VICTORY LIFE CHURCH

2019 Employee Benefits Guide

January 1, 2019 to December 31, 2019

Brown & Brown INSURANCE

Important Contacts

Provider Type	Provider Name	Provider Phone Number	Website
Medical	Blue Cross Blue Shield of OK	1-800-942-5837	www.bcbsok.com
Virtual Dr. Visits	MD Live	1-888-676-4204	www.mdlive.com/bcbsok
Dental	Delta Dental of OK	1-866-685-2112	www.deltadentalok.org
Vision	MetLife	1-855-638-3931	www.metlife.com/mybenefits
Life	Metlife	1-800-638-6420	www.metlife.com/mybenefits
FSA	Elaina Fowler	580-916-9022, x38272	
AFLAC	David Eastep	580-513-8237	www.aflac.com

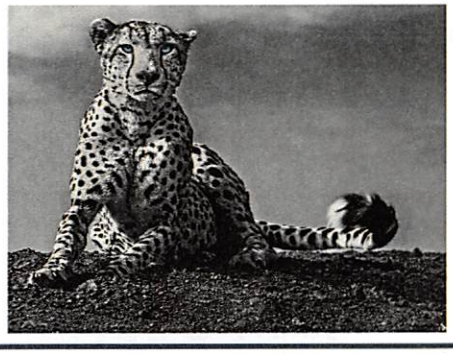
Your Human Resources Contact:
Elaina Fowler
Human Resources Director
elaina.fowler@victorylifechurch.com
580-916-9022 x 38272

Your Benefits Helpline:
Brown & Brown Insurance
Jean Mlller
Account Manager
jmiller@bb-ok.com
800-335-3295 x 112

Who is Brown & Brown?

Brown & Brown is our employee benefits broker. Not only do they help us shop and find the best benefits package possible, they also are available throughout the year to help YOU with:, claims, enrollment questions, eligibility issues, finding doctors in your network, and more!

Call Brown & Brown with questions about your benefits!



Our Commitment to You!

The benefit plans are designed to recognize the diverse needs of our staff. In our efforts to provide enhanced benefit coverage and plan options, we continuously search for ways to make this possible.

Once again, we are able to provide competitive and comprehensive benefit options that allow you to design your own plan based on individual needs. Additionally, our plans provide long-term financial security for you and your family.

Only you can determine which benefits are the best for you and your family. We want you to understand all your options and make informed decisions.

Benefit Basics

Eligibility

Full-time employees working 30 hours per week are eligible to elect a variety of benefits described in this guide. New hires are eligible for benefits following 60 days of employment and coverage begins on the first of the following month. Dependent children may be covered until age 26 on the medical, dental and vision plans regardless of student status. Children's voluntary life benefits terminate at age 21 unless full time student verification is submitted. Spouses may be covered on the medical, dental, vision, and voluntary life plans.

You and/or your eligible dependents must enroll within 30 days of becoming eligible. You will not be eligible to enroll until the next Open Enrollment period if you choose not to enroll for coverage within the 30-day eligibility period unless you experience a Qualifying Life Event.

Qualifying Events

Your elections will remain in effect during the entire benefit plan year unless you experience a Qualifying Life Event. If you experience a Qualifying Life Event listed below, you may change or cancel your coverage during the benefit plan year. You must notify Human Resources within 30 days of the event to ensure there is no disruption of your coverage.

- Birth/Adoption
- Marriage
- Dependent Child Age Limit
- Loss of Health Coverage
- FMLA related leave
- Eligible for Medicare
- Death
- Divorce

You may add or drop coverage for yourself and/or dependents as a result of a qualifying event.

For a complete list of Qualifying Life Events, please contact Human Resources.

It is important that you notify Human Resources upon any life event change in order to ensure there is no interruption or discrepancies in your benefits. Any request for coverage change or cancellation must be consistent with your Qualifying Life Event and you must have the proper supporting documentation (i.e. birth certificate, marriage license, final divorce paperwork, etc.)

Medical & Prescription Drug

Victory Life Church provides you with medical insurance through Blue Cross Blue Shield of OK utilizing the **Blue Preferred Network**. To find an in-network physician, please visit www.bcbsok.com. Please carefully review the benefits below to decide what best suits you and your families needs.

BCBS Preferred PPO Network	Option 1 MOBPF216		Option 2 MOBPF203	
	In Network	Out of Network	In Network	Out of Network
Annual Deductible Individual Family	 $2,500 $7,500	 $5,000 $15,000	 $1,000 $3,000	 $1,500 $4,500
Annual Out-of-Pocket Maximum Individual Family	 $6,000 $13,000	 $12,000 $26,000	 $3,000 $9,000	 $6,500 $16,500
	You Pay:			
Preventive Services	No Charge	No Charge	No Charge	No Charge
Virtual Visit	$30	N/A	$20	N/A
Office Visits Primary Care Specialty Visit	 $30 $50	 30% after deductible	 $20 $20	 30% after deductible
Lab & X-Ray	No Charge if Billed w/ Office Visit	30% after deductible	No Charge if Billed w/ Office Visit	30% after deductible
Major Diagnostics Imaging/MRI/CT	50% after deductible	50% after deductible	20% after deductible	40% after deductible
Outpatient Facility	$250 + 50% after deductible	$250 + 50% after deductible	20% after deductible	40% after deductible
Inpatient Hospital	$500 + 50% after deductible	$500 + 50% after deductible	20% after deductible	$300 + 40% after deductible
Emergency Room	$300 + 50% after deductible	$300 + 50% after deductible	$100 + 20% after deductible	$100 + 20% after deductible
Urgent Care Center	Copay May Apply	50% after deductible	Copay May Apply	40% after deductible
Prescription Drugs Tier I Tier II Tier III Tier IV Specialty Mail Order	 $0 or $10 $10 or $20 $50 or $70 $100 or $120 $150 or $250 2.5x Copay	Applicable In-network Copay plus 20%	 $0 or $10 $10 or $20 $35 or $55 $75 or $95 $150 or $250 2.5x Copay	Applicable In-network Copay plus 20%

This guide is a general description of coverage(s) provided. For a detailed description of policy terms and conditions, please refer

Dental

Victory Life Church continues to offer dental insurance through Delta Dental of OK. As with all Plans, you benefit and save most if your dentist is in-network, due to additional discounts that result in less out-of-pocket expense.

The best way to avoid surprises is to always ask your dentist to submit a **pre-determination of benefits** for anything other than routine services, and to wait for the decision to come back from the insurance company. That way you know how much your service will be before it is performed, so long as your dentist bills the same way as the pre-determination.

	Delta Dental PPO	
Services	Plan 1	Plan 2
Calendar Year Deductible Individual Family	$50 $150	$50 $150
Calendar Year Maximum	$1,000	$1,000
Preventive Services *Oral Exams* *Cleanings* *X-Rays* *Fluoride Treatment* *Sealants*	You Pay: 0%, deductible waived *Preventive benefits do not apply to annual maximum*	You Pay: 0%, deductible waived *Preventive benefits do not apply to annual maximum*
Basic Services *Fillings* *Simple Extractions* *Root Canals*	You Pay: 20% after deductible	You Pay: 20% after deductible
Major Services *Bridges* *Dentures* *Implants* *Crowns* *Surgery*	Not Covered	You Pay: 50% after deductible
Orthodontia	Plan pays 50% up to $1,000 Per Lifetime	Plan pays 50% up to $1,000 Per Lifetime

To locate a provider, see the status of your claims, etc. go to www.deltadentalok.org and follow the easy registration instructions or call 1-866-685-2112.

Vision

Victory Life Church will continue to offer the Vision plan through MetLife. You will save by utilizing providers who are in the Metlife Vision PPO network.

There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance for your services. When visiting out-of-network providers, you pay for all services in full, and then file a claim for reimbursement according to your out-of-network benefits schedule.

	In-Network *You Pay*	**Out-of-Network** *Reimbursement*
Eye Exam	$10 copay	Up to $45
Lenses		
Single	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $65
Lenticular	$25 copay	Up to $100
Frames	$130 retail allowed + 20% off balance	Up to $70
Contact Lenses		
Elective Lens Fitting	$60 copay	
Elective	$130 allowance	Up to $105
Medically Necessary	Paid in full	Up to $210
Frequency		
Eye Exam	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 12 months	
Contacts	Once every 12 months (in lieu of lenses and frames)	

Additional Charges May Apply

To locate a provider, see the status of your claims, etc. go to www.metlife.com/mybenefits and follow the easy registration instructions or call 1-855-638-3931.

$ Employee Contributions

Below are employee contributions costs based on semi-monthly (24) pay periods.

Medical Option 1	
Semi-Monthly	
Employee Only	$68.41
Employee + Spouse	$338.02
Employee + Child(ren)	$235.83
Employee + Family	$505.46

Medical Option 2		
Semi-Monthly		Insure OK Qualified
Employee Only	$142.60	$45.33
Employee + Spouse	$499.94	$98.93
Employee + Child(ren)	$364.50	$267.23
Employee + Family	$721.86	$320.85

Dental		
Semi-Monthly	Plan 1	Plan 2
Employee Only	$10.28	$16.40
Employee + Spouse	$20.56	$32.79
Employee + Child(ren)	$27.47	$43.81
Employee + Family	$37.75	$60.20

Vision	
Semi-Monthly	
Employee Only	$4.22
Employee + Spouse	$8.45
Employee + Child(ren)	$7.16
Employee + Family	$11.80

LIFE and AD&D

Basic Life and AD&D

Victory Life Church provides all full-time employees Basic Life and Accidental Death & Dismemberment coverage provided through Metlife.

Benefit Amount	$25,000
Eligibility	All Full-time employees working 30 hours or more
Age Reduction Schedule	65% of the original amount at age 65 and 50% of the original at age 70

Voluntary Life and AD&D

All eligible employees may purchase additional life coverage through Metlife. If you enroll when first eligible, you may choose an amount up to the Guaranteed Issue amount **without** answering medical questions . If you choose an amount over the Guaranteed Issue, OR if you decline life insurance when first eligible and wish you enroll at a later date, you will be required to answer medical questions at that time. The chart below is a brief outline of the plan.

	Employee	Spouse	Child(ren)
Benefit Amount	Increments of $10,000	Increments of $5,000	$1,000 to $10,000
Maximum Benefit	5x salary or $500,000	50% of employee amount up to $100,000	15 Days-6 months = $100 6 months-21 years = $10,000 (To age 26 if FT student)
Guarantee Issue (timely applicants only)	$100,000	$25,000	

Individuals can only be insured once on the voluntary life insurance policy. If you and your spouse both work for Victory Life Church, you cannot cover each other and your children can only be enrolled under one parent.

Conversion Privilege & Portability Option: When you terminate employment, retire or lose insurance eligibility due to a status change, you have the Conversion Privilege / Portability Option available. You have 31 days immediately following loss of your coverage to apply and submit first premium payment. Subject to the terms as described in the Certificate of Coverage.

Voluntary Life and AD&D

Premiums are determined by the employee's age and benefit amount elected. See the chart below to determine your cost. Actual payroll deduction may vary slightly due to rounding.

Employee & Spouse Coverage	Employee Age Semi-Monthly Premium for:										
	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$1,000	$0.04	$0.05	$0.05	$0.06	$0.10	$0.15	$0.22	$0.32	$0.61	$0.99	$0.99
$5,000	$0.19	$0.23	$0.26	$0.32	$0.48	$0.73	$1.11	$1.61	$3.06	$4.93	$4.93
$10,000	$0.37	$0.47	$0.52	$0.65	$0.96	$1.47	$2.23	$3.22	$6.12	$9.87	$9.87
$15,000	$0.56	$0.70	$0.77	$0.97	$1.45	$2.20	$3.34	$4.83	$9.18	$14.81	$14.81
$20,000	$0.74	$0.93	$1.03	$1.29	$1.93	$2.93	$4.45	$6.44	$12.24	$19.74	$19.74
$25,000	$0.93	$1.16	$1.29	$1.61	$2.41	$3.66	$5.56	$8.05	$15.30	$24.66	$24.66
$30,000	$1.11	$1.40	$1.54	$1.94	$2.90	$4.39	$6.67	$9.66	$18.36	$29.61	$29.61
$40,000	$1.48	$1.86	$2.06	$2.58	$3.86	$5.86	$8.90	$12.88	$24.48	$39.48	$39.48
$50,000	$1.85	$2.33	$2.58	$3.23	$4.83	$7.33	$11.13	$16.10	$30.60	$49.35	$49.35
$60,000	$2.22	$2.79	$3.09	$3.87	$5.79	$8.79	$13.35	$19.32	$36.72	$59.22	$59.22
$70,000	$2.59	$3.25	$3.61	$4.51	$6.75	$10.26	$15.57	$22.54	$42.84	$69.09	$69.09
$75,000	$2.77	$3.49	$3.86	$4.84	$7.24	$10.99	$16.69	$24.15	$45.90	$74.03	$74.03
$100,000	$3.70	$4.65	$5.15	$6.45	$9.65	$14.65	$22.25	$32.20	$61.20	$98.70	$98.70
$150,000	$5.55	$6.97	$7.72	$9.68	$14.48	$21.98	$33.38	$48.30	$91.80	$148.05	$148.05
$200,000	$7.40	$9.30	$10.30	$12.90	$19.30	$29.30	$44.50	$64.40	$122.40	$197.40	$197.40
$250,000	$9.25	$11.63	$12.88	$16.13	$24.13	$36.63	$55.63	$80.50	$153.00	$246.75	$246.75
$300,000	$11.10	$13.95	$15.45	$19.35	$28.95	$43.95	$66.75	$96.60	$183.60	$296.10	$296.10
$350,000	$12.95	$16.27	$18.02	$22.57	$33.77	$51.27	$77.88	$112.70	$214.20	$345.45	$345.45
$400,000	$14.80	$18.60	$20.60	$25.80	$38.60	$58.60	$89.00	$128.80	$244.80	$394.80	$394.80
$450,000	$16.65	$20.93	$23.18	$29.02	$43.42	$65.92	$100.13	$144.90	$275.40	$444.15	$444.15
$500,000	$18.50	$23.25	$25.75	$32.25	$48.25	$73.25	$111.25	$161.00	$306.00	$493.50	$493.50

Dependent Child Coverage				
$1,000	**$2,000**	**$4,000**	**$6,000**	**$10,000**
$0.15	$0.29	$0.58	$0.73	$1.46

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$ Flexible Spending Accounts

Are you using after-tax money to pay for healthcare and daycare? If you are, you're paying more in taxes than you should be. Victory Life Church offers both Medical and Dependent FSA Options. Your contributions are taken from your paycheck before federal income and Social Security taxes are deducted. Eligible expenses are reimbursed to you with tax-free dollars from your account(s).

Health Care Flexible Spending Account Plan Highlights

- You can contribute from a minimum of $120 to a maximum of $2,650 per plan year.
- The Flexible Spending Accounts have a 90-day run-out period in which you may submit claims for reimbursement at the end of the Plan Year, and/or upon your termination.
- Any money in your FSA account that is left over at the end of the plan year will be forfeited.
- Examples of eligible expenses are:
  - ⇒ Copays for office visits or prescription drugs
  - ⇒ Dental treatment and orthodontia, e.g., fillings, X-rays, braces and caps
  - ⇒ LASIK surgery, eyeglasses, contact lenses, solutions and supplies
  - ⇒ Medical equipment and supplies

Dependent Day Care Flexible Spending Account Plan Highlights

- Contribute up to $2,500 (married filing separate tax returns) or $5,000 (single or married filing a joint tax return) per plan year to your account.
- Eligible expenses include day care, after school programs, and elder care.

Here's a scenario...

Bob and Jane's combined gross income is $30,000. They have 2 children and file their income taxes jointly. Since Bob and Jane expect to spend $2,000 in adult orthodontia and $3,000 for day care next plan year, they decide to direct a total of $5,000 into their FSAs.

	Without FSAs	With FSAs
Annual Salary	*$30,000*	*$30,000*
FSA contributions:	*0*	*-5,000*
Gross income	*30,000*	*25,000*
Estimated taxes:		
Federal	*-2,550**	*-1,776**
State	*-900***	*-750***
FICA	*-2,295*	*-1,913*
After-tax earnings:	*$24,255*	*$20,314*
Eligible out-of-pocket		
Medical and dependent care expenses:	*-5,000*	*0*
Remaining spendable income:	*$19,255*	*$20,561*
Spendable income increase:		***$1,306***

**Assumes standard deductions and four exemptions.*

*** Varies, assume 3percent. The example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.*

2019 Important Notices

This booklet contains information about the rights that you have when you are covered under the health insurance plans

Victory Life Church
3412 W. University Blvd
Durant, OK 74701

Your Human Resources Contact:
Elaina Fowler
elaina.fowler@victorylifechurch.com
580-916-9022, x38272

Your Benefits Advocate: Brown & Brown Insurance
jmiller@bb-ok.com
800-335-3295

Notices in this packet include :

- Medicare D Notice of Creditable Coverage
- Notice of Privacy Practices
- Patient Protection Disclosure
- Special Enrollment Notice
- Medicare Part D Coordination of Benefits
- Mental Health Parity and Addiction Equity Act of 2008
- Newborns' & Mothers' Health Protection Act
- Women's Health & Cancer Rights Act of 1998
- Uniformed Services Employment and Re-Employment Rights Act of 1994
- Qualified Medical Support Orders
- Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)
- Grandfathered Status
- Coverage of Preventive Health Services for Non-Grandfathered Plans, including Women's Preventive Care
- Appeal Process for Non-Grandfathered Plans
- Requirements of Family Medical Leave Act of 1993

Brown & Brown INSURANCE

Important Notice from Victory Life Church About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Victory Life 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. Victory Life Church has determined that the prescription drug coverage offered by the Victory Life Church Blue Cross Blue Shield Plan 1 and Plan 2 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Victory Life Church coverage may be affected. There are some situations in which Medicare pays primary and others in which your group health plan pay primary. For questions about your specific situation, please contact Human Resources at 580-920-1791.

If you do decide to join a Medicare drug plan and drop your current Victory Life Church coverage, be aware that you and your dependents may not be able to get this coverage back until the next group health plan open enrollment period.

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

You should also know that if you drop or lose your current coverage with Victory Life Church and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information, or call Human Resources at 580-920-1791. 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 this coverage through Client Name 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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2019
Name of Entity / Sender:	Victory Life Church
Contact-Position / Office	Human Resources
Address	3412 W. University Blvd, Durant OK 74701
Phone Number	580-920-1791

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
  Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Instructions for Notice

- Effective Date of this Notice - January 1, 2019
- Privacy Officer— Elaina Fowler, HR Director, 580-920-1791, elaina.fowler@victorylifechurch.com
- Organizations this Notice applies to: Victory Life Church

Patient Protection Disclosure

The Victory Life Church medical plan generally does not require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of participating primary care providers, contact your employer's plan administrator or the health insurance issuer. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the health insurance issuer 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 your plan administrator.

08/31/11; 04/14

Special Enrollment Notice

This notice is being provided to insure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage: If you are declining coverage 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 (or after the employer stops contributing toward the other coverage).
Example: *You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.*

Marriage, Birth, or Adoption: If you have a new dependent as a result of a 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, or placement for adoption.
Example: *When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.*

Medicaid or CHIP: 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.
Example: *When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.*

01/12; 04/14

Medicare Part D – Coordination of Benefits

The Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA) created a voluntary prescription drug program for Medicare beneficiaries and made numerous other changes to the Medicare program. Medicare beneficiaries can receive subsidized prescription drug coverage through the Medicare Part D program. Part D eligible individuals can enroll in a qualified Medicare Part D plan or keep their current employer-sponsored coverage. Medicare beneficiaries can also enroll in a Part D plan and retain employer-sponsored prescription drug coverage. If an employer-sponsored group health plan is providing coverage to any individuals who are also enrolled in a Part D plan, the group health plan must cooperate with the Part D plan in order to satisfy certain coordination of benefits (COB) requirements established by the MMA.
The Centers for Medicare & Medicaid Services (CMS) has provided guidance regarding COB issues. The COB requirements of Medicare Part D impact all employers that sponsor prescription drug coverage for Medicare Part D eligible individuals.
The COB issues most applicable to group health plans include:

- Determining whether a Part D plan or a group health plan will be the primary payer;
- Calculating expenditures for purposes of determining a beneficiary's out-of-pocket threshold; and
- Deciding how a group health plan will share information with CMS and Part D plans.

More Information
CMS maintains a website with detailed guidance on COB requirements under Medicare Part D at: www.cms.gov/COBPartD/.

EM 1/14

The Mental Health Parity and Addiction Equity Act of 2008

Under the MHPAEA, the financial requirements and treatment limits that group health plans and health insurance issuers apply to MH/SUD benefits generally cannot be more restrictive than those applicable to medical and surgical benefits. The MHPAEA supplemented the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. The MHPAEA also extended the parity requirements to substance use disorder benefits.

The MHPAEA generally became effective for plan years beginning on or after Oct. 3, 2009 (Jan. 1, 2010, for calendar year plans). The MHPAEA generally applies to plans sponsored by employers with more than 50 employees, including self-insured plans and fully-insured arrangements. The MHPAEA does not require large group health plans and their health insurance issuers to cover MH/SUD benefits. The MHPAEA's requirements apply only to large group health plans and their health insurance issuers that choose to include MH/SUD benefits in their benefit packages.

However, other state and federal laws may require a plan to provide these benefits. The health care reform law, the Affordable Care Act (ACA), builds on the MHPAEA and requires some plans to cover MH/SUD services as one of ten essential health benefits categories. Specifically, non-grandfathered health plans in the individual and small group markets are required to provide essential health benefits (which include MH/SUD services), as well as comply with the federal parity law requirements, beginning in 2014.
The MHPAEA contains the following parity requirements:

- The financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket limits) applicable to MH/SUD benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.
- Treatment limitations (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements. Non-quantitative treatment limitations (such as medical management standards, formulary design and determinations of usual, customary or reasonable amounts) are subject to a separate parity requirement.
- If medical and surgical benefits are offered on an out-of-network basis, a plan or issuer must also offer MH/SUD benefits on an out-of-network basis.
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In addition, the MHPAEA requires plans to make certain information available with respect to MH/SUD benefits, such as the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for MH/SUD services.

10/08; BK 3/14

Newborns' and Mothers' Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act (NMHPA) was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than 48 hours following a vaginal delivery and 96 hours following a delivery by cesarean section. The regulations provide an exception to the NMHPA's general rule regarding length of hospital stay for situations where the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than 48 or 96 hours, as applicable. In October 2008, final regulations relating to the NMHPA were jointly issued by the Internal Revenue Service (IRS), Department of Labor (DOL) and Department of Health and Human Services (HHS). The final regulations replace the interim final regulations that were issued in 1998 and are effective for plan years beginning on or after Jan. 1, 2009. For additional information regarding this coverage, refer to the Summary Plan Description (SPD).

Women's Health and Cancer Rights Act of 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? These benefits are subject to the same benefits that apply to mastectomy benefits under the plan. See your Summary Plan Description (SPD) or plan administrator for additional details.

3/01; BK 11/13

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm
An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets
An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

09/02/14

Qualified Medical Child Support Order

A qualified medical child support order is a court order used to enforce an order for a health plan participant to provide child support health benefits. It requires a health plan to include a child as covered under a health plan, even if the child(ren) or the participant do not meet the conditions of the health plan. A QMSCO is typically used to gain coverage for a child under a non-custodial parent's group health plan. It is normally obtained by a divorced or separated spouse or by a state child support or Medicaid agency. For more information, visit this site:
http://www.dol.gov/ebsa/publications/QMCSO.html or
http://www.acf.hhs.gov/programs/cse/

09/02/14

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)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: www.myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado & Child Health Plan Plus

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404-656-4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid Website: http://www.indianamedicaid.com
All other Medicaid Phone: 1-800-403-0864

IOWA – Medicaid

Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633; Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: http://health.utah.gov/medicaid
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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.

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.

Coverage of Preventive Health Services

The Affordable Care Act (ACA) requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements for the services. This requirement generally became effective for plan years beginning on or after Sept. 23, 2010. It does not apply to grandfathered health plans.

For plan years beginning on or after Sept. 23, 2010, non-grandfathered group health plans must cover certain preventive care services and may not charge copayments, coinsurance or deductibles for these services when delivered by a network provider.

The recommended preventive care services covered by these requirements are:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that are currently recommended by the Centers for Disease Control and Prevention (CDC) and included on the CDC's immunization schedules;
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration (HRSA) guidelines; and
- For women, evidence-informed preventive care and screening provided in guidelines supported by HRSA (for plan years beginning on or after Aug. 1, 2012).

The list of recommended preventive services is available through HHS at: www.healthcare.gov/what-are-my-preventive-care-benefits.

08/11, EM 01/14

Women's Preventive Care Services

The Affordable Care Act (ACA) requires non-grandfathered health plans to cover certain preventive health services without imposing cost-sharing requirements for the services. The ACA's preventive care mandate generally became effective for plan years beginning on or after Sept. 23, 2010. In August 2011, the Department of Health and Human Services (HHS) issued additional preventive care guidelines for women. These additional guidelines, which are generally effective for plan years beginning on or after Aug. 1, 2012, require non-grandfathered health plans to cover women's preventive health services (such as well-woman visits, breastfeeding support, domestic violence screening and contraceptives) without charging a copayment, a deductible or coinsurance.

Non-grandfathered health plans must include these services without cost-sharing for plan years beginning on or after Aug. 1, 2012, subject to the contraceptive coverage exception described below for religious employers.

Exemption

On Aug. 3, 2011, HHS issued an amendment to the interim final rules to allow certain nonprofit religious employers offering health coverage, such as churches, to decide whether or not to cover contraceptive services, consistent with their beliefs.

A final rule regarding contraceptive coverage and religious employers was issued on June 28, 2013. This rule finalizes the exemption to the contraceptive coverage requirement for group health plans of certain nonprofit religious employers. To qualify for the exemption, the employer must be a nonprofit entity that is referred to in section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code. This definition primarily includes churches, other houses of worship and their affiliated organizations.

8/11; EEM 10/12

Appeals Process

The Affordable Care Act (ACA) requires non-grandfathered group health plans and health insurance issuers to implement improved internal claims and appeals procedures and follow minimum requirements for external review.
To receive more information you can view sample notices at: www.dol.gov/ebsa/compliance_assistance.html#section2 and look for the following:

- Revised Model Notice of Adverse Benefit Determination,
- Revised Model Notice of Final Internal Adverse Benefit Determination, and
- Revised Model Notice of Final External Review Decision.

05/13; 04/14

Requirements of Medical Leave Act of 1993 (FMLA)

Family and Medical Leave Act of 1993 (federal law) entitles an eligible employee to job-protected, unpaid leave 1) upon the birth or adoption of a son or daughter of the employee, or one's placement with the employee for foster care; or 2) when the employee's spouse, son, daughter, or parent has a serious health condition and requires care from the employee.

The law also gives employees job-protected, unpaid leave for the employee's own serious illness.

Family Medical Leave may or may not apply, depending on a variety of factors. For more information regarding FMLA, you can refer to the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/dol/topic/benefits-leave/fmla.htm

09/02/14

Domestic Partnership Laws

At the federal level, there are no laws that require or prohibit domestic partner benefits in the workplace. However, the federal Defense of Marriage Act of 1996 (DOMA) impacted the administration of employer-provided domestic partner benefits. Also, a number of states have enacted same-sex marriage, civil union and domestic partnership laws that affect domestic partner benefits.
On June 26, 2013, the U.S. Supreme Court struck down the part of DOMA that limits marriage to opposite-sex unions for purposes of federal law.

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VICTORY LIFE CHURCH

This brochure of Employee Benefits is designed to provide basic information regarding employee benefit plans and programs available to eligible employees. It does not detail all the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts or the Summary Plan Descriptions (SPD) for the various benefit plans and programs. This brochure merely summarizes the employee benefit plans and programs and does not create any contractual rights for any current or former employee, or for any other individual. The benefit provisions of the applicable plan document, contract or SPD will govern the determination of any individual's rights under any employee benefit plan or program. This document does not constitute a plan document or SPD as defined by the Employment Retirement Income Security Act of 1974, as amended (ERISA).

If you have any questions about your Guide, contact Human Resources.

Revised 11/12/2018

Brown & Brown INSURANCE