gracepoint

THE SOURCE FOR WELLNESS

BENEFITS AT A GLANCE

January 1, 2022 - December 31, 2022

CONTENTS & CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit vendors.
For general information contact Human Resources.

BENEFIT INFORMATION

YOUR BENEFITS PLAN

Gracepoint offers a variety of benefits allowing you the opportunity to customize a benefits package that meets your personal needs.

In the following pages, you'll learn more about the benefits offered. You'll also see how choosing the right combination of benefits can help protect you and your family's health and finances – and your family's future.

Benefit	Who pays the cost?
Medical Insurance	Gracepoint pays the majority of the employee portion of the medical plan. You may enroll your eligible dependents for an additional cost.
Dental Insurance	Gracepoint pays a portion of the employee cost for dental coverage. You may elect dental coverage for yourself and your eligible dependents on a voluntary basis and you will be responsible for the cost above what Gracepoint contributes.
Vision Insurance	You may elect vision coverage for yourself and your eligible dependents on a voluntary basis and you will be responsible for the cost.
Basic Life Insurance	Gracepoint pays the entire cost.
Voluntary Life Insurance	The employee pays the entire cost.
Voluntary Short and Long Term Insurance	The employee pays the entire cost.

ELIGIBILITY

All Regular full-time employees are eligible to join the Gracepoint Benefits Plan on the 1st of the month following 60 days. You may also enroll your dependents in the Benefits Plan when you enroll.

Eligible dependents include:

- Your legal spouse
- Your married or unmarried natural children, step-children living with you, legally adopted children and any other children for whom you have legal guardianship, who are:
  - Under 26 years of age;
  - A dependent who is older than 26 years of age, but less than 30 years of age may be eligible for medical benefits. To be eligible, a Dependent must:
    - Be unmarried and not have dependents of his or her own; AND
    - Be a resident of Florida or a student; AND
    - Not have coverage of their own, or covered under any other plan; AND
    - Not entitled to benefits under Medicare

WHEN CAN YOU ENROLL?

You can sign up for Benefits at any of the following times:

- After completing your initial eligibility period;
- During the annual open enrollment period;
- Within 30 days of a qualified family-status change.

If you do not enroll at one of the above times, you must wait for the next annual open enrollment period.

BENEFIT INFORMATION

CHOOSING YOUR BENEFITS

You must actively choose any benefit that you pay for or share in the cost with Gracepoint.

Your part of the cost is automatically taken out of your paycheck. There are two ways that the money can be taken out:

- BEFORE YOUR TAXES ARE CALCULATED – medical, dental, vision, flexible spending account (FSA)
- AFTER YOUR TAXES ARE CALCULATED – voluntary life/ accidental death & dismemberment, disability and voluntary products

?

WHY DO I PAY FOR BENEFITS WITH BEFORE-TAX MONEY?

There is a definite advantage to paying for some benefits with before-tax money:

Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

MAKING CHANGES

Generally, you can only change your benefit choices during the annual benefits enrollment period. However, you may be able to change your benefit choices during the plan year if you have a change in status including:

- Your marriage
- Your divorce or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

If you fail to notify Human Resources within 30 days of a family status change, you will be required to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

WHEN COVERAGE ENDS

Coverage will stop on the last day of the month in which employment with the company ends. Life insurance ends the last day of employment.

KEY BENEFIT TERMS

COBRA – A Federal law that allows workers and dependents who lose their medical, dental, or vision coverage to continue any of these coverages for a specified length of time by electing and paying for continuation benefits.
Copayment – A flat fee that you pay for medical services, regardless of the actual amount charged by your doctor or another provider. This generally applies to physicians' office visits and prescription drugs.
Deductible – The amount you pay toward medical and dental expenses each year before the plan begins paying benefits.
Out of Pocket Maximum – The maximum amount you will pay in deductibles, copayments and coinsurance during the year.

MEDICAL INSURANCE

Gracepoint offers three medical plans through Cigna. To find participating providers go to www.cigna.com and click on "Find a Doctor", choose the appropriate provider type. The Low and Mid plans use the Cigna Open Access Plus (IN) and High plan provider network uses the Cigna Open Access Plus (Choice) Network.

The chart below provides a brief overview of the medical plans. This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage. If the below illustration of benefits conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your exact description of services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

	LOW Open Access Plus – In Network	MID Open Access Plus – In Network	HIGH Open Access Plus – Choice
IN-NETWORK:			
Plan or Calendar Year Basis	Calendar Year	Calendar Year	Calendar Year
Deductible (Individual/Family)	$4,000 / $8,000	$2,750 / $5,500	$1,500 / $3,000
Coinsurance	70% / 30%	80% / 20%	80% / 20%
Maximum Out-of-Pocket (Individual/Family)	$8,100, $16,200	$5,750 / $11,500	$4,000 / $8,000
Maximum Out-of-Pocket Includes	Deductible, Coinsurance & Copayments	Deductible, Coinsurance & Copayments	Deductible, Coinsurance & Copayments
Lifetime Medical Maximum	Unlimited	Unlimited	Unlimited
PREVENTIVE CARE:	Covered 100%	Covered 100%	Covered 100%
Wellness			
Immunizations			
Mammography/Colonoscopy			
COPAYMENTS:			
Telemedicine (24/7 – 365 days a year)	$40 Copayment	$30 Copayment	$25 Copayment
Primary Physician Office Visits – *No Referral Required*	$40 Copayment	$30 Copayment	$25 Copayment
Specialist Visits	$50 Copayment	$30 Copayment	$25 Copayment
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	Deductible & Coinsurance	$150 Copayment	$100 Copayment
Urgent Care	$100 Copayment	$50 Copayment	$50 Copayment
OUTPATIENT DIAGNOSTIC SERVICES:			
Lab Services	Covered 100%	Covered 100%	Covered 100%
X-Ray Services	Covered 100%	Covered 100%	Covered 100%
Complex Diagnostic	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
PRESCRIPTIONS:			
Retail (30 day supply)	$20 / $55 / $100	$10 / $40 / $70	$10 / $35 / $60
Mail Order (90 day supply)	3 X retail	3 X retail	3 X retail
OUT-OF-NETWORK:			
Deductible (Individual/Family)	In-Network Only	In-Network Only	$3,000 / $6,000
Maximum Out-of-Pocket (Individual/Family)	In-Network Only	In-Network Only	$10,000/ $20,000
Lifetime Medical Maximum	In-Network Only	In-Network Only	Unlimited
Coinsurance	In-Network Only	In-Network Only	60% / 40%

MEDICAL CONTRIBUTION SCHEDULE

LOW Health Network Only Open Access	Employee Pays (Per Pay Period)	Employer Contribution (Per Pay Period)	Total (Per Pay Period)
Employee Only	$ 50.08	$228.46	$ 278.54
Employee + Spouse	$249.92	$346.15	$ 596.07
Employee + Child(ren)	$186.09	$306.92	$ 493.01
Family	$380.83	$426.92	$ 807.75

MID Health Network Only Open Access	Employee Pays (Per Pay Period)	Employer Contribution (Per Pay Period)	Total (Per Pay Period)
Employee Only	$ 83.54	$270.00	$ 353.54
Employee + Spouse	$327.35	$429.23	$ 756.58
Employee + Child(ren)	$245.00	$380.77	$ 625.77
Family	$494.50	$530.77	$1,025.27

HIGH Health Network Option Open Access	Employee Pays (Per Pay Period)	Employer Contribution (Per Pay Period)	Total (Per Pay Period)
Employee Only	$121.08	$286.15	$ 407.23
Employee + Spouse	$386.94	$484.62	$ 871.56
Employee + Child(ren)	$306.87	$415.38	$ 722.25
Family	$569.55	$611.54	$1,181.09

DENTAL INSURANCE

Gracepoint is offering dental coverage through Cigna this year. The Dental PPO Plans allow you to use in-network or out-of-network benefits. If out-of-network dentists are used, you will be responsible for paying the difference between Cigna's allowed amount and what the dentist may charge, also known as "balance billing". The charts below provides a brief overview of the plans.

	LOW Dental PPO Plan		HIGH Dental PPO Plan	
	In-Network	Out-of Network*	In-Network	Out-of Network*
Calendar Year Deductible				
Individual	$50	$100	$50	$50
Family	$150	$300	$150	$150
Annual Maximum	$1,250		$2,000	$1,250
Diagnostic & Preventive				
Exams Cleanings Fluoride X-Rays Sealants	Covered in full	Calendar Year Deductible	Covered in full	Covered in full
Regular Restorative Services Amalgam Fillings Extractions - Single Tooth Endodontics (Root Canal) Periodontics (Gum Disease)	Covered 80% after deductible	Covered 50% after deductible	Covered in full after after deductible	Covered 80% after deductible
Major Services				
Crowns Bridges Dentures	Covered 50% after deductible	Covered 30% after deductible	Covered 60% after deductible	Covered 50% after deductible
Orthodontia Services Children only under the age of 19	Not covered		50% $1,000 Lifetime Maximum	

- Subject to balance billing. Please refer to your plan document for specific details.

	LOW PLAN Employee Cost Per Pay Period	HIGH PLAN Employee Cost Per Pay Period
Employee Only	$ 5.54	$11.65
Employee + Spouse	$12.22	$36.87
Employee + Child(ren)	$14.58	$43.07
Family	$24.37	$63.81

VISION INSURANCE

Gracepoint offers vision coverage through SunLife using the VSP network. The VSP vision network consists of optometrists, ophthalmologist opticians and optical retailers. You have the option of visiting any provider, however by choosing a participating provider, you receive the highest level of benefits.

	Vision VSP Network	
	In-Network	Out-of-Network
Routine Eye Exams	$10 Copayment	Reimbursed up to $45
Lenses*	$25 Copayment	Reimbursed from $30 to $100 Depending on type of lenses
Frames	$130 allowance + 20% Discount. $80 allowance at Costco, Walmart and Sam's	$70 allowance
Contact Lenses	$130 allowance	Reimbursed up to $105
Frequency		
Exam	Once every 12 months	
Lenses or contact lenses	Once every 12 months	
Frame	Once every 24 months	

- Covered lenses include single vision, bifocal, trifocal and lenticular.
- Lenses, Frames & Contacts are limited to either one pair of contacts or frames/lenses per calendar year.

	Employee Cost Per Pay Period
Employee Only	$ 2.50
Employee + Spouse	$ 4.99
Employee + Child(ren)	$ 5.49
Family	$ 7.99

BASIC AND VOLUNTARY LIFE INSURANCE

Gracepoint provides all full-time employees working 30 or more hours per week the option to purchase voluntary life insurance coverage through a group plan. The chart below provides an overview of the plan.

Basic Life Insurance	Sunlife
Employee Only	1x annual basic earnings up to a maximum of $150,000. **The Basic Life insurance is paid 100% by Gracepoint.**
Voluntary Life Insurance	**Sunlife**
Employee Only	Increments of $10,000 up to a maximum of 5x salary or $500,000, whichever is less. Minimum Election: $20,000
Employees Under Age 65	No evidence of insurability up to max of $100,000 (newly eligible employees only).
Spouse	Increments of $5,000 up to a maximum of 50% of employee amount or $100,000, whichever is less. Minimum Election: $10,000
Spouses Under Age 65	No evidence of insurability up to max of $25,000 (newly eligible dependents only).
Benefit Reduction Schedule	At age 65, benefits reduce by 35% of original amount, at age 70, benefits reduce by 35% of in force amount.
Children	$10,000

VOLUNTARY LIFE

Life Rates per $10,000 of benefit
(Spouse rate is based on employee's age)

Age	Employee/ Spouse	Child
29 and under	$.80	$1.95
30-34	$.90	
35-39	$1.30	
40-44	$2.10	
45-49	$3.30	
50-54	$5.50	
55-59	$9.20	
60-64	$11.10	
65-69	$16.30	
70+	$30.80	

EMPLOYEE ELECTION:

_____ Benefit Amount
/ 10,000
x_____ Monthly Rate (from chart)
= _____
x12
/26
=_____ Bi-Weekly Contribution

SPOUSE ELECTION:

_____ Benefit Amount
/ 10,000
x_____ Monthly Rate (from chart)
= _____
x12
/26
=_____ Bi-Weekly Contribution

CHILD(REN) ELECTION: $10,000

Bi-weekly contribution for all children in the family is $0.91
(*The cost is not based on the number of children)*

SHORT TERM DISABILITY

The plan provides for short-term income continuation if you become disabled due to non-occupational injury or sickness. Benefits commence the 15th day after the onset of an illness or injury. Your benefit will be 60% of your basic weekly salary to a max of $1,500. The maximum duration is 11 weeks. If elected, the employee pays 100% of the Short Term Disability premium.

Voluntary STD Premium Calculation Worksheet

You may elect 60% of your covered weekly earnings to a maximum of $1,500 per week. Your weekly earnings amount is your basic weekly pay. Overtime pay or other compensation that is not considered as basic income should not be included. To calculate your **approximate** STD bi-weekly premium, follow these steps:

STEP 1	Enter your basic weekly pay (divide your annual pay by 52) rounded to the nearest dollar.	1. _____
STEP 2	Multiply the amount in Step 1 by 60% and enter the result (rounded to the next higher dollar). This is your weekly benefit. Do not enter more than $1,500.	2. _____
STEP 3	Divide the amount in Step 2 by 10 and enter that amount.	3. _____
STEP 4	Enter the rate for your age from the chart below. The rate is determined by your age and will be reevaluated on each subsequent coverage policy anniversary.	4. _____
STEP 5	Multiply the amount in Step 3 by the amount in Step 4 and then enter it here. This is your **approximate** monthly premium.	5. _____
STEP 6	Multiply the amount in Step 5 by 12 and then divide by 26 and then enter it here. This is your **approximate** bi-weekly premium.	6. _____

AGE	Monthly Rate per $10 of Weekly Benefit
24 and younger	0.87
25-29	0.87
30-34	0.87
35-39	0.88
40–44	0.63
45-49	0.61
50–54	0.72
55-59	0.92
60–64	1.23
65-69	1.36
70+	1.36

LONG TERM DISABILITY

The plan provides for long-term income continuation if you become disabled and cannot perform some of the material duties of your regular occupation on a full-time basis subject to certain conditions and limitations. Please refer to the plan document for further details. Benefits commence after three months after the onset of the disability. The benefit is 60% of your basic monthly earnings to a monthly maximum of $7,500 for the first two years, then 40% after year two. If elected, the employee pays 100% of the Long Term Disability premium.

VOLUNTARY LONG-TERM DISABILITY

PREMIUM CALCULATION

Monthly Pay		$_____
		/ 100.00
		= $_____
Rate per $100.00		x .79
		X 12
	/ 26	
Weekly Premium	=$_____	

FLEXIBLE SAVINGS ACCOUNT (FSA)

What is a Flexible Spending Account?

A Flexible Spending Account enables you to set aside a predetermined dollar amount in an account to cover eligible out-of-pocket health care and dependent day care expenses throughout the year. IRS rules allow you to contribute to your account(s) through payroll deduction on a pre-tax basis (before federal income tax & social security) reducing your taxable income. The dollars set aside in a Flexible Spending Account are actually worth more because they are tax-free. As a participant, you pay no taxes on the contributions or the withdrawals. Any unused money left in the account at the end of the year will be forfeited. Please be conservative with your elections.

Health Care Reimbursement FSA

This program allows Gracepoint employees to use pre-free FSA dollars to pay for certain IRS-approved medical*, dental and vision expenses to a maximum of $2,850 a year*. Elected funds will be available as of January 1, 2022. Remember to keep receipts for all items purchased through your FSA. The IRS may require you to provide proof of qualified expenses to Discovery Benefits.

Dependent Care FSA

The Dependent Care FSA allows Gracepoint employees to use pretax dollars toward qualified dependent care such as caring for children under the age 13. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year*. Examples include:

- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

2022 Flexible Spending Account Maximums	
Health Care Reimbursement	Dependent Care
Monies can be put aside to pay for non-covered medical, dental or vision expenses up to a maximum of $2,850. Employees and eligible dependents do not need to participate in the Gracepoint medical, dental or vision plans to participate in the healthcare reimbursement account.	Monies can be put aside for reimbursement for dependent daycare expenses incurred during the upcoming year up to a $5,000 maximum. Dependent Care Reimbursement Account & the Federal Tax Credit You have the option to take either a tax credit on your federal income tax return for your dependent care expenses or receive pretax reimbursement of expenses through the reimbursement account. You cannot use the reimbursement account and the federal tax credit for the same expenses.

Voluntary Benefits

Employees may choose to enroll in a variety of supplemental coverage available through AFLAC. A broad selection of employer-sponsored products is available to enhance your benefit package and meet your individual needs. Following are some of the benefits available to you:

Accident Coverage - These plans help cover the unexpected expenses resulting from covered accidents.

Hospital Income Coverage - Hospital Income plans pay specific benefits such as admissions to the hospital. This can be used to help fill the gaps caused by most major medical plans (co-payments and deductibles).

Critical Illness - The Critical Illness plan pays a lump sum upon diagnosis of a covered critical illness for you to use where it's needed most. It can help pay coinsurances, deductibles, caregivers, special medical equipment, loss of income and extra living expenses.

Whole Life Insurance - Whole life insurance policies build cash value and premiums will never increase.

Please refer to Aflac handouts for detailed benefits and pricing.

Employee Assistance Program (EAP)

As an employee of Gracepoint, you have access to a team of counselors and service professionals. Completely confidential, personalized guidance services are available 24 hours a day, seven days a week, to provide you immediate help and support on a host of life and work issues – focusing on keeping you healthy and productive.

Services include:

- Confidential Emotional Support
- Work-Life Solutions
- Legal Guidance
- Financial Resources
- Online Support
- Help for New Parents
- Free Online Will Preparation

Telephone: 877-595-5281
Online: guidanceresources.com
App: GuidanceResources Now
Web ID: EAPBusiness

Retirement – 401(k)

As a new employee of Gracepoint, you will be able to participate in our 401(k). The 401(k) plan allows you to defer federal income taxes as you accumulate money for your retirement through convenient payroll deductions.

There are many benefits to contributing towards a 401(k) account:

- Gracepoint's matching contribution (up to 4%) as follows:
  100% on first 3% of employee deferrals (what you contribute)
  50% on next 2% of employee deferrals (what you contribute)
- Federal income taxes on contributions and on any interest or investment earnings in your 401(k) account are deferred until you leave the company or become 59 ½ years of age for withdraws.
- Contributions to the 401(k) are made from pre-tax salary through payroll deductions.
- 26 investment alternatives.
- Guided Portfolio Services are available free of charge.
- Unlimited transfers among interest & investment options through a toll free telephone service or via the internet.
- Customer Service is available 24/7.

401(k) Plan Eligibility:
Must be 21 years of age. All full-time employees are eligible after 60 days.

Vesting:
Employee deferrals are fully and immediately vested. Matching contributions are subject to the vesting schedule below:

The discretionary fund declared by the Board is vested upon length of employment:	Vested %
Less than 2 years of employment	0%
2 years of employment	20%
3 years of employment	40%
4 years of employment	60%
5 years of employment	80%
6 years of employment	100%

Holidays

Gracepoint observes the following holidays each year:

New Year's Day
Memorial Day
Fourth of July
Labor Day
Thanksgiving Day
The day after Thanksgiving Day
Christmas Day

Paid Time Off (PTO)

Eligible full-time employees shall accumulate PTO at the following rates:

Years of eligible service	PTO Hours Accumulated Per Pay Period	PTO Hours Accumulated Per Year
0-3 years	4.31 hours	14 days
3-5 years	7.08 hours	21 days
5-10 years	8.61 hours	28 days
10+ years	10.15 hours	33 days

You are eligible to use your PTO hours after 90 days from your date of hire. For all eligible employees, a maximum of two hundred (200) PTO hours may be carried over to start the new fiscal year. Any hours in excess of two hundred (200) hours will be automatically transferred to the employee's sick bank, to a maximum of 480 hours.

Payment for accrued leave at separation
There will be no payment for any PTO balances upon leaving the organization. All hours will be forfeited.

Personal Time

Bereavement – Each employee is eligible for three paid days for the death of an immediate family member. Immediate family members include: father, mother, brother, sister, son, daughter, life-partner, husband, wife, step-mother, step-father, step-son, step-daughter, brother-in-law, sister-in-law, grandmother, grandfather, mother-in-law, father-in-law, grandson and granddaughter.

Jury Duty – Each employee is paid their normal rate of pay for up to six days when summoned for jury duty, unless county statute dictates otherwise.

Miscellaneous Benefit

Referral Program – Gracepoint will pay $50 for the referral of a full-time employee who is hired and stays with the organization for six (6) months. The referring employee must be noted on the new employee's application in order to be paid.

ONLINE ENROLLMENT

WEB BENEFITS DESIGN CORPORATION

STEPS TO ONLINE ENROLLMENT

- Step 1

  Logon to www.mybensite.com/gracepoint or call the Open Enrollment Call Center at **888-502-5635**.

- Step 2

  You will be asked to register as a user on the system by clicking "create a new user account". When creating a new user account, you must enter your last name, date of birth, and last 4 digits of the employee's SSN.

- Step 3

  You will also be asked to enter an email address (this becomes your User Name), along with your password. Once that has been completed, you will be logged into the website with access to the enrollment system.

- Step 4

  Once logged in, select the "Enroll Now" tab. You will be guided through a series of screens, each taking only a few moments to complete. All of your benefit elections will be displayed on a cost "per paycheck" basis, based on your specific benefit options.

Inside the website you will find important information such as benefit summaries, forms, summary plan descriptions, provider search directories, frequently asked questions, health and wellness resources and much more. Please review this information thoroughly before entering the enrollment section of the website. It is important that you understand your benefit options BEFORE starting the enrollment process.

If at any point during this process you have questions or require technical support, please call 800-906-9159.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery, to less than 48 hours, and (2) following a cesarean section, to less then 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

1. Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage;
2. Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage;
3. Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage;
4. Require a mother to give birth in a hospital; or
5. Restrict benefits for any portion of a period within a hospital length of stay described in this notice.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

SECTION 111

Effective January 1, 2009 group health plans are required by Federal government to comply with Section 111 of the Medicare, Medicaid, and SCHIP Extensions of 2007's new Medicare Secondary Payer regulations. The mandate is designed to assist in establishing financial liability of claims assignments. In other words, it will help establish who pays first. The mandate requires group health plans to collect additional information, more specifically Social Security numbers for all enrollees, including dependents 6 months of age or older. Please be prepared to provide this information on your benefits enrollment form when enrolling into benefits.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires Gracepoint to notify you, as a participant or beneficiary of the Gracepoint Health and Welfare Plan, of your rights related to benefits provided through the plan in connection with a mastectomy. You, as a participant or beneficiary, have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical compilations of the mastectomy, including lymphedema.

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your Summary Plan Description. Keep this notice for your records and call Human Resources for more information.

MICHELLE'S LAW

The law allows for continued coverage for dependent children who are covered under your group health plan as a student if they lose their student status because of a medically necessary leave of absence from school. This law applies to medically necessary leaves of absence that begin on or after January 1, 2010

If your child is no longer a student, as defined in your Certificate of Coverage, because he or she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if your child was (1) covered under the plan and (2) enrolled as at student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

Your employer will require a written certification from the child's physician that states that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

HIPAA PRIVACY POLICY FOR FULLY-INSURED PLANS WITH NO ACCESS TO PHI

The group health plan is a fully-insured group health plan sponsored by the "Plan Sponsor". The group health plan and the plan sponsor intend to comply with the requirements of 45 C.F.R. §164.530 (k) so that the group health plan is not subject to most of HIPAA's privacy requirements.

I. No access to protected health information (PHI) except for summary health information for limited purpose and enrollment / dis-enrollment information.

Neither the group health plan nor the plan sponsor (or any member of the plan sponsor's workforce) shall create or receive protected health information (PHI) as defined in 45 C.F.R. §160.103 except for (1) summary health information for purpose of (a) obtaining premium bids or (b) modifying, amending, or terminating the group health plan, and (2) enrollment and dis-enrollment information.

II. Insurer for group health plan will provide privacy notice

The insurer for the group health plan will provide the group health plan's notice of privacy practices and will satisfy the other requirements under HIPAA related to the group health plan's PHI. The notice of privacy practices will notify participants of the potential disclosure of summary health information and enrollment / dis-enrollment information to the group health plan and the plan sponsor.

III. No intimidating or retaliatory acts

The group health plan shall not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals for exercising their rights , filing a complaint, participating in an investigation, or opposing any improper practice under HIPAAA.

IV. No Waiver

The group health plan shall not require an individual to waive his or her privacy rights under HIPAA as a condition of treatment, payment, enrollment or eligibility. If such an action should occur by one of the plan sponsor's employees, the action shall not be attributed to the group health plan.

PATIENT PROTECTION:

If the Group Health Plan generally requires the designation of a primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professionals, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, or for information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or refer to the carrier website.

It is your responsibility to ensure that the information provided on your application is accurate and complete. Any omissions or incorrect statements made by you on your application may invalidate your coverage. The carrier has the right to rescind coverage on the basis of fraud or misrepresentation.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009

Effective April 1, 2009, a special enrollment period provision is added to comply with the requirements of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. If you or a dependent is covered under a Medicaid or CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after the date eligibility is lost. If you or a dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, you may be able to enroll yourself and/or your dependent(s). However, you must enroll within 60 days after you or your dependent is determined to be eligible for State premium assistance. Please note that premium assistance is not available in all states.

MEDICARE PART D

This notice applies to employees and covered dependents who are eligible for Medicare Part D.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cigna and about your options under Medicare's prescription 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.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plan (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription 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. Cigna has determined that the prescription drug coverage offered by the Welfare Plan for Employees of Gracepoint under the Cigna option are, on average for all plan participants, expected to pay out as much as the 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.

You should also know that if you drop or lose your coverage with Cigna and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

When can you join a Medicare Drug Plan?

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

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

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Cigna coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you decide to join a Medicare drug plan and drop your current Cigan coverage, be aware that you and your dependents will 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 Cigna 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 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 our office for further information (see contact information 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 Cigna 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 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 notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date:	1/1/2022
Name of Entity/Sender:	Gracepoint
Contact--Position/Office:	Human Resources
	5707 N 22nd Street
	Tampa, FL 33610
Phone Number:	813-272-2244

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 begins in October 2013 for coverage starting as early as January 1, 2014.

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.[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:

Human Resources, 813-272-2244

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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name Gracepoint Wellness		4. Employer Identification Number (EIN)
5. Employer Address 5707 N 22nd Street		6. Employer Phone Number 813-272-2244
7. City Tampa	8. State FL	9. Zip Code 33610
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone Number (if different from above)	12. E-mail address	

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

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

[X] All Employees. Eligible employees are:

All Full Time Employees working at least 30 hours.

[ ] Some employees. Eligible employees are:

- With respect to dependents:

[X] We do offer coverage. Eligible Dependents are:

Your Legal Spouse. Your married or unmarried natural children, step-children living with you, legally adopted children and any other children for whom you have legal guardianship, who are under 26 years of age. A dependent who is older than 26 years of age, but less than 30 years of age may be eligible for medical benefits if the dependent is:

- unmarried and not have dependents of his or her own; AND
- Be a resident of Florida or a student; AND
- Not have coverage of their own, or covered under any other plan; AND
- Not entitled to benefits under Medicare

[ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

[ ] **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

[ ] **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

[ ] Yes (Go to question 15) [ ] No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? **$** **50.08**

b. How often? [ ] Weekly [X] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

[ ] Employer won't offer health coverage

[ ] Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15)

a. How much would the employee have to pay in premiums for this plan? **$** _____

b. How often? [ ] Weekly [ ] Every 2 weeks [ ] Twice a month [ ] Monthly [ ] Quarterly [ ] Yearly

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 (Section 36(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTES

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and 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 Summary 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 summary, contact Human Resources.

Presented by:

M.E. WILSON
100 YEARS
OF DOING THE RIGHT THING.