cost less. Over the long-term, if our health benefits program can help you maintain or improve your health, we all win. That's why we are excited to offer a High Deductible Health Plan option that includes a Health Savings Account (HSA) component. When you enroll in the **SureFit HSA and OAPIN HSA** plans, you may open an HSA account that accumulates funds to cover your health care expenses.

Christ Fellowship provides an HSA contribution in the amount of \$750 per plan year to employees enrolled in an employee-only plan or \$1,500 to employees enrolled in a non-single plan coverage.

HSA's offer you the following advantages:

- **Tax Savings:** You contribute pre-tax dollars to your HSA. Interest accumulates tax-free and funds are tax-free to withdraw for health care expenses including dental and vision. Exceptions include:
 - » HSA Contributions are pre-tax for federal income tax but after tax for CA and NJ state taxes purposes
 - » HSA Earnings (investment gains and earned interest) are taxable for NH and TN state tax purposes
 - » If you are under age 65, HSA withdrawals used for non-qualified expenses are subject to a 20% tax penalty and included in gross income
- **Reduce your out-of-pocket costs:** You can use your HSA funds to pay for eligible medical and prescription expenses. The HSA funds you use can help satisfy your plan's annual deductible.
- **Invest the funds and take them with you:** Unused HSA funds are yours to keep (not use it or lose it) even if you retire or leave the company. Additionally, you can invest your HSA funds, so your available health care dollars can grow over time.
- **Preventive care without the cost:** Receive 100% coverage for nationally recommended preventive care, with no deduction from your HSA or out-of-pocket costs when you see an in-network provider.
- **The opportunity for long-term savings:** Unused HSA funds carry over year to year – money you can use to reduce future out-of-pocket health care expenses. You can even save HSA dollars to use after you retire.

To see a full list of current eligible and ineligible medical expenses visit:

www.irs.gov/pub/irs-pdf/p969.pdf

Maximum allowable HSA contributions are federally defined each year.

For 2025, the annual maximum contribution is \$4,300 for single individuals or married filing separately, and \$8,550 for family.

For 2026, the annual maximum contribution is \$4,400 for single individuals or married filing separately, and \$8,750 for family.

Individuals over 55 can make a \$1,000 catch up contribution.

To qualify for an HSA, you must meet the following criteria:

- Be enrolled in a High Deductible Health Plan (HDHP) on the 1st day of the month contributions are made
- Not be enrolled in another health plan that is not an HDHP Plan including a spouse's plan, Medicare, TRICARE, or VA
- Not be enrolled in a General-Purpose Health Care FSA (enrollment in a Limited Purpose FSA is permitted)
- Not be claimed on someone else's tax return

WHICH ACCOUNT IS RIGHT FOR ME? FSA OR HSA?

HEALTHEQUITY



Health Care FSA (Flexible Spending Account):

General Purpose Health Care FSA reimburses you for health, prescription, dental, and vision expenses not covered or only partially covered by your medical, dental, and vision plans.

2026 limits:

» \$3,400

Dependent Care FSA (Flexible Spending Account):

A **Dependent Care FSA** reimburses you for dependent care expenses that you incur in order for you (and your spouse) to work, including childcare or care for dependents who are mentally or physically incapable of caring for themselves. The maximum contribution amount is \$7,500 if you are married filing a joint return or if you are a single parent. If you are married but filing separately, the annual maximum contribution is \$3,750.

For a complete list of eligible expenses reimbursable with an FSA account, as well as a complete list of ineligible expenses, please visit the following IRS website: www.irs.gov/publications/p502/ar02.html#en_US_publink100017894

HSA (Health Savings Account):

What is a Health Savings Account (HSA)?

An HSA allows an individual to set aside pre-tax dollars in a trust or custodial account to pay for qualified medical expenses.

2026 limits:

- » \$4,400 Single
- » \$8,750 Family
- » \$1,000 over 55+ catch-up contribution

To qualify for an HSA, you must meet the following criteria:

- You must be enrolled in a High Deductible Health Plan
- You cannot be enrolled in Medicare
- You cannot be enrolled in another health plan that is not an HDHP Plan

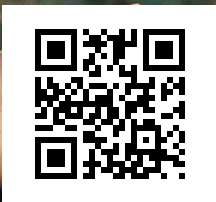
HSAs offer you the following advantages:

An HSA allows an individual to set aside pre-tax dollars in a trust or custodial account to pay for qualified medical expenses.

- **Tax Savings.** You contribute pre-tax dollars to the HSA. Interest accumulates tax-free and funds are tax-free to withdraw for healthcare expenses (including dental and vision)
- The funds are yours. Unused account dollars are yours to keep, even if you retire or leave the company.
- Funds are not use-it or lose-it, they carry over from year to year.

VISION INSURANCE

HUMANA | GROUP #775327 | 866-995-9316



Scan or click the QR code to access the carrier's website



BENEFIT SUMMARY	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Eye Examination	\$10	Up to \$30	12 Months
Materials Copay	\$10	--	
Eyeglass Frames	\$160 Allowance; 20% off balance	Up to \$80	24 Months
STANDARD EYEGLASS LENSES			
Single Vision	\$10	Up to \$25	12 Months
Bifocal	\$10	Up to \$40	
Trifocal	\$10	Up to \$60	
Lenticular	\$10	Up to \$100	
CONTACT LENSES (IN LIEU OF EYEGLASSES)			
Conventional	\$160 Allowance; 15% off balance	Up to \$128	12 Months
Disposable	\$160 Allowance	--	
Medically Necessary	Covered 100%	Up to \$210	
EMPLOYEE SEMI-MONTHLY (24) PAYROLL DEDUCTIONS			
Employee Only		\$3.00	
Employee + Spouse		\$6.01	
Employee + Child(ren)		\$5.71	
Employee + Family		\$8.97	



Elective Contact Lenses are in lieu of glasses (lenses & frames). You are not eligible for glasses under our plan until 12 months after you receive contacts and vice versa.

This information summarizes the Christ Fellowship Church Vision benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

DENTAL INSURANCE

HUMANA | GROUP #775327 | 800-233-4013



Scan or click the QR code to access the carrier's website >>>

DENTAL BENEFITS

	DMO HS195	PPO LOW		PPO HIGH	
Annual Deductible (Individual/Family)	N / A	\$50 / \$150		\$50 / \$150	
Annual Benefit Maximum	N / A	Unlimited		Unlimited	
Orthodontia Lifetime Maximum	N / A	\$1,000 / \$1,000		\$1,000 / \$1,000	
Network Line	HS195 DHMO/Prepaid	PPO/Traditional Preferred		PPO/Traditional Preferred	
	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network

PREVENTIVE SERVICES - DEDUCTIBLE WAIVED

Oral Evaluations					
Prophylaxis: Cleanings	No Charge	100%	100%	100%	100%
Fluoride Treatment (child only)					
Bitewing X-rays, Full Mouth X-rays					

BASIC SERVICES

Sealants					
Space Maintainers					
Amalgam Restorations (Silver Fillings)					
Resin Based Restorations (anterior and posterior)	See Fee Schedule	80%	80%	100%	80%
Extractions (routine and surgical)					
Endodontic Treatments					
Periodontic Treatments					

MAJOR SERVICES

Crowns					
Dentures	See Fee Schedule	50%	50%	60%	50%
Bridges					

ORTHODONTIA SERVICES

Diagnostics and Treatments	See Fee Schedule (child and adult)	50% (child only)		50% (child only)	
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EMPLOYEES SEMI-MONTHLY (24) PAYROLL DEDUCTIONS

Employee Only	\$0.00	\$0.00	\$3.80
Employee + Spouse	\$0.00	\$14.67	\$22.85
Employee + Child(ren)	\$0.00	\$19.81	\$30.35
Employee + Family	\$0.00	\$26.72	\$40.93

This information summarizes the Christ Fellowship Church Dental benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

EMPLOYER-PAID BASIC LIFE & AD&D INSURANCE

MUTUAL OF OMAHA | GROUP #G000BTBL

Scan or Click the QR code to access the carrier's website >>>



SUMMARY OF BENEFITS

LIFE BENEFIT

1x Annual Salary up to \$200,000 (rounded to the next \$1,000)

AD&D BENEFIT

1x Annual Salary up to \$200,000 (rounded to the next \$1,000)

BENEFIT REDUCTION

Benefits will reduce:

age 65: to 65%

age 70: to 40%

age 75: to 25%

ADDITIONAL FEATURES

- Conversion
- Travel Assistance
- Hearing Discount Program
- Will Prep Services

VOLUNTARY LIFE AND AD&D INSURANCE

MUTUAL OF OMAHA | GROUP #G000BTBL

Scan or click the QR code to access the carrier's website >>>



SUMMARY OF BENEFITS

EMPLOYEE LIFE BENEFIT	SPOUSE LIFE BENEFIT	CHILD LIFE BENEFIT
Benefit Increment: \$10,000	Benefit Increment: \$5,000	Benefit Increment: \$10,000 from 14 days old - 26 years old
Minimum Benefit: \$10,000	Minimum Benefit: \$5,000	Minimum Benefit: \$10,000
Maximum Benefit: 10x Salary up to \$500,000	Maximum Benefit: 100% of EE amount up to \$250,000	Maximum Benefit: \$10,000
Guarantee Issue Amount: 10x Salary up to \$150,000	Guarantee Issue Amount: \$50,000	Guarantee Issue Amount: \$10,000
Benefits will reduce:	age 65: to 65% age 70: to 40% age 75: to 25% Benefits Terminate by age 100	

*Refer to your ADP Benefits Portal for Rates

EVIDENCE OF INSURABILITY (EOI)

EOI will be required for all amounts above the Guaranteed Issue or for late applicants applying outside of their new hire eligibility timeframe.

This information summarizes the Christ Fellowship Life and AD&D benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.

SHORT-TERM DISABILITY INSURANCE (STD)

MUTUAL OF OMAHA

Scan or click the QR code to access the carrier's website >>>



100% Employer-Paid!

BENEFITS SUMMARY

Elimination Period for Accident	7 days
Elimination Period for Illness	7 days
Benefit Duration	12 weeks
Benefit Percent	up to 60% of salary
Benefit Maximum	\$3,500

LONG-TERM DISABILITY INSURANCE (LTD)

MUTUAL OF OMAHA

Scan or click the QR code to access the carrier's website >>>



100% Employer-Paid!

BENEFITS SUMMARY

Elimination Period for Accident	90 days
Elimination Period for Illness	90 days
Benefit Amount	up to 60% of monthly salary
Benefit Maximum	\$12,500 per month
Duration of Benefits	Social Security Normal Retirement Age as long as you remain disabled
Definition of Disability	24 Months Own Occupation

Disability insurance provides income protection while you are unable to work due to a qualified non-work-related medical condition (STD examples: injury, illness, procedure, pregnancy, childbirth)

Benefits coordinate with any state, federal or other disability programs



This information summarizes the Christ Fellowship Disability benefits plans and is for illustrative purposes only. In the event of a discrepancy between this illustration and the official plan documents, the official documents will govern.



One Membership. Thousands of Ways to Stay Active and Save Money.

- 12,200+ Gyms
- 9,700+ On-Demand Videos
- Enroll Your Spouse²

No annual fees or long-term contracts.
Switch gyms anytime.



Plus: 5,800+ Premium Gym Options at exercise studios,
outdoor experiences, and others with 20% – 70%
discounts at most locations³

Get Started: <https://discoverhealthyrewards.sites.cigna.com>

¹ Add a spouse/domestic partner to a primary membership for additional monthly fees. Spouses/domestic partners must be 18 years or older. Fees may vary based on fitness center selection.

² Monthly fees are subject to applicable taxes.

³ Costs for premium exercise studios exceed \$28/mo. and an enrollment fee will apply for each premium location selected, plus applicable taxes. Fees vary based on premium fitness studios selected.

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CIGNA IDENTITY THEFT



Identity Matters.

Protecting **PRIVACY** and **SECURITY**.

Three ways to enroll

- 1) Cigna medical employees who have provided their email addresses on myCigna.com® will receive a registration link via email from IdentityForce.
- 2) Call 833-580-2523
- 3) Visit <https://cigna.identityforce.com/starthere>

Now is the time to protect what is most important. As our digital activity expands, fraud and scams increase exponentially, along with vulnerabilities that result from having sensitive personal information exposed. It's why **IdentityForce** offered through Cigna¹ will be included in your Cigna medical coverage at **no additional cost for you and any child(ren) living in your household up to age 26.**² We're here to provide you with **award-winning** identity theft protection built to proactively monitor, alert, and help fix any identity theft compromises.

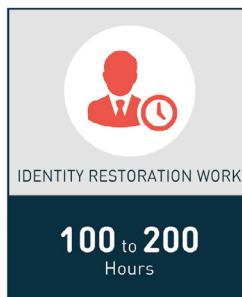
WHY NOW?

Our identities have become more than just a name, birthdate, and social security number. Today our identities include voice signatures and fingerprints, personal property records, health records, and even social media data. All of these details can be capitalized on by criminals to commit identity fraud, whether used directly in forms of synthetic identity theft, or used in social engineering attempts to extract money or personal details that provide additional opportunities for identity crimes.

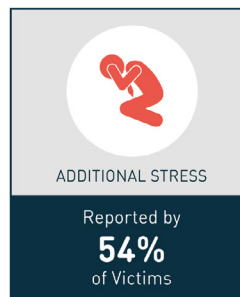
ID THEFT IMPACT

No one should have to deal with a lifetime of damage that could result from identity theft. We all likely know someone who has already been a victim of identity theft themselves, or had their good name compromised. Security incidents, scams, and fraud continue to grow as our world becomes increasingly digitalized and virtual, and protecting personal information is essential.

We not only proactively monitor the Dark Web, credit reports, and real-time fraud issues, but we will help fix any compromises to personal information. We'll make sure your identity is restored without the burden of phone calls and paperwork.



SANS Institute. "Identity Theft." 2021.



ITRC. "Consumer Aftermath Report." 2021.



Aite Group. "U.S. Identity Theft: The Stark Reality." 2021.

¹ The program and services are provided by an independent company/entity and not by Cigna. Program and services are subject to all applicable program terms and conditions. Program availability is subject to change.

² Family Coverage, which includes coverage for any adults living in your household, is available to purchase directly through Sontiq for a low monthly cost. You can purchase this coverage through your profile once you have registered for your IdentityForce monitoring services.



Protect What Matters Most™

#1 Rated Consumer ID Theft Plans

As seen on CNBC and Investopedia



SOURCE | Rated Best Overall Identity Theft Service by Select on CNBC (Aug 2021) and a Best Identity Theft Protection Service of 2021 by Forbes Advisor

Identity Theft Protection

Plan Features	UltraSecure ID
PRIVACY & SECURITY	
Password Manager	●
Bank and Credit Card Activity Alerts	●
Identity Vault and Secure Storage	●
Auto On Monitoring	●
Advanced Fraud Monitoring (Instant Inquiry Alerts)	●
Change of Address Monitoring	●
Court Records Monitoring	●
Fraud Alert Reminders	●
Dark Web Monitoring	●
Compromised Credentials Alerts	●
Sex Offender Notification	●
Social Media Activity Alerts (Adult and Child)	●
Data Breach Notification	●
Identity Threat Alerts	●
Junk Mail Opt Out	●
Smart SSN Tracker (SSN Monitoring)	●
Medical ID Fraud Protection	●
Mobile App (iOS and Android)	●
Two Factor Authentication	●
Lost Wallet Assistance	●
Child Monitoring (SSN and Dark Web)	●
401(k), HSA & Investment Account Activity Alerts	●
CREDIT MONITORING	
Credit Report Assistance	●
Credit Freeze and Lock Assistance (Adult and Child)	●
Credit Report Monitoring (Daily)	1 Credit Bureau
Credit Report and Score (Quarterly)	1 Credit Bureau
Credit Score Simulator	●
Credit Score Tracker (Monthly)	●
RESTORATION SERVICES	
White Glove Restoration	●
Pre-existing Identity Theft Restoration	●
Deceased Family Member Fraud Remediation ³	●
Identity Theft Insurance	\$1,000,000 ⁴
Stolen Funds Replacement	●
Any Financial Account Covered	●

³ Deceased Family Member Fraud Remediation | Available for adults or eligible dependents enrolled in an active IdentityForce Family Plan at the time of their death.

⁴ The expense reimbursement insurance benefit for members is underwritten by Hamilton Insurance DAC, and its affiliates, under a master group policy issued in the name of CyberScout Limited, Sontiq Inc. and all subsidiaries for the benefit of members. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. A summary of the terms of coverage is set forth [here](#). The complete policy is available from Sontiq on request. Hamilton Insurance DAC administers all claims and Sontiq and Cigna Corporation and its operating subsidiaries shall have no responsibility with respect to such identity theft and/or cyber benefit. Restoration services are provided by Sontiq, Inc.

The program and services are provided by **Sontiq, Inc. and not by Cigna Corporation or its operating subsidiaries**. Program and services are subject to all applicable program terms and conditions. Product availability may vary by location and plan type and is subject to change.

References to third-party organizations or companies, and/or their products, processes or services, does not constitute an endorsement or warranty thereof. Your use of such products, processes or services are at your sole risk. Product may be updated or modified prior to availability.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation.

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EMPLOYEE ASSISTANCE PROGRAM

Employee Assistance Program

We're Here to Help



Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

We're Here to Help

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

EAP Benefits

- Access to EAP professionals 24 hours a day, seven days a week
- Provides information and referral resources
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

*Face-to-face visits can also be used toward legal consultations

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period.

- Legal assistance and financial resources
 - Online will preparation
 - Legal library & online forms
 - Financial tools and resources
- Resources for:
 - Substance use and other addictions
 - Dependent and elder care resources
- Access to a library of educational articles, handouts and resources via mutualofomaha.com/eap

What to Expect

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is **no cost** to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help

Visit mutualofomaha.com/eap or call **800-316-2796** for confidential consultation and resource services.



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452833_Enhanced

EMPLOYEE DISCOUNT PROGRAM



IOA is Proud to Bring You...

BENEPLACE

A best-in-class savings platform that's reliable, budget-friendly, and focused on one thing: rewarding you with discounts on products and services from the brands you love.



Fast, Valuable Savings for You!

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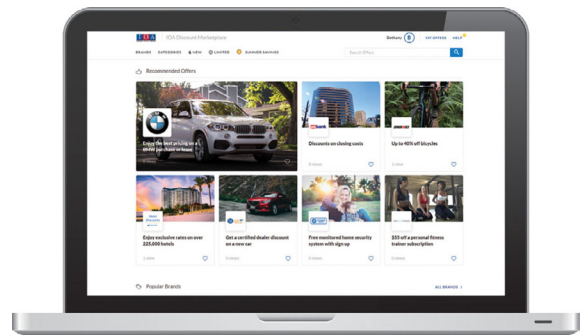
Simple search and other easy online shopping tools help you save money on the products and services you need.

Trusted Brands

Access to hundreds of offers from well-known brands that you love and trust.

Personalized Experience

Favorite lists and other familiar personalization tools help you rediscover valuable offers quickly.



Easy, Simple Options for You!

[HTTPS://IOAUSA.SAVINGS.BENEPLACE.COM](https://ioausa.savings.beneplace.com)

Here are just a few of the categories the Beneplace platform offers:



Automotive



Dining & Grocery



Education



Electronics



Entertainment



Flowers & Gifts



Health & Wellness



Home & Garden



Retail



Travel



When it comes to healthcare, we're in your corner.

As a TouchCare member, you have a personal Health Assistant in your pocket. We're here to answer any and all of your healthcare and benefit questions. Here are just a few examples of what we can help with (at no cost to you):



Benefit Navigation

TouchCare assists with more than just medical insurance. We also support members with voluntary benefits (FSA, HSA, HRA).



Bill Negotiation

Members send us their bills, tell us what they feel is wrong, ask questions – and we work on their behalf to fix any errors.



Cost Comparison

TouchCare Health Assistants ensure you never overpay for care by carefully researching all options and costs.



Provider Search

We'll always navigate you to highly-rated providers that are in-network and conveniently located.

We're here to help

TouchCare services were designed to make your life easier.

Never pay more than you have to

RxCare

Get assistance finding the lowest cost options for all of your prescriptions.

Ancillary Benefits

We will help you leverage the right benefit, at the right time, to save you time and money.

Keep in touch with all of your benefits

Benefit Refresher

Consult with an expert regarding your benefits anytime throughout the year.

Questions

You have questions; we have expertly researched answers. Your HA is always there to help.

TERMS TO KNOW



SCAN OR CLICK THE QR CODE TO WATCH A [SHORT VIDEO](#) ON THE TERM YOU WOULD LIKE TO KNOW

AD&D: Accidental Death & Dismemberment

ANNUAL ENROLLMENT: Designated period of time during which an employee may enroll in group health coverage. Also, designated period of time during the year when individuals without group coverage may enroll in health coverage without needing medical underwriting.

CARRIER: The insurance company.

CLAIM: The request for payment for benefits received in accordance with an insurance policy.

COINSURANCE: A payment made by the covered person in addition to the payment made by the health plan on covered charges, shared on a percentage basis. For example, the health plan may pay 80% of the allowable charge, with the covered person responsible for the remaining 20%. The 20% amount is then referred to as the coinsurance amount.

COPAY: A co-payment, or copay, is a capped contribution defined in the policy and paid by an insured person each time a medical service is accessed. It must be paid before any policy benefit is payable by an insurance company.

CREDITABLE: Is the prescription drug coverage offered by an employer plan that pays, on average, the same amount as Medicare pays.

DEDUCTIBLE: A deductible is the amount you must pay each year before your carrier begins to pay for services. If you have a PPO plan, there is usually a separate higher deductible for using out of network providers.

ELIMINATION PERIOD: This is the time period between injury or illness and the receipt of benefit payments.

EMBEDDED DEDUCTIBLE: An embedded deductible is a system that combines individual and family deductibles in a family health insurance policy. When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible in order for after-deductible benefits to kick in, each individual only needs to meet the individual deductible in order for after-deductible benefits to kick in.

EOB (Explanation of Benefits): EOB stands for Explanation of Benefits. This is a document produced by your medical insurance carrier that explains their response and action (whether it is payment, denial, or pending) to a medical claim processed on your behalf.

EVIDENCE OF INSURABILITY (EOI): This is the medical information you must provide that requires review and approval by the insurance company BEFORE coverage becomes effective. This may include medical records and a physical exam.

HMO: Health Maintenance Organization, this type of medical plan is Network exclusive. A participant must receive services from in-network providers except in a case of medical emergency.

IN-NETWORK: Refers to the use of providers who participate in the health plan's provider network. Many benefit plans encourage members to use participating in-network providers to reduce out-of-pocket expenses.

MAC: Maximum allowable charge

MAIL ORDER PRESCRIPTIONS: Used for maintenance drugs, members can order and refill their prescriptions via postal mail, Internet, fax, or telephone. Once filled, the prescriptions are mailed directly to the member's home.

MAINTENANCE DRUGS: A medication that is anticipated to be taken regularly for several months to treat a chronic condition such as diabetes, high blood pressure and asthma, this also includes birth control.

NON-EMBEDDED DEDUCTIBLE: A non-embedded deductible is also referred to as an aggregate deductible. Under an aggregate deductible, the total family deductible must be paid out-of-pocket before after-deductible benefits kick in for the health care services incurred by any family member.

OUT-OF-NETWORK: The use of health care providers who have not contracted with the health plan to provide services. HMO members are generally not covered for out-of-network services except in emergency situations. Members enrolled in Preferred Provider Organizations (PPO) and Point-of-Service (POS) coverage can go out-of-network, but will pay higher out-of-pocket costs.

OUT-OF-POCKET MAXIMUM: The total amount a covered person must pay before his or her benefits are paid at 100%. Deductible, copayments, and coinsurance may apply towards the maximum out of pocket, depending on the plan.

PARTICIPATING PROVIDER: Individual physicians, hospitals and professional health care providers who have a contract to provide services to its members at a discounted rate and to be paid directly for covered services.

PCP (PRIMARY CARE PHYSICIAN): A physician selected by the member, who is part of the plan network, who provides routine care and coordinates other specialized care. The PCP should be selected from the network that corresponds to the plan in which you are a member. The physician you choose as your PCP may be a family or general practitioner, internist, gynecologist or pediatrician.

PPO: Benefits paid for both in and out of a network of doctors. Member makes choice with knowledge that better benefits are available in network. Plans feature office visit copays, deductibles at a variety of levels and then coinsurance to a maximum out of pocket expense. Usually includes copays for prescription drugs.

PREVENTIVE CARE: Care rendered by a physician to promote health and prevent future health problems for a member who does not exhibit any symptoms. Examples are routine physical examinations and immunizations.

REFERRAL: A written recommendation by a physician that a member may receive care from a specialty physician or facility.

SPECIALIST: A participating physician who provides non-routine care, such as a dermatologist or orthopedist.

UCR: Usual, customary, reasonable

MANDATORY NOTICES

IMPORTANT NOTICE ABOUT THIS GUIDE AND THE LEGISLATIVE NOTICES INCLUDED

A Plan Sponsor's responsibilities include making sure the health plan complies with ERISA, ACA and other federal and state regulations. Various federal notices are set forth below. Even if employers use third-party service providers to manage the plan, there are still certain functions that may make the employer responsible as a fiduciary. Plan Sponsors are recommended to maintain comprehensive record-keeping documents for up to seven years.

Insurance Office of America does not intend for you to use this guide as a substitute for legal counsel. Should you have any questions or concerns, you should contact your legal counsel for further guidance on all matters pertaining to compliance. Importantly, since this information is intended as a brief overview, please refer to the applicable federal regulations for more specific and detailed information. In addition, please note that States may have additional laws, restrictions and benefits that are more protective of individuals. You should always consult your State's benefits and insurance laws for further guidance.

Important Notice:

Medicare Part D Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Christ Fellowship Church** 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. **Christ Fellowship Church** has determined that the prescription drug coverage offered by the **SureFit Copay OAPIN - OAPIN Copay and OAP Copay** plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage.

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your re-enrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be canceled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

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 under the group plan 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

Important Notice: Medicare Part D Creditable Coverage Disclosure

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 your Human Resources for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the group plan coverage changes. You also may request a copy of this notice at any time.

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)**.

Contact Human Resources for more information:

Christ Fellowship Church

Dave Kush, Executive Director of Human Resources
5343 Northlake Blvd.

Palm Beach Gardens, FL 33418

dave.kush@christfellowship.church

561-776-3261

For questions about Medicare prescription drug coverage,

Grace Agency is here to help.

GRACE MEDICARE INSURANCE CONSULTANTS I O A

Educating you about Medicare insurance options and resources to meet your health and wellness goals.

OURS IS A KINDER AND GENTLER APPROACH TO THE WORLD OF MEDICARE INSURANCE

800-791-4840 | info@graceagency.org

Important Notice: Medicare Part D Non-Creditable Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your **Christ Fellowship Church** 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are three 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. **Christ Fellowship Church** has determined that the prescription drug coverage offered by the **SureFit HSA and HSA OAP IN** plans is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the group plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from the group plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in

your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage under the group plan, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the group plan. If you are losing creditable prescription drug coverage from a group plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the prescription drug coverage under the group plan, is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 group plan coverage as an employee, or dependent or spouse of an active employee will not be affected. There is coordination of benefits and the group plan will be your primary coverage and Medicare will be your secondary coverage.

Important Notice: Medicare Part D Non-Creditable Coverage Disclosure

However, if you drop current coverage under the group plan and enroll in a Medicare prescription drug plan, you will not be able to re-enroll for medical and prescription drug coverage until the next annual enrollment period, or upon a qualifying life event for which enrollment is permitted, if earlier (and only if you are eligible for coverage at the time your reenrollment would be effective). In addition, your current coverage pays for medical expenses, in addition to prescription drugs, and if you choose to drop prescription drug coverage, you must also drop your medical coverage as well.

If you (or a dependent/spouse) are covered under the group plan through COBRA and later are covered by Medicare, the medical and prescription drug coverage under the group plan will be cancelled, if permitted by law. Once you cease to be covered under COBRA, you may not reinstate your COBRA coverage under the group plan.

Therefore, before deciding whether to join a Medicare drug plan, you should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the Medicare drug plans in your area. Please refer to group plan's summary plan description for information about coverage, how the group plan coordinates with Medicare and when coverage terminates under the group plan.

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

Contact your Human Resources Employee Benefits Administrator for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if the group plan coverage changes. You also may request a copy of this notice at any time.

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)**.

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Dave Kush, Executive Director of Human Resources
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800-791-4840 | info@graceagency.org

Mandatory Notices

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 toward your or your dependents other coverage). However, you must request enrollment within 30 days after your or your dependents other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Human Resources.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

If not attached to this document, you may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Model General Notice of COBRA Continuation of Coverage Rights

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 must 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;
- 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."

Mandatory Notices

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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;
- 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.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit

<https://www.medicare.gov/medicare-and-you>

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.

Mandatory Notices

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

Plan and COBRA continuation coverage can be obtained on request:

Christ Fellowship Church

Dave Kush, Executive Director of Human Resources

5343 Northlake Blvd.

Palm Beach Gardens, FL 33418

dave.kush@christfellowship.church

561-776-3261

Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

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

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care

Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Women's Health and Cancer Rights Act of 1998

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance of your enrolled plan will apply.

If you would like more information on WHCRA benefits, contact your plan administrator or Human Resources.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours

Mandatory Notices

as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 July 31, 2025. Contact your State for more information on eligibility –

Patient Protection Notice

The **Sure Fit** plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, **Sure Fit Plans** may designate one for you. For information on how to select a primary care provider, contact the plan administrator.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider: You do not need prior authorization from **Sure Fit Plans** or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

State Contacts

ALABAMA – Medicaid
Website: myalhipp.com Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program – dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): www.mycohibi.com HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: www.flmedicaidtprecovery.com/ flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: www.in.gov/medicaid www.in.gov/fssa/dfr Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: www.kancare.ks.gov Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPROGRAM@ky.gov KCHIP Website: kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: www.maine.gov/dhhs/of/ applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: mn.gov/dhs/health-care-coverage Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

State Contacts

<p>NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>VIRGINIA – Medicaid and CHIP</p> <p>Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p>
<p>NEW YORK – Medicaid</p> <p>Website: www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831</p>	<p>WASHINGTON – Medicaid</p> <p>Website: www.hca.wa.gov Phone: 1-800-562-3022</p>
<p>NORTH CAROLINA – Medicaid</p> <p>Website: medicaid.ncdhhs.gov Phone: 919-855-4100</p>	<p>WEST VIRGINIA – Medicaid and CHIP</p> <p>Website: dhhr.wv.gov/bms_mywvhipp.com Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p>NORTH DAKOTA – Medicaid</p> <p>Website: www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>	<p>WISCONSIN – Medicaid and CHIP</p> <p>Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
<p>OKLAHOMA – Medicaid and CHIP</p> <p>Website: www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>WYOMING – Medicaid</p> <p>Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269</p>
<p>OREGON – Medicaid and CHIP</p> <p>Website: healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>	<p>To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:</p>
<p>PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/agencies/ebsa 1-866-444-EBSA (3272)</p>
<p>RHODE ISLAND – Medicaid and CHIP</p> <p>Website: www.eohhs.ri.gov Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)</p>	<p>U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565</p>
<p>SOUTH CAROLINA – Medicaid</p> <p>Website: www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Paperwork Reduction Act Statement</p>
<p>SOUTH DAKOTA – Medicaid</p> <p>Website: dss.sd.gov Phone: 1-888-828-0059</p>	<p>According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.</p>
<p>TEXAS – Medicaid</p> <p>Website: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493</p>	<p>The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.</p>
<p>UTAH – Medicaid and CHIP</p> <p>Utah's Premium Partnership for Health Insurance (UPP) Website: medicaid.utah.gov/upp Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: medicaid.utah.gov/expansion Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program CHIP Website: chip.utah.gov</p>	<p>OMB Control Number 1210-0137 (expires 1/31/2026)</p>
<p>VERMONT – Medicaid</p> <p>Website: dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427</p>	

CONTACTS



LINE OF COVERAGE	CARRIER	CUSTOMER SERVICE
Medical	CIGNA	866-494-2111 www.mycigna.com
Flexible Spending Account (FSA)	WAGE WORKS	866-469-4910
Health Savings Account (HSA)	WAGE WORKS	866-469-4910
Dental	HUMANA	800-233-4013 www.humana.com
Vision	HUMANA	866-995-9316 www.humana.com
Employer Paid Basic Life and AD&D	MUTUAL OF OMAHA	
Voluntary Life & AD&D	MUTUAL OF OMAHA	
Short Term Disability (STD)	MUTUAL OF OMAHA	Life claims: 800-755-8805 Disability claims: 800-877-5176 www.mutualofomaha.com
Long Term Disability (LTD)	MUTUAL OF OMAHA	
Voluntary Supplemental Insurance	MUTUAL OF OMAHA	
Employee Assistance Program (EAP)	MUTUAL OF OMAHA	800-316-2796 www.mutualofomaha.com/eap



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For assistance with benefits questions, membership card issues, claims, and billing inquiries please contact one of your IOA service team members per the contact information below:

NAME - TITLE	PHONE	EMAIL
Gianclaudio Planzo <i>Employee Benefit Consultant</i>	813-262-2461	gianclaudio.planzo@ioausa.com
Ashley Woodard <i>Employee Benefits – Account Executive</i>	813-262-2457	ashley.woodard@ioausa.com



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