Your Benefits
Health Vitality Finance

2017-2018 Benefit Summary

For Active Employees, Revised 5/1/2017

Partners in Value

At the Archdiocese of Cincinnati, we do all we can to mitigate the effect of rising healthcare costs. We look at the design of our benefit programs, the providers we work with and the role you can play in keeping our plans affordable. We're asking you to partner with us to control costs by learning about your coverage and how to use it most effectively. The Archdiocese of Cincinnati provides you with a number of tools and resources, but it's up to you to stay informed, make the right choices and then make the most of the benefits you have. Choose well, use well and be well!

The Archdiocese of Cincinnati reserves the right, in its sole discretion, to amend, modify, or terminate the Plan at any time and for any reason. Notice of any changes to the Plan, or a termination of the Plan, will be issued to participants and their beneficiaries within a reasonable amount of time prior to the change's implementation.

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The Archdiocese of Cincinnati Healthcare Plan fully complies with the ethical and religious directives of the United States Conference of Catholic Bishops.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice.

This document is an outline of the coverage and services provided by the carrier(s) or vendor(s). It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details and are available for your reference through Archdiocese of Cincinnati or upon request.

The Archdiocese of Cincinnati reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. Notice of any changes to the Plan, or a termination of the Plan, will be issued to participants and their beneficiaries within a reasonable amount of time prior to the change's implementation.

Online Enrollment

Steps to Enroll

For your convenience, the Archdiocese of Cincinnati will be using the online enrollment system, www.myenroll.com. Consider your 2017/2018 options carefully and follow these steps to make smart enrollment choices:

Step 1: Confirm your eligibility and understand your options

» Read this benefit summary to understand your benefit options

» Go online to benefits.catholiccincinnati.org to learn more about your benefits

Step 2: Plan for your needs

» Review your current benefits and coverage levels: what makes the most sense for you and your family?

» Decide which dependents you will cover; you will have two coverage levels to choose from:

- Employee Only
- Family

Step 3: Request your www.myenroll.com user ID and password

» If you don't already have one, go to www.myenroll.com to request your user ID and password

» The MyEnroll-issued password expires in 48 hours; if you do not log in within that time-frame, you will have to request another password

Step 4: Gather proof documents for new dependents

» Scan in necessary proof documents and save the documents to your desktop as one PDF per dependent

- **You will need to submit these during the online enrollment process by attaching the scanned documents to your MyEnroll file when prompted**

» You can also fax your proof documents to 1.887.265.2144

Step 5: Enroll

» Log on to www.myenroll.com using your user ID and password

» Click "Go" located within the pink box at the top of your MyEnroll page

» When prompted, submit the necessary proof documents for new dependents

Step 6: Conclude enrollment

» Review the summary and signature page. If you are happy with your selections, click Accept and Finalize; this will conclude your enrollment

MyEnroll Customer Service Contact Information:

1.866.694.6423

AOCBenefits@basusa.com

Who Is Eligible?

Eligible Employees

» Active employees who are deemed eligible for benefits under the Archdiocese of Cincinnati Healthcare Plan, according to the plan provisions, must satisfy a waiting period prior to benefits becoming effective. Benefits will become effective the first day of the month following date of hire. This section of this book is intended to be a summary of the eligibility provisions outlined in the Summary Plan Description (SPD). For greater detail, please consult the SPD online at benefits.catholiccincinnati.org.

Eligibility for the Medical, Dental and FSA Plans

» Full-time employees who work 30+ hours per week or teach 15+ classroom hours per week.

» Variable-hour employees who have worked an average of 30+ hours per week or have taught an average of 15+ classroom hours per week during the prior 12-month measurement period.

» Teachers who are employed by Athenaeum of Ohio and teach 14+ classroom hours per week (or have taught an average of 14+ classroom hours per week during the prior 12-month measurement period for variable hour teachers).

Eligibility for Life, AD&D and Long-Term Disability Insurance

» All employees who are scheduled to work 20+ hours per week or teach 12+ classroom hours per week.

» Teachers who are employed by Athenaeum of Ohio and teach 9+ classroom hours per week.

Applies to All Benefits

» School employees are eligible if they meet the above-stated hourly requirements for the period of time school is in session.

» Employment at more than one location will be combined for eligibility purposes.

Eligible Spouses or Children

» The plan allows coverage for your legal opposite-sex spouse and/or your child(ren) (biological, adopted, step or foster) from birth to the end of the month that your child attains age 26.

» Eligible spouses and dependent children may select the Archdiocese of Cincinnati Healthcare Plan even if the spouse has access to group medical insurance coverage as an employee or the child has access to group medical insurance coverage available through the employer of another parent. Your location administrator will request you to complete an Affidavit of Spouse/Dependent Children Eligibility form. In this case, however, the Archdiocese will require the employee to pay 100% of the cost of the spouse or dependent coverage. Please see page 8 of this booklet for detail on the dependent surcharge cost.

Who Is Eligible? continued

Eligible Seminarians

To be eligible for benefits, seminarians must be enrolled full-time in the Priestly Formation Program of the Archdiocese of Cincinnati (whether studying for an ultimate assignment within the Archdiocese of Cincinnati or another diocese). Coverage begins the first day of the month following the beginning of studies. Healthcare and Prescription Drug coverage is available for:

» All seminarians studying at Mt. St. Mary Seminary for other dioceses
» All seminarians studying for the Oratory
» All seminarians studying for our diocese at Mt. St. Mary Seminary and other college seminaries

The Healthcare Plan through **the Archdiocese of Cincinnati no longer offers Supplemental Retiree Health Insurance through Anthem, OptumRx and Dental Care Plus**. This change was effective December 31, 2016 and applies to all current and future retirees, as well as pre-65 retirees.

Enrollment Requirements

Dependent Enrollment Requirements

If you enroll dependents in the Healthcare Plan, you are required to submit additional proof documentation with your enrollment. Please see the list of proof document requirements on page 7. Once you make your 2017/2018 plan year elections, you will not be permitted to change your election during the plan year unless you experience a qualifying life event in accordance with the Archdiocese of Cincinnati Cafeteria Plan.

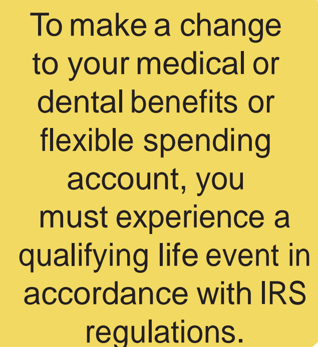
Coordination of benefits rules apply if you have dependents enrolled with other coverage. Please refer to your Summary Plan Description for more information. A copy of the Summary Plan Description is available at benefits.catholiccincinnati.org.

Qualifying Life Event

Because your Cafeteria Plan employee contributions and FSA contributions are made on a pretax basis, it is important that you make your elections during your enrollment period carefully because you can only make changes during the year if you have a qualifying life event listed below.

Changes to your Medical, Dental or Flexible Spending Account can be made if preceded by a documented qualifying life event and if they are made **within 30 days of the event**. Your change must be consistent with your life event/status change. The following events qualify for a change in coverage:

- Marriage
- Divorce or legal separation
- Birth or placement for adoption of a child*
- Death of a dependent
- Ineligibility of a dependent
- Loss of other coverage
- Change in your employment status or that of your spouse
- Significant change in health coverage attributable to your employment or that of your spouse
- A court order
- Entitlement to Medicare or Medicaid



If you experience one of these events and want to change your benefits, **you must make the change within 30 days after the event occurs**. Changes cannot be made before the event occurs. If you miss the window for making a change, there are no exceptions and you must wait to make an election during the next annual open enrollment period.

*When adding a new baby to the plan, you must call BAS as soon as possible with the Social Security Number to ensure that Anthem does not drop the baby's coverage.

Required Proof Documents for Dependent Coverages

Legal Marriage*

One of the following:

» Marriage certificate

» Federal income tax return

Biological Child

One of the following:

» Birth certificate of biological child

» Documentation on hospital letterhead indicating the birth date of child(ren) under 6 months old

» Federal income tax return

Adopted Child

One of the following:

» Official court/agency papers (initial stage)

» Official Court Adoption Agreement (mid-stage)

» Birth certificate (final stage)

» Federal income tax return

Foster Child

» Official court or agency placement papers

Stepchild

All of the following:

» Child's birth certificate showing the child's parent is the employee's spouse

» Marriage certificate showing legal marriage between the employee and the child's parent

» Court document showing that the employee's spouse has custody of the child or is required to cover child

Other Child

» Court papers demonstrating legal guardianship, including the person named as legal guardian

Court-Ordered Medical Coverage

One of the following:

» Qualified Medical Child Support Order (QMCSO)

» National Medical Support Notice (NMSN)

*If your spouse has group coverage available through his/her employer, a surcharge will apply for your covered dependent(s).

Medical Benefits

Anthem

Our medical plan is with Anthem. Please reference Anthem's Guide to Using Your Anthem BlueCross & BlueShield Health Plan posted online at benefits.catholiccincinnati.org

- Summary of Benefits — a detailed description of your coverage
- Understanding online tools available to you — register at www.anthem.com
- Understanding preventive care services — a detailed list

July 2017 Medical Benefit Changes

Deductible	From	To
Single	$425	$470
Family	$850	$940

Out-of-Pocket Maximum	From	To
Single	$2,300	$2,430
Family	$4,600	$4,860

Premium Rates and Contributions for 2017/2018 Plan Year

The Archdiocese offers a comprehensive benefits package to employees and their families. With healthcare costs escalating year after year, the Archdiocese strives to provide the best possible coverage at affordable prices. Effective July 1, 2017, the health plan rates will increase approximately 2.5% for the 2017/2018 plan year. This nominal increase is possible due to the Archdiocese's continued efforts to proactively manage the expenses of the plan.

Active Employees			
Monthly			
	Total Cost	Employer Contribution	Employee Contribution
Single	$667	$634	$33
Family*	$1,553	$1,476	$77

Active Employees			
Annual			
	Total Cost	Employer Contribution	Employee Contribution
Single	$8,004	$7,608	$396
Family*	$18,636	$17,712	$924

*Dependent Surcharge: Any eligible spouse or child may participate in the Archdiocese of Cincinnati Healthcare Plan. However, there is a surcharge related to the cost of covering any spouse or child that is able to be covered under any employer group health plan available to the spouse and/or the child's other parent. The surcharge equals the difference between the "Total Cost" of Single and Family coverage as provided above.

$1,553 - $667 = $886 and $886 + $33 = $919

$919 cost to employee per month if dependent surcharge applies.

Scan the QR code provided here with your smartphone to be automatically directed to www.anthem.com mobile site.

Medical Benefits, continued

	In-Network	Out of Network
Plan Payment Levels		
Annual deductible (Individual / Family)	$470 / $940	$940 / $1,880
Coinsurance – AOC pays	80%	60%
Annual out-of-pocket limit (Individual / Family)	$2,430 / $4,860	$3,645 / $7,290
Physician Services		
Primary Care Physician office visits	$25 copay	60%
Specialist Physician's office visits	$30 copay	60%
Online LiveHealth Physician visits	$10 copay	N/A
Surgery performed in the physician's office	$25 Primary Care / $30 Specialist	60%
Well-Child Care (birth through 18)	100%	60%
Routine Physicals	100%	60%
Allergy treatments	$5 copay	60%
Well-Woman Care and Mammogram services	100%	60%
Prostate cancer screen	100%	60%
Inpatient Hospital – Facility Services		
Inpatient hospitalization and facility services	80%	60%
Outpatient Care		
Operating room, recovery room, procedure room and treatment services	80%	60%
Emergency/Urgent Care		
Hospital emergency room, Not Admitted	80%	80%
Hospital emergency room, Admitted	Charges Waived	Charges Waived
Ambulance services	80%	80%
Skilled Nursing-Facility Services		
Skilled nursing facility	80%	60%
	Maximum 90 days per year	
Rehabilitation hospital	80%	60%
	Maximum 60 days per year	
Maternity		
Initial visits to confirm pregnancy	$25 copay for office visit	60%
Subsequent prenatal/postnatal visits	$25 per office visit	60%
Delivery (inpatient, birthing center) services	80%	60%
Chiropractic Care		
Chiropractic services	$25 copay per office visit	60%
	Maximum 12 visits per year	
Outpatient Rehabilitation		
Physical, speech and occupational rehabilitation therapy	$25 copay per office visit	60%
	Maximum 20 visits each per year	
Cardiac and Pulmonary Rehabilitation	$25 copay for office visit	60%
	Unlimited visits	
Mental Healthcare		
Outpatient benefits	$25 office visit / 80% facility	60%
Inpatient benefits	80%	60%
Alcohol / Drug Abuse		
Outpatient benefits	$25 office visit / 80% facility	60%
Inpatient benefits	80%	60%

Medical Benefits, continued

Advanced Imaging

MRI, MRA, PET, CT non-maternity ultrasound and nuclear cardiology

Here's how the program works:

- If your doctor determines you are in need of one of the advanced imaging scans noted above, he/she will contact Anthem to initiate the pre-authorization process.
- Anthem will review the referred imaging provider to confirm they offer the best quality of care and price in your area.
- If another provider in your area is recommended, this will be handled with your doctor during the pre-authorization process and you will be directed accordingly by your doctor.
- If your doctor chooses not to refer you to the preferred facility, Anthem will contact you to let you know of the preferred choices in your area.
- Should your doctor fail to obtain the pre-authorization, your claim cost will not be impacted.

Save $$!

Deductible is waived and **coinsurance is reduced** by half to 10% for advanced imaging at a free-standing imaging center

Why is Anthem Calling Me?

We care about your health, so you might get a confidential call from Anthem

Anthem calls with your best interest at heart

Anthem can call for a variety of reasons. Sometimes they'll call to offer to help you with health issues, such as losing weight, quitting smoking, preparing for surgery or making healthier life choices. Other times, they'll call to give you important health reminders. If you're expecting a baby, they might introduce you to a supportive program that can help you enjoy a healthier pregnancy. Best of all, these programs have no extra cost, and Anthem will always explain how they work with your benefits.

Keep in mind:

These calls are *always* confidential, so you can feel comfortable talking with Anthem.

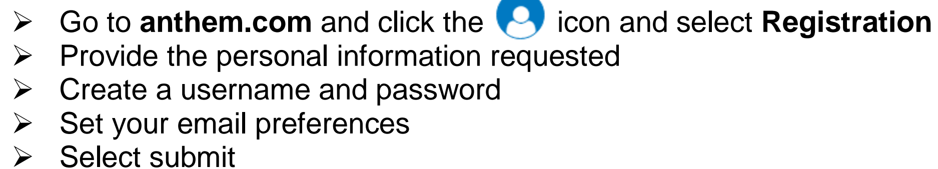
Anthem is not calling to "sell" anything. They only call when they identify an area where they can help. The suggestions or programs they'll recommend are already included in your health benefits.

You will be asked to verify your name and date of birth. That's because Anthem wants to make sure they're speaking to the right person before we discuss your health. It's a way to protect your personal health information.

Medical Benefits, continued

Online and Mobile Access

Find providers, view ID cards, and much more at www.anthem.com via the web or free mobile app.



From your computer

- Go to **anthem.com** and click the icon and select **Registration**
- Provide the personal information requested
- Create a username and password
- Set your email preferences
- Select submit

From your mobile device

- Search for **Anthem Blue Cross and Blue Shield** in your app store and select **Install**
- Open the app and select **Register Now**
- Confirm your identity
- Create a username and password
- Set your email preferences
- Confirm and select **Register**

Find a Provider

If you're a member	If you're not a member yet
1. **Go to www.anthem.com and log in.** Or use your ID number or the first three letters to search without logging in. Scroll down the page and select **Find a Doctor**.	1. **Go to www.anthem.com.** Scroll down the page and select **Find a Doctor**. Under **Search as a Guest** click **Search by Selecting a Plan or Network**.
2. Next, select a type of provider, place or name. Select **Search.**	2. Select "Medical" then choose your state and select the Blue Access Network. Next, select a type of provider, place or name. Select **Search.**
3. Select a provider for more information.	

Medical Benefits, continued

Know before you go—use Anthem's Estimate Your Cost tool!

Our *Estimate Your Cost* tool allows you to compare costs for nearly 40 medical procedures like MRIs and CT scans from doctors and hospitals in your area. The tool also shows performance and safety ratings. To get started:

» Register and log in to www.anthem.com

» On your *Account Summary* landing page, look for the *Estimate Your Cost* tool on the right side

» Click on **Start Cost Search**

» On the *Estimate Your Cost* page, choose options from the drop-down menus to start comparing

LiveHealth Online

www.livehealthonline.com or free mobile app

LiveHealth Online allows you to live chat with your choice of a board-certified doctor 24/7, 365 days a year. LiveHealth Online doctors are able to answer questions, provide diagnosis of conditions such as cold and flu, allergies, sinus infections and more and prescribe basic medications when needed. And the cost of the appointment is your office visit copay!

LiveHealth Online Psychology allows you to speak face-to-face with a licensed therapist or psychologist using your smartphone, tablet or webcam. Appointments are available within just a few days, offering flexibility during daytime, evenings and weekends. LiveHealth Online Psychology visits are also covered by your office visit copay!

Medical and behavioral health visits from the **comfort of your own home** at the cost of an office visit copay!

Scan the QR code provided here with your iPhone to be automatically directed to the LiveHealth app at apple.com.

Scan the QR code provided here with your Android smartphone to be automatically directed to the LiveHealth app at play.google.com/store.

24/7 Nurseline

888.249.3820

Call the 24/7 Nurseline to talk with a registered nurse about your health concern, whether it be allergies, fever, types of preventive care, or other topics. The nurses are able to help you determine if you need to seek care, and if so, the urgency. Spanish speaking nurses and translators are available.

If you prefer not to speak to a live nurse, you can access the AudioHealth library of prerecorded messages on more than 300 different health topics in both English and Spanish. You can access these messages by calling the Nurseline and selecting the option for the AudioHealth library.

Medical Benefits, continued

ConditionCare

888.249.3820

The ConditionCare nurse managers can help with controlling the following ongoing conditions: asthma, COPD, coronary artery disease, diabetes and heart failure. The nurse managers are trained in these conditions to work with both children and adults. They can help you better manage your condition through education about the condition and symptoms and how to properly and effectively follow your medication instructions and treatment plan.

Future Moms

888.249.3820

Future Moms helps expectant mothers get the care they need and make healthy choices. Nurse coaches are available to answer questions, provide educational booklets, and assess and manage risks, among other things.

Anthem Discounts

You can access more information regarding these discounts by visiting www.anthem.com and clicking on Discounts.

Vision and Hearing

1-800 CONTACTS® — Get contact lenses quick and easy — plus discounts only available to Anthem members, like $20 off when you spend $100 or more and free shipping.

Glasses.comTM — Get the latest, brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

Premier LASIK — Save 15% on LASIK with all in-network providers. Prices are as low as $695 per eye with select providers.

Amplifon — Get a low-price guarantee with the seven top companies that work with Amplifon. Save $50 on one hearing aid or $125 on two. Plus, get a three-year repair/loss/damage warranty and a free two-year supply of batteries.

Beltone™ — Get hearing screenings and in-home service at no additional cost, and up to 50% off all Beltone hearing aids.

Medical Benefits, continued

Anthem Discounts, continued

You can access more information regarding these discounts by visiting www.anthem.com and clicking on Discounts.

Fitness and Health

Jenny Craig® — Join Jenny Craig and obtain and 50% off All Accces Enrollment plus 5% off all Jenny Craig Food.

Lindora® — Save 20% on weight-loss programs.

SelfHelpWorks — Choose one of the online Living programs and get a 40% discount to help you lose weight, stop smoking, manage stress or face an alcohol problem.

GlobalFit™ — Save on gym memberships, home fitness equipment and GlobalFit's Virtual Gym.

ChooseHealthy™ — Get preferred pricing on fitness club memberships and a one-week free trial. Enjoy discounts on acupuncture, chiropractors and massage — plus 40% off certain wellness products.

~~**Performance Bicycle** — Get $20 off a purchase of $80 or more in store or online.~~ No longer available

Garmin — Save 20% on the vivofit 2, vivosmart, vivoactive, or Foreuner 15 wearable activity trackers.

Family and Home

Safe Beginnings® — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

VPI Pet Insurance — Get 5% off pet insurance. Get peace of mind knowing that you have help paying the medical costs for your pet's accidents, illnesses and routine medical care.

ASPCA Pet Health Insurance — Get 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

LinkWell — Get coupons for healthier products.

LifeMart® — Get great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

HelpCare Plus — Get discounts on Senior Care Services by paying $11.25 per month. You even get a pharmacy discount card.

Medical Benefits, continued

Anthem Discounts, continued

You can access more information regarding these discounts by visiting www.anthem.com and clicking on Discounts.

Medicine and Treatment

Puritan's Pride — Save 10% and get free shipping on a large selection of vitamins, minerals, herbs, supplements and much more.

Allergy Control products — Save 25% on Allergy Control encasings for your bed. Plus, save 20% on a variety of doctor-recommended products for a healthier home and enjoy free shipping on orders of $150 or more.

National Allergy® supply — Save 15% on mattress encasings, air filtration products, compressors and other products that can help relieve your allergy, asthma and sinus symptoms.

Prescription Drugs

Your OptumRx prescription benefit is separate from your Anthem medical benefit and is accessed using a separate OptumRx ID card.

OptumRx

	Retail – 30 Days	Mail Order – 90 Days
Generic	$10	$25
Formulary	$30	$75
Non-formulary	$60	$150

» Generic drugs must be dispensed when available. If member prefers to obtain the non-formulary brand product, member will pay brand copay PLUS the difference in cost between the brand and the generic product.

» If there is medical justification for the use of brand vs. generic, the physician may call in a request for prior authorization to be reviewed by the Prior Authorization department.

» Formulary brand refers to drugs that are not yet available as a generic.

» Non-formulary brand refers to the brand product for drugs that are available as a generic.

Contact OptumRx Customer Service at 1.800.797.9791 or visit www.optumrx.com to:

- View your claim history
- Check status of mail orders
- Find network retail pharmacies
- Search generic and meds
- Refill scripts through mail service pharmacy

Scan the QR code provided here with your smartphone to be automatically directed to www.optumrx.com

Prescriptions can be confusing.

To help you navigate your prescription drug plan, the Archdiocese of Cincinnati has implemented the following programs:

Specialty Pharmacy

If you are prescribed specialty drugs, the OptumRx Specialty Pharmacy, BriovaRx will be your specialty pharmacy. These specialty pharmacy partners will do more than just fill your prescriptions. You and your prescriber will be assigned a team to support you throughout the course of your specialty medication therapy.

To help you take full advantage of your enhanced specialty pharmacy program please note:

» Whether your specialty medication is oral or injectable, or your caregiver, doctor, or you administer it, OptumRx/BriovaRx can deliver your order to your physician's office or to your home. Shipping is at no charge to you.

» Your plan will cover up to a 30-day supply of your specialty medications at your plan's copayment for a 30-day supply of specialty medications.

» If you have questions, please contact Customer Service at the number on the back of your ID card.

Prior Authorization

Your prescription drug plan requires prior authorization on certain medications. Prior authorization helps ensure select medications are prescribed according to FDA guidelines. If you are prescribed one of the medications that require prior authorization, you will be notified after you fill your first prescription. At that time, if you wish to keep using your medication, it must be pre-approved before your benefit plan will continue to cover it.

Prior Authorization Process

Your doctor can start the prior authorization review process by contacting the OptumRx Prior Authorization department at 1.800.711.4555. A pharmacy technician then works with your doctor to get the information needed for the review. Once OptumRx receives a completed prior authorization form from your doctor, they will conduct a detailed clinical review within three business days. OptumRx will then send you and your doctor a letter regarding the prior authorization decision.

Important: The information needed for the prior authorization review must be submitted to OptumRx by your doctor.

Flexible Spending Account (FSA)

Benefit Allocation Systems (BAS)

A flexible spending program allows you to commit a certain tax-free amount to a spending account set aside for healthcare and/or childcare expenses. Healthcare and child care amounts are kept separate and require separate elections.

» Pretax money (roughly a 30% savings).

» Reimbursements for allowable expenses (dictated by Section 125 of the Internal Revenue Code) such as deductibles, copays, vision/dental expenses, childcare expenses.

» Claims are filed by the employee to BAS by filling out necessary forms and providing required substantiation (receipts, invoices, etc.).

Employees may also use the Benny card (similar to a debit card) to pay for eligible expenses. Substantiation (receipts, invoices, etc.) may also be requested for Benny Card transactions.

» Employees may carry over up to $500 of any remaining healthcare balance at the end of the plan year to the next plan year.

Deciding how much to fund your flexible savings account can seem intimidating. A good rule of thumb is to take a close look at your healthcare or child care expenses over the last 12-18 months, such as prescription drugs, doctor's visits, eyeglasses, deductibles and copayments, to help you decide the amount to set aside in your FSA.

Healthcare:

Annual Maximum Contribution = $2,600 (minimum is $240).

Dependent Care:

Annual Maximum Contribution = $5,000 per couple for married filing jointly and single head of household

or

$2,500 per individual for married filing separately (there is no minimum for dependent care)

FSA receipts due to **BAS** no later than September 30, 2018, for July 2017 through June 2018 expenses

Important Note: Should your employment terminate, your FSA participation will end on your last day of employment. Per the Internal Revenue Code, any funds remaining in your account, against which claims have not been incurred by or prior to your date of termination, will be forfeited.

Basic Life and AD&D Insurance

The Standard

The Archdiocese of Cincinnati provides its eligible employees with $50,000 of Group Life and $50,000 Accidental Death and Dismemberment (AD&D) insurance.

Features of your Life coverage include a Right to Convert Provision, a Portability of Insurance Provision, Waiver of Premium (which will continue Life coverage without payment of premium while you are Totally Disabled), an Accelerated Benefit for the terminally ill and Travel Assist.

The Accidental Death and Dismemberment (AD&D) coverage is available in the event of an accidental death or dismemberment, meaning the loss of use of specific body parts or functions such as outlined in your plan certificate.

Age Reduction

The Basic Life insurance of $50,000 is subject to the age reduction schedule.

This coverage reduces by 35% at age 65, 58% at age 70, and 70% at age 75.

Long-Term Disability (LTD) Insurance

The Standard

LTD insurance provides income replacement in the amount of 60 percent of the first $8,333 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, pension, etc.). The maximum monthly benefit is $5,000 and the minimum monthly benefit is $100. Benefits begin after a benefit waiting period of 180 days.

To be eligible for LTD insurance, for the benefit waiting period and the first 24 months for which LTD benefits are paid, you must be unable, as a result of physical disease, injury, pregnancy or mental disorder, to perform with reasonable continuity the material duties of your own occupation and suffering a loss of at least 20 percent of pre-disability earnings when working in the employee's own occupation. After that, you must be unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of any reasonable gainful occupation. You are not considered disabled when earning 80 percent or more of pre-disability earnings in any occupation.

An eligible employee who needs to make a Long-Term Disability claim can do so by notifying his/her Location Administrator, who will help facilitate the process. LTD claims must be approved by The Standard Insurance Company.

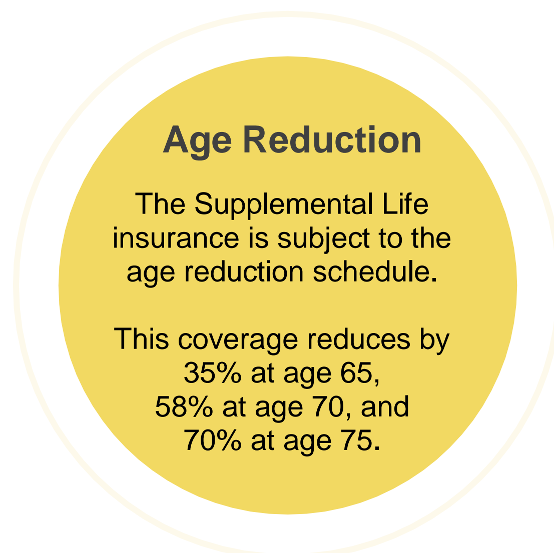
An example of the Basic Life age reduction schedule

John Doe is a benefits-eligible employee of the Archdiocese of Cincinnati. When John turns 65, his employer-paid Basic Life insurance benefit of $50,000 will reduce to $32,500. When he turns 70, is benefit will reduce to $21,000. When he turns 75, his benefit reduces to $15,000. These reductions will take place on the next anniversary of the plan year (July 1) following John's birthday.

Supplemental Life Insurance

The Standard

The Archdiocese of Cincinnati recognizes that different individuals have varying comfort levels and needs in regards to life insurance. It is important that you analyze a variety of factors to determine where you and your family need expanded coverage (e.g., risk factors, age, wellness, and medical history).



Eligibility

Employee — See the Eligibility for Life, AD&D and Long-Term Disability Insurance section on page 4

Spouse — Employee's legal opposite sex spouse

Children — Eligible dependent children from live birth to age 26

Benefit

» Remember that the Archdiocese of Cincinnati provides you with $50,000 coverage. For additional Group Term Life above the $50,000, employees can elect Supplemental Life Insurance in increments of $10,000 up to $500,000.

» The Employee must elect Supplemental Life coverage, in order for him/herself to elect coverage for a spouse/dependent. Spouse coverage amount can be elected in increments of $10,000, not to exceed the employee's benefit amount.

» Eligible children may be covered from birth to age 26. You can elect a benefit amount of $2,500, $5,000, $7,500, or $10,000.

» If an employee or spouse elects or increases coverage during annual enrollment, an Evidence of Insurability* form must be completed and approved by The Standard. This form is available within the MyEnroll system.

» If an employee or spouse currently has the maximum Guaranteed Issue amount with The Standard at annual enrollment, they can apply for additional amounts of coverage; however, Evidence of Insurability* will be required.

*Benefit won't become effective until Evidence of Insurability is approved by The Standard.

An example of the Supplemental Life age reduction schedule

John Doe is 64 years old with $100,000 in Supplemental Life Insurance. When John turns 65, his benefit will reduce to $65,000. When he turns 70, his benefit will reduce to $42,000. When he turns 75, his benefit reduces to $30,000. These reductions will take place on the next anniversary of the plan year (July 1) following John's birthday. At the same time, his premium amount will be adjusted according to the age-banded rates illustrated on page 19.

Supplemental Life Insurance, continued

Premium

To determine your premium, take your age at your last birthday, find the rate as shown per $10,000 unit of life insurance, and multiply that rate by the number of $10,000 units you desire. Do the same thing for your spouse at his/her age for the number of units requested.

Example	Amount of Insurance	Monthly Cost
Employee – 33	$50,000	$5.65
Spouse – 28	$20,000	$1.76
Children – Live birth to age 26	$10,000	$0.50
Total Monthly Cost		$7.91

Monthly premium rates are based on your age at your last birthday. They will change on the plan anniversary date coinciding with or next following your last birthday as you advance to a higher age bracket.

Employer and Spouse: Monthly Premium Rates Per $10,000 of Life Insurance

Age (at last birthday as of the anniversary date)	Rate
Under age 20	$0.63
20–24	$0.75
25–29	$0.88
30–34	$1.13
35–39	$1.50
40–44	$2.00
45–49	$2.88
50–54	$4.63
55–59	$8.00
60–64	$11.00
65–69	$20.75
70–74	$33.50
75–79	$54.25
80+	$87.88

Child(ren) (live birth to age 26): Monthly Cost Per Benefit Amount Selected)

Benefit Amount Selected	Rate (Regardless of # of children)
$2,500	$0.125
$5,000	$0.250
$7,500	$0.375
$10,000	$0.500

Travel Assistance

The Standard

www.standard.com/travel

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you, your spouse and dependent children up to age 26 navigate these issues and more at any time of the day or night.

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers the following aid both before and during your trip.

- Passport, Visa, weather and currency exchange information, health hazards advice and inoculation requirements
- Emergency ticket, credit card and passport replacement, funds transfer and missing baggage
- 24/7/365 phone access to registered nurses for health and medication information, symptom decision support and help understanding treatment options
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains
- Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services
- Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization
- Logistical arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability; for more complex situations, assistance with making arrangements with providers of specialized security services

Contact Travel Assistance

Phone

United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda
800.527.0218

Everywhere else
+1.410.453.630

Email

Assistance@uhcglobal.com

Voluntary Dental

Dental Care Plus

There are two dental plans to choose from. They are both 100% paid by the employee. They both have the same level of care and coverage. What distinguishes one program from the other is cost and flexibility. When you choose your dental plan you are locking in for the entire plan year unless you experience a qualifying life event.

» Dental **HMO** Plan— Lower monthly premium and a large selection of dentists from which to choose. Members need to select and receive treatment from a participating dentist in order to receive benefits.

» Dental **Indemnity** Plan— Higher out-of-pocket costs (both in monthly premium and per-visit fees) with additional network flexibility. In the Dental Indemnity Plan, members are responsible for the portion of fees that are not reimbursed by the plan.

» To find a dentist visit www.dentalcareplus.com or call 1.800.367.9466.

Voluntary Dental Benefits	DHMO Plan Select this plan if your dentist is in the Dental Care Plus HMO network	OR	Indemnity Plan If your dentist is not in the Dental Care Plus HMO network, you may wish to elect this plan
Monthly Employee Cost			
Single	$27.94		$30.85
Family	$80.24		$87.86
Individual Maximum per calendar year	$1,000		$1,000
Annual Individual (Single) Deductible (basic and major only)	$50		$50
Annual Family Deductible (basic and major only)	$150		$150
Percentage Paid by Dental Care Plus			
Preventative Benefits	100%		100%
Basic Benefits	50%		50%
Major Benefits	50%		50%
Orthodontic Benefits	None		None

Scan the QR code provided here with your smartphone to be automatically directed to Dental Care Plus.

Archdiocese of Cincinnati
www.CatholicCincinnati.org

Vision Discount

Total Vision Services

With your Dental Care Plus Voluntary Dental benefits, you also have access to a free vision discount program*! You and your covered dependents will be enrolled in one of two programs offered by Total Vision Services (TVS): the TVS product or the Coast to Coast product. Both programs feature discounts with unlimited usage, no paperwork to file and no health restrictions. Your enrollment in the appropriate program is automatic and based on your home ZIP Code.

Total Vision Services Plan

The Total Vision Services Plan enables you and your covered dependents the opportunity to purchase optical goods and services at substantial savings at reputable optical providers. The program provides discounts of 20% to 60% on eyeglasses, contact lenses (excluding disposables) and many other items offered at retail. You will also receive savings of 10% to 30% on medical eye exams and surgical procedures including refractive surgery.

How to Use the Total Vision Services Plan

Simply present your Dental Care Plus ID card at any of the provider locations to receive your program discount. If you decide to use your own eye doctor and not take advantage of the reduced examination fees under the TVS product, take your prescription to any of the provider locations and they will fill it for you at TVS product rates.

Coast to Coast

Coast to Coast (CTC) has contracted with more than 12,000 eye care professionals nationwide to provide you and your family a 20% to 30% discount on eyeglasses, contact lenses (excluding disposables) and many other items offered at retail. Discounts of 10% to 30% on eye examinations are available at most participating locations. You can save up to 40% on contact lenses through mail order.

How to Use the Total Coast to Coast Plan

You will receive a separate ID card through the mail at your home address. Tell the provider that you are a member with access to the Coast to Coast Vision Program. You must present your ID card prior to service. Should you decide to use your own eye doctor and not take advantage of savings on examination fees under the Coast to Coast Program, take your prescription to any of the provider locations to receive the Coast to Coast discount on materials (frames and lenses).

For plan eligibility, discount amounts or to search for a participating provider, visit www.dentalcareplus.com/vision or call (513) 921-7500 or (800) 869-5400.

*This is not an insurance plan.

Hearing Services Program

EPIC Hearing Health Care

With your dental plan from The Dental Care Plus Group, you automatically receive access to the hearing services program, administered by EPIC Hearing Health Care. This program provides savings to you and your family on hearing devices, including name-brand hearing aids and batteries. All without having to pay premiums or file claims.

How this works:

» Call **(888) 899-1485** to speak with a hearing counselor who will assess your needs and refer you to a provider on EPIC's national network. You can also start the process by visiting **www.EpicHearing.com**.

» You will receive a Hearing Service Plan booklet outlining all plan services and pricing.

» Your hearing counselor coordinates all referral paperwork so you can set up an appointment with an EPIC provider.*

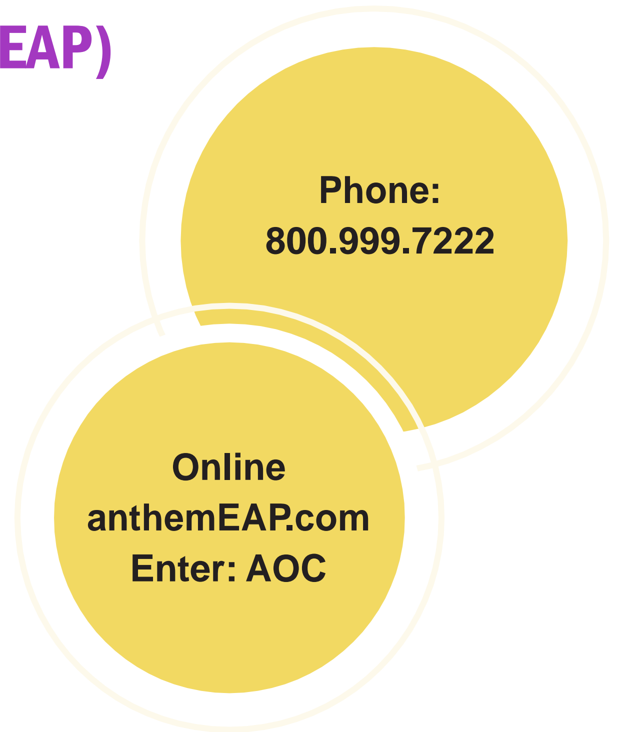
The Savings Add Up

	Full Billed	EPIC Charge	EPIC Savings
Basic Level Hearing Aids** for one person/2devices each	$2,400	$990	$1,410
Basic Level Hearing Aids** for two people/2 devices each	$4,800	$1,980	$2,820

*This is not an insurance plan.
**Hearing aid costs will vary based on level of technology.

Employee Assistance Program (EAP)

Anthem EAP



What is an EAP?

An EAP is a service that provides access to counselors and resources to help employees and their household members with everyday problems and questions.

How do I access the EAP?

You can access the EAP 24 hours a day either online or via phone, and there is never any need to make an appointment first.

Online, you have access to articles, checklists, quizzes and other helpful tools. You can also attend webinars or take online classes.

Via phone, EAP counselors are able to assist with setting up one of your four (4) free counseling sessions* with a licensed professional. They are also able to direct you to professionals and experts able to consult with you on various topics.

What topics can I discuss with an EAP counselor?

The EAP is able to assist with a large range of topics including, but not limited to, the following:

- » Child and elder care
- » Tobacco cessation
- » Relationship issues
- » Financial planning and budgeting
- » ID recovery and credit counseling
- » Setting goals for retirement
- » Adoption
- » Small claims and personal injury
- » Grief and loss
- » Workplace safety
- » Addiction and recovery
- » Foreclosures and bankruptcy
- » Estate planning
- » Career advice
- » Car and home buying
- » Family health

*The four (4) free counseling sessions are available on a per household member per issue basis.

When You Retire

Medicare

Medicare and Group Health Plan Coverage

When you retire and are Medicare-eligible, you have a number of important decisions to make. These may include whether to enroll in Medicare Part B, join a Medicare Prescription Drug Plan, buy a Medigap policy.

Understanding your choices

To help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's best for you. You can visit www.medicare.gov and select "Compare Medicare Prescription Drug Plans" and "Compare Health Plans and Medigap Policies in Your Area." You can also call your State Health Insurance Assistance Program. To get their telephone number, call 1.800. MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

Medicare Part B benefits are optional and are available to all retirees when they become entitled to Medicare Part A. Medicare Part B may be purchased by most persons age 65. Failure to purchase Medicare Part B will drastically affect an individual's ability to recover any costs incurred for physician services and other Medicare Part B covered items.

Medicare Part D (prescriptions)

Those eligible for Medicare are provided a letter of creditable coverage. The letter states that the prescription drug program currently provided by the Archdiocese Healthcare Plan exceeds Medicare Part D. Medicare participants and individuals over age 65 are advised that they could select the Archdiocese of Cincinnati Healthcare Plan instead of Medicare Part D. The letter permits Medicare eligible persons to join Medicare Part D at a later date, if they choose, without paying a late entrant "penalty." This letter will be provided annually prior to Medicare open enrollment.

RetireMED®iQ is an additional source of information. They are an independent health plan advisory service that offers guidance to individuals in need of insurance options upon retirement. Their goal is to give retirees information and guidance to choose the insurance plan that best meets their retirement budget, needs and lifestyle - at no cost to the retiree. **RetireMED®iQ** can be reached at **1.844.388.6565** or **www.retiremed.com**.

Terms to Know

Annual Deductible

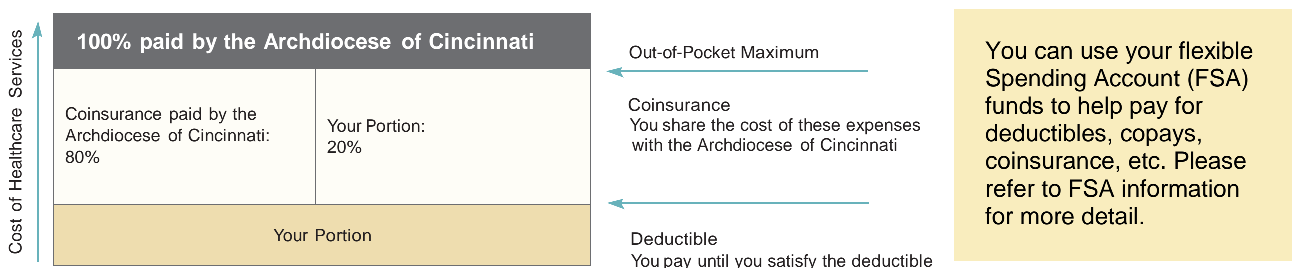
You pay 100% of your healthcare expenses each year up to a set amount called your annual (calendar year) deductible. Your FSA can help you pay until you reach your annual deductible. Please see the FSA section for more information.

Coinsurance

After you reach the annual deductible, you and the Archdiocese of Cincinnati share the cost of your care. This cost-sharing is called coinsurance. Generally, you pay 20% and the Archdiocese of Cincinnati pays 80% of eligible in-network expenses. Out-of-Network expenses are generally covered at 60%.

Out-of-Pocket Maximum

Your out-of-pocket maximum is the most you will pay in a year for eligible medical expenses and protects you from financial hardships due to medical costs. Your deductible and coinsurance (but not copays) count toward your out-of-pocket maximum. After you reach this amount, the Archdiocese of Cincinnati pays for 100% of eligible medical expenses for the rest of the calendar year.



You can use your flexible Spending Account (FSA) funds to help pay for deductibles, copays, coinsurance, etc. Please refer to FSA information for more detail.

Important Information about Your Continuation of Coverage Rights

As a church plan, the Archdiocese of Cincinnati's Health Plan and Dental Plan (collectively the "Plan") are not subject to federal COBRA coverage. The Plan is subject to Ohio's continuation coverage requirements, but the Archdiocese has chosen to be more generous than required when offering continuation coverage.

<u>What is continuation coverage?</u>

The Archdiocese of Cincinnati offers continuation coverage to all employees and their covered dependents who lose coverage under the Plan as a result of their involuntary termination of employment. To be eligible, you must have been covered by the Plan at the time of your termination of employment and your termination must not have been on account of gross misconduct. While not required by law, the Archdiocese of Cincinnati also offers continuation coverage to spouses and dependents who were covered by the Plan at the time of an active employee's death. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Terms to Know, continued

How much does continuation coverage cost?
For the 2017 - 2018 fiscal year, the monthly cost of continuation coverage is as follows:

Medical		Single $667 per month	Family $1,553 per month
Dental	HMO	Single $27.94 per month	Family $80.24 per month
Dental	Indemnity	Single $30.85 per month	Family $87.86 per month

How can you elect continuation coverage?
To elect continuation coverage, you or your family members must complete the Election Form and furnish it according to the directions on the form. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How long will continuation coverage last?
The Archdiocese of Cincinnati continuation coverage is available for up to twelve months. Continuation coverage may end early in certain circumstances, like failure to pay premiums, fraud, or intentional misrepresentation.

When and how must payment for continuation coverage be made?

Premium payments must continue to be made to the location where you last worked by the first day of the month. You may contact the Health Care Administrator at the location to confirm the correct amount of your first payment.

Contact Information

If you would like to further research your benefit options, find a provider, or ask detailed questions about your benefit coverage, you may contact the insurance companies/service provider directly. Listed below are toll-free phone numbers and websites for those that provide services to Archdiocesan employees.

Benefit	Administrator	Phone	Website/Email
Medical	Anthem	1.800.887.6055	www.anthem.com
Prescription	OptumRx	1.800.797.9791	www.optumrx.com
Life & AD&D/LTD/Voluntary Life	The Standard	Life 1.800.628.8600 LTD 1.800.368.1135	www.standard.com
Voluntary Dental	Dental Care Plus	1.800.367.9466	www.dentalcareplus.com
Flexible Spending Account (FSA)	BAS	1.866.694.6423	AOCBenefits@basusa.com
EAP	Anthem EAP	1.800.999.7222	www.anthemEAP.com
Benefits Customer Service (MyEnroll)	BAS	1.866.694.6423	AOCBenefits@basusa.com

If you have questions regarding the enrollment process, your payroll deductions, or need general benefit information, please contact BAS or your location administrator.

Scan with your smart phone to be directed to the corresponding vendor.

Anthem:

Scan the QR code provided here with your smartphone to be automatically directed to www.anthem.com mobile site.

Optum Rx:

Scan the QR code provided here with your smartphone to be automatically directed to www.optumrx.com

Dental Care Plus:

Scan the QR code provided here with your smartphone to be automatically directed to Dental Care Plus.

Benefits Information Online

At home or on the road you can go to:
www.benefits.catholiccincinnati.org

Find a wealth of information about your benefits and explore helpful decision-making tools. Here's just a small sampling of what you'll find:

» Open enrollment information
» Benefit plan information
» Links to providers such as Anthem, OptumRx, BAS
» Helpful decision-making tools
» Health news
» Explanations of government benefits
» Find specific information and summaries of the benefits offered by the Archdiocese of Cincinnati

This document is an outline of your coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details.

Policies are available for your reference and will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice.

Important Notices

The information contained in this overview gives a general description of the Archdiocese of Cincinnati's benefit plans. It does not give you all the details of the program's plans. If you need more information, please refer to your summary plan description booklets. In all cases, the official plan documents, policies and certificates of insurance must remain the final authority.

Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

The Archdiocese of Cincinnati Health and Welfare Plan (the "Plan") has maintained a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or www.dol.gov/ebsa/healthcarereform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Rescission of Coverage

Beginning with Plan Years starting on or after September 23, 2010, a grandfathered plan may rescind coverage only under limited circumstances (such as in the case of fraud or an intentional misrepresentation of fact). This applies to a cancellation or discontinuation of coverage that has retroactive effect (unless the cancellation is effective retroactively due to a failure to timely pay premiums). A grandfathered health plan must provide at least 30 calendar days' advance notice to an enrollee before coverage may be rescinded.

Rules Limiting Reimbursement for Over-the-Counter Medications

Effective for expenses incurred beginning in 2011, health FSAs, (including grandfathered plans) may not reimburse participants for the cost of medication unless the medication is a prescribed drug or insulin, and thus may not reimburse costs of most over-the-counter medications.

Women's Health & Cancer Rights Act (WHCRA)

Federal and State legislation require group health plans and health insurers provide coverage for reconstructive surgery following a mastectomy. Specifically, these laws state that health plans that cover mastectomies must also provide coverage in a manner determined in consultation with the attending physician and patient for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and;
- Prostheses and treatment for physical complications for all stages of mastectomy, including lymphedemas.

Military Leave Employees

Continuation of Coverage Due to Military Service

In the event you are no longer Actively at Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military Service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible dependents (if any) under the Plan by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active member contribution for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

- The 24-month period beginning on the first date of your absence from work; or
- The day after the date on which you fail to apply for or return to a position of employment

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www.CatholicCincinnati.org

Important Notices, continued

Regardless whether you continue your health coverage, if you return to your position of employment, your health coverage and that of your eligible dependents (if any) will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your eligible dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Health Insurance Portability & Accountability Act (HIPAA)

Enrollment Rights Under the Health Insurance Portability and Accountability ACT (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse or child(ren)) because of other health insurance, you may be able to enroll yourself and your dependents in an Archdiocese of Cincinnati plan if you or your dependents lose eligibility for that other coverage. You must request enrollment within 31 days of the date the other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Notice of Availability

This notice describes how you may obtain a copy of the Plan's Notice of Privacy Practices, which describes the ways that the Plan uses and discloses your protected health information (PHI). The Archdiocese of Cincinnati provides health benefits to eligible employees and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses PHI.

Children's Health Insurance Program Reauthorization Act

New Special Enrollment Period for Health Coverage

Eligible employees and their dependents may enroll in the Archdiocese of Cincinnati health coverage at time of hire, during open enrollment or when they experience a qualifying event such as marriage, birth of a child or loss of other coverage.

The group health plans provided by Archdiocese of Cincinnati include two additional special enrollment opportunities. These two qualifying events are when:

1. The employee or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
2. The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

An employee must request this special enrollment within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. Thirty-day notice is required for all other special enrollments.

Should you have a qualifying event and want to enroll in health coverage, contact your location administrator. 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.

Important Notices, continued

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your state for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – 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	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

Important Notices, continued

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Important Notices, continued

The Newborns' Act

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

Notice of Creditable Prescription Drug Coverage

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Archdiocese of Cincinnati 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone
with Medicare through Medicare prescription drug plans. 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.

Individuals can enroll in a Medicare drug plan when you first become eligible, and each year from October 15 through December 7. If you lose your current creditable prescription drug coverage or decide to leave the Archdiocese of Cincinnati you may be eligible for a Medicare Special Enrollment Period.

Archdiocese of Cincinnati has determined that the prescription drug coverage offered by the Notice of Archdiocese of Cincinnati Health Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because Archdiocese of Cincinnati's coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you decide to join a Medicare drug plan and you are an active employee or family member of an active employee, you may also continue your Archdiocese of Cincinnati coverage. In this case, the Archdiocese of Cincinnati plan will continue to pay primary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Archdiocese of Cincinnati coverage, Medicare will be your only payer. Active employees can re-enroll in the Archdiocese of Cincinnati Healthcare Plan at annual enrollment or if you have a special enrollment event.

You should know that if you waive or leave coverage with the Archdiocese of Cincinnati and you go 63 continuous days or longer without creditable prescription drug coverage (once the applicable Medicare enrollment period ends), your monthly Part D premium may go up by at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if the Archdiocese of Cincinnati coverage changes, or upon request.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. Here's how to get more information about Medicare prescription drug coverage:

Important Notices, continued

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number).
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

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

For more information about this notice or your prescription drug coverage, please contact:

Name of Entity:	Archdiocese of Cincinnati
Contact:	Charlotte Carpenter
Address:	Archdiocese of Cincinnati 100 East Eighth Street Cincinnati, OH 45202
Phone Number:	513.421.3131

Notes

100 East Eighth Street
Cincinnati OH, 45202

www.catholiccincinnati.org

This benefit summary prepared by