Catholic Health

Benefits of Caring

2026 Benefits Guide

mychbenefits.org

Benefits of Caring

Catholic Health is proud to offer a rich selection of benefits to our employees, while keeping your costs as low as possible in the process. The Benefits of Caring program reflects both our dedication to our employees and our shared commitment to caring for our community of patients and neighbors.

This guide summarizes your benefits, and helps you to make the choices that will get you the most from our programs.

If you have questions about benefits and enrollment that are not answered in this guide, you can find answers by visiting www.mychbenefits.org. The "Whom to Contact With Questions" page in this booklet also lists contact information for all of the providers and partners listed in this book; they can help answer specific questions.

Mission statement

We, at Catholic Health, humbly join together to bring Christ's healing mission and the mission of mercy of the Catholic Church expressed in Catholic health care to our communities.

This booklet is intended to provide highlights of the Benefits of Caring program, but in no way do the descriptions presented in this guide supersede the provisions contained within the Catholic Health Services of Long Island Health & Welfare Benefits Plan (the "Plan"), or the Plan's Summary Plan Description, or any relevant insurance contract. In the event of any discrepancies, the actual provisions of the Plan document will prevail. Catholic Health, in its sole discretion reserves the right to amend or discontinue any or all of the benefits under the Plan and any or all of the programs within its Benefits Program at any time. Participation in the Benefits of Caring Program does not give you any right to continued employment. In addition, note that this Plan is intended and designed to be administered consistent with the tenets of the Catholic faith. Therefore, the Plan will not cover any costs or benefits that do not comply with the Ethical and Religious Directives of the Catholic Church.

Who we are

Catholic Health is the health care ministry of the Diocese of Rockville Centre. We are one of the largest employers on Long Island. The many locations that participate in the Benefits of Caring Program are:

Hospitals

- Good Samaritan University Hospital
- Mercy Hospital
- St. Catherine of Siena Hospital
- St. Charles Hospital
- St. Francis Hospital & Heart Center®
- St. Joseph Hospital

Nursing Homes

- Good Samaritan Nursing & Rehabilitation
- Our Lady of Consolation Nursing & Rehabilitation
- St. Catherine of Siena Nursing & Rehabilitation

Home Care Organizations

- Catholic Health Home Care
- Good Shepherd Hospice

Long Term Home Health Care Programs

- Good Samaritan
- Our Lady of Consolation

Community Based Organizations

- Suffolk Hearing & Speech Center

Catholic Health Services, Inc.

What's New

We Strongly Encourage You to Take Action During Open Enrollment. 2026 Open Enrollment Is Nov. 4 – 14.

The annual Open Enrollment period is your opportunity to review your current benefit elections and make sure they continue to suit your needs for the upcoming Plan year. Taking action during the Open Enrollment period is strongly encouraged. See below for what's changing for 2026. Before enrolling, please carefully review the benefit options available to you and your family in this benefits guide and on the Benefits Portal.

Changes in 2026

As healthcare costs increase everywhere, we work hard to keep your medical and prescription drug costs as affordable as possible. Please note that the plan is designed to provide you and your family with the most affordable care when you use Catholic Health Providers and facilities. In most cases, services at Catholic Health Providers and facilities have no copays, coinsurance, or deductibles.

Medical Plan Changes:

- Changes have been made to the copays, deductibles, coinsurance, and out-of-pocket maximum for our Medical Plan options. Please review the plan comparison charts on the pages to follow in this booklet, or on the Benefit Portal (**www.mychbenefits.org**) for more detailed information.
- Changes have been made to the Plan's coverage and procedural requirements if you have an elective procedure and choose to use an out-of-network provider at an in-network facility (see the Section titled "Medical Comparison" on pages 5 and 6 of this booklet for changes to the plans in 2026).

Pharmacy Plan Changes:

- Rx Speciality will be limited to the MyCHSRx Tier. For certain specialty drugs not available through MyCHSRx (i.e., limited distribution drugs), members will have access to OptumRx Specialty. The specialty drugs obtained through OptumRx Specialty are subject to 60% coinsurance ($80 min/$200 max copay).

Voluntary Benefit Enhancements

Hospital Indemnity:

- In addition to the base benefit, if a covered member is treated in a Catholic Health hospital, they will receive a supplemental benefit payment.
- Introducing a claim feed from Anthem to MetLife: If you are a covered member under the Catholic Health Medical Plan, you may receive automatic payment for eligible claims. 111

Accident Insurance:

- Coverage has been expanded to include surgery replacement of elbow, hip, knee, or shoulder; general anesthesia, and more.
- Features increased benefit amounts, including medical testing maximum.

Critical Illness:

- Rates are decreasing in 2026.
- Features increased benefit amounts, including an increase to the skin cancer benefit.

Identity Theft:

- Expanded to include Cybercrime coverage, providing up to $50,000 in reimbursement for losses related to scams, cryptocurrency theft reimbursement, wire transfer fraud, and more
- Data removal tool: If activated, the tool monitors sites for your personal information, and submits requests for removal; provides monthly reports so you are aware of your digital presence.

For more information on the Voluntary Benefit enhancements, please call 1-866-554-8713 to speak with a Voluntary Benefit Specialist.

Other Changes:

- The Health Care Flexible Spending Account (HC FSA) maximum annual contribution has increased to $3,400.
- The HC FSA rollover amount from 2026 into 2027 will increase to $680.
- The Childcare Pre-tax Savings Account annual contribution has increased to $7,500 if you are single or married and filing jointly, and $3,750 if you are married and filing separately.
- The Transit and Parking FSA maximums have each increased to $340/month.

Questions and Answers

When does Open Enrollment start?

Open Enrollment starts on November 4, 2025 and ends on November 14, 2025.

When are my benefit changes effective?

Benefit changes made during Open Enrollment are effective January 1, 2026. Your first paycheck in January will reflect the 2026 deductions.

When are my benefit elections due?

You must enroll in benefits on the Enrollment website no later than 11:59 pm EST on November 14, 2025. All benefit-eligible employees are strongly encouraged to review their 2026 benefit elections during the Open Enrollment period to make sure their elections and enrolled dependent(s) are accurate. Late enrollment changes will not be accepted.

How can I access the Enrollment website?

Go to **www.mychbenefits.org** and click **Enroll Now**.

How do I speak with a Benefits Counselor?

Call the Employee Benefits Center at **1-877-87MYBEN** (1-877-876-9236) during Open Enrollment to speak with a Benefits Counselor.

Where can I find a rate sheet?

Rate sheets will be available beginning November 4 on the Enrollment Portal on the Benefits Portal. Visit the Enroll Now page at **www.mychbenefits.org** and log in to view 2026 benefit rates.

Where can I find more detailed benefits information than what is presented here?

The full Benefits of Caring information can be found on the Benefits Portal (**www.mychbenefits.org**).

Is enrollment required this year?

Enrollment is strongly encouraged for all employees this year. During Open Enrollment, log on to the Enrollment portal on the Enroll Now page of the Benefits Portal (**www.mychbenefits.org**) to elect your benefits for 2026.

How to Enroll

Catholic Health offers three ways to enroll in 2026 benefits:

1. Enroll on the Benefits Portal

Visit **www.mychbenefits.org** and click on **Enroll Now** to complete the step-by-step enrollment process. The Enrollment website is available 24/7 via computer or mobile device—enroll when it's convenient for you.

2. Meet with an In-Person Benefits Counselor

During the Open Enrollment period, the Enrollment Café will be set up in designated rooms at select locations. Computer stations will be available and a Benefits Counselor will be able to assist you in your benefit elections.

All Enrollment Café locations will offer walk-in appointments. Visit **www.mychbenefits.org** to view an Enrollment Cafe schedule.

3. Call the Employee Benefits Center

Call the Employee Benefits Center before November 14 at **1-877-87MYBEN** (1-877-876-9236), Monday through Friday 8 am - 8 pm EST.

Who is Eligible

You can enroll in the Benefits of Caring program if you:

- Are a benefits eligible full-time employee or a benefits eligible part-time employee;
- Meet the Catholic Health eligibility requirements, including any waiting period, and;
- Are actively at work when your coverage is scheduled to begin.

You may also enroll eligible dependents in many of our benefit programs.

Eligible dependents are:

- Your spouse
- Your children, provided that they are within the age limits for the plan(s)

  Qualifying children include:

  - Natural children
  - Legally adopted children (or a child placed for adoption) if the child is under 18 years of age at the time of the adoption (or placement for adoption)
  - Stepchildren (as defined under federal law)
  - Eligible foster children
  - Any other person whose welfare is the legal responsibility of the employee pursuant to a written divorce settlement, written separation agreement, court order or order by an administrative process having the force and effect of state law.
- Your grandchild if (1) you have taken a federal tax deduction for the individual as a "Qualifying Relative" under the Internal Revenue Code in the year prior to the year in which you elect to cover the individual and you intend to take such a deduction for the year for which coverage is sought; and (2) the individual shares your primary residence as his or her primary residence.
- Any individual not described in the foregoing "Eligible Dependents" categories who is eligible to file a tax return jointly with you under Internal Revenue Code section 6013.

Note: The Select Plan (a medical coverage option) is not available to spouses who have access to benefits through their own employer.

Dependent Child Age-Out

- Our **medical plans** cover dependent children until the end of the year in which they turn age 26, and any age if they are physically or mentally disabled and financially dependent on the employee.
- Our **dental plans** cover dependent children until the end of the year in which they turn age 26, and any age if they are physically or mentally disabled and financially dependent on the eligible employee.
- Our **enhanced vision** coverage through Davis Vision is offered until the end of the year in which your dependent children turn age 26, and any age if they are physically or mentally disabled and financially dependent on the eligible employee.
- Our **dependent life** insurance benefit is offered for unmarried dependent children from date of birth until the end of the year in which they turn age 26. Children ages 26 and older are eligible for child life insurance if they are disabled, unmarried, and financially dependent on the employee.
- Our **voluntary benefit plans** are offered until the end of the year in which your dependent children turn age 26.

When To Make Changes

Once you have made your enrollment choices, you generally cannot make any changes until the next annual Open Enrollment period. However, you may make certain changes if you have a qualified status change or another permitted election change.

If you have a qualified status change, and are looking to make benefit election changes, you must initiate the qualified status change on the Benefits Portal (**www.mychbenefits.org**) within 31 days of the event. You will need to upload documentation as proof of the event (i.e., proof of gain/loss of other coverage, marriage certificate, birth certificate, etc.), and can then submit your election changes.
Note: Newborns are NOT automatically added to your coverage.

Qualified status changes and other permitted election changes include, but are not limited to:

1. Your legal marital status changes.
2. You increase or decrease your number of dependents (birth, death, adoption or placement for adoption).
3. Your dependent child is no longer eligible for coverage according to the terms of the plan(s) (exceeds age limitations). The Benefits of Caring Program covers dependent children until the end of the year in which they turn 26.
4. A court decree orders that you must provide health coverage for your dependent.
5. Coverage under your spouse's plan is significantly curtailed or ceases.
6. You, your spouse, or your dependent child begin or terminate employment, or your spouse or dependent child switches from full-time or part-time employment (or vice versa) and you, your spouse and/or dependent child becomes or ceases to be eligible for coverage.
7. You switch from full-time to part-time employment (or vice versa). Benefit changes become effective the first of the month following this type of change.
8. Your spouse or dependent child(ren), who formerly was not a resident of the United States, arrives in the United States.

Dependent Documentation

If you are enrolling a dependent in the healthcare plan for the first time, you will be asked to provide documentation to prove eligibility. Documents will be verified by the Employee Benefits Center.

A partial list of documents you may be asked to provide includes:

- Marriage Certificate
- Federal Tax Return
- Birth Certificate
- Adoption Certificate
- Court Order/QMCSO

Please be assured and understand that any/all information you provide to the Employee Benefits Center is kept secure and confidential, at ALL times.

If you have any questions about this process or need assistance, please call the Employee Benefits Center at **1-877-87MYBEN** (1-877-876-9236) Monday through Friday 8 am to 8 pm Eastern Time.

Please note - if you are newly enrolling a dependent, he/she will not be enrolled under your coverage until you upload the necessary documentation and it is approved by the Employee Benefits Center.

Medical Plan

The Benefits of Caring program offers four medical plans, administered by Anthem; the plan you choose will determine what facilities, physicians, and services are covered. Read about each of these options below, and select the health care benefits that are right for you and your family. Rate sheets are available on the Enrollment Portal - visit the benefit site (www.mychbenefits.org), click on Enroll Now to log in, and navigate through the enrollment process to the Medical Plan screen.

Anthem Preferred Provider Organization (PPO)

The Anthem PPO plan grants you complete flexibility to choose your doctor or other provider from a wide network each time you or your covered dependents need care.

The PPO offers out-of-network (OON) benefits; but certain services may not be covered OON. Seek care in the Anthem network or choose a Catholic Health Provider for affordable options.

Anthem Point of Service (POS)

With the Anthem POS program, **it is recommended that you select a Primary Care Physician (PCP) to coordinate your care.** However, you can self-refer to a specialist. You have complete flexibility to choose your doctor or other provider within the Anthem network, or choose a Catholic Health Provider, each time you or your covered dependents need care.

This plan offers out-of-network benefits; however, certain services may not be covered out-of-network.

Anthem Exclusive Provider Organization (EPO)

With the Anthem EPO program, you **must choose a doctor or provider within the Anthem network**, or choose a Catholic Health Provider, each time you or your covered dependents need care.

There are no out-of-network benefits under the EPO plan.

Select Plan

The Select Plan is free for most employees with little or no out-of-pocket costs.

The Select Plan is designed for employees who are comfortable receiving care for themselves and their families at Catholic Health facilities and by Catholic Health Providers. It also includes the 1 Gustave L. Levy Place location of Mt. Sinai Hospital in Manhattan and NY Presbyterian Columbia University Irving Medical Center in Manhattan for services that are not provided at Catholic Health facilities. You also have access to physicians in the Anthem network. **Please note: Other Mt. Sinai and NY Presbyterian locations are not covered under the Select Plan, and you will be responsible for the full cost.**

There are no out-of-network benefits offered under this plan.

If your spouse is offered coverage by their employer, **you may not enroll him/her** in the Select Plan.

Important Reminders

- You are not required to choose a Primary Care Physician to coordinate your care, although it is recommended for the POS plan.
- With the PPO, POS, and EPO plans, if you are traveling or have covered dependents away at school, you have access to BlueCross BlueShield PPO network providers across the country. For more information, visit **www.anthem.com/chs** and click on **Find a Provider**.
- Tell your Anthem physician to send your lab work to Catholic Health facilities, Quest Diagnostics, or LabCorp. You may have out-of-pocket expenses if your lab work is sent to a different lab.
- **Emergency Services (All Plans)** Under all medical plans, emergency services are covered at in-network cost-sharing levels, even if provided by an out-of-network provider or facility. You cannot be balance-billed for emergency services under the No Surprises Act (NSA).

Note that this Plan is intended and designed to be administered consistent with the tenets of the Catholic faith. Therefore, the Plan will not cover any costs or benefits that do not comply with the Ethical and Religious Directives of the Catholic Church.

Enrolling a Spouse?

In order to control our cost and keep coverage affordable for all employees, there is a pre-tax spousal coverage surcharge for spouses enrolled in the Catholic Health Medical Plan who are offered medical coverage by their employer. It may be worth comparing your spouse's coverage at Catholic Health with what they would pay on their employer's plan. If your spouse is offered medical coverage by their employer, there will be a pre-tax spousal surcharge of $20 per paycheck if you cover your spouse under the Catholic Health Medical Plan (PPO, EPO, and POS options only).

Catholic Health Providers

You receive the most affordable care when you go to Catholic Health Providers. To view the Catholic Health Providers directory, visit **www.anthem.com/CHS**, click on **Find a Provider** and then click the link for the **Catholic Health Tier 1 Directory**. The Directory can also be found on the Catholic Health Intranet, both on the homepage and on the MyHR page.

Medical Plan Comparison

Anthem PPO Plan	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 (Out-of-Network)
Deductible	$0	$1,250 Individual/$2,500 Family	$2,500 Individual/$5,000 Family
Medical Out-of-Pocket Max.	$8,600 Individual/$17,200 Family		$12,000 Individual/$24,000 Family
Office Visits[1] *primary care/specialist*	$0 Primary/ $0 Specialist Copay	$40 Primary/ $65 Specialist Copay	Deductible and 40% Coinsurance
Mental Health Office Visit	$0 Copay	$25 Copay	Deductible and 40% Coinsurance
Preventive Care	$0 Copay	$0 Copay	Deductible and 40% Coinsurance
Emergency Department *waived if admitted*	$50 Copay	$200 Copay	$200 Copay
Urgent Care Center	$30 at CH $55 at NY Excel Urgent Care and CityMD	$75 Copay	Deductible and 40% Coinsurance
Inpatient Care	$0 Copay	Deductible and 30% Coinsurance	Deductible and 40% Coinsurance
Outpatient Care	$0 Copay	Deductible and 30% Coinsurance	Deductible and 40% Coinsurance
Cardio and Ortho Procedures	$0 Copay	50% Coinsurance (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
Routine Vision Care	$5 copay for 1 exam every 24 months plus discounts on frames/lenses		Covered In-Network Only

Member cost share (deductible, coinsurance and/or copay as applicable depending on the plan) will apply to all non-Tier 1 (non-Catholic Health) facility services, including admissions through the emergency department.

Anthem POS Plan	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 (Out-of-Network)
Deductible	$0	$2,000 Individual/$4,000 Family	$6,000 Individual/$12,000 Family
Medical Out-of-Pocket Max.	$8,600 Individual/$17,200 Family		$13,000 Individual/$32,000 Family
Office Visits[1] *primary care/specialist*	$0 Primary/ $0 Specialist Copay	$50 Primary/ $75 Specialist Copay	Deductible and 50% Coinsurance
Mental Health Office Visit	$0 Copay	$35 Copay	Deductible and 50% Coinsurance
Preventive Care	$0 Copay	$0 Copay	Deductible and 50% Coinsurance
Emergency Department *waived if admitted*	$50 Copay	$200 Copay	$200 Copay
Urgent Care Center	$30 at CH $55 at NY Excel Urgent Care and CityMD	$75 Copay	Deductible and 50% Coinsurance
Inpatient Care	$0 Copay	Deductible and 40% Coinsurance	Deductible and 50% Coinsurance
Outpatient Care	$0 Copay	Deductible and 40% Coinsurance	Deductible and 50% Coinsurance
Cardio and Ortho Procedures	$0 Copay	50% Coinsurance (Deductible does not apply)	50% Coinsurance (Deductible does not apply)
Routine Vision Care	$5 copay for 1 exam every 24 months plus discounts on frames/lenses		Covered In-Network Only

[1] Tier 1 physician copays apply to physicians in your health plan's network. Use the "Find a Provider" tool on the anthem.com/chs site to find care providers within the Catholic Health Tier 1 Directory. Coverage for other providers depends on whether or not they are in the Anthem network. Consult Tier 2 to find out what your coverage is for the providers you choose.

Reimbursement for out-of-network care (PPO and POS only) is based on 175% of the National Medicare fee schedule. (Emergency department visits may be reimbursed differently.) You are responsible for the out-of-network coinsurance percentage of this amount after deductible, which may be different from what a provider charges.

Members who use out-of-network providers and facilities may also be subject to "balance billing" by the provider or facility, which occurs when a provider requires the member to pay the difference between what the provider bills and what the plan reimburses. You can contact Anthem to learn the reimbursement schedule for a particular service.

New for 2026: If you receive an elective (non-emergency) procedure at an in-network facility and choose to use an out-of-network provider, the Plan will provide coverage only if you complete with your provider a No Surprise Act (NSA) Notice and Consent form before receiving care. This process confirms that you understand the provider is out-of-network and agree to receive services at out-of-network cost-sharing levels and to be subject to balance billing by your provider.

Certain types of services — such as anesthesiology, radiology, pathology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services — are not subject to this NSA consent requirement and are protected from balance billing by your provider.

Medical Plan Comparison

Anthem EPO Plan	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 (Out-of-Network)
Deductible	$0	$1,500 Individual/$3,000 Family	**The EPO Plan does not cover out-of-network services except for emergency care and other limited situations required by the NSA.**
Medical Out-of-Pocket Max.	$8,600 Individual/$17,200 Family		
Office Visits[1] *primary care/specialist*	$0 Primary/ $0 Specialist Copay	$45 Primary/ $70 Specialist Copay	
Mental Health Office Visit	$0 Copay	$25 Copay	
Preventive Care	$0 Copay	$0 Copay	
Emergency Department *waived if admitted*	$50 Copay	$200 Copay	
Urgent Care Center	$30 at CH $55 at NY Excel Urgent Care and CityMD	$75 Copay	
Inpatient Care	$0 Copay	Deductible and 35% Coinsurance	
Outpatient Care	$0 Copay	Deductible and 35% Coinsurance	
Cardio and Ortho Procedures	$0 Copay	50% Coinsurance (Deductible does not apply)	
Routine Vision Care	$5 copay for 1 exam every 24 months plus discounts on frames/lenses		

Member cost share (deductible, coinsurance and/or copay as applicable depending on the plan) will apply to all non-Tier 1 (non-Catholic Health) facility services, including admissions through the emergency department.

Select Plan	Tier 1: Catholic Health Facilities and Providers (In-Network)	Tier 2: Anthem Network (In-Network)	Tier 3 (Out-of-Network)
Deductible	$0	$0	**The Select Plan does not cover out-of-network services except for emergency care and other limited situations required by the NSA.**
Medical Out-of-Pocket Max.	$8,600 Individual/$17,200 Family		
Office Visits[1] *primary care/specialist*	$0 Primary/ $0 Specialist Copay	$0 Primary/ $0 Specialist Copay	
Mental Health Office Visit	$0 Copay	$0 Copay	
Preventive Care	$0 Copay	$0 Copay	
Emergency Department *waived if admitted*	$0 Copay	$200 Copay	
Urgent Care Center	$0 at CH $55 at NY Excel Urgent Care and CityMD	$75 Copay	
Inpatient	$0 Copay	Mt.Sinai and NY Presbyterian Columbia Hospital: $0 Copay[2]; Other facilities not covered	
Outpatient	$0 Copay	Mt.Sinai and NY Presbyterian Columbia Hospital: $0 Copay[2]; Other facilities not covered	
Routine Vision Care	$5 copay for 1 exam every 24 months plus discounts on frames/lenses		

[1] Tier 1 physician copays apply to physicians in the Catholic Health Providers directory. Coverage for other providers depends on whether or not they are in the Anthem network: consult Tier 2 to find out what your coverage is for the providers you choose.

[2] Non-Catholic Health facility care is only covered at the Mt. Sinai location at 1 Gustave L. Levy Place, New York, NY 10029 or NY Presbyterian Columbia University Irving Medical Center location.

New for 2026: If you receive an elective (non-emergency) procedure at an in-network facility and choose to use an out-of-network provider, the Plan will provide coverage only if you complete with your provider a No Surprise Act (NSA) Notice and Consent form before receiving care. This process confirms that you understand the provider is out-of-network and agree to receive services at out-of-network cost-sharing levels and to be subject to balance billing by your provider.

Certain types of services — such as anesthesiology, radiology, pathology, laboratory, neonatology, assistant surgeon, hospitalist, and intensivist services — are not subject to this NSA consent requirement and are protected from balance billing by your provider.

MyCHSRx Pharmacy

Copays and coinsurance are reduced when you use MyCHSRx Pharmacy. Elect to receive a 90-day supply and you will pay 2 MyCHSRx reduced copays for a 3-month supply.

You can pick up your prescription at any of the following inpatient pharmacies:

- Good Samaritan University Hospital, West Islip
- Mercy Hospital, Rockville Centre
- St. Catherine of Siena Hospital, Smithtown
- St. Charles Hospital, Port Jefferson
- St. Francis Hospital & Heart Center®, Roslyn
- St. Joseph Hospital, Bethpage

MyCHSRx also delivers to:

- Catholic Health Services, Rockville Centre
- 2200 Northern Blvd, Greenvale
- DeMatteis Center, Greenvale
- South Bay Cardiovascular, West Islip

Home delivery is available if you are not working at any of the delivery locations or if you work from home.

MyCHSRx:
516-207-7100
MyCHSRx@chsli.org
intranet.chsli.org/my-chs-rx

Prescription Drug Plan

Prescription drug coverage is included when you enroll in medical benefits.

OptumRx Quick Reference Guide

Why pay more for your prescriptions? When considering your prescription drug options, note that copays and coinsurance are reduced when you use the MyCHSRx Pharmacy.

	PPO, EPO, POS, and Select	
Up to 30-day supply	**MyCHSRx**	**Participating Retail Pharmacy**
Generic Drug	$10 copay	$20 copay
Brand Formulary Drug	20% coinsurance $25 min / $50 max	25% coinsurance $50 min / $100 max
Brand Non-Formulary Drug	40% coinsurance $40 min / $80 max	50% coinsurance $75 min / $175 max
Specialty Drug	50% coinsurance $50 min / $100 max	60% coinsurance $80 min / $200 max*
Up to 90-day supply	Obtain up to 90-day supply of a maintenance medication at 2x the MyCHSRx copay (at MyCHSRx) or 2x the retail copay (through OptumRx mail order)	
Prescription Drug Deductible	$50 individual / $100 family	
Out-of-Pocket Maximums	$2,000 per Individual or $4,000 per Family	

**Rx Speciality will be limited to the MyCHSRx Tier. For certain specialty drugs not available through MyCHSRx (i.e., limited distribution drugs), members will have access to OptumRx Specialty.*

Notwithstanding anything in this book to the contrary, the prescription drug plan will not cover any costs or benefits that do not comply with the Ethical and Religious Directives of the Catholic Church.

For questions about your prescription drug benefits, visit www.optumrx.com or call 1-844-642-9089.

Get Help Managing Your Prescriptions and Save with US-Rx Care

US-Rx Care offers a voluntary pharmacy care management program that analyzes all of your prescription drugs and communicates with your doctor on your behalf regarding quality of care and cost-saving opportunities.

This program is an enhancement to your existing pharmacy benefit plan. There are no copayment or formulary changes.

If you have any questions regarding this program or would like to complete a proactive medication review, please contact US-Rx Care at **1-800-241-8440**.

myStrength

MyStrength is part of Teladoc Health's Mental Health Complete Program.

This program includes an array of resources and services—from self-guided programs that you can access on demand to virtual mental health visits. Teladoc Health is the world's leading virtual care provider, making access to health care easier for people everywhere.

Get started

You can join by visiting **TeladocHealth.com/Comfort/CHSLI** or calling **1-800-835-2362**. If you have questions about the program, email **membersupport@teladochealth.com**.

Prior Authorization Review

The Prior Authorization process to determine if a health service is medically necessary is administered by Anthem. This Utilization Review process will include all review activities, whether they take place prior to the service being performed (Preauthorization), when the service is being performed (concurrent) or after the service is performed (retrospective).

The Catholic Health Medical Plan requires participants to obtain Preauthorization for certain services and treatments. Please review the information below regarding the general process for obtaining Preauthorization. Note that processes may differ for specific services and treatments, such as court ordered treatment and coverage for participating crisis stabilization centers.

Services requiring Preauthorization include, but are not limited to:

- Outpatient Services
  - Pain injections (including Botox)
  - Chemotherapy and radiation
  - Infusion therapy
- Maternity
  - Inpatient admission that exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean delivery
- Same-Day Surgeries (excluding diagnostic procedures)
- Behavioral Health and Substance Abuse
  - Partial Hospitalization Program (PHP)
  - Intensive Outpatient Program (IOP)
  - Residential Treatment Center (RTC)
- Hospital and Facility Admissions
- Scheduled Air Ambulance

If your physician recommends that you, or a covered dependent, undergo a procedure that requires authorization, you or your physician must contact Anthem by calling the number on your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

If Anthem has all information necessary to make a determination regarding a **non-urgent Preauthorization review**, they will make a determination and provide notice to you and/or your provider within 15 calendar days of receipt of the request. If they require additional information, it will be requested within 15 calendar days. You or your provider will then have 45 calendar days to submit the information.

If Anthem has all information necessary to make a determination regarding an **urgent Preauthorization review**, they will make a determination and provide notice to you and/or your provider within 72 hours of receipt of the request. If they require additional information, it will be requested within 24 hours. You or your provider will then have 48 hours to submit the information.

Even though your physician can, and often will, obtain Preauthorization for you, **the responsibility for obtaining Preauthorization for procedures and admissions is ultimately yours as the member. If you do not follow this process, you may be responsible for a penalty of 50% up to $5,000, plus related charges***. In addition to paying a penalty, no benefits will be paid for an admission or procedure that is not medically necessary. This penalty and benefit reduction also applies to certain same-day surgery and professional services rendered during an inpatient admission.

Tips for Pre-Certifying Services

We recommend having the following information ready when calling Anthem:

- Your contact information.
- Health Plan ID card number.
- Name and address of the hospital/facility where you will be receiving care.
- Name and telephone number of the prescribing or admitting doctor.
- Reason for admission (if applicable) and type of services to be performed.

For any questions, call **1-800-496-6132** (the same number listed on the back of your Health Plan ID card), and an Anthem customer service representative will be able to assist you (hours of operation are 8 am to 5 pm Eastern, Monday to Friday).

*The financial penalty for failure to pre-certify falls upon the provider and not the patient for in-network inpatient pre-certification.

Dental Plan

You may select a program from the Cigna Dental PPO or choose the Cigna Dental Care DHMO. Rate sheets are available on the Enrollment Portal – visit the benefit site (www.mychbenefits.org), click on Enroll Now to log in, and navigate through the enrollment process to the Dental Plan screen. Visit www.mychbenefits.org for information on where to find a network dentist in your chosen dental plan.

Cigna Dental PPO Plans - Choose either our Core or Buy-Up Programs

Save with Cigna DPPO Advantage Network Dentists

When searching for a dentist on the Cigna portal, select the Cigna DPPO Advantage network to find dentists who provide a higher benefit level of coverage with greater savings!

- **Cigna Dental Advantage dentists:** These dentists will accept a fixed fee for the services they provide, and the claim will be processed in accordance with the in-network benefit amounts below. This is the highest level of coverage with no balance billing.
- **Cigna DPPO dentists:** Claims will be processed in accordance with the out-of-network benefit amounts below. These dentists have agreed to accept a discounted rate, so you should not be balance billed beyond the out-of-network amounts below.
- **Non-Network dentists*:** Claims will be processed in accordance with the out-of-network benefit amounts below. These dentists may balance bill you, meaning they can charge you the difference between what they typically bill for the service and the Maximum Reimbursable Charge (MRC).

	Buy-Up Dental Plan		Core Dental Plan	
Benefit	**In-Network** (DPPO Advantage)	**Out-of-Network** (DPPO/Non-Network*)	**In-Network** (DPPO Advantage)	**Out-of-Network** (DPPO/Non-Network*)
Class I: Cleanings, oral examinations, topical fluoride applications, x-rays, space maintainers and sealants	100%	80%	100%	80%
Class II: Fillings, simple extractions, crown, denture and bridge repair, endodontics, general anesthesia, oral surgery and periodontics	90%	70%	80%	50%
Class III: Bridges, dentures, crowns, inlays and onlays	60%	50%	50%	40%
Class IV: Orthodontia	50%	50%	50%	50%
Deductible (waived for Class I): Individual/Family	$50/$100	$100/$200	$50/$100	$100/$200
Annual Max. Benefit: Per Person	$2,000	$2,000	$1,500	$1,000
Orthodontia Lifetime Maximum: Per Person	$2,000	$1,500	$1,000	$1,000

** For services provided by a non-network dentist, Cigna will reimburse according to the Maximum Reimbursable Charge. The MRC is calculated at the 90th percentile of all provider charges in the geographic area. Non-network dentists may balance bill up to their usual fees, and do not offer plan discounts.*

Cigna Dental Care® DHMO

Or, Select Our Alternate Dental Plan

With the DHMO plan, each time you or your covered dependents need care you must choose a dentist within the Cigna Dental Care Access Plus network. There are no out-of-network benefits offered for the DHMO plan. **Fees apply to certain procedures. Please see the fee schedule on the Enrollment website (www.mychbenefits.org).**

Finding a network dentist is easy.

There are several ways to choose your network primary care dentist:

- Find a dentist at **www.Cigna.com**. The online dental directory is updated weekly.
- Call **1-800-Cigna24** (1-800-244-6224) to speak to a customer service representative. Representatives can send you a customized dental directory listing via e-mail.

For a complete listing of services, please call 1-800-Cigna24.

Key DHMO Features

- **No deductibles.** You don't have to reach a certain level of out-of-pocket expenses before your insurance kicks in.
- **No dollar maximums.** Your coverage won't run out after your covered expenses reach a certain dollar amount.
- **Easy to understand plan.** The fees you pay your dentist are clearly listed on your Patient Charge Schedule (PCS).
- The network **primary care dentist** you choose will manage your overall dental care.
- **Covered family members** can choose their own network primary care dentists - near home, work, or school.
- There's **no age limit on sealants**, which help prevent tooth decay.
- Call **1-800-244-6224** for 24/7 access to the Dental Information Line. This line is staffed by trained health care professionals who can answer questions about dental treatment and clinical symptoms.

Cigna Dental Oral Health Integration Program®

This program reimburses out-of-pocket costs for preventive dental treatments to combat dental issues such as gum disease and tooth decay. The program is for people with certain medical conditions with a higher risk of oral health issues. There's no additional cost – if you qualify and enroll, you get reimbursed.

To get reimbursed, qualifying employees first have to enroll in the Cigna Dental Oral Health Integration Program by either:

- Going to myCigna.com, selecting Coverage > Dental and filling out the registration form online
- Calling the number on the back of their Cigna ID card and asking for a mailed registration form

Reimbursement is as simple as 1, 2, 3...

1. An enrolled employee goes to their dentist and pays their usual copay or coinsurance for the covered service.
2. If they visit a dentist in the Cigna network, the dentist will send us a claim for reimbursement. If they choose to see a dentist not in the Cigna network, the employee may have to submit their claim.
3. Cigna will review the claim and mail reimbursements for eligible dental services in about 30 days.

Vision Plan

Basic eye care and eyewear discounts are included with your Anthem Health coverage. You may enroll in the Davis Enhanced Vision Plan for enhanced coverage. Rate sheets are available on the Enrollment Portal - visit www.mychbenefits.org, click on Enroll Now to log in, and navigate through the enrollment process to the Vision Plan screen.

Basic: Blue View Vision

Your Blue View Vision network

Blue View Vision offers you one of the largest vision care networks, with a wide selection of experienced ophthalmologists, optometrists, and opticians. **When you enroll in a Catholic Health Medical Plan, this basic coverage is included at no additional cost**. The network also includes retail locations, like LensCrafters®, Target Optical®, JCPenney® Optical, Sears Optical℠, Pearle Vision®, and New York-based Anthem Vision and Davis Vision Centers.

Out-of-network services

If you choose an out-of-network provider, you will receive an allowance toward an eye exam and you pay the rest. Network benefits and discounts will not apply. When you use a non-participating provider, you will pay in full at the time of service, then file a claim for reimbursement to Blue View Vision, Attn: OON Claims, PO BOX 8504, Mason, OH 45040-7111.

Using your Blue View Vision Plan

The Blue View Vision network is for routine eye care only. To receive routine eye care, use your Medical ID card. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network.

Exclusions and Limitations

See **www.anthem.com** for a full listing of exclusions and limitations.

Your Blue View Vision Plan At-A-Glance:

Vision Care Services	In-Network	Out-of-Network***
Routine Eye Exam (once every 24 months)	$5 Copayment	$40 allowance
Blue View Vision Discount	Member Cost (when purchasing frames and lenses)	
Eyeglass Frame*	35% off retail price	Out-of-Network coverage not available
Contact Lenses** (Conventional)	15% off retail price	Out-of-Network coverage not available
Standard Plastic Lenses		
Single Vision	You Pay $50	Out-of-Network coverage not available
Bifocal	You Pay $70	Out-of-Network coverage not available
Eyeglass Lense Option*		
UV Coating	You Pay $15	Out-of-Network coverage not available
Tint (Solid and Gradient)	You Pay $15	Out-of-Network coverage not available
Standard Scratch-Resistance	You Pay $15	Out-of-Network coverage not available

Note: Blue View Vision's Additional Savings Program is subject to change without notice.

** 20% discount if frames, lenses or lens options are purchased separately.*

*** Discount does not apply to fitting fees or services.*

**** Out-of-Network allowance applies to exams only. There is no out-of-network allowance for lenses or frames.*

Enhanced: Davis Enhanced Vision Plan

The supplemental plan offers greater coverage and discounts

The Enhanced Davis Vision Plan by MetLife is a voluntary benefit that offers you greater coverage on many vision services and products. You may enroll in this plan even if you choose not to enroll in the Medical Plan.

Enhanced Benefits

This plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases, such as glasses and contact lenses. The plan includes access to the Davis Vision Exclusive Collection of Frames and Contact Lenses at no out-of-pocket cost (in lieu of allowance). The Collection includes Fashion, Designer, and Premier frames and contact lenses. The Davis network includes thousands of provider locations including Visionworks, Costco, Walmart, and more.

The Enhanced Davis Vision Plan also covers prescription safety glasses. If you are enrolled in the Enhanced Vision Plan through Davis Vision, you can purchase one set of frames every 12 months. Purchasing safety glasses will apply towards your frame allowance – for example, you can purchase a set of frames for safety eyewear or dress eyewear every 12 months.

Hearing Aid Benefit

Additionally, the Enhanced Davis Vision Plan covers a wide selection of digital hearing aids from multiple manufacturers.

- Up to 40% savings compared to national average selling prices
- Four year limited warranty and four year FREE battery supply
- 60-day satisfaction guarantee and a $200 mail-in-rebate on top-rated hearing aids
- All levels of technology, from essential to advanced and premium
- All styles of hearing aids, including discrete inner ear models and the popular mini receiver in-the-canal
- An array of colors to meet your preferences
- Bluetooth, smart phone compatible, wireless and rechargeable models
- 10% discount on accessories, such as TV streamers

For more details and information on the Enhanced Vision Plan, please visit **www.mychbenefits.org**.

Using Your Davis Enhanced Vision Plan

If you enroll in the Davis Enhanced Vision Plan, you will receive a separate Davis Vision ID card. To access a complete list of in-network providers near you and additional benefit information, visit **www.metlife.com/mybenefits** or call **1-844-638-2454** (1-844-MET-CHLI).

Exclusions and Limitations

See **www.metlife.com/mybenefits** for a full listing of exclusions and limitations.

Your Enhanced Vision Plan At-A-Glance:

Vision Care Services	In-Network	Out-of-Network
Exam with Dilation *once every 12 months*	$0 copayment	$35 allowance
Davis Vision Discount	**Member Cost**	**Out-of-Network**
Eyeglass Frame ***(dress or safety eyewear)*** *once every 12 months*		
Retail	$0 copay, $200 allowance; 20% off balance over $200	Up to $50
Exclusive Collection Frames*	100% covered	Up to $50
Contact Lenses *(once every 12 months instead of eyeglasses)*		
Retail	$0 copay, $130 allowance; 15% off balance	Up to $100
Exclusive Collection Contacts*	100% covered	None
Contact Evaluation, Fitting & Follow-Up Care		
Elective	15% discount	None
Medically Necessary	100% covered	$200 allowance
Standard Plastic Lenses		
Single Vision	$0 copay	Up to $25
Bifocal/Trifocal/Progressive	$0 copay	Up to $40/$65/$40

**Available at most participating independent provider offices. Collection is subject to change.*

Flexible Spending Accounts (FSA)

Reduce Your Taxes By Setting Money Aside For Eligible Expenses

Health Care FSA

The Health Care FSA offers a real tax savings advantage. Many people find it a cost effective way to pay for such items as medical and dental plan deductibles/copayments, eyeglasses, contact lenses, orthodontics, and other health related expenses that are not covered by insurance. Even taxpayers who do not itemize their expenses can take advantage of this tax break using the Health Care FSA. **Expenses that are eligible for reimbursement include those incurred by you and your dependents.**

Maximum annual contribution allowed by the IRS is $3,400 per participant. The minimum annual contribution is $100.

- IRS regulations state that expenses reimbursed under your Health Care FSA may not be reimbursed under any other plan or program. Only your out-of-pocket expenses are eligible.
- Up to $680 may be rolled over for use in the next year. IRS requires that any unused money left in your account at the end of the year in excess of $680 be forfeited.
- The amount you contribute to this account is not subject to federal, state, or Social Security (FICA) taxes.
- Annual election is deducted in even increments from each paycheck remaining in the year and contributed to your Health Care FSA.
- When a medical, dental, or prescription drug expense is incurred, the claim is automatically processed. Claims for other eligible expenses should be submitted manually. Please note: employees not enrolled in our medical, dental, or prescription plan will have to submit their claims manually.
- Services must be incurred within the plan year and must be claimed by March 31 of the following year.

These plans, as well as your entire health program, are intended and designed to be administered consistent with the tenets of the Catholic faith. Please visit the Benefits Portal for a full list of eligible expenses.

Childcare Pre-tax Savings Account

This account is for childcare expenses or expenses to care for a spouse or elderly parent who resides in your home.

Extend your income by using the Childcare Pre-tax Savings Account to pay for dependent care expenses incurred while you are at work with income tax-free dollars. If you are paying for day care expenses now, you are paying with taxable dollars and probably taking the federal tax credit at the end of the year. If you use the Childcare Pre-tax Savings Account, you will pay these expenses with pre-tax dollars throughout the year. In most instances, the savings realized through participation in the Childcare Pre-tax Savings Account will be greater than the savings available through the tax credit.

- Maximum annual contribution allowed by the IRS is $7,500 if you are single or married and filing jointly, and $3,750 if you are married and filing separately.
- The minimum annual contribution is $100.
- Claims for dependent children are covered up until their 13th birthday. Claims incurred after their 13th birthday are not eligible for reimbursement.
- IRS requires that unused money left in your account at the end of the plan year be forfeited.
- The amount you contribute to this account is not subject to federal, state, or Social Security (FICA) taxes.
- Participation in this account will reduce or eliminate the ability to use the federal tax credit for dependent care.
- In order to be eligible, the care being provided must allow both you and your spouse, if you are married, to go to work.
- Annual election is deducted in even increments from each paycheck remaining in the year and added to your Childcare Pre-tax Savings Account.
- Services must be incurred within the plan year.

Who is a Qualified Dependent?

Generally, if a person qualifies as your eligible dependent for medical benefits, he/she qualifies as a dependent under the Health Care FSA. (See page 2 for a list of eligible dependents.)

Under the Dependent Care FSA, dependents are defined as children up until their 13th birthday or children 13 or over who are physically or mentally unable to care for themselves. A spouse or elderly parent residing in your home, who is physically or mentally unable to care for himself or herself, also qualifies.

If I have more questions...

To get answers to other questions, please visit **www.myflexdollars.com** or call the Employee Benefits Center at **1-877-87MYBEN** (1-877-876-9236).

To view your account, register at www.myflexdollars.com.

Neither your employer nor Baker Tilly provides tax or legal advice. Always ask your attorney or tax advisor for the appropriate tax advice for your situation.

Please refer to the Benefits Portal for a complete list of eligible expenses.

Transit Flexible Spending Account Program

The Transit and Parking Program allows employees to pay, on a pre-tax basis, for the costs incurred for purposes of transportation between an employee's home and place of employment. This can be done monthly or set up to be recurring. Please visit the Benefits Portal for details on enrollment.

The transit and parking maximum pre-tax limits are:

- Transit Limit: $340 per month
- Parking Limit: $340 per month

Life and Accidental Death & Dismemberment Insurance and Disability Income

Life Insurance and Disability benefits provide peace of mind to you and your family in the case of an accident or sickness.

Basic Life Insurance and Accidental Death & Dismemberment

This benefit, offered to all benefit eligible employees at no cost, is equal to your annual base salary rounded to the next higher $1,000. The minimum basic coverage is $20,000 if you're a benefit eligible full-time employee, or $5,000 if you're a benefit eligible part-time employee. The maximum basic coverage is $650,000.

You're automatically covered for an additional benefit equal to your basic life insurance coverage in case of accidental death, loss of limb, or eyesight. While Catholic Health pays the full cost of this coverage, amounts in excess of $50,000 will be subject to imputed income tax. That means the premium for coverage over $50,000 will be reported as taxable income to you.

Your Basic Life and Accidental Death & Dismemberment Insurance coverage will be reduced upon reaching age 70, and again at 75, 80, and 85. Premiums are calculated on the reduced amount of coverage.

Supplemental Life Insurance for You

You may elect Supplemental Life Insurance in the amount of 1 to 6 times your annual base salary.

During the annual Open Enrollment period, you may elect Supplemental Employee Life Insurance equal to 1 time more than you currently have, without proof of good health provided that is does not exceed the $1.5 million maximum when combined with your Basic Life Insurance amount. If you are not currently enrolled in Supplemental Life Insurance, any election you make during Open Enrollment will require proof of good health.

Supplemental Life Insurance for Your Dependents

You also may enroll your eligible dependents for coverage under one of the following life insurance plans:

- **Spouse Life Insurance:** Your spouse may be insured for $5,000, $20,000, $50,000, $100,000, or $150,000. The spouse life insurance amount cannot exceed 100% of the employee's combined basic and supplemental life insurance amount.
- **Child Life Insurance:** Children are eligible from birth, or until the end of the year in which they turn age 26 regardless of student status. Children ages 26 and older are eligible for child life insurance if they are disabled, unmarried, and financially dependent on the employee. You may elect to insure your child(ren) for $4,000 or $10,000.

Please note that if both you and your spouse are Catholic Health employees, you may not cover your spouse as a dependent, nor may your spouse cover you as a dependent. Children may only be covered by one family member who is an employee of Catholic Health.

Short Term Disability (STD)

STD coverage continues part of your pay for up to 26 weeks if you are ill or injured and unable to work.

This plan pays a benefit of up to 50% of your covered earnings – to a weekly maximum of $170. Benefit eligibility begins on the eighth calendar day of disability, subject to medical documentation. Contact your Human Resources representative for additional information.

Supplemental Short Term Disability

The Voluntary Supplemental Short Term Disability insurance program provides additional income replacement, beyond the New York State Disability plan, in the event you are unable to work due to a non-work related illness or injury.

Following the waiting period (7 days for sickness, 7 days for accident), the plan provides a benefit equal to an additional $100 per week or $200 per week of income, depending upon your election, less income you may receive from other sources. The benefit continues as long as you are disabled, up to a maximum of 26 weeks.

Long Term Disability (LTD)

LTD coverage can help protect your income if a major illness or injury prevents you from working for an extended period of time.

This plan pays a benefit of up to 60% of your monthly covered earnings – to a maximum of $10,000 per month. If you are disabled and unable to perform your job, LTD payments begin after 26 weeks. LTD benefits will be offset by any amount you are eligible to receive from other sources, such as Social Security or Workers' Compensation.

Critical Illness Insurance

Administered by MetLife – Catholic Health does not sponsor or subsidize voluntary benefits, including Critical Illness Insurance

The out-of-pocket costs of a serious illness can take a toll on your finances, even with medical insurance. Critical Illness Insurance helps provide financial protection in the event of a covered serious illness **or cancer**.* The policy pays a lump sum benefit directly to you if you or a covered family member is diagnosed with a covered condition. You can use this benefit any way you choose – deductibles and coinsurance, expenses your family incurs to be by your side, or simply to replace your lost earnings from being out of work. You choose the benefit amount when you enroll.

Employees must be actively at work on the effective date of coverage in order to enroll in Critical Illness Insurance.

**The policies have exclusions and limitations which may affect any benefits payable. See a complete list of covered conditions, along with complete provisions, exclusions, and limitations.*

Examples of covered illnesses may include:

- Heart attack
- Major organ transplant surgery
- End stage renal (kidney) failure
- Invasive cancer
- Alzheimer's Disease
- Coronary artery bypass
- Stroke

Plan Features:

- You do not have to be terminally ill to receive benefits.
- Coverage options are available for your spouse and children.
- Employee coverage pays a lump sum benefit of $10,000 - $40,000; available in $10,000 increments.
- Coverage is portable, which means you can take your policy with you if you change jobs or retire.

Accident Insurance

Administered by MetLife – Catholic Health does not sponsor or subsidize voluntary benefits, including Accident Insurance

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact, which is often substantial. Accident Insurance can help cover the out-of-pocket medical expenses and extra bills that can follow an accident. The total benefit you receive is based on the type of injury, its severity and the medical services you received in treatment and recovery.

The plan pays benefits for a variety of injuries and accident-related expenses, including:

- Fractures
- Dislocations
- Hospitalization
- Physical Therapy
- Emergency Department Treatment
- Transportation

Plan Features:

- Benefits are paid for accidents that occur on and off the job.
- You can elect to cover your spouse and children.
- Guaranteed issue! There are no health questions or physical exams required.
- Coverage is portable, which means you can take your policy with you if you change jobs or retire.

Hospital Indemnity Insurance

Administered by MetLife – Catholic Health does not sponsor or subsidize voluntary benefits, including Hospital Indemnity Insurance

Even with medical insurance, a hospital stay can jeopardize your regular income and challenge your ability to cover everyday living expenses. Hospital Indemnity Insurance provides payments, in addition to your medical plan, to help cover eligible expenses associated with a hospital stay. Benefits are paid directly to you, and you can use the money however you choose. Benefits are designed to help offset expenses your medical plan doesn't cover, such as deductibles, coinsurance, and everyday bills.

In addition to the base benefit, if a covered member is treated in a Catholic Health hospital, they will receive a supplemental benefit payment.

Plan Features:

- Benefits are paid regardless of any other insurance you have.
- Guaranteed issue! There are no health questions or physical exams required.
- Coverage is available for your spouse and children.
- Premiums are paid through convenient payroll deductions.
- Coverage is portable, which means you can take your policy with you if you change jobs or retire.

The policies or provisions listed on this page may vary or be unavailable in some states. The policy has exclusions and limitations that may affect any benefits payable.

Enrolling in Voluntary Benefits

Employees can enroll in the voluntary benefit plans when they are newly eligible, with a qualified status change, or during the annual Open Enrollment period.

More Information

For more information about the benefits on this page and the previous page, go to **www.mychbenefits.org**.

Identity Theft Protection

Administered by Allstate Identity Protection – Catholic Health does not sponsor or subsidize voluntary benefits, including Identity Theft Protection

In 2017, 16.7 million Americans were victims of identity fraud. The amount stolen totaled $16.8 billion.[1] Protecting your identity is more important now than it ever was before.

Identity Theft Protection is an affordable solution to a growing problem. It provides comprehensive, proactive identity theft monitoring and dedicated recovery assistance. By constantly monitoring your personal and financial data, this service catches fraud early and helps you act quickly to limit the damage of stolen information.

Allstate Identity Protection leads the identity protection industry with the Pro Plus monitoring service, which alerts you at the first sign of fraud and fully restores your identity. Allstate Identity Protection offers 24/7 customer care to ensure your identity is fully restored.

Plan Features:

- Proactive identity monitoring
- Password protection
- Credit monitoring
- Data breach solutions

Cyber Features with Pro Plus Cyber Plan:

- Personal device protection for desktop and mobile
- Personal ransomware expense reimbursement
- Digital safety tools for content monitoring and alerting

[1] *Javelin Strategy & Research, 2018 Identity Fraud: Fraud Enters a New Era of Complexity, 2018*

Legal Plan

Administered by MetLife – Catholic Health does not sponsor or subsidize voluntary benefits, including Legal Insurance

Affordable legal assistance can sometimes be difficult to find. With a high-quality Legal Insurance plan, you get more than a valuable service – you gain peace of mind knowing that good legal help is within reach. When you enroll in the MetLaw Legal Plan, you'll have access to a network of attorneys who can assist you with services via office consultation and/or telephone advice such as:

- Consumer Protection and Personal Property Protection Services
- Debt Collection and Identity Theft Defense
- Tax Audits
- Civil Lawsuit Defense
- Documents and Will Preparation
- Real Estate Legal Services
- Traffic Ticket Defense (excludes DUI)

Plan Features:

- Coverage is portable, which means you can take your policy with you if you change jobs or retire
- Telephone advice and office consultations for personal legal matters

The policy or its provisions may vary or be unavailable in some states.
The policy has exclusions and limitations which may affect any benefits payable.

Laws and Notices

Notice of Required Coverage Following Mastectomies

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 of 1998 (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. Please contact the Plan Administrator for more detailed information regarding deductibles and coinsurance for these benefits under the Plan.

Availability of Summary Annual Report

A copy of the 2024 Summary Annual Report ("SAR") for the Catholic Health Services of Long Island Health & Welfare Benefits Plan (the "Plan") can be found by accessing the following link (www.mychbenefits.org) and clicking Enroll Now to log in. Federal law requires the Plan Administrator to furnish to each participant and beneficiary under the Plan a summary of the Plan's financial status. This is known as a summary annual report (SAR) because it summarizes the information on the Plan's annual report (Form 5500 series) filed with the government. If you want a paper version of the SAR, please request one from the MyHR Team. There is no additional charge for it. If you have any questions regarding the SAR, please contact the Plan Administrator at 516-705-6947.

Catholic Health Services of Long Island Health & Welfare Benefits Plan Notice of Special Enrollment Periods

If you are declining enrollment in the Catholic Health Services of Long Island Health & Welfare Benefits Plan's health coverage options 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 the Plan's health coverage features if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 31 days after the marriage, birth, adoption, or placement for adoption. Also, if you or your eligible dependent are covered under Medicaid or a State Children's Health Insurance Program (CHIP) and that coverage ends, you may be able to enroll yourself and any affected dependent in this Plan's medical coverage. You must request enrollment within 60 days after the Medicaid or CHIP coverage ends. If you or your eligible dependent become eligible under Medicaid or a State CHIP plan for financial assistance to pay for health coverage under this Plan, you may be able to enroll yourself and any affected dependent in this Plan. You must request enrollment within 60 days after the date a government agency determines that you are eligible for that financial assistance.

Notice of Health Information Privacy Practices

The Plan maintains a Notice of Privacy Practices (Privacy Notice) that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you are a new participant covered under any of the Plan's health benefit options, you will receive a copy of the Privacy Notice upon enrollment. In addition, a copy of the current Privacy Notice is always available on our website, and upon request by calling us at 516-705-6947.

Availability of Summary Health Information

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

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: www.mychbenefits.org. A paper copy is also available, free of charge, by calling 516-705-6947.

Notice of Summary Plan Description (SPD)

The SPD includes important updates to the Plan and explains the terms and conditions of your Plan, including eligibility, participation dates, termination provisions and exclusions relating to the benefits offered under the Plan. The SPD will be amended effective as of 1/1/26 and is available electronically in the enrollment system by logging in through the Benefits Portal (www.mychbenefits.org). Please share this with your family members who are also covered under any of the benefits offered under this Plan. If you want a paper version of the SPD (no charge), please request one from MyHR, and/or if you have any questions about the updates made to the Plan, please contact MyHR. The SPD also includes a notice regarding your COBRA continuation rights under the Plan. Please share this COBRA notice with your covered spouse.

Verify Your Social Security Number

You and your employer are obligated to provide the IRS with correct identifying information about each individual covered under your health insurance. You may be subject to an IRS penalty under the Internal Revenue Code Section 6723 if you fail to provide correct identifying information. Please take this time to confirm that the Social Security Number we have on file for you and your dependents is correct – you can review your SSN on your most recent Form W2 available through self-service. If you have any questions, or any corrections need to be made, please reach out to MyHR at 516-705-6947 or MyHR@chsli.org.

Premium Assistance Under Medicaid & The Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 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 July 31, 2025. Contact your State for more information on eligibility.

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website:
www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: www.njfamilycare.org/index.html
CHIP Premium Assistance Phone: 609-631-2392
CHIP Phone: 1-800-701-0710

NEW YORK – MEDICAID

Website: www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

PENNSYLVANIA – MEDICAID

Website: www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
Phone: 1-800-692-7462
CHIP Website: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

To see if any more States have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, you can contact either:

U.S. DEPARTMENT OF LABOR

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice From Catholic Health 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 Catholic Health 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. Catholic Health has determined that the prescription drug coverage offered by the Catholic Health Services of Long Island Health and Welfare Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through 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 Catholic Health coverage will not be affected.

You can keep your Catholic Health coverage if you elect Part D, but this plan will NOT coordinate with your Part D coverage if this plan is not the primary payer.

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

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

You should also know that if you drop or lose your current coverage with Catholic Health 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 November to join.

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

Contact the person listed below 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 this coverage through Catholic Health 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: October 2025
Name: Catholic Health
Address: 3 Huntington Quadrangle, Suite 301S
Melville, NY 11747
Phone: 516-705-6947

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there was added 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 and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through the Marketplace began in October 2013.

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% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

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

How Can I Get More Information?

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

Employer Information

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide employer information.

Name:	Catholic Health
EIN:	11-3403968
Address:	3 Huntington Quadrangle, Suite 301S Melville, NY 11747
Contact:	Catholic Health c/o Human Resources Service Center: MyHR
Phone:	516-705-6947

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you are covered 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. (Both you and, if you are married and your spouse is covered by the plan, your spouse should take the time to carefully read this notice.)

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 known as 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)

You must give notice of some qualifying events

For the other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child (other than due to the attainment of a certain age)), you must notify the Plan Administrator (using a Plan provided form) within 60 days after the later of (1) the date the qualifying event occurs or (2) the date coverage would end because of the qualifying event. You must send notification to the Plan, along with any required documentation via mail, email or fax as provided below:

To: Catholic Health Services of Long Island d/b/a Catholic Health

c/o Human Resources Service Center: MyHR

By Mail: 3 Huntington Quadrangle, Suite 301S, Melville, NY 11747

By Email: MyHR@chsli.org or online on the Benefit Portal

By Fax: 516-705-2828

Please submit your election changes online on the Benefit Portal (www.mychbenefits.org), and submit documentation of the event that occurred, such as a photocopy of a divorce order showing the date of the divorce. If you have any question about what type of documentation is required, you should contact the Plan Administrator at the address provided above or by calling 516-705-6947.

Note: If your dependent loses coverage under the Plan due to the attainment of a certain age, there is no need to notify the Plan Administrator. The Plan will offer COBRA continuation coverage automatically to your dependent if he or she has become ineligible due to attainment of a certain age.

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. (NOTE: The rest of this paragraph applies to health plans other than the health care flexible spending account plan. For the rules that apply to the health care flexible spending account, see the "Special Rules for Health Care Flexible Spending Accounts" section below.) COBRA coverage generally lasts for 18 months if the qualifying event is 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 two 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 the Social Security Administration 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 total 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. To notify the Plan Administrator of a disability determination, you should follow the same procedures described above under "You Must Give Notice of Some Qualifying Events". Your notice must include documentation of the Social Security Administration's decision and it must be provided within 60 days after the date of that decision, or, if later, within 60 days after the later of (1) the date the original qualifying event occurred or (2) the date that coverage would otherwise end (if COBRA coverage is not elected) because of the original qualifying event. However, regardless of the deadline described in the previous sentence, your notice must be provided no later than the date your COBRA coverage would terminate without a disability extension.

Second qualifying event extension of 18-month period of COBRA 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 (following the same procedures described above under "You Must Give Notice of Some Qualifying Events"). 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), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but this extension is available only 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.

Special rules for health care flexible spending accounts

For a health care flexible spending account (Health FSA), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA coverage under the Health FSA cannot be extended beyond that time for any reason.

EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her Health FSA account for a Plan Year and then her employment terminates six months after the beginning of the Plan Year. By that time, she has contributed $600 to her FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for expenses incurred before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is $400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her termination date, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay ($612).

Any deadlines or other rules for filing a request for reimbursement under the Health FSA will continue to apply if you elect continuation coverage under the Health FSA. Review the Health FSA details in this Summary for more information.

Additional continuation coverage rights for employees on military leave

If you take a leave of absence from employment with the Employer because of military service and your coverage (for you and your covered spouse or dependents) would otherwise terminate, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You will be required to pay for such coverage in an amount determined under USERRA. (If your leave is for a period of 30 days or less, you will be required to pay only the amount that active employees pay for similar coverage.) This continuation coverage is basically identical to the continuation coverage described in this COBRA notice and it may end for any of the reasons that COBRA continuation coverage would end, except that the maximum coverage period is different. Specifically, note that USERRA continuation coverage will end no later than the first of the following days: (1) the last day of the 24-month period beginning on the date your military leave of absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with the Employer.

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.

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

For additional information about COBRA continuation rights or to report any address changes, please contact the Plan Administrator at the address of phone number provided above.

Non-Discrimination Statement

Catholic Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Catholic Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Catholic Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Linda Foy at 516-705-3850.

If you believe Catholic Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Linda Foy, CPHRM. Assistant Vice President, Enterprise Risk Management. Catholic Health, 992 North Village Ave., Rockville Centre, NY 11570 Phone 516-705-3850. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Linda Foy is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-516-705-3850.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-516-705-3850

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-516-705-3850.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-516-705-3850.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-516-705-3850.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-516-705-3850.

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-516-705-3850

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-516-705-3850

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-516-705-3850.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-516-705-3850

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-516-705-3850.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-516-705-3850

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-516-705-3850.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-516-705-3850.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-516-705-3850.

Corporate Counseling Associates

Your Work Life Assistance Program

FEATURES INCLUDE:

- Toll-free 24/7 access to a qualified work-life counselor
- Assistance locating resources and referrals per your request
- Information-rich website loaded with content and tools for managing work, personal, and everyday issues
- Support for you, as well as those in your family and/or household
- Follow-up to be sure that the assistance met your complete satisfaction

To help you make time for what matters most, you and your family now have access to the Work/Life Assistance Program provided by CCA, Inc. Available any time, any day by phone, Web, or in person, CCA offers live assistance from a professional counselor—as well as a rich web-based library of practical resources—to provide support for any work, personal, childcare/eldercare, or everyday issue that's important to you and your family.

ALWAYS AVAILABLE! ALWAYS CONFIDENTIAL!...TOLL FREE AT (800) 833 – 8707

Login at www.myccaonline.com, login code: CHS

Whom To Contact With Questions

General Contacts

Employee Benefits Center		1-877-87MYBEN (1-877-876-9236)	www.mychbenefits.org	Review benefit options and elections, obtain enrollment assistance, and complete dependent verification
MyHR		516-705-MYHR (6947)	Email: MyHR@chsli.org	General HR and 403(b) information

Plan	Vendor	Phone Number	Web Site	Services
Health & Welfare				
Medical Plans Group #: 377650	Anthem Blue Cross and Blue Shield	1-800-496-6132	www.anthembluecross.com	Find a network provider, customer service, check the status of a claim
Prescription Plan	OptumRx	1-844-642-9089	www.optumrx.com	Customer service and plan information
MyCHSRx		516-207-7100	Email: MyCHSRx@chsli.org	Customer Service and Rx plan info
MyCHSRx Specialty		631-468-6910		
MyStrength		1-800-835-2362	TeladocHealth.com/Comfort/CHSLI	Schedule virtual mental health visits and find self-guided programs
Preauthorization		1-800-496-6132		Ask questions about the priorauthorization process.
Dental Plans Group #: 3332036	Cigna	1-800-244-6224	www.mycigna.com	Find a network provider, customer service, check claim status
Vision Plans	Anthem Basic Davis Vision by MetLife	1-866-723-0515 1-844-638-2454 (844-MET-CHLI)	www.anthem.com www.metlife.com/mybenefits	Find a network provider, customer service, check the status of a claim
Life Insurance	Voya Financial	Life Insurance Claims: 1-888-238-4840	https://presents.voya.com/EBRC/chsli	Customer Service
Disability/ Leave Administration	Matrix Absence Management	1-877-202-0055	https://www.secure.rsli.com/userservices/	Initiate a claim for Long Term Disability benefits and LOA request
Flexible Spending Accounts (including Transit)	Baker Tilly	1-877-87MYBEN (1-877-876-9236)	www.myflexdollars.com	Check balance or verify eligibility of an expense
Work/Life Assistance Plan	CCA	1-800-789-2720	www.myccaonline.com	Learn more about the Work/Life Assistance Plan
COBRA	Baker Tilly	1-800-307-0230, Prompt 3	www.mybenefitdollars.com	Learn about Continuation of Coverage
Voluntary Benefits				
Voluntary Benefit Specialist		1-866-554-8713		
Critical Illness	MetLife	1-844-638-2454 (1-844-MET-CHLI) Call Line Open 8 am - 8 pm EST	https://online.metlife.com/edge/web/public/benefits/	Provides income protection in the event of a covered serious illness
Accident Insurance	MetLife	1-844-638-2454 (1-844-MET-CHLI) Call Line Open 8 am - 8 pm EST	https://online.metlife.com/edge/web/public/benefits/	Reduce the financial impact after an accident causing bodily injury
Hospital Indemnity	MetLife	1-844-638-2454 (1-844-MET-CHLI) Call Line Open 8 am - 8 pm EST	https://online.metlife.com/edge/web/public/benefits/	Get help covering expenses after a hospital stay
Legal Plan	MetLife	1-844-638-2454 (1-844-MET-CHLI) Call Line Open 8 am - 8 pm EST	www.legalplans.com Email: clientinquiry@legalplans.com	Receive affordable legal assistance
Identity Theft Protection	Allstate Identity Protection	1-800-789-2720	www.allstateidentityprotection.com	Limit chance of experiencing fraud
Retirement				
403(b)	Fidelity	1-800-343-0860	www.NetBenefits.com/AtWork	Enroll in and plan your retirement
Retirement Educators	TruePlan	Kentrel Herbert: 631-495-0318 John Rosenfeld: 914-907-3791		Loans, hardships, roll-over, and consolidation requests

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