Catholic Health

Benefits of Caring

2027 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
- Good Samaritan University Hospital St. Charles Campus
- 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

Care at Home

- 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. Open enrollment is Nov. 3–Nov. 13.

Changes in 2027

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 out-of-pocket maximums 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.
- For 2027, our preferred Urgent Care partners are **Catholic Health Urgent Care** and **NY Excel Urgent Care**. The copays for these urgent care facilities will not change in 2027. **There will no longer be a discounted copay for CityMD** – this facility will now fall under Tier 2.
- If your spouse is offered medical coverage by their employer, the pre-tax spousal surcharge in 2027 is **$50 per paycheck** if you cover your spouse under the Catholic Health Medical Plan (PPO, EPO, and POS options only).
- **New 2027 Anthem ID card:** Our Plan's Anthem Group Number is changing. All employees enrolled in the Medical Plan for 2027 will receive a new ID Card in the mail. You will also have access to your new ID card on the Sydney Health mobile app.
- **Under the POS and Select Plans:** the office visit maximum will increase to 60 visits per year for Physical Therapy, and 30 visits per year for Speech and Occupational Therapy.

Important select plan changes:

- Beginning in 2027, the Select Plan will change networks from the PPO Network to the **Blue Access Network**. This change will primarily impact Stony Brook providers as they are not in the Blue Access Network. If you want to stay enrolled in the Select Plan for 2027, you should check with Anthem to confirm if your existing providers remain in the Blue Access Network – you can do so online at **anthem.com**, on the Sydney Health mobile app, or calling the number on your ID card. If they are not, you might want to consider changing your plan option. If you need assistance finding an in-network provider, please contact **RENEW** at 631-465-4300
- The Select Plan will only be available to employees and dependents who reside in New York State within certain counties, including Nassau, Suffolk, Brooklyn (Kings), Queens, and Manhattan. A full list of counties can be found on the Benefit Portal. **If you reside outside of these counties:**
  - The Select Plan will not appear in the enrollment system for you.
  - If you're enrolled in the Select Plan in 2026 and do nothing during OE, you will be enrolled in the POS option effective 1/1/2027.
- There will be a copay for office visits incurred with an Anthem Tier 2 provider
- Full-time employees who are in a salary tier less than $120,000 and enroll dependents will have a paycheck contribution. (Employee-only coverage remains at $0 paycheck contribution.)

Confirm your covered dependents are eligible for benefits!

A Dependent Eligibility Verification will take place in early 2027 for all spouses and children enrolled in the Catholic Health Benefits of Caring Program. Once the verification begins, you will be required to provide documentation to verify your enrolled dependent(s) eligibility. Please start to gather the documentation now so it is available when the verification process begins.

During Open Enrollment, review your covered dependents and remove anyone who may no longer be eligible for coverage. For more information on eligibility and documentation requirements, please click on the Eligibility link on the Benefits Portal (**www.mychbenefits.org**) homepage.

Employees who have verified newly enrolled dependents within the past six months will not be included in the Dependent Eligibility Verification. If your enrolled child turned age 26 during 2026, no action is required. Age-ineligible children are removed automatically based on plan rules. If you have questions, contact the Baker Tilly Employee Benefits Center at 1-877-87MYBEN (1-877-876-9236).

Questions and answers

When does Open Enrollment start?
Open Enrollment starts on November 3, 2026 and ends on November 13, 2026.

When are my benefit changes effective?
Benefit changes made during Open Enrollment are effective January 1, 2027. Your first paycheck in January will reflect the 2027 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 13, 2026. All benefit-eligible employees are strongly encouraged to review their 2027 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 3 on the Enrollment Portal on the Benefits Portal. Visit the Enroll Now page at **www.mychbenefits.org** and log in to view 2027 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 2027.

How to enroll

Catholic Health offers three ways to enroll in 2027 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 13 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. 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 only available to employees and dependents who reside in New York state within certain counties, including Nassau, Suffolk, Brooklyn (Kings), Queens, and Manhattan. It is free for most employees who enroll in Employee-Only coverage, with few or no out-of-pocket costs when you seek care with a Catholic Health provider or facility.

The Select Plan uses the Blue Access Network. It is designed for employees who are comfortable receiving care for themselves and their families at Catholic Health facilities and by Catholic Health Providers.

Please note that Stony Brook is not in the Blue Access Network.

The network **does include** 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 Blue Access Network.

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.

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 of care.

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, for emergency services protected by the No Surprises Act (NSA), you cannot be balance-billed and are responsible only for your applicable in-network cost-sharing levels, even when provided by an out-of-network provider or facility.



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 $50 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.	$10,000 Individual/$20,000 Family		$14,000 Individual/$28,000 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	$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.	$10,000 Individual/$20,000 Family		$15,000 Individual/$36,000 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	$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.

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.	$10,000 Individual/$20,000 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	$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.	$10,000 Individual/$20,000 Family		
Office Visits[1] *primary care/specialist*	$0 Primary/ $0 Specialist Copay	$45 Primary/ $75 Specialist Copay	
Mental Health Office Visit	$0 Copay	$25 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	$75 Copay	
Inpatient	$0 Copay	Mt.Sinai and NY Presbyterian Columbia Hospital: $1,000 Copay[2]; Other facilities not covered	
Outpatient	$0 Copay	Mt.Sinai and NY Presbyterian Columbia Hospital: $500 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.

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
- Good Samaritan University Hospital St. Charles Campus, 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.

Resources for Employee Navigation, Engagement & Well-Being

(RENEW) is a free comprehensive health and wellness resource that helps Catholic Health employees and their families get the most from their benefits.

It isn't always easy to navigate health care. That's where a RENEW Wellness Navigator can help. You can contact a Wellness Navigator if you are enrolled in a Catholic Health Medical Plan.

You might need a Wellness Navigator if:

- You have a health condition that places you at high risk of developing more serious health issues.
- You have a chronic health condition, requiring several specialists to work together.
- You experience a severe health episode and suddenly need to find new services you've never used before.
- You were recently discharged from a hospital and have questions about your care.

When you enroll in RENEW, you and your covered family members access personalized support to achieve wellness goals and help manage the cost and coordination of complex care. You work with a Wellness Navigator and your providers to receive coordinated, cost-effective and high-quality care. Wellness Navigators help set goals, build good habits and guide you through the health care system.

Your RENEW Wellness Navigator is employed by Catholic Health. Wellness Navigators adhere to Catholic Health's Privacy and HIPAA policies. Only authorized care team members directly involved in your care will have access to your information.

Learn more:

If you or a covered family member can benefit from working with a Wellness Navigator, call **(631) 465-4300** or email **renew@chsli.org**.

More information is available under the LiveWell section of the Catholic Health intranet.

Teladoc Health's Mental Health Complete

Formerly MyStrength

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

Note on Prior Authorization

Prior Authorization is administered by Anthem. Please contact Anthem at 1-800-496-6132 (the same number listed on the back of your Health Plan ID card) with any questions, 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:

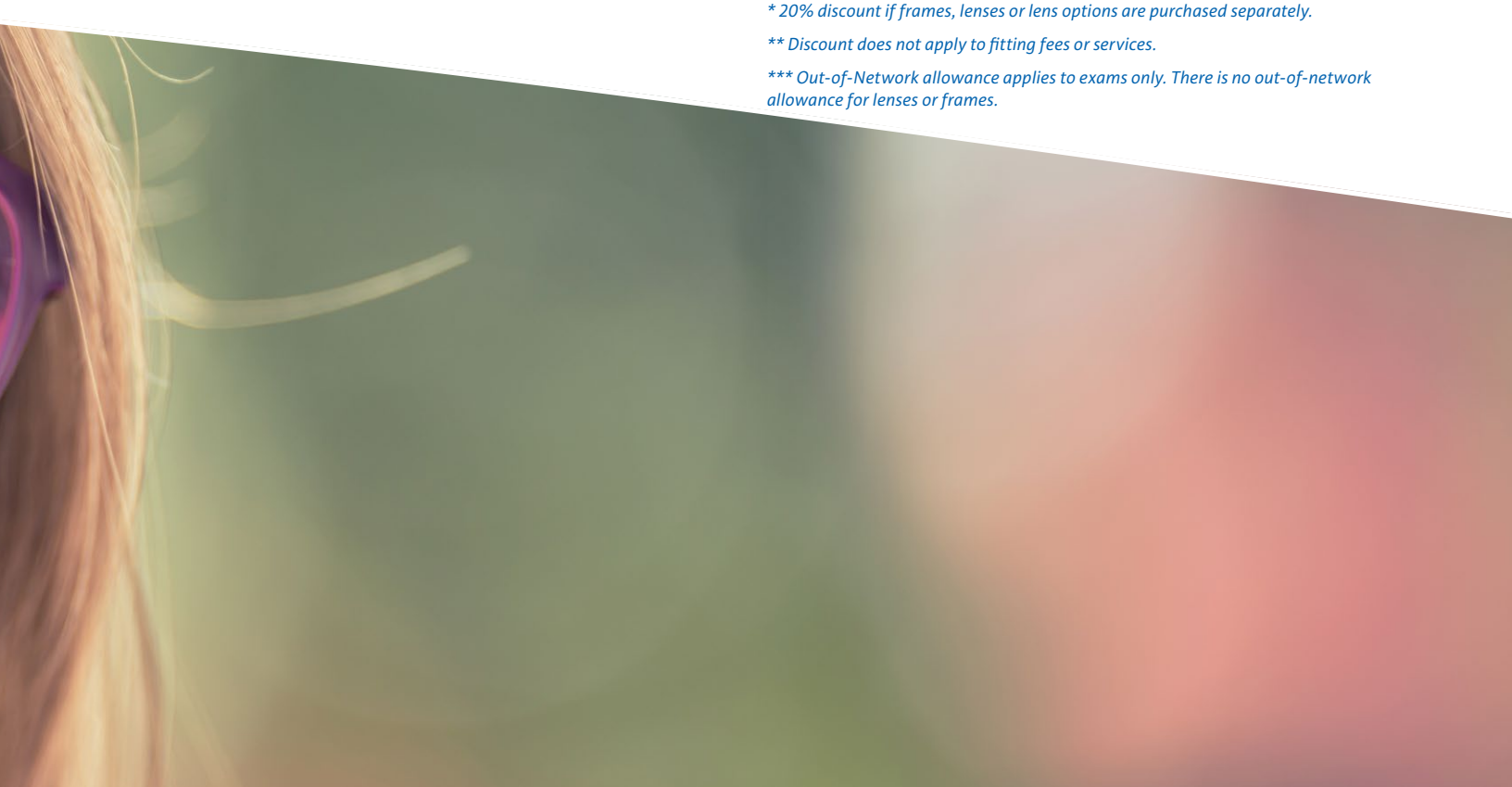
Vision Care Services	In-Network	Out-of-Network***
Routine Eye Exam (once every 24 months)	$5 Copayment	$40 allowance
Blue View Vision Discount	Member Cost (when purchasing frames and lenses)	
Eyeglass Frame*	35% off retail price	Out-of-Network coverage not available
Contact Lenses** (Conventional)	15% 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-MET-CHLI** (1-844-638-2454).

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 Medically Necessary	 15% discount 100% covered	 None $200 allowance
Standard Plastic Lenses Single Vision Bifocal/Trifocal/Progressive	 $0 copay $0 copay	 Up to $25 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.

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
- Skin Cancer

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.
- The plan includes a $50 Health Screening Benefit for eligible preventive screenings, payable once per calendar year for each covered employee, spouse and dependent child.

**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.*

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 and dislocations
- Hospitalization
- Physical Therapy
- Medical testing, including X-rays, MRIs, ultrasounds and CT scans
- Surgical treatment, including covered elbow, hip, knee or shoulder replacement
- 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.
- The plan also includes a $50 Health Screening Benefit, once per calendar year, for eligible preventive screenings.

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.

If you receive covered treatment at a designated Catholic Health facility, you may receive an additional supplemental benefit in addition to your base Hospital Indemnity benefit.

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.



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 Legal Plans: 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 MetLife Legal Plan, you'll have access to a network of attorneys who can provide advice, prepare and review legal documents, and represent you in a wide range of covered personal legal matters, such as:

- Wills, Trusts and Estate Planning
- DIY Estate Planning Documents
- Home Purchase, Sale and Other Real Estate Matters
- Debt Collection and Identity Theft Defense
- Family Law Matters, including Adoption
- Civil Lawsuit Defense
- Traffic Ticket Defense (excludes DUI)

Plan Features:

- Attorney fees are paid by the plan when using a network attorney for covered services
- Option to use an out-of-network attorney, with reimbursement subject to plan limits
- Continuation or individual coverage options may be available if your employment ends

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.

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**.

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 2025 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 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're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

NEW JERSEY–MEDICAID AND CHIP

Medicaid Web: www.nj.gov/humanservices/dmahs/individuals-families/familycare/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Web: www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK–MEDICAID

Web: www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

PENNSYLVANIA–MEDICAID

Web: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

Phone: 1-800-692-7462

CHIP Web: 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, 2026, or for more information on special enrollment rights, you can contact either:

U.S. DEPARTMENT OF LABOR
Employee Benefits Security Administration
www.askebsa.dol.gov
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 2026
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 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.

Catholic Health System of Long Island, Inc.
Notice of Health Information Privacy Practices

Your Information. Your Rights. The Plan's Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communications
- Ask the Plan to limit the information the Plan shares
- Get a list of those with whom the Plan has shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

The Plan's Uses and Disclosures

The Plan may use and share your information to:

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

Privacy Contact for questions about the Plan's Health Information Privacy Practices:

Catholic Health System of Long Island, Inc. (d/b/a Catholic Health)
c/o Health Plan Privacy Official
3 Huntington Quadrangle, Suite 301S
Melville, NY 11747
(516) 705-6947

Introduction

Catholic Health System of Long Island, Inc. ("Catholic Health") sponsors the health plan components of the Catholic Health Services of Long Island Health & Welfare Benefits Plan (referred to in this Notice as the "Health Plans" or just the Plan). The Health Plans may use or disclose health information about participants and their covered dependents as required for purposes of administering the Health Plans. Some of these functions are handled directly by Catholic Health, while other functions are performed by other service providers under contract with the Health Plans or by insurance carriers.

This Notice of Privacy Practices ("Notice") applies to each of the benefits included in the Health Plans sponsored by Catholic Health, including, but not limited to medical, vision, prescription drug, dental, long term care, health reimbursement arrangement and health care flexible spending account benefits (if any). However, for any benefits that are provided through insurance contracts, you will receive a separate notice, similar to this one, from the insurer and only that notice will apply to the insurer's uses or disclosures of your health information.

The Plan is required by law to maintain the privacy of certain health information about you and to provide you this Notice of the Plan's legal duties and privacy practices with respect to that protected health information. This Notice also provides details regarding certain rights you may have under federal law regarding medical information about you that is maintained by the Plan.

The Plan is required by law to abide by the terms of this Notice while it is in effect. This Notice is effective beginning February 16, 2026 and will remain in effect until it is revised.

If the Plan's health information privacy practices, policies and/or procedures are changed so that any part of this Notice is no longer accurate, the Plan will revise this Notice. A copy of any revised Privacy Notice will be available upon request to the Privacy Contact Person indicated later in this Notice. Also, if required under applicable law, the Plan will automatically provide a copy of any revised notice to employees who participate in the Plan. The Plan reserves the right to apply any changes in its health information policies and/or procedures retroactively to all health information maintained by the Plan, including information that the Plan received or created before those policies/procedures were revised.

Your Rights

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

Get a copy of health and claims records

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

Ask the Plan to correct health and claims records

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

Request confidential communications

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

Ask the Plan to limit what it uses or shares

- You can ask the Plan not to use or share certain health information for treatment, payment, or the Plan's operations.

The Plan is not required to agree to your request, and may say "no" if it would negatively affect the administration of the Plan.

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

- You can ask for a list (accounting) of the times the Plan has shared your health information for 6 years prior to the date you ask, who received it, and why.
- The Plan will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked the Plan to make). The Plan will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel the Plan has violated your rights by contacting the Plan using the Privacy Contact information on page 1.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

- Catholic Health will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell the Plan your choices about what it may share. If you have a clear preference for how the Plan shares your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell the Plan your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety, as permitted by law.

In these cases the Plan will never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

The Plan's Uses and Disclosures

How does the Plan typically use or share your health information?

The Plan typically uses or shares your health information in the following ways, including for treatment, payment and health care operations, except where 42 CFR Part 2 ("Part 2") imposes stricter rules regarding substance use disorder (SUD) information. See the discussion of the special rules that apply to certain SUD records below as we will not disclose your SUD information subject to Part 2 without your written consent, except as expressly permitted by Part 2.

Pay for your health services

The Plan can use and disclose your health information to pay for your health services.

- Example: The Plan processes your health care claims to coordinate payment to providers or to reimburse you for eligible expenses you have paid.

Health care operations

- The Plan may use or disclose PHI for purposes that are related to the operation of the Plan including utilization review programs, quality assurance reviews, insurance or reinsurance contract renewals and other functions that are appropriate for purposes of administering the Plan.
- The Plan is not allowed to use genetic information to decide whether to offer you coverage or the price of that coverage.

Example: We may use health information about you to offer wellness program services for you.

Help manage the health care treatment you receive

The Plan may use your health information and share it with professionals who are treating you.

Example: A doctor sends the Plan information about your diagnosis and treatment plan so we can arrange additional services.

Administer your plan

The Plan may disclose your health information to the plan sponsor for plan administration.

- Example: A business associate for the Plan may provide certain statistics to the plan sponsor to explain the costs of the Plan.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law, including those described in the discussion of the special rules that apply to certain SUD records below, before we can share your information for these purposes.

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

Help with public health and safety issues

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

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

Do research

The Plan can use or share your information for health research.

Comply with the law

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

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

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

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

The Plan can use or share health information about you:

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

Respond to lawsuits and legal actions

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

The Plan's Responsibilities

- The Plan is required by law to maintain the privacy and security of your protected health information in the manner required by applicable law, including the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and information subject to more stringent protections under other applicable law such as Part 2 relating to SUD diagnosis, treatment, or referral.
- The Plan will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- The Plan must follow the duties and privacy practices described in this Notice (as may be amended from time to time) and give you a copy of it.
- The Plan will not use or share your information other than as described here unless you authorize the Plan, in writing, to use or share your information for another purpose. If you tell us we can use information for some other purpose, you may change your mind at any time. Let the Plan know in writing if you change your mind.

Please note that protected health information shared with entities not bound by HIPAA (e.g., law enforcement, etc.) may be re-disclosed and lose federal protection.

That is, if the Plan shares your health information (as permitted by HIPAA) with a recipient that is not subject to HIPAA, your health information may be re-disclosed by that recipient and may no longer be protected by federal privacy laws.

- Example: If you authorize the disclosure of your health information to a third party in connection with a legal action, that information may not be protected under HIPAA once shared with the third party.

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

Special Protections for Substance Use Disorder (SUD) Information Under 42 CFR Part 2 ("Part 2")

The Plan may receive SUD treatment information from providers or programs covered by 42 CFR Part 2 (42 USC 290dd-2) (a "Part 2 Program"), other HIPAA covered entities (that are not Part 2 Programs), or the business associates of HIPAA covered entities. Part 2 provides stricter confidentiality protections than HIPAA. For example, we may only receive SUD treatment information that is subject to Part 2 if you consent to the disclosure or as otherwise permitted by law.

When we lawfully receive such information, we will only use and disclose it (or testimony relaying the content of such records) as follows:

- You provide the Plan with your written consent for the use or disclosure.
- A court order entered after notice and an opportunity to be heard and that meets the requirements of Part 2 authorizes the disclosure.
- The disclosure is permitted without your consent by Part 2 regulations (such as in the case of medical emergencies, to public health authorities in certain cases where the records have been de-identified, or for scientific research, audit or evaluation in certain cases, etc.).
- The Plan received SUD information about you from a Part 2 Program, other HIPAA covered entity or HIPAA business associate through your consent to uses and disclosures of your SUD records for purposes of treatment, payment or health care operations and the Plan uses or further discloses your SUD records for any of the purposes permitted by HIPAA as described elsewhere in this Notice. Note that in this circumstance the consent through which the Plan received your SUD records was limited to treatment, payment and health care operations but Part 2 rules permit the Plan to more broadly redisclose those records for any purpose permitted by HIPAA.

In no event, however, will the Plan use or disclose your SUD records subject to Part 2 (or testimony that describes the information contained in such records), in any civil, criminal, administrative, or legislative proceedings against you, unless (a) you provide written consent or (b) unless we are required to do so pursuant to a court order after you (or the holder of the record) are provided notice of the court order and the opportunity to be heard in the manner required by applicable law. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Information disclosed pursuant to Part 2 or HIPAA may be subject to redisclosure and may no longer be protected by federal law.

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

www.ccaplatform.com/go/chs

Who 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 #: L16923	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		
Teladoc Mental Health Complete		1-800-835-2362	TeladocHealth.com/Comfort/CHSLI	Schedule virtual mental health visits and find self-guided programs
Preauthorization	Anthem	1-800-496-6132		Ask questions about the priorauthorization process.
RENEW		1-631-465-4300	renew@chsli.org	Wellness Navigators assist in locating in-network providers, help you manage care you are receiving, and answer questions
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	presents.voya.com/EBRC/chsli	Customer Service
Disability/ Leave Administration	Matrix Absence Management	1-877-202-0055	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.ccaplatform.com/go/chs	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	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	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	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

Notes

Catholic Health

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