EMPLOYEE BENEFITS GUIDE

JANUARY 1, 2023 – DECEMBER 31, 2023

Central Florida Cross Network

The information in this Benefits Guide is presented for illustrative purposes only. The text contained in this Guide was taken from various plan documents and/or benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this guide, contact Human Resources. 11.22.22 AS

Brown & Brown

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Medicare Part D Notice

If you (and/or your dependent) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 27 for more details.

Central Florida Cross Network

Brown & Brown INSURANCE®

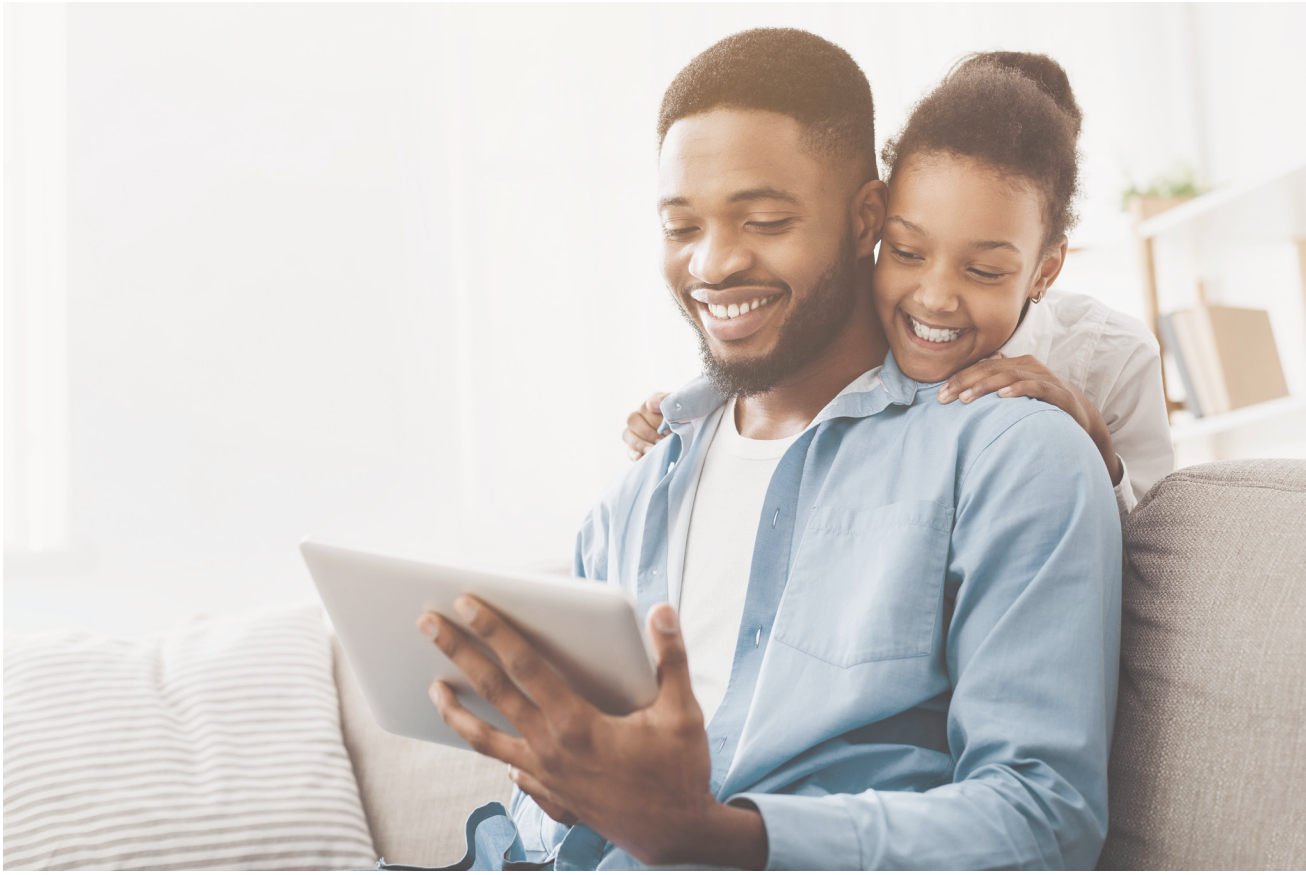
INTRODUCTION

Holy Cross offers a valuable benefits package that provides choices and flexibility for the diverse and changing needs of our employees. As a healthcare consumer, it's important you take an active role in understanding your needs, your family's needs, and the benefit options available to you.

This guide offers a comprehensive overview of your benefit options, including information on eligibility and how to enroll. We encourage you to read the information carefully and familiarize yourself with the benefits you're offered before making your selections. Throughout the year, you can use this guide as a reference.

Have a question or need more information about something in this guide?

Your benefits broker, Brown & Brown, is here to help! Reach out to your dedicated Client Care Advocate with any benefits questions, including enrolling in benefits as a new hire, prior authorizations, finding a provider, ordering ID cards, processing life events, and more. Your Client Care Advocate's contact information can be found on the Contacts page.



BENEFITS OVERVIEW

Eligibility

Full-time employees (working 30+ hours per week) are eligible to enroll in the benefits outlined in this guide.

New hires are eligible for benefits on the 1st of the month following 60 days of employment.

Family members eligible for dependent coverage include:

- Legal spouse
- Natural, adopted, foster or stepchild(ren)
- Child(ren) for whom court appointed or legal guardianship has been awarded

Eligible dependent children may be covered until:

- Medical: end of the calendar year they turn age 26, or age 30 if unmarried with no dependents; a Florida resident or student; not enrolled in any other health coverage policy or plan; not entitled to Medicare benefits
- Dental, vision, voluntary life: end of the month they turn age 26

A handicapped dependent child may continue coverage beyond the age limit if determined to meet plan requirements.

It is your responsibility to notify Human Resources if your dependent child no longer meets the eligibility requirements under the plan(s).

How to Enroll

Enrollment will take place online via Employee Navigator. **Employees are required to log in to make their elections during the open enrollment period.** Enrollment instructions are included on pages 6 – 9 of this guide.

Carriers require full names, birth dates, social security numbers and home addresses for everyone enrolling in coverage, so please make sure you have all of the necessary information on hand for you and any dependents you're covering. Also, keep in mind to update your beneficiaries and/or complete and submit an Evidence of Insurability (EOI) form, if necessary.

Please review your paycheck after coverage goes into effect to ensure all deductions and benefit elections are accurate.

Qualifying Life Events

Once your benefits are effective, you may not make changes to your benefits until the next open enrollment period unless you experience a qualifying life event.

Qualifying life events that allow mid-year changes include (but are not limited to):

- Marriage, divorce, legal separation
- Birth or adoption of child
- Death of spouse, child or other qualified dependent
- Loss/gain of other group coverage
- Change of dependent status
- Change in employment status (employee, spouse or child)

The type of plan change you can make to your benefits due to a life event depends on the qualifying event that you experience. For example, if you get married, you can add your spouse to coverage under your plan(s) and/or cancel coverage under your plan(s) if enrolling in your spouse's coverage. Documentation of the life event will be required by your employer to make benefit changes.

If you do not make changes within 30 days of the qualifying event, you must wait until the following open enrollment period. It is your responsibility to notify Human Resources within 30 days of the qualifying event.

ENROLLMENT INSTRUCTIONS

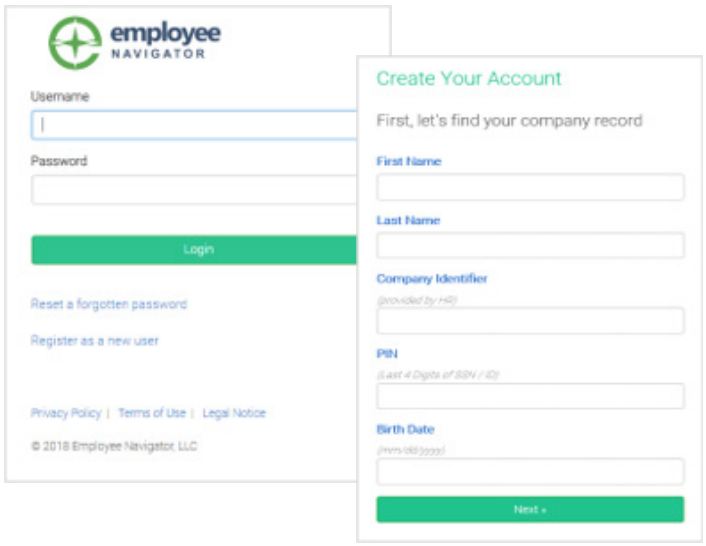
Employee Navigator

Step 1: Log in/Register

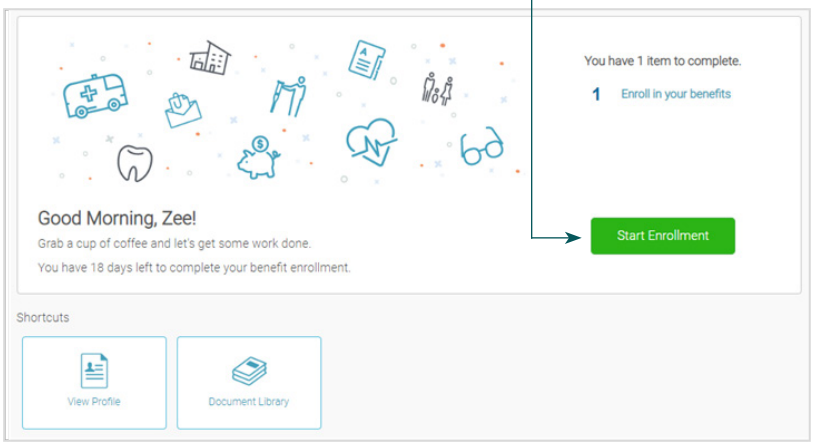
Go to employeenavigator.com and click “Login” on the top right of the page.

If logging on for the first time, select “Register as a new user” and complete the required fields.
You will need the following information in order to complete the registration process:

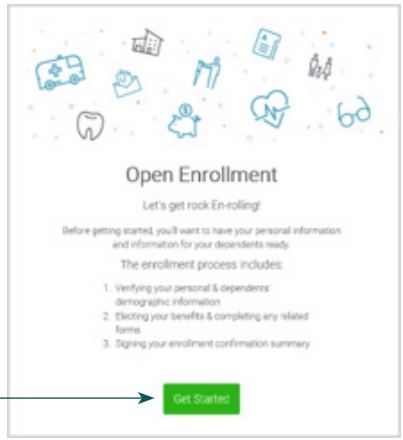
- First name
- Last name
- Company Identifier: **HCLCO**
- PIN: last 4 of your SSN
- Birth date



Once you have registered or logged in, you will be directed to your homepage. Click on “Start Enrollment.”



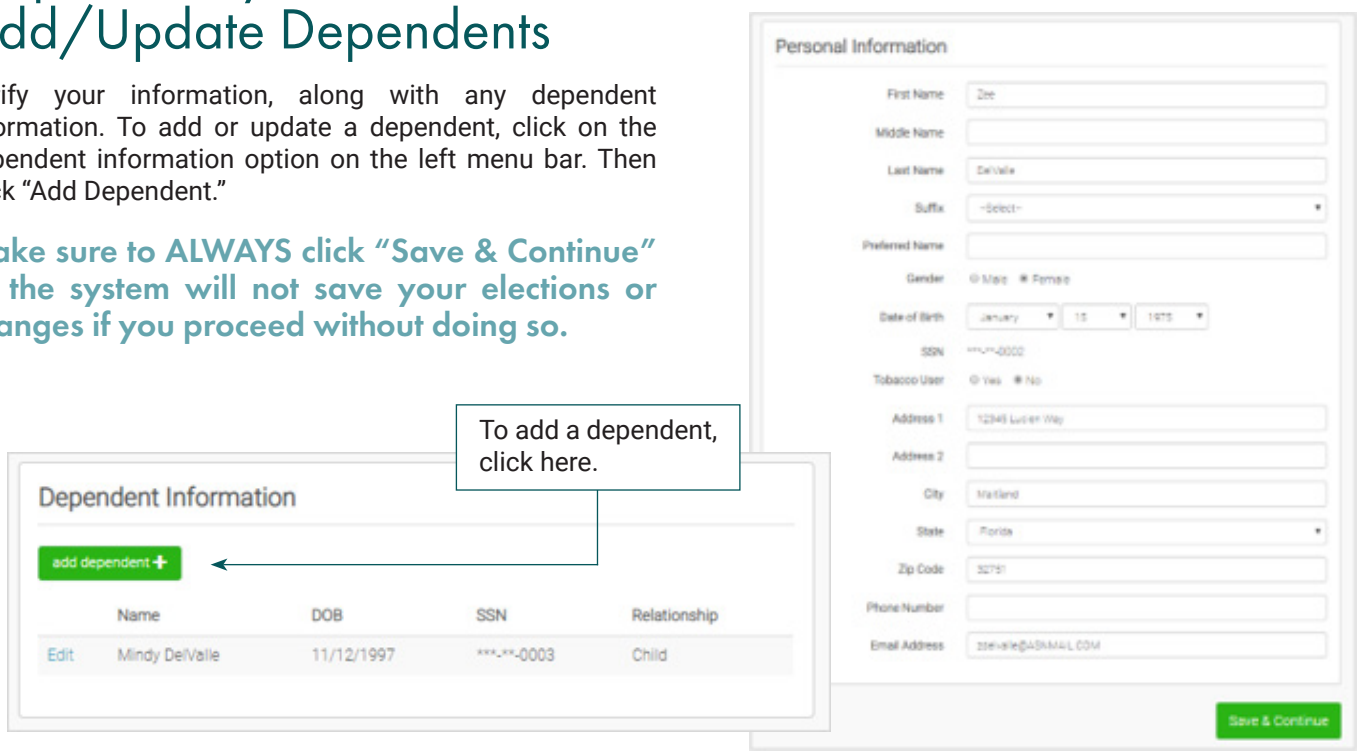
The next page will give an overview of the enrollment process. When you’re ready, click on “Get Started.”



Step 2: Verify Information & Add/Update Dependents

Verify your information, along with any dependent information. To add or update a dependent, click on the dependent information option on the left menu bar. Then click “Add Dependent.”

Make sure to ALWAYS click “Save & Continue” as the system will not save your elections or changes if you proceed without doing so.

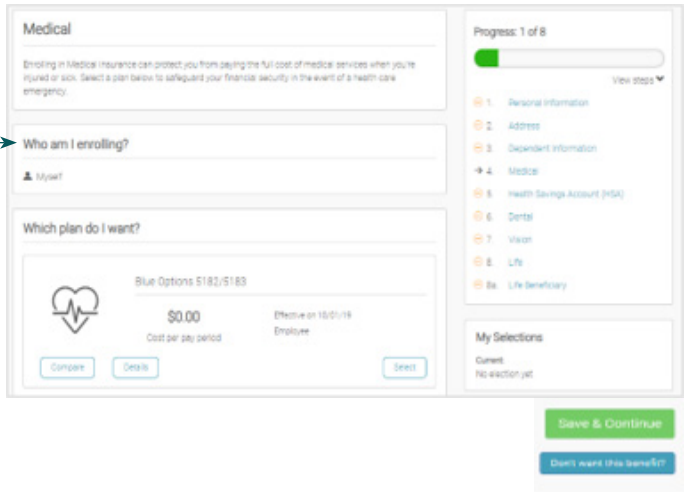


Step 3: Begin Enrollment

You will then be directed to begin the benefit enrollment process. The system will show you the cost for each plan based on who you are enrolling. When you have dependents you would like to cover, they will appear under the “Who am I enrolling?” section of the page.

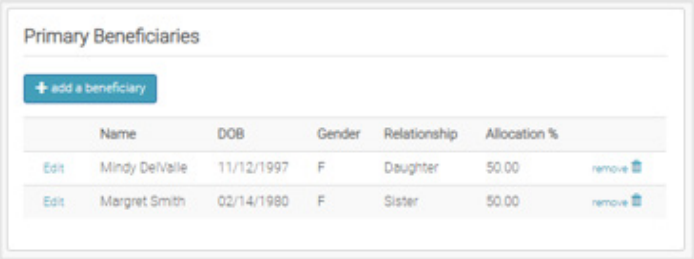
Select the plan you would like to enroll in (along with any dependents), then click “Save & Continue.” If you wish to waive a benefit, simply scroll down to the bottom and select the “Don’t Want This Benefit?” option. You will need to select a reason for waiving coverage.

Continue through the enrollment process by either waiving or enrolling in the benefits offered to you.



Step 4: Add/Update Life Insurance Beneficiaries

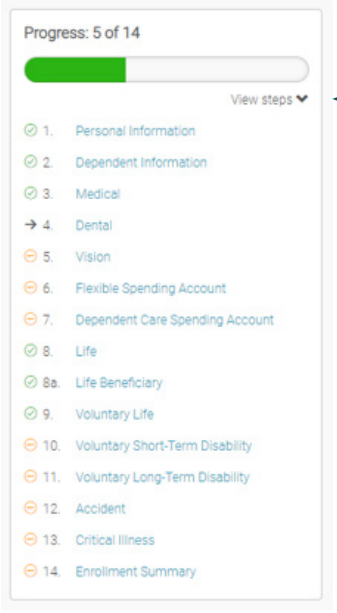
Your employer provides you with basic life/AD&D at no cost to you, but you will need to indicate a beneficiary. Click “Save & Continue” and the system will prompt you to add a primary and/or contingent beneficiary.



After providing all primary beneficiaries, the overall (total) allocation of primary beneficiaries must equal 100%. If adding contingent beneficiaries, the total allocation for contingent beneficiaries must also equal 100%.

If you would like to purchase additional life insurance (voluntary life insurance), slide the button to the desired benefit amount. The cost per pay period will be displayed. You will need to indicate beneficiaries in this section as well.

Once you have completed the benefits portion, you will be prompted to complete any required forms, such as an Evidence of Insurability (EOI) form.



Enrollment Tip: If at any point during the enrollment process you wish go back to a benefit and change/view that election, click on “View Steps” on the top right hand side of the page. The drop down selection of steps will appear. A green check mark means the step has been completed. An orange circle means the step has not been completed.

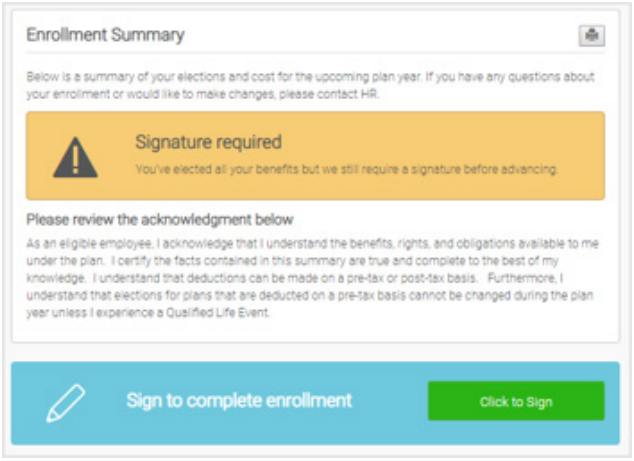
ALL steps must be completed in order to complete your enrollment process.

Step 5: Review Elections & Complete Enrollment

When you have completed electing your benefits, you will be directed to your Enrollment Summary. This page will provide you with your cost per pay amount. You can save and/or print the Enrollment Summary for your records.

You must electronically sign the Enrollment Summary in order to complete your enrollment.

After the Enrollment Summary is signed, you will receive a confirmation email from Employee Navigator. The email will include a link back to the Employee Navigator website.



Enrollment Assistance & Benefits Support

If you have questions about your benefit options or the Employee Navigator system, contact your Client Care Advocate from Brown & Brown:

Debbie Cox
321-214-2399
debbie.cox@bbrown.com

MEDICAL INSURANCE

Florida Blue

	Truli C2056		BlueOptions HSA 05182/05183		BlueOptions 5907	
IN-NETWORK BENEFITS	**Truli**		**BlueOptions**		**BlueOptions**	
Employee Primary Residence	Florida		Nationwide		Nationwide	
Calendar Year Deductible	Embedded		Non-Embedded		Embedded	
Individual | Family	$2,500	$5,000	$2,500	$5,000	$2,000	$4,000
The Plan Pays	90%		90%		100%	
Calendar Year Out of Pocket Max (Includes Coinsurance, Copays & Deductible)	Embedded		Embedded		Embedded	
Individual | Family	$6,500	$13,000	$5,000	$10,000 (Ind: $6850)	$5,000	$10,000
PHYSICIAN & EMERGENT CARE						
Preventive Care	$0		$0		$0	
Primary Care Physician/Specialist	$20	$100	VCP*: Deductible/ 10% after deductible	VCP*: Deductible/ 10% after deductible	VCP*: $0 / $0 first 3 visits then $30	VCP*: $20 / $60
Specialist	$90		$90 after deductible		$90	
PCP Required | Referral Required	Yes	No	No	No	No	No
Virtual Visits	$0		Deductible		$0	
Urgent Care	$75		$50 after deductible		$50	
Emergency Room (In or out of network)	$650		20% after deductible		50% after deductible	
HOSPITALIZATION & OUTPATIENT CARE						
Inpatient	10% after deductible		10% after deductible		Deductible	
Outpatient	10% after deductible		10% after deductible		Deductible	
Physician Fees	10% after deductible		10% after deductible		$0	
INDEPENDENT FACILITY CARE						
Labs	10% after deductible		10% after deductible		$0	
X-rays	10% after deductible		10% after deductible		$60	
Complex Diagnostic Imaging	10% after deductible		10% after deductible		Deductible	
PRESCRIPTION DRUGS						
Prescription Drug List/Formulary	Truli Rx Medication Guide		Open		Open	
Mandatory Generic	Yes		Yes		Yes	
Deductible	$0		Combined with medical		$0	
Tier 1	$5 / $15		$10 after deductible		$10	
Tier 2	$10 / $75		$50 after deductible		$50	
Tier 3	$150 / $300		$80 after deductible		$80	
Tier 4	N/A		N/A		20% after deductible	
3x retail copay	3x retail copay		2.5x retail copay		2.5x retail copay	
OUT-OF-NETWORK BENEFITS						
Deductible Individual | Family	Emergency benefits only		$5,000	$10,000	$7,500	$15,000
The Plan Pays			60%		60%	
Out of Pocket Max			Unlimited		Unlimited	
Balance Billing			Yes		Yes	

PAYROLL DEDUCTIONS PER PAYPERIOD (2X PER MONTH			
Employee	$-	$-	$42.32
Employee& Spouse	$327.02	$334.29	$430.77
Employee & Children	$254.79	$261.17	$345.80
Employee& Family	$564.36	$574.56	$709.97

**VCP: Value Choice Provider*

Finding a Medical Provider

When seeking medical care, always look for a provider contracted with your medical plan's provider network. The provider network is the doctors, hospitals, pharmacies, and other healthcare providers that your plan has contracted with to provide medical care to its members. Staying in-network for care will allow you to keep your healthcare costs down while best utilizing your plan.

Truli plan: To find an in-network provider, locate the provider search tool on the carrier's website (trulihealth.com).

Florida Blue plan: To find an in-network provider, locate the provider search tool on the carrier's website (floridablue.com) and search under the BlueOptions network.

Should you enroll in the **Truli C2056**, you must select a Primary Care Physician (PCP). If you do not select one, Florida Blue will designate one to you. You can change your PCP during the plan year by contacting Florida Blue.

Medicare Part D Creditability

All plans are Medicare Part D creditable. See the 'Notices' section in this guide for further information.

Preventive Care

Chronic diseases, such as heart disease, stroke, cancer, and diabetes, are the number one cause of death and disability in the United States and one of the highest drivers of healthcare costs.[1] Visiting your doctor regularly for preventive care services can not only help catch chronic diseases early, but help prevent them all together.

Under the Affordable Care Act, routine preventive screenings and services obtained at an in-network provider are covered at no cost to you under your health plan. For additional information concerning your preventive care and what is covered, log in to your member account on the carrier's website (floridablue.com).

Florida Blue App

Access your medical plan information any time, anywhere! The Florida Blue app gives you on-the-go access to your medical network, claims history, tools and support. View your member ID card, compare costs, see provider reviews or find in-network options for quick care.

1. Center for Disease Control and Prevention. (2019, October 23). About Chronic Diseases. Retrieved September 28, 2020 from https://www.cdc.gov/chronicdisease/about/index.htm

HEALTH SAVINGS ACCOUNT

Health Equity

Employees who elect the **BlueOptions HSA 05182/05183** medical plan may be eligible to open and contribute to a Health Savings Account (HSA). An HSA is a bank account which you may fund with tax-exempt dollars from your paycheck to help pay for eligible medical, dental and vision expenses, including your medical plan deductible, coinsurance and/or copays.

Once your HSA is set up, the money accumulates and grows tax-free through interest or investment earnings. You'll receive a debit card to access the funds and you'll have the option of either using the account to pay for current medical expenses or saving your funds for future needs. Unused HSA funds roll over from year to year, so you never have to worry about spending the money by a certain date. An HSA is also portable between employers, meaning you can take it with you if you change jobs.

Eligibility

In order to open and contribute to an HSA, you must meet certain eligibility requirements set by the IRS. Those requirements include:

- You must be covered by a High Deductible Health Plan (HDHP) and cannot be covered by a non-HDHP medical plan (including a Healthcare Reimbursement Flexible Spending Account)
- You cannot be enrolled in Medicare, receiving Social Security benefits or planning to within the next 6-8 months**
- You cannot be claimed as a dependent on another person's tax return
- You cannot be covered by TRICARE or receiving medical benefits from the Veteran's Administration

It is your responsibility to adhere to applicable tax regulations and/or restrictions. Please speak with a tax professional if you have questions about your individual situation.

Eligible HSA Expenses

HSAs are tax-advantaged accounts, so the IRS defines the types of expenses you can pay for with your account. You can use your HSA funds to pay for most medical, dental and vision care and services, for both you and your tax-eligible dependents – even if they aren't enrolled on your medical plan! Below are examples of eligible and ineligible HSA expenses. For a full list, please visit irs.gov.

Eligible HSA Expenses

- Deductibles, coinsurance and copays
- Primary care or specialist office visits
- Urgent care visits
- Prescriptions and over-the-counter medications
- Durable medical equipment
- Chiropractic and physical therapy
- Feminine care products
- Dental expenses (e.g., cleanings, fillings, braces)
- Vision expenses (e.g., eye exams, laser eye surgery, glasses, contacts)
- Hearing aids
- COBRA and Medicare premiums

Ineligible HSA Expenses

- Dietary supplements
- Personal use items (e.g., deodorant, teeth whitening)
- Medicated shampoos, conditioners and soaps
- Non-prescription sunglasses
- Gym membership fees

**Subject to IRS maximum contribution limits*
***If you defer enrollment in Medicare, consult with a tax advisor about tax implications of HSA contributions*

Annual Contributions Limits

The IRS establishes annual HSA contribution limits for individuals contributing to an HSA. The contribution limits are based on your medical plan coverage level. Individuals over age 55 can contribute an additional $1,000 per year as a “catch-up” HSA contribution.

2023 IRS ANNUAL HSA CONTRIBUTION LIMITS	
Self-Only Coverage	$3,850
Family Coverage	$7,750

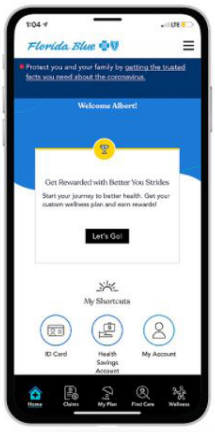
Opening an HSA

To open an HSA (or for more information), visit Health Equity’s website at healthequity.com, call 866-346-5800 or contact HR. **An account MUST be opened for contributions to be deposited. If an account is not opened, funds cannot be deposited.**

MEDICAL PLAN MEMBER RESOURCES

Florida Blue

Member Portal



The more you know about healthcare costs and the options you have, the easier it may be for you to make better decisions. When you register for your member portal on floridablue.com, or the Florida Blue app, you will have access to tools and information to help you manage and improve your health, such as:

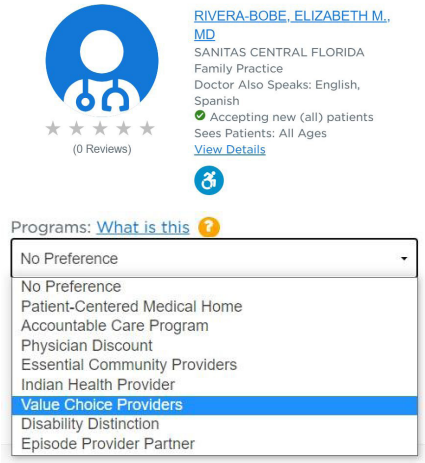
- Find a provider
- Manage and track your claims
- Compare and buy prescriptions
- Compare and estimate treatment costs
- View wellness information and much more

Value Choice Providers

Throughout Florida, members are never far away from a Florida Blue Value-Choice Provider. Florida Blue offers more than 12,000 Value Choice Providers, which includes primary care providers at any Sanitas Medical Center or Diagnostic Clinic Medical Group location. These Value Choice Providers offer you quality care for many conditions.

How do I find a Value Choice Provider?

When searching for a provider on the Florida Blue website (floridablue.com), select "Value Choice Provider" from the "Programs" drop down menu. This will refine your search to providers within the program.



Care Consultants

Talking to a Care Consultant can save you time and a lot of money — and make important decisions easier. Whether it's your first office visit, a series of ongoing medical treatments or a new medication, call our Care Consultants first. You'll find out how your benefits work, what factors can affect your costs and which programs are available to assist you. The team can help you plan your next steps and make sure you get the most value from your benefits. Call the Care Consultants if you need help:

- Understanding your benefits or claims
- Finding in-network providers or centers
- Saving on your medical costs
- Maximizing your health savings
- Establishing ongoing care

Contact a Care Consultant by calling 1-888-476-2227.

24/7 Nurseline[1]

Health questions can come up at any time and you don't have to wait for answers. With Florida Blue's Nurseline, you'll get answers, plus helpful resources that you can use. Whether you have an immediate health concern, or a general question about your doctor's plan of treatment—the nurseline is always open.

Don't leave health questions unanswered. Call the Nurseline to get help with your health questions right away.

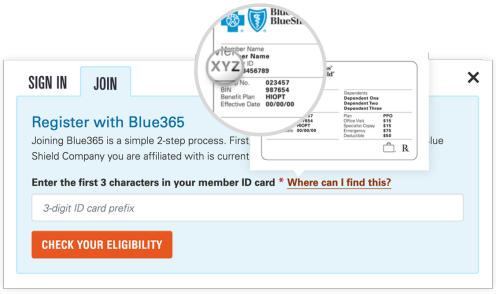
Contact Nurseline 24/7 at 877-789-2583.

Blue365

Florida Blue makes living well more affordable. Blue365 is a free health and wellness discount program offered to you as a member of the Blue Cross and Blue Shield System. We offer year-round discounts on gym memberships, fitness gear, healthy eating options and more.

How to get started

Visit blue365deals.com/BCBSFL and click "Join" on the top left corner of the page. Then, enter your BCBS (Florida Blue) member information. You will then enter your personal information to complete your registration and begin enjoying your discounts!



What kind of discounts will I find?

Apparel & footwear: savings on sneakers, outdoor apparel and certain fitness brands

Fitness: $29 monthly fee for access to network of 10,000+ gyms nationwide. Discounts on workout equipment, wearable health trackers (e.g. Fitbits), clothes and shoes

Hearing & vision: Over $800 off LASIK, save money on frames, access a free hearing screening and discounted prices on hearing aids and more

Home & family: Savings on vitamins and dietary supplements, breast pumps and accessories, outdoor activities, pet supplies, health and wellness products and more

Nutrition: Personalized nutrition plans, diet/weight loss programs, meal delivery programs and more

Personal care: Free apps to manage prescriptions, dental savings, skin care, dental care, medical bracelets and more

Travel: Travel club memberships, hotels and resorts

Florida Blue Blue365

1. Please remember that all decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, are solely your responsibility and the responsibility of your Physicians and other healthcare Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received, and when and how care should be provided. In making Health Dialog available to you, neither BCBSF nor Health Dialog Services Corporation shall be deemed to be providing medical care or advice.

1. UnitedHealthcare Internal Claims Analysis, 2016.

VIRTUAL VISITS

Virtual visits allow you to see and talk to a certified medical professional from your mobile device or computer without an appointment, 24/7. Most visits take about 10-15 minutes and the doctor you speak with can write a prescription, if needed, that you can pick up at your local pharmacy.

When to Use

Virtual visits can be a great option for medical care when your doctor is not available, you become ill while traveling, or anytime you're considering visiting a hospital emergency room for a non-emergency health condition.

Common conditions treated during a virtual visit include:

- Rash
- Cold/Flu
- Allergies
- Bronchitis
- Fever
- Diarrhea
- Sore throat
- Stomachache
- Pink eye
- Bladder infection
- Migraines/ Headaches

You should not use a virtual visit in the event of an emergency, when you're experiencing a complex or chronic medical condition, if the type of medical care you need requires an exam or test, or when you have an injury requiring bandaging or another type of in-person care (such as a sprain or broken bone).

Benefits of Using a Virtual Visit

- **Visits anywhere** – Install the mobile app and access healthcare from anywhere, at any time.
- **Open 24 hours** – Doctors are available 24 hours a day, 365 days a year.
- **No appointments** – Just sign in and have your visit. No more germy waiting rooms.
- **Prescriptions** – Prescriptions are sent electronically to the pharmacy of your choice.

How to Access

Florida Blue provides access to virtual care services through Teladoc as part of your medical plan. To connect with a Teladoc provider, register for your account at teladoc.com or call 1-800-Teladoc (835-2362). You can also access virtual visits by downloading the Teladoc app from the App Store if you have an iPhone or Google Play Store if you have an Android device.

TELADOC®

HEALTHCARE CONSUMERISM

Lifestyle behaviors, such as physical activity, diet and tobacco use, can play a significant role in how much you spend on healthcare. With healthcare costs continuing to rise, that means it's increasingly important that you play an active role in prioritizing your health.

An important part of prioritizing your health includes utilizing your healthcare benefits wisely. Visit your doctor regularly for preventive screenings, and take steps to better understand how your medical plan works, including how to compare quality and pricing when seeking services. Being a good consumer of your healthcare will allow you to make smarter decisions while minimizing costs.

Pharmacy Discount Programs

When shopping for household items, do you ever compare prices from one retailer to another? Then why not do the same with your prescription drugs?

Did you know...

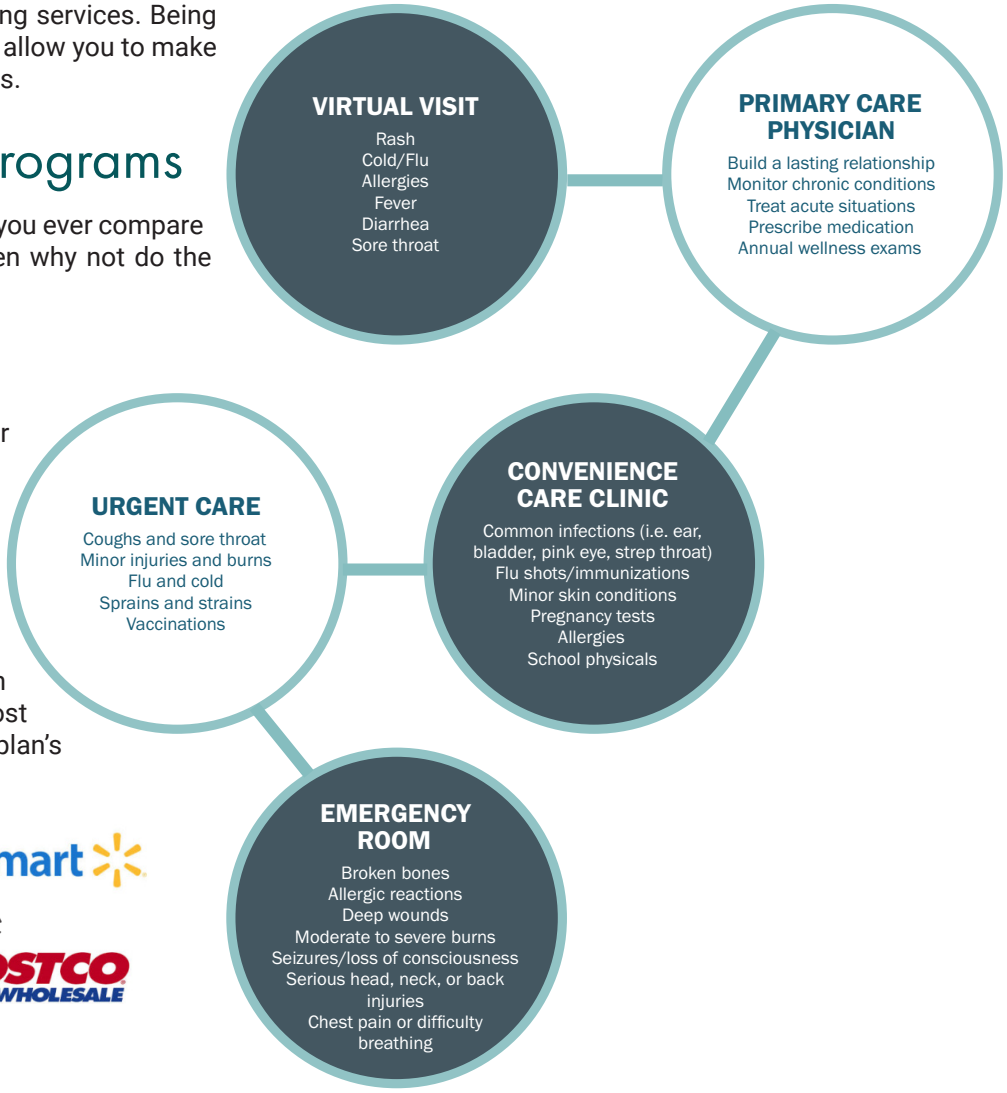
- Pharmacies such as Winn Dixie, Walmart, Sam's Club and Costco offer prescription discount programs that allow you to purchase medications for as low as $4 for a 30-day supply
- Publix and Winn Dixie pharmacies offer select free antibiotics and maintenance medications

Keep in mind that when using certain pharmacy discount programs, your cost may not be applied to your medical plan's deductible/out-of-pocket maximum.

Publix. Walmart Winn-Dixie Sam's Club COSTCO WHOLESALE

Choose the Right Type of Care

When in need of medical care, understanding your options and making an informed choice about what type of care to seek is crucial to your personal and financial well-being. Making the wrong choice could result in spending significantly more time and money than you would have by choosing the most appropriate type of care for your situation.



DENTAL INSURANCE

Principal

	Low		High	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Maximum Plan Pays Per Enrolled	$1,000		$1,500	
Lifetime Orthodontic Maximum	$1,000		$1,500	
Coinsurance				
Preventive	100%	100%	100%	100%
Basic	80%	80%	80%	80%
Major	50%	50%	50%	50%
Orthodontia	50%	50%	50%	50%
Benefits Based on	Contracted Rates	MAC	Contracted Rates	90th Percentile
Balance Billing	No	Yes	No	Yes
Calendar Year Deductible (Individual/Family)	$100/$300		$100/$300	
Deductible Waived for Preventive Services	Yes		Yes	
Maximum Rollover	Included		Included	
SCHEDULE OF BENEFITS				
Routine Exams (2 per 12 months)	Preventive		Preventive	
Cleaning (2 per 12 months)	Preventive		Preventive	
X-Rays				
Bitewing	Preventive		Preventive	
Full Mouth	Preventive		Preventive	
Sealants (under age 19)	Preventive		Preventive	
Fillings				
Amalgam	Basic		Basic	
Composite Resin	Basic		Basic	
Oral Surgery*	Basic		Basic	
Root Canal	Basic		Basic	
Periodontal Maintenance*	Basic		Basic	
Periodontal Surgery*	Basic		Basic	
Endosteal Implants	Not Covered		Major	
Crowns/Bridges/Dentures	Major		Crowns: Basic / All Other: Major	
Orthodontia	Covered up to age 19		Covered up to age 19	

** Coinsurance based on complexity of procedure*

SEMI-MONTHLY PAYROLL DEDUCTIONS		
Employee	$14.27	$28.01
Employee + Spouse	$28.18	$54.73
Employee + Child(ren)	$42.14	$66.55
Employee + Family	$59.38	$97.89

Finding a Dentist

Verify your provider(s) are contracted in the Principal Plan Dental Network to best utilize the plan. Participating provider information can be found on the carrier's website (principal.com/dentist).

Member Portal

Register for your member account on principal.com/login once your dental coverage is active and get access to your dental plan information 24/7. Find an in-network dentist, print your member ID card, view past claims and find other helpful tools and information.

Principal App

Simplify your life with the Principal app! Securely access your account at your convenience to find a provider, view your member ID card or view your plan and claim summary.

Maximum Rollover Benefit

Your Principal dental plan includes a maximum rollover benefit. This program rewards you and your covered dependents for seeking dental care regularly, while remaining below the threshold amount and not exhausting your calendar year maximum. Using the maximum rollover benefit to roll over unused dollars means that you will have more dollars available for your dental services in future years.

How does it work? If Principal spends less than 50% of your calendar year maximum on your dental claims during the year, you can roll over 25% and accumulate up to 1x your annual maximum. The amount accumulated is added to your annual maximum for the following year(s).

Track your maximum rollover balance by logging into your account at principal.com/login.

1. Center for Disease Control and Prevention. (2020, August 25). Oral Health Fast Facts. Retrieved September 28, 2020 from https://cdc.gov/oralhealth/fast-facts/index.html

VISION INSURANCE

Principal

IN-NETWORK BENEFITS	
Vision Examination	$10 copay
Single, Bifocal & Trifocal Lenses	$25 copay
Progressive Lenses	Standard: $0 copay Premium: $95 - $105 copay Custom: $150 - $175 copay
Frame	$150 allowance + 20% off overage
Contact Lens Exam & Fitting	Up to $60 copay
Elective Contact Lenses – *in lieu of lenses/frames*	$150 allowance
Laser Vision Correction	15% off retail or 5% off promotional pricing at VSP participating centers
OUT-OF-NETWORK BENEFITS	Reimbursement up to
Vision Examination	$45
Single Lenses	$30
Bifocal Lenses	$50
Trifocal Lenses	$65
Frame	$70
Elective Contact Lenses – *in lieu of lenses/frames*	$105
FREQUENCY	
Exams	12 months
Lenses/Contacts	12 months
Frames	24 months
SEMI-MONTHLY PAYROLL DEDUCTIONS	
Employee	$4.56
Employee + Spouse	$9.07
Employee + Child(ren)	$10.27
Employee + Family	$16.18

Finding a Vision Provider

To receive discounts and preferred member pricing, we encourage you to seek care from doctors and vision facilities that belong to the VSP Choice Network. Participating provider information can be found on the carrier's website (principal.com/vsp).

Principal App

Simplify your life with the Principal app! Securely access your account at your convenience to find a provider, view your member ID card or view your plan and claim summary.

Online Vision Savings Tips

Zenni Optical and Warby Parker offer eyewear at a less expensive cost than many other eyewear retailers, but keep in mind they may not be in-network providers under the vision plan. Because the vision plan covers either glasses or contacts each year, individuals that wear both may consider utilizing the vision plan for the contact lens benefit and purchasing eyewear from one of the below retailers.

Warby Parker

Trendy prescription glasses you can try on at home before buying. Pick up to 5 frames to have mailed to you for free. If you decide to keep one (or more), purchase them online and Warby Parker will mail you a new pair with your prescription lenses in them. Return the frames within 5 days with the prepaid return label. Find Warby Parker's styles and prices online at warbyparker.com.

Zenni Optical

Affordable frames starting at just $8! Trendy, not spendy prescription glasses for men, women and children. Sunglasses and blue light blockers are also available. Find their selection and prices online at zennioptical.com.

LIFE INSURANCE

Principal

Life insurance offers peace of mind by providing financial protection to your loved ones in the event of your death. If you have family members who depend on you for financial support, life insurance can protect them from the unknown and help them through an otherwise difficult time of loss. Please be sure to add/review your beneficiary information and contact your Human Resources department should you have any changes throughout the year.

Basic Life/AD&D (100% Employer Paid)

Holy Cross provides $50,000 worth of Basic Life and Accidental Death & Dismemberment (AD&D) Insurance through Principal to all full-time employees at no cost to the employee. The basic life/AD&D insurance benefit reduces by 35% at employee's age 65 and 50% at employee's age 70.

Voluntary Life

Employees who would like to supplement their basic life insurance benefits may purchase additional life insurance coverage. If you purchase coverage for yourself, you may also purchase coverage for your dependents. To be eligible for coverage you must be actively at work, you and your dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility). An overview of the voluntary life insurance benefit options is listed on the following page.

The voluntary life insurance benefits reduce according to the following schedule:

- Employee: Reduces by 35% at employee's age 65 and 50% at employee's age 70
- Spouse: Reduces by 35% at spouse's age 65 and 50% at spouse's age 70

Important Life Insurance Terms

Conversion: When you terminate employment or insurance eligibility, you may apply for an individual policy by converting the current policy in force to an individual policy. Included with Basic and Voluntary Life.

Guarantee Issue (GI): The amount of coverage available to new hires enrolling in benefits for the first time without providing Evidence of Insurability.

Evidence of Insurability: Evidence of Insurability (EOI) is a medical questionnaire used by the carrier to determine whether an applicant will be approved for or declined coverage. If enrolling in voluntary life coverage, the carrier may require EOI before some or all of your coverage is effective. An EOI form is required if:

- Newly eligible for coverage and electing above the GI amount(s) for yourself and/or your spouse
- Previously waived coverage and electing more than two increments for yourself and/or your spouse for the first time
- Enrolled and want to increase your current coverage for yourself by more than $20,000 and/or spouse by more than $10,000.

It is the EMPLOYEE'S responsibility to complete and submit an EOI form when required. Benefit coverage and payroll deductions for any amount subject to EOI will not take effect until the EOI is approved by the carrier.

Portability: When you terminate employment or insurance eligibility, you may apply for an individual policy by porting the current policy in force. This provision allows for the continuation of your current group policy, but on an individual basis. Included with Voluntary Life.

Annual Increase (Employee and Spouse)

Applies to existing eligible employees regardless of previous election. You may annually elect to increase the amount of your or your spouse's insurance by up to two increments without providing an Evidence of Insurability (EOI) form. To be eligible, you must be actively employed. The election can only be made once a year during open enrollment and is subject to the plan maximums. It is not subject to the Guarantee Issue (GI) limit.

VOLUNTARY LIFE INSURANCE BENEFIT OVERVIEW			
	Minimum	**Guarantee Issue**	**Maximum**
Employee	$10,000	$60,000*	**$300,000** ($10,000 increments)
Spouse	$5,000	20,000	**$100,000 or 50% of employee's benefit amount**, whichever is less ($5,000 increments)
Child(ren)	$5,000	$10,000	**$10,000 or 50% of employee's benefit amount,** whichever is less ($5,000 increments) (Birth to 13 days: $1,000)

**$10,000 if employee is age 70+*

Cost of Coverage

When you enroll in this benefit, you pay the full cost through payroll deductions. The payroll deductions are age banded based on the employee's age and spouse's age as of the first day of the plan year. Your actual payroll deduction may vary slightly due to rounding.

If the benefit amount you would like to select is over the maximum amount shown in the table, select the benefit amount from the first column (coverage amount) that when multiplied by another number results in the benefit amount you want (subject to policy maximums). For example, if you would like to elect $150,000 in coverage, use the $50,000 row rate which applies to your age band and multiply by 3.

EMPLOYEE SEMI-MONTHLY PAYROLL DEDUCTIONS								
Coverage Amounts	**Employee's Age**							
	<29	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**
$10,000	$0.55	$0.61	$0.91	$1.47	$2.27	$3.70	$5.80	$8.06
$20,000	$1.10	$1.22	$1.82	$2.94	$4.53	$7.39	$11.60	$16.11
$30,000	$1.65	$1.83	$2.73	$4.41	$6.80	$11.09	$17.40	$24.17
$40,000	$2.20	$2.44	$3.64	$5.88	$9.06	$14.78	$23.20	$32.22
$50,000	$2.75	$3.05	$4.55	$7.35	$11.33	$18.48	$29.00	$40.28
$60,000	$3.30	$3.66	$5.46	$8.82	$13.59	$22.17	$34.80	$48.33
$70,000	$3.85	$4.27	$6.37	$10.29	$15.86	$25.87	$40.60	$56.39
$80,000	$4.40	$4.88	$7.28	$11.76	$18.12	$29.56	$46.40	$64.44
$90,000	$4.95	$5.49	$8.19	$13.23	$20.39	$33.26	$52.20	$72.50
$100,000	$5.50	$6.10	$9.10	$14.70	$22.65	$36.95	$58.00	$80.55

SPOUSE SEMI-MONTHLY PAYROLL DEDUCTIONS								
Coverage Amounts	**Spouse's Age**							
	<29	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**
$5,000	$0.28	$0.31	$0.46	$0.74	$1.13	$1.85	$2.90	$4.03
$10,000	$0.55	$0.61	$0.91	$1.47	$2.27	$3.70	$5.80	$8.06
$15,000	$0.83	$0.92	$1.37	$2.21	$3.40	$5.54	$8.70	$12.08
$20,000	$1.10	$1.22	$1.82	$2.94	$4.53	$7.39	$11.60	$16.11

CHILD(REN) SEMI-MONTHLY PAYROLL DEDUCTIONS*	
$5,000	$0.50
$10,000	$1.00

**Regardless of how many children you have*

ANNUAL NOTICES

Health Insurance Marketplace Coverage Options

In 2014 a new option to buy health insurance began: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the 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 begins November 1, 2023 and ends on December 15, 2023. You can get coverage through the Marketplace for 2024 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP). Here are some important dates:

November 1, 2023: Open Enrollment starts
December 15, 2023: Last day to enroll or change 2024 health plan
January 1, 2024: 2024 Insurance coverage begins

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 9.61% (2022) 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.[1]

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

1. 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.

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

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

Notice of Special Enrollment Rights

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

- **Loss of Other Coverage** – If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- **Marriage, Birth or Adoption** – If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
- **Medicaid or CHIP** – If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy. To request special enrollment or obtain more information, please contact the plan administrator.

The Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health & Cancer Rights Act of 1998

Did you know that your medical plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information regarding this benefit, contact customer service at the number listed on the back of your medical ID card.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member to receive assistive reproductive services.

Your Right to Receive a Notice of Privacy Practices

Client Name is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of its Notice of Privacy Practices by contacting the medical carrier. (See telephone number on your medical ID card.)

Premium Assistance: Medicaid & CHIP

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or 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 askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.

The following list of states is current as of July 31, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ | Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp | Phone: 916-445-8322 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid-Website: https://in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI – HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: medicaid.la.gov or ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: https://dphhs.mt.gov/montanahealthcareprograms/welcome/memberservices/index | Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: https://medicaid.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://dhhs.nh.gov/oii/hipp.htm | Phone: 603-271-5218 HIPP: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://oregonhealthcare.gov/index-es.html | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://eohhs.ri.gov | Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov/ | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip | Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.org/en/famis-select / https://coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: https://hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ | Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Medicare Part D Notice of Creditable Coverage

Remember: Keep this 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).

Important Notice from Holy Cross 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 Holy Cross 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. Holy Cross has determined that the prescription drug coverage offered through UnitedHealthcare are, 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 coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to reenroll in our program during the next open enrollment period.

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

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

For more information about this notice or your current prescription drug coverage: Contact the person listed below. 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 Holy Cross 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 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 socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

CMS Form 10182-CC Updated April 1, 2011

Date:	January 1, 2023
Name of Entity/Sender:	Holy Cross
Contact – Position/Office:	Dennis McGavock
Address:	780 N. Sun Drive Lake Mary, FL 32746
Phone Number:	407-333-0797, ext 1105

Notice of Privacy Practices

The HIPAA Privacy Rule restricts the use and disclosure of member personal health information by "Covered Entities" and their "Business Associates." As the sponsor and funding source of your health benefits under a Florida Blue plan, Holy Cross ("Plan Sponsor") is subject to the Privacy Rule as a "Covered Entity." Florida Blue processes claims under your plan and so is also subject to the Privacy Rule as our "Business Associate."

This Notice of Privacy Practices describes addresses how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Plan Sponsor

As a practical matter, we may rarely, if ever, come in contact with your personal health information. With limited exception, most use and disclosure of personal health information will be handled by Florida Blue. For that reason, you'll see that most of this Notice addresses Florida Blue's handling of personal health information and your related interactions with Florida Blue.

In the event that the Plan Sponsor comes into contact with any of your personal health information, we will not use or disclose that information in any way that is inconsistent with the restrictions and requirements described below as applicable to Florida Blue, to the extent those restrictions and requirements apply to us as your employer. For example, we will not use that information in connection with any benefit determinations, because that is Florida Blue's responsibility. And we may not use any personal health information for any employment purpose unrelated to participation in the plan. On the other hand, we could be required to respond to federal and state law enforcement in appropriate cases. In addition, you have all of the Legal Rights described below with respect to any personal health information that we may have.

If you have any questions, comments or complaints about Plan Sponsor's handling of personal health information, please contact the department, office or individual that is responsible for Human Resources at Plan Sponsor.

Insurance Company

When Florida Blue uses the term "personal information," we mean information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage. By "health information," we mean information that identifies you and relates to your medical history (i.e., the healthcare you receive, or the amounts paid for that care).

How Florida Blue Uses and Discloses Personal Information

To process claims under your plan, Florida Blue needs personal information about you, and we obtain that information from many different sources – particularly you, your employer or benefits plan sponsor if applicable, other insurers, HMOs or third-party administrators (TPAs), and healthcare providers. In administering your health benefits, we may use and disclose personal information about you in various ways, including:

Healthcare Operations: We may use and disclose personal information during the course of administering the plan – that is, during operational activities such as quality assessment and improvement; licensing; accreditation by independent organizations; performance measurement and outcomes assessment; health services research; and preventive health, disease management, case management and care coordination. For example, we may use the information to provide disease management programs for members with specific conditions, such as diabetes, asthma or heart failure. Other operational activities requiring use and disclosure include administration of stop loss; detection and investigation of fraud; administration of pharmaceutical programs and payments; transfer of policies or contracts from and to other health plans; facilitation of a sale, transfer, merger or consolidation of all or part of Florida Blue with another entity (including due diligence related to such activity); and other general administrative activities, including data and information systems management, and customer service.

Payment: To help pay for your covered services, we may use and disclose personal information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review. For example, we may use your medical history and other health information about you to decide whether a particular treatment is medically necessary and what the payment should be – and during the process, we may disclose information to your provider. We also mail Explanation of Benefits forms and other information to the address we have on record for the subscriber (i.e., the covered employee). In addition, we make claims information contained on our secure member website and telephonic claims status sites available to the subscriber and all covered dependents. We also use personal information to obtain payment for any mail order pharmacy services provided to you.

Treatment: We may disclose information to doctors, dentists, pharmacies, hospitals and other healthcare providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We also may use personal information in providing mail order pharmacy services and by sending certain information to doctors for patient safety or other treatment-related reasons.

Disclosures to Other Covered Entities: We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain healthcare operations purposes. We may use or disclose personal information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to Your Employer, as sponsor and funding source of your plan, subject to specified conditions. Research – to researchers, provided measures are taken to protect your privacy.
- **Business Partners** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.
- **Law Enforcement** – to federal, state and local law enforcement officials. Legal Proceedings – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

Disclosure to Others Involved in Your Healthcare

We may disclose health information about you to a relative, a friend, the subscriber of your health benefits plan or any other person you identify, provided the information is directly relevant to that person's involvement with your healthcare or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by calling the toll-free Member Services number on your ID card.

If you are a minor, you also may have the right to block parental access to your health information in certain circumstances, if permitted by state law. You can contact us using the toll-free Member Services number on your ID card – or have your provider contact us.

Your Legal Rights

The federal privacy regulations give you several rights regarding your health information:

- You have the right to ask us to communicate with you in a certain way or at a certain location. For example, if you are covered as an adult dependent, you might want us to send health information (e.g. Explanation of Benefits (EOB) and other claim information) to a different address from that of your subscriber. We will accommodate reasonable requests.
- You have the right to ask us to restrict the way we use or disclose health information about you in connection with healthcare operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict disclosures to persons involved in your healthcare.
- You have the right to ask us to obtain a copy of health information that is contained in a "designated record set" – medical records and other records maintained and used in making enrollment, payment, claims adjudication, medical management and other decisions. We may ask you to make your request in writing, may charge a reasonable fee for producing and mailing the copies and, in certain cases, may deny the request. You have the right to ask us to amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement.
- You have the right to ask us to provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a reasonable fee.
- You have the right to be notified following a breach involving your health information.
- You have the right to know the reasons for an unfavorable underwriting decision. Previous unfavorable underwriting decisions may not be used as the basis for future underwriting decisions unless we make an independent evaluation of the basic facts. Your genetic information cannot be used for underwriting purposes.
- You have the right with very limited exceptions, not to be subjected to pretext interviews. (Florida Blue does not participate in pretext interviews.)

You may make any of the requests described above (if applicable), may request a paper copy of this notice, or ask questions regarding this notice by calling the toll-free Member Services number on your ID card.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please send your inquiry to the following address:

Florida Blue
Customer Service – Privacy Unit
P.O. Box 740815
Atlanta, GA 30374-0815

You may stop the paper mailing of your EOB and other claim information by visiting www.uhc.com. Then you can log in any time to view past copies of EOBs and other claim information.

You also may write to the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Remember, that if you have any questions, comments or complaints about Your Employer's handling of personal health information, please contact the department, office or individual that is responsible for Human Resources at Your Employer.

Uses and Disclosures Requiring Your Written Authorization

In all situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization for marketing purposes that are unrelated to your benefit plan(s), before disclosing any psychotherapy notes, related to the sale of your health information, and for other reasons as required by law.

If you have given us an authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorizations, please call the toll-free Member Services number on your ID card.

Safeguarding Your Information

We guard your information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal law pertaining to the security and confidentiality of personal information.

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future.

Please note that we do not destroy personal information about you when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after your coverage terminates, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

HEALTHCARE GLOSSARY

Applicable Cost Share
The share of costs covered by your insurance that you pay out of your own pocket. Includes deductibles, coinsurance, and copays. Does not include premiums, balance billing amounts for non-network providers, or non-covered services.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance
The portion of the cost for care received for which an individual is financially responsible, which is usually calculated as a percentage (such as 20%). Often coinsurance applies after a specific deductible has been met and may be subject to an individual out-of-pocket. For example, if the plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The plan pays the rest of the allowed amount.

Copayment
A payment you make at the time that selected services are rendered, and no additional payment is required. Copayments are typically flat amounts (for example, $15), covering such items as office visits, prescriptions, and emergency care.

Covered Expenses
Healthcare expenses that are covered under your health plan.

Deductible
The amount of eligible expenses you must pay, out of pocket each plan year, before the plan begins to pay. The deductible may not apply to all services.

Embedded Deductible
An embedded deductible is an individual deductible level within a family contract. For example, if there is a family deductible of $3,000 with an individual embedded deductible of $1,500, when any one individual family member reaches $1,500 in expenses, their benefit plan coverage takes effect.

Non-embedded Deductible
A non-embedded deductible requires that the entire family deductible be met before benefit plan coverage takes effect by any one or combination of family members.

Evidence of Insurability
A medical questionnaire used to determine whether an applicant will be approved or declined coverage.

Guarantee Issue
The amount available without providing an Evidence of Insurability (EOI). An EOI will be required for any amounts above this, for late enrollees or increases in insurance.

In-Network
Care received from physicians, facilities or suppliers that are contracted with the insurer to provide services on a negotiated discount basis.

Late Entrant
A member that becomes insured more than 30 days after initial eligibility or becomes insured again after previously waiving coverage.

Mandatory Generic
When you request a brand name drug when there is a generic equivalent, you pay the generic copay plus the cost difference between the brand and generic drug. Dispense as written (DAW) may be allowed. With DAW you will not be charged a cost difference.

Out-of-Network
Care received from physicians, facilities or suppliers that are not contracted with the insurer to provide services on a negotiated discount basis.

Out-of-Pocket Expense
Amount you pay toward the cost of healthcare services, may include deductibles, copays and/or coinsurance.

Out-of-Pocket Maximum
The maximum dollar amount a member is required to pay out of pocket during a benefit period. Plans may vary but deductibles and coinsurance may apply toward meeting the out-of-pocket maximum.

Preferred Provider
A provider who has a contract with your carrier/vendor to provide services to you at a discount.

Pre-existing Condition
Any Injury/Sickness for which you received medical treatment, advice or consultation, care or services including diagnostic measures, or had drugs or medicines prescribed or taken in the X months prior to the day you become insured. For example: Disabilities that occur during the first 6 months of coverage due to a pre-existing condition that occurred during the 3 months prior to coverage are excluded.

Provider
Physician (medical, dental or vision), healthcare professional or facility licensed, certified or accredited as required by state law.

Prior Authorization/Pre-Service Notification
The decision by the plan or health insurer that a healthcare service, treatment plan, prescription drug, medical equipment, or other healthcare services defined in the certificate of coverage, is medically necessary. The plan may require preauthorization for certain services before receiving them, except in an emergency.

UCR (Usual, Customary & Reasonable)
The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount is sometimes used to determine the allowed amount.

CONTACTS

Holy Cross

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407-333-0797 ext. 1105
dennis@hclm.org

Brown & Brown

Debbie Cox
Employee Benefits Client Care Advocate
321-214-2399
debbie.cox@bbrown.com

Medical

Florida Blue
800-352-2583
floridablue.com

Health Savings Account

Health Equity
866-346-5800
healthequity.com

Dental

Principal
800-247-4695
principal.com/dentist

Vision

Principal (VSP Choice Network)
800-877-7195
principal.com/vsp

Life/AD&D

Principal
800-843-1371
www.principal.com

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