The Roman Catholic

Diocese of St. Petersburg

Benefits at a Glance

Religious / Laity

PLAN YEAR: July 1, 2018 – June 30, 2019

USI UNDERSTAND. SERVICE. INNOVATE.

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Carrier Contact Information

Enrollment or Benefit Eligibility		
Lisa Baggett	727-344-1611 x5397	
CARRIER	**CONTACT NUMBER**	**WEBSITE**
Meritain Health		
Medical	800-925-2272	www.meritain.com
Participating Providers	800-343-3140	
Precertification	800-242-1199	
Case Management	800-242-1199	
Disease Management	888-610-0089	
Dental	800-925-2272	
Flexible Spending Account (FSA)	800-566-9305	
Express Scripts		
Prescription Drug Benefits	800-903-6219	www.express-scripts.com
VSP		
Vision	800-877-7195	www.vsp.com
Allstate		
Accident	800-521-3535	www.allstate.com
Critical Illness		
Group Indemnity Medical		
The Hartford		
Life Insurance	888-563-1124	www.hartford.com
Short & Long Term Disability	800-549-6514	
LegalShield		
Legal and ID Theft	800-654-7757	www.legalshield.com
The Hartford Guidance Resources		
Employee Assistance Program	800-327-1850	www.guidanceresources.com Enter Company Organization: HLF902
Gabriel Roeder Smith		
Pension Plan – Susan Gigler	954-527-1616	Sue.gigler@grsconsulting.com
KB Pension		
401(k) – Chris Chiaro	941-953-7452	cchiaro@kbgrp.com
UBS		
John Benitoa Ryan Brannon	813-903-6694 813-903-6690	John.benitoa@ubs.com Ryan.brannon@ubs.com
Benefit Resource Center (BRC)		
BRC	855-USI-6699	www.BRCEast.com

Benefit Resource Center

Welcome to the Benefit Resource Center

Let our experienced Personal Benefit Advocates assist you and your family with your benefit questions and claims issues.

Our Personal Benefit Advocates will be able to:

- Answer your benefit plan/policy questions
- Assist you with eligibility and claim problems with carriers
- Provide claim appeals information and explain the process
- Explain allowable family status election changes (adding newborns, marriage, divorce, etc.)
- Provide vendor plan contact information

Call today and let us know how we can help you answer any questions you may have about your employee benefit programs.

Your one-call benefits information hotline

The Diocese of St Petersburg has partnered with USI to assist with your benefits inquires.

Toll-free Benefit Resource Center available to:

- Answer questions regarding your health and other benefit plans
  - Network: Is my doctor on the plan?
  - Plan Coverage: Does my plan cover this?
  - Billing: I received a bill from my provider, do I need to pay?
- Help you understand how a carrier paid your claim
- Specialist support to help you with complex claims issues
- Medical appeals information and support
- Life event (family status) rules – what changes can I make?
- Life Insurance Beneficiary form requirements
- How do I complete an Evidence of Insurability form and where do I send it?
- What happens if I have coverage under two different medical plans?

USI

Benefit Resource Center

855-USI-6699 (Toll-Free)

BRC.East@usi.com

Monday - Friday 8:00 a.m. - 5:00 p.m. ET

Call for assistance with:

- **Benefit Plan/Policy Questions**
- **Claim Issues with Carriers**
- **Eligibility Questions**
- **Plan Contact Information**

Your one-call benefits information hotline

Health Benefit Information

Your Benefits Plan

The Diocese of St Petersburg (the Diocese) is pleased to offer a comprehensive benefits package to our employees. The benefit package includes medical, dental, vision, pharmacy, short term disability (STD) long term disability (LTD), basic life and AD&D, and voluntary (optional) insurance products. This 2018-2019 Employee Benefits booklet provides you with a general summary of the benefits available to you and your eligible dependents. Please refer to the carrier summaries and certificates of coverage for detailed coverage descriptions and provisions.

Benefits Guide Overview

This guide provides a general overview of your benefit choices to help you select the coverage that is right for you. Be sure to make choices that work to your best advantage. Of course with choice, comes responsibility and planning is recommended. Please take time to read about and understand the benefit plans thoroughly, and enroll on time. Included in this guide are summary explanations of the benefits and costs as well as contact information for each provider.

It is important to remember that only those benefit programs for which you are eligible and have enrolled in apply to you. We encourage you to review each section and to discuss your benefits with your family members. Be sure to pay close attention to applicable co-payments and deductibles, how to file claims, pre-authorization requirements, networks and services that may be limited or not covered (exclusions).

This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans but rather is a quick reference to help answer most of your questions. Please see your Summary Plan Description for complete details. We hope this guide will give you a clear explanation of your benefits and help you be better prepared for the enrollment process. The Diocese reserves the right, in its sole and absolute discretion, to amend, modify or terminate, in whole or in part, any or all of the provisions of the benefit plans.

Eligibility

All Regular full-time employees are eligible to join the Diocese Benefits Plan on the first of the month following 30 days of employment. “Regular Full-Time Employees” must be regularly scheduled and working at least 30 hours per week.

You may also enroll your dependents in the Benefits Plan when you enroll. There is no domestic partner coverage.

Eligible dependents include:

- Your spouse, unless you are legally separated or divorced;
- 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 for medical;

**Dependent’s coverage will end the end of their birth month when they reach age 26.

Please note that documentation may be required to prove dependent eligibility. Some examples are:

- Marriage License
- Birth Certificate
- Adoption Papers
- Court Order

When Can You Enroll?

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

- After completing 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.

Health Benefit Information

Choosing Your Benefits

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

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

- **Before your taxes are calculated** – medical, dental, vision, and flexible spending account
- **After your taxes are calculated** – voluntary life

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 at anytime 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 do not notify Human Resources within 30 days of a family status change, you will have to wait until the next annual enrollment period to make benefit changes unless you have another family status change.

Enrollments are processed through the online enrollment system.
Please log onto https://login.paylocity.com

If you need your login or password reset, please contact the payroll administrator at you location or Lisa Baggett (727) 344-1611, ext 5397, or lsb@dosp.org

When Coverage Ends

Medical, dental, and vision coverage will stop on the last day of the month in which employment with the company ends. Life and disability coverage will end on your last day worked.

Contract teachers: Benefits terminate on the contract termination date as long as the contract is fulfilled.

Key Benefit Terms

Coinsurance – The percentage of the medical or dental charge that you pay after the deductible has been met.

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 calendar year before the plan begins paying benefits.

Out of Pocket Maximum – The maximum amount you will pay in coinsurance during the calendar year.

Health Care Reform Updates

Important Notes Regarding HealthCare Reform Individual Mandate

Please note that effective January 1, 2014, the Affordable Care Act (more commonly known as HealthCare Reform or ACA) requires every person to be enrolled in a health insurance plan. There are several ways to be insured and one option is to participate in the Diocese health insurance plan. Other methods include Medicare, Medicaid, individual policies - either purchased directly with an agent or insurance carrier, or through the marketplace exchange (healthcare.gov).

Employers and insurance carriers are required to provide Form 1095C to all benefit eligible employees, which shows that minimum essential coverage was offered, the calendar months you and your family members were offered coverage, including which months in the prior year you were covered in the Diocese plan, and if your contribution was affordable according to IRS standards. The Diocese's medical plans meet all of these requirements. Look for these statements annually towards the end of January or February, unless extensions are provided by the IRS.

Other important ACA mandates which have been previously incorporated into our plans include:

- 90 day maximum waiting period limit (The Diocese offers benefits the first of the month following thirty days of employment)
- All adult child dependents to age 26 must be eligible
- Free preventive services exams (one annual per covered member; limitations apply)
- Pre-existing condition exclusions or limitations prohibited
- Annual dollar limits on essential health benefits prohibited
- Out-of-pocket maximums not exceed $7,350 individual / $14,700 family for 2018 (the Diocese's are far below these maximums).
- Out-of-pocket maximums include copays, deductible, and coinsurance

Getting more from your Health Care Dollars

Member Resources

24-hour access to tools you can really use at www.myMERITAIN.com.

The Meritain Health member website, www.myMERITAIN.com, is designed to provide a secure, user and family-friendly, one-stop-shop for you to access the account and claims information you can use to manage your health and wellness.

We're committed to providing you with all the basics you expect, along with added features to support a healthy lifestyle, assist you with medical decisions, and give insight into the maximization of your healthcare dollars.

Go to myMERITAIN.com to log in to our secure site.
New users can create an account by following the easy instructions. You'll need your health plan ID Card the first time.

Return users, just sign in using your username and password. The first time you access the site, you will be prompted to re-register with a new username and password for enhanced security. Then take advantage of the smart, safe resources your health plan offers, right at your fingertips.

Privacy Regulations.
Members over 18 years of age have partially protected information according to HIPAA Privacy Regulations. *Members over 18 having difficulty creating an account with their SSN, please contact Meritain Health Customer Service at:* ***1.800.925.2272.***

At myMERITAIN.com you can:

- Look up health and wellness topics in our online medical library.
- Find the status of a claim.
- Find network doctors, clinics and hospitals.
- Look up prescription and over-the-counter drug information.
- Order ID Cards.

MERITAIN HEALTH
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What Card Do You Show?

Prescription Drug Benefits at a Reduced Cost – Did you know that you can obtain prescription drugs at local retailers at a reduced cost and sometimes even free? **Publix** offers a variety of generic Oral Antibiotic medications to you absolutely free. Bring in your prescription for an approved medication and receive it FREE, up to a 14-day supply. Publix now offers the diabetes medication, Metformin at no charge. **CVS, Target, Walgreens & Wal-Mart** also offer over 400 generic prescriptions for $4 and a 90 day supply for approximately $10. **Remember, DO NOT show your Meritain ID card to receive these benefits or you will be charged your Meritain drug rate.**

In addition to the network of physicians, hospitals, emergency rooms, and urgent care clinics, you also have the option of going to the convenient care clinics located within some grocery and drug stores, for minor illness such as ear aches, colds, flu and so on. By selecting one of these providers, you pay only the regular office visit copay; a significant savings over the emergency room and urgent care copayments.

Please visit the various websites for locations, hours of operations and scope of services.

CVS Minute Clinic: www.cvs.com

Publix Little Clinic: www.Publix.com

Walgreen's Take Care Clinic: www.walgreens.com

Frequently Asked Questions About Your Medical Plan

Q. What should I do if I have a problem getting a claim paid?

A. Start by contacting the carrier's member services number to determine the nature of the problem. If the issue is the way the doctor or other service provider has billed the claim, then contact your doctor or Claims Advocate at USI. If the insurance company has an eligibility issue, contact Human Resources for assistance.

Q. What is the difference between brand formulary, brand non-formulary, and generic drugs?

A. Brand formulary is a prescription drug that is listed on the formulary (i.e., a list of prescription drugs covered by the plan). These drugs are protected by a patent issued to the original innovator or marketer. Brand non-formulary drugs are patent protected but are not listed. A generic equivalent drug can become available when the patent protection runs out, and is deemed equal in therapeutic power to the brand name originals.

Q. When should I go the Urgent Care vs. Emergency Room?

A. For non-life threatening injury/illness after normal doctor's office hours.

Finding a Provider

Locate healthcare professionals and facilities using the criteria that's best suited to your needs.

Selecting a doctor and other healthcare professionals for you and your family is important. The online directory, available 24 hours a day, 7 days a week, makes it easy.

DocFind is the premier online search tool from Aetna.* Up-to-date listings of participating doctors, other medical professionals and facilities are available at your fingertips. With the easy-to-use format, you can search online by name, specialty, gender and/or hospital affiliation.

Looking for an Aetna provider? It's easy!

You can use DocFind anywhere you have Internet access. If you have questions while searching for a healthcare professional, simply click on the "Contact DocFind" link located at the top of any DocFind page to send us a comment or question.

- Log on to http://www.aetna.com/docfind/custom/mymeritain/

If you are looking to change your primary care physician, or need to locate a specialist, DocFind's "Standard Search" can help:

- Enter the geographic information for the area where you wish to find a participating healthcare professional.
- Select the type of healthcare professional or facility you wish to find, such as a primary care physician, specialist, or medical hospital.
- If you choose, narrow your search by specialty, gender, languages spoken, hospital affiliation and/or name. Or you may request a list of all healthcare professionals who match your geographic and plan requirements.
- The 'Select a Plan' dropdown box allows you to choose your provider network; be sure to select **Aetna Choice® POS II**.
- That's it! You will be presented with a list of healthcare professionals who match your criteria. You can obtain additional information about each provider by clicking on the "Provider Detail" link.

If you know the name of the healthcare professional you're looking for, follow these instructions:

- Enter the geographic information for the area where you wish to find a participating healthcare professional.
- Input the name of the individual healthcare professional you wish to find.
- Select the type of healthcare professional you would like to find. Then hit "Continue."
- It's that easy! You will be presented with a list of healthcare professionals or facilities that match your requirements. You can obtain additional details about a particular provider by clicking on the "Provider Detail" link.

With DocFind you can:

- Choose the search option that works for you. Search by using a variety of criteria such as specialty, gender and/or hospital affiliation, or search using the healthcare professional's name.
- Make the informed choice. DocFind gives you easy access to information about healthcare professionals, including information that is not available in paper directories. This includes information about which plans the provider accepts, medical school attended, board certification status and gender, as well as information about the provider's offices, such as handicapped access, etc. Other features include maps, driving directions and listings (where applicable) of other office locations.
- Get up-to-date information. DocFind is updated three times per week, giving you access to the latest available information.
- Review a list of transplant facilities and pediatric congenital heart surgery facilities in our institutes of Excellence™ network.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates.*

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

Questions? Please contact Meritain Health Customer Service at the number on your ID Card.

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www.myMERITAIN.com

Medical Insurance

The Diocese offers two medical plans from Meritain Health. Both of these plans are open access, and do not require you to select a Primary Care Physician (PCP) or obtain a referral to seek care from contracted specialists. To find participating providers go to www.aetna.com/docfind/custom/mymeritain. For step by step instructions, refer to page 9.

The chart below provides a brief overview of the plan. 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.

	Plan A		Plan B	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Deductible (Individual / Family)	$750 / $2,250	$1,050 / $3,000	$1,000 / $3,000	$1,500 / $4,500
Max Out-of-Pocket (Ind./Family)	$2,500 / $5,000	$4,500 / $9,000	$3,500 / $7,000	$5,500 / $11,000
Out-of Pocket Max Includes	Deductible, Coinsurance, & Copays		Deductible, Coinsurance, Copays & Rx	
Lifetime Major Medical Maximum	Unlimited		Unlimited	
Coinsurance	90%	50%	80%	50%
PREVENTIVE SERVICES: Wellness Immunizations Mammography/Colonoscopy	Covered 100%		Covered 100%	
CO-PAYS:				
Office Visits	$20 copay	Covered 50% after Deductible	$30 copay	Covered 50% after Deductible
Specialist Visits	$60 copay	Covered 50% after Deductible	$80 copay	Covered 50% after Deductible
Inpatient Hospital	Covered 90% after Deductible	Covered 50% after $500 PAD* and after annual Deductible	Covered 80% after $300 PAD* and after annual Deductible	Covered 50% after $1,000 PAD* and after annual Deductible
Outpatient Surgery	Covered 90% after Deductible	Covered 50% after Deductible	Covered 80% after Deductible	Covered 50% after Deductible
Emergency Room	Covered after $200 PAD* then 90% after annual Deductible	Covered 50% after Deductible (or same as in network if emergency)	Covered after $200 PAD* then 80% after annual Deductible	Covered 50% after Deductible (or same as in network if emergency)
Urgent Care	$100 copay	Covered 50% after Deductible	$100 copay	Covered 50% after Deductible
OUTPATIENT DIAGNOSTIC:				
Lab Services	Covered 100%	Covered 50% after Deductible	Covered 100%	Covered 50% after Deductible
X-Ray Services	Covered 100%	Covered 50% after Deductible	Covered 100%	Covered 50% after Deductible
Complex Diagnostic **Precertification is Required	Independent Testing Facility: Covered 90% after Deductible Other Facility: Covered 80% after deductible	Covered 50% after Deductible	Independent Testing Facility: Covered 80% after Deductible Other Facility: Covered 70% after deductible	Covered 50% after Deductible
PRESCRIPTIONS:				
Retail (30 day supply)	$10 / $40 / $75 / 50% up to $250		$10 / $50 / $100 / 50% up to $250	
Mail Order (90 day supply)	$20 / $80 / $150 / 50% up to $500		$20 / $100 / $200 / 50% up to $500	
HEARING AIDS:	$2,500 Allowance Per Ear After In-Network Deductible Every 3 Years		$2,500 Allowance Per Ear After In-Network Deductible Every 3 Years	

*PAD: Per admission deductible

Precertification

Key To Your Good Health

You can help make sure you and your family get quality healthcare when and where you need it. Meritain Health's Medical Management program is designed to ensure that you and your eligible dependents receive the right healthcare while avoiding unnecessary costs.

It's easy to precertify

Your provider will often handle your precertification, but as an active participant in your healthcare, you can call us to begin the process. To precertify care, you'll need to call the phone number on your ID Card and provide information about the patient, the provider and the procedure. A special medical management team will then review your treatment plan. Your team will help make sure you're getting the right care, in the right setting for the right length of time.

You may need to call to precertify the following:

- Prior to elective or non-emergency admission to a hospital.
- Within 48 hours (or two working days) following an emergency admission to hospital.
- Prior to having certain elective diagnostic treatments specified in your plan booklet.
- Prior to hospice admission.
- When you need to obtain home healthcare.
- Before certain diagnostic procedures.

You can verify the services that require precertification in your health plan booklet. You can also call customer service using the number on the back of your ID card.

It's important to remember that if we do not receive your precertification, you may have extra financial responsibility for your healthcare services.

You have the right to appeal

If you or your doctor aren't satisfied with the decision of the medical management team, you have a right to appeal this outcome. You can find steps for the appeal process in your health plan booklet.

If you have any questions about precertification, we can help. Simply call Meritain Health using the phone number on your ID Card.

This material is being provided as an informational tool. It is recommended that plans consult with their own experts or counsel to review all applicable federal and state legal requirements that may apply to their group health plan. By providing this publication and any attachments, Meritain Health is not exercising discretionary authority over the plan and is not assuming a plan fiduciary role, nor is Meritain Health providing legal advice.

MERITAIN™ HEALTH
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ADVOCATES FOR HEALTHIER LIVING

Advocates for Healthier Living

Meritain Health provides easy-to-use healthcare benefits you can use to stay healthy and productive. Contact us at the number on your ID Card if you have any questions about your plan.

Healthcare Bluebook

Save on Healthcare Costs and Earn Valuable Incentives!

How Healthcare Bluebook™ can help

Want to save money on healthcare services for you and your family, as well as find providers that offer a Fair Price™ in your area? Healthcare Bluebook and your employer are working hard to help you spend less on your healthcare! You can earn cash incentives as part of the Go Green to Get Green™ program.

"Go Green to Get Green" and earn cash incentives

Healthcare Bluebook is an online tool that can help you better understand what you should pay for healthcare procedures, as well as find providers offering fair prices in your area. Healthcare Bluebook is a free service, and is easy to find through your member website, **www.meritain.com**.

Within the Healthcare Bluebook tool, providers are listed as **green**, **yellow** or **red**. Your employer offers incentives for certain healthcare services when you visit a "green" provider. That's because "green" providers offer high-value services, at or below the Fair Price, providing you the most value for your healthcare dollar.

When you visit "green" providers for the following healthcare services, you'll earn a cash incentive:

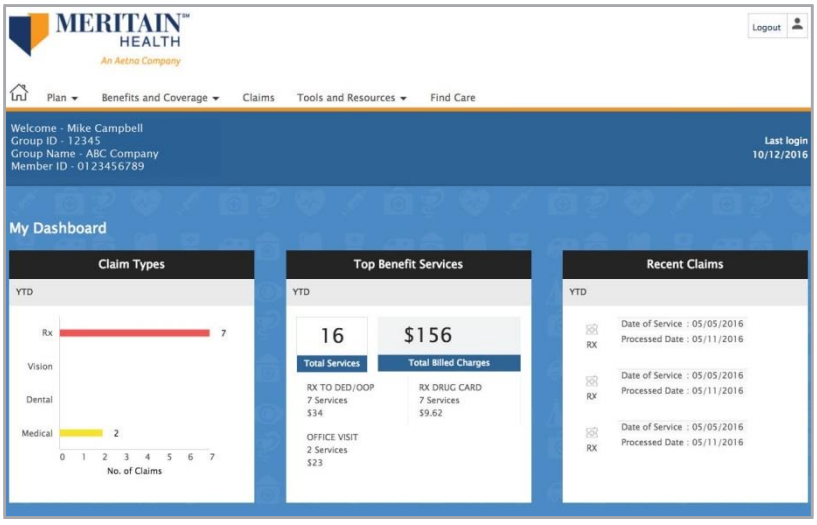
Procedure	Incentive	Procedure	Incentive
Most CT scans	$25	Lithotripsy	$50
Most MRIs	$25	Removal of adenoids	$50
Transthoracic Echocardiogram (TTE)	$25	Sleep study	$50
TTE with doppler	$25	Tonsillectomy	$50
Cataract surgery	$50	Colonoscopies	$100
Cholecystectomy (laparoscopic)	$50	Knee arthroscopy	$100
Ear tube placement (tympanostomy)	$50	Shoulder arthroscopy	$100
Heart perfusion imaging	$50	Upper gastrointestinal endoscopies	$100

Healthcare Bluebook

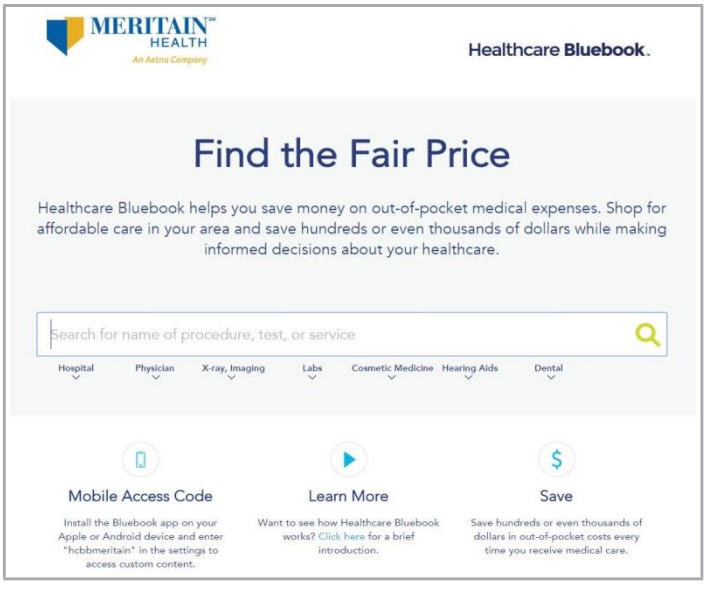
How to locate providers using Healthcare Bluebook:

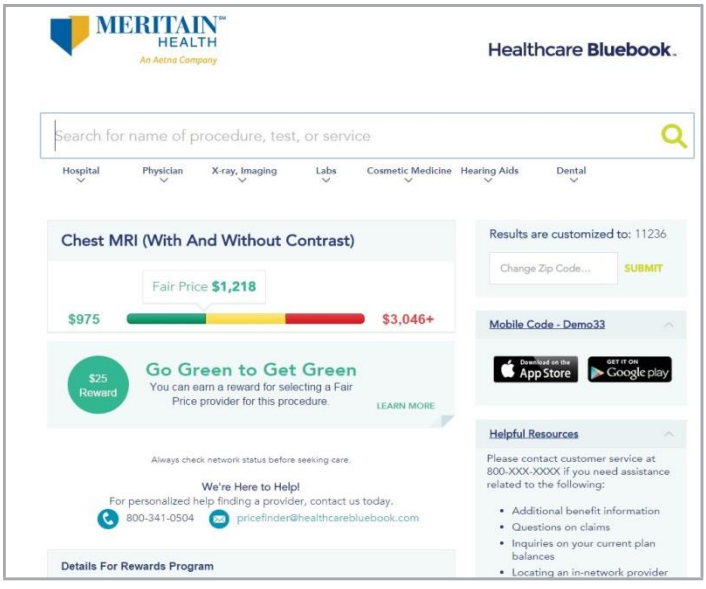
1. First, just log in to your member website at **www.meritain.com**. If you don't have an account, you can create one by following the prompts.

2. Once logged in to your member website, simply click on the *Healthcare Bluebook* tile near the bottom of the page.



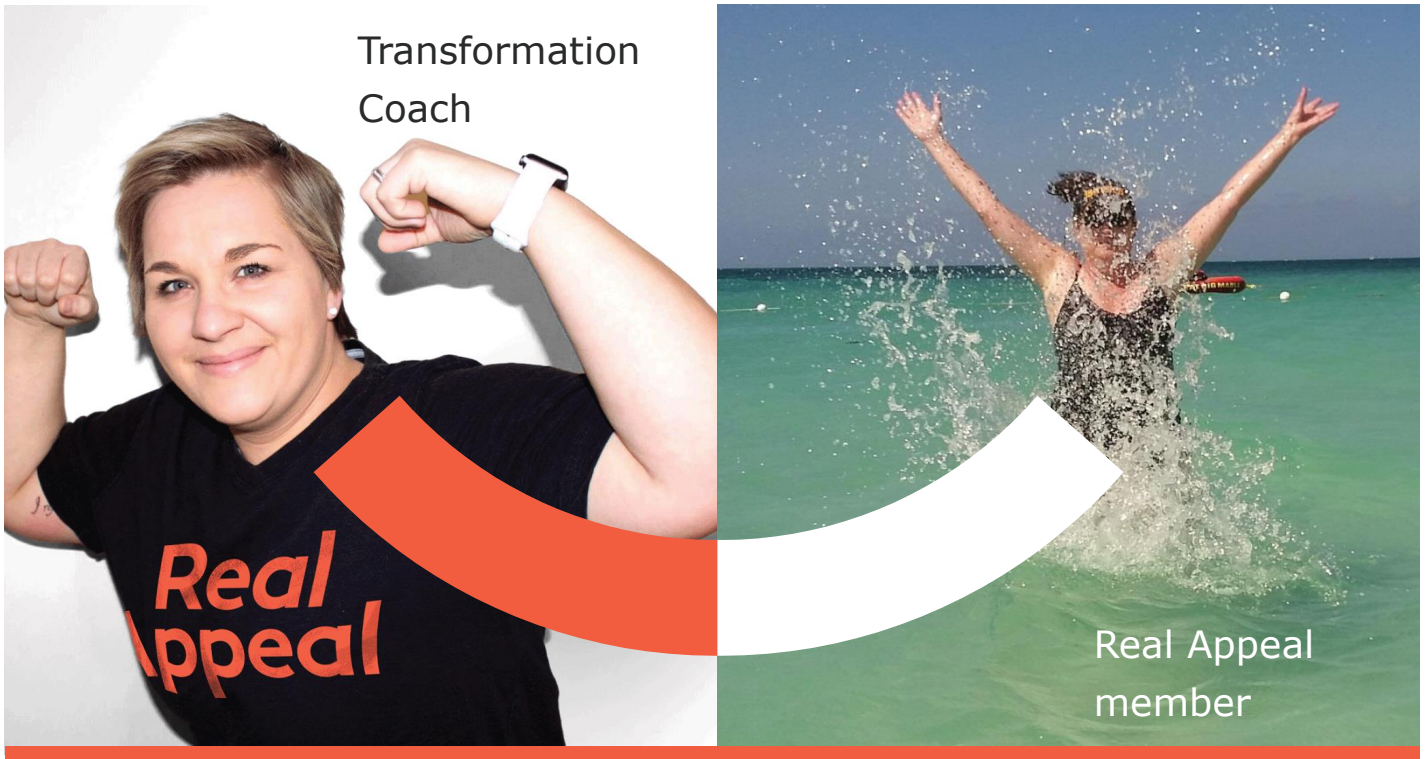
3. To search for specific healthcare services, simply use the drop-down menu or enter text into the search box. Healthcare Bluebook will then display pricing and provider information, including green, yellow and red provider rankings.





If you have questions or need help finding fair-priced facilities, just call Healthcare Bluebook's PriceFinder support team at **1.800.341.0504** or email them at **pricefinder@healthcarebluebook.com**. You can also call Meritain Health Customer Service using the phone number located on your member ID Card

Real Appeal



Weight loss that's free.*
A transformation that's real.

Real Appeal is a free, 52-week online weight loss program, customized to what works for you. With Real Appeal, you learn simple steps to help you transform.

Start your Real Appeal success story at
dosp.realappeal.com

Called 2 B Healthy

Real Appeal

*Real Appeal is available at no additional cost to active employees and covered retirees with our Aetna Meritain insurance and a body mass index (BMI) of 23 or higher.

Dental Insurance

The Diocese Dental plan is offered through Meritain Health using the Aetna network.

The plans allows you to use both in-network or out-of-network benefits. If out-of-network dentists are used, you may be responsible to pay the difference between Meritain's allowed amount and what the dentist may charge.

Since the plan pays the same benefit whether I go to an in network provider or an out of network provider, why should I bother finding someone in network?

Balance Billing! You should expect out of network providers to bill you for the difference between the provider's charge and the allowed amount. For example, if the out of network provider's charge is $100 and the allowed amount is $70, the out of network provider may bill you for the remaining $30. An in-network provider may not balance bill you for covered services.

	Meritain Dental Plan	
Network	In-Network	Out-of-Network
Calendar Year Deductible - Individual / Family	$125 / $375	
Calendar Year Maximum per person	$2,000	
Preventive Services	Deductible Waived	
Exams		
Fluoride (children under 16 only)	100%	
X-Rays		
# Prophylaxis Cleanings / Year	1 every 6 months	
Basic Services	Deductible Applies	
Amalgam Fillings		
Extractions – Single Tooth	80%	
Endodontics (Root Canal)		
Periodontics (Scaling & Planing)		
Major Services	Deductible Applies	
Crowns		
Bridges	80%	
Dentures		

See Exclusions and Limitations section for benefit guidelines.

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Vision Insurance

The Diocese offers a vision plan through VSP (Vision Service Plan). This vision plan provides coverage both in and out of network. The chart below provides a brief overview of the plan.

	VSP Vision	
BENEFIT FREQUENCY:		
Examination	Once every 12 months	
Lenses/Contacts	Once every 12 months	
Frames	Once every 24 months	
NETWORK:	In Network	Out of Network
In Network	VSP	N/A
BENEFIT COVERAGE:		
Examination	$10 Copay	Up to $45
Single Vision	$25 Copay	Up to $30
Bifocal	$25 Copay	Up to $50
Trifocal	$25 Copay	Up to $65
Frames	Featured Frame Brands: $150 allowance after $25 Copay Other Frames: $130 allowance after $25 Copay Costco Frames: $70 allowance after $25 Copay 20% discount on amounts over allowance	Up to $70
Contact Lenses: Elective In lieu of glasses	$200 allowance for a contact lens exam and materials	Up to $105
Laser Vision Correction	Discounts available	No Discounts
Additional Pairs Benefit	20% off additional glasses and sunglasses, including lens options, from the same VSP doctor within 12 months of your last exam.	No Discounts

Payroll Deductions

The charts below show the monthly payroll deduction amounts for each of the benefits offered.

Medical, Dental, and Vision

Active Participants	Choice Plan A	Choice Plan B
Employee Only	$110.00	$0.00
Employee + Spouse	$738.00	$496.00
Employee + Child(ren)	$568.00	$358.00
Family	$955.00	$649.00

Flexible Spending Accounts (FSA)

The Diocese offers a Health Care and a Dependent Care Flexible Spending Account. You may elect to have both types of accounts and contribute separate pretax dollar amounts to each. These accounts are kept completely separate; for instance, you could not be reimbursed for dependent care expenses from the health care account.

Health Care Accounts
A health care FSA can reimburse you for eligible medical, dental and vision expenses, up to the amount you elect to contribute for the plan year. Typical eligible expenses are:

- Deductible for group health and/or dental plan
- Copayments for group health and/or dental plan
- Many charges that are not covered by health/dental plan are also eligible for FSA reimbursement, such as:
  - Eyeglasses, contact lenses;
  - Hearing exams, hearing aids,
  - Medical expenses of a dependent not covered by a health plan
  - Orthodontia
  - Vision corrective surgery (such as Lasik)

A complete list can be found at www.irs.gov.

Your Health Care Contribution
The maximum amount you may contribute to $1,000 per year. The minimum contribution amount is $100.

Dependent Care Accounts
The second type of FSA is a dependent care account. This can be used to pay for care of dependent children under age 13 by a babysitter, day care center, or before-school or after-school program. Care for a disabled spouse, parent or child over age 12 is also eligible for reimbursement.

Your Dependent Care Contribution
The Internal Revenue service limits the amount you can contribute to a dependent care FSA, up to:
- $5,000 per year, if you are married and filing a joint return, or if you are a single parent
- $2,500 per year, if married and filing separate federal tax returns

Estimate what your daycare expenses will be for the year, and allocate enough from your pay, up to the allowable contribution, to cover those expenses.

Just remember this: FSA dollars are "use-it-or-lose-it" funds. You may only carry over $500 to the following year, so plan carefully!

FSA Worksheet
This worksheet is designed to help you estimate eligible medical care expenses not covered under any health insurance plan. This sheet includes some of the more common categories of eligible medical expenses. If you have a question regarding an expense eligibility, please consult with Meritain before including it in your election.

Health Plan Deductible	$
Health Plan Coinsurance or Copays	$
Eye Care (glasses, contact lenses, solutions, exams, LASIK)	$
Prescription Costs	$
Any other unreimbursed medical costs	$
Dental deductibles, coinsurance or any unreimbursed costs	$
Yearly Expected Health Care Expense Total	**$**

Voluntary Products

Group Accident

Group Voluntary Accident Insurance pays benefits for on- and off-the-job accidents, plus some benefits that correspond with medical care. And, because accident insurance is supplemental, it pays in addition to other coverage you may already have in place. This coverage pays a benefit up to a specified amount for accidental death, dismemberment, dislocation/fracture, initial hospitalization confinement, hospitalization confinement, intensive care, ambulance service, medical expenses and outpatient physician's treatment.

Coverage	EE	EE + SP	EE + CH	F
Monthly Rates	$14.52	$26.88	$24.60	$36.96

Group Critical Illness

Group Voluntary Critical Illness coverage helps offer financial support with a $10,000 or $20,000 lump sum benefit if you are diagnosed with a covered critical illness. With the expense of treatment often so high, seeking the treatment you need seems like a heavy financial burden. But when a diagnosis occurs, what you should be focusing on is getting better. With Allstate Benefits, you gain the power to take control of your health when faced with a covered event such as Heart Attack, Stroke, Heart Transplant, Coronary Artery Bypass Surgery, Major Organ Transplant, Paralysis, End Stage Renal Failure, Alzheimer's disease, and Cancer.

$10,000 Benefit Monthly Rates	EE	EE + SP	EE + CH	F
Non-Tobacco	$34.60	$51.48	$35.15	$52.04
Tobacco	$59.67	$88.62	$60.21	$8913

$20,000 Benefit Monthly Rates	EE	EE + SP	EE + CH	F
Non-Tobacco	$67.20	$99.71	$68.29	$100.83
Tobacco	$177.35	$117.98	$118.43	$175.02

Group Indemnity Medical

Group Indemnity Medical insurance can help cover out-of-pocket medical costs, which is especially helpful if your major medical deductible has not been met. These cash benefits are paid directly to you, regardless of other coverage. You can use the money toward deductibles, copays, premiums and even to help cover your daily living expenses. This plan no pre-existing conditions or waiting period for pregnancy.

Monthly Rates	EE	EE + SP	EE + CH	F
Low Plan	$31.59	$69.03	$54.60	$78.26
High Plan	$39.26	$89.83	$67.86	$100.62

Life and Disability Insurance

Basic Life Insurance
1 times (1X) your annual salary up to 100,000. Additional coverage available

Basic Accidental Death and Dismemberment
1 times (1X) your annual salary up to $100,000. Additional coverage available

Please make sure that Human Resources has your most up to date beneficiary designation. You may designate a beneficiary on your annual Benefit Election website and request changes or at any time by contacting Human Resources.

Short Term Disability Plan
Provides income replacement of 60% up to $1,250 per week. Benefits begin on day 31 for qualified disability. Maximum benefit period is 9 weeks.

Long Term Disability Plan
Provides income replacement of 60% up to $5,000 month. Benefits for qualified disability begin after 90 days, or the end of the STD maximum benefits period, whichever is later.

Voluntary Supplemental Life Insurance and AD&D

Provider - Hartford
You can purchase supplemental life insurance through payroll deductions for yourself and your dependents through Hartford. In order to elect coverage for your dependent spouse and/or child(ren), you must elect supplemental life coverage for yourself. Employee rates vary depending on your age and benefit amount. Coverage is portable if you leave the company. Please refer to Hartford's voluntary life rate chart to determine your monthly premium deductions for this coverage.

Life Insurance - The employee can choose an amount between $10,000 and $500,000 in increments of $10,000, not to exceed 5x basic annual earnings.

Spousal Life Insurance - The employee can choose 50% of Employee's Optional Life amounts in increments of $5,000. Spouse optional life coverage may not exceed 50% of the employee's coverage.

Child Life Insurance - an amount between $1,000 and $10,000, in increments of $1,000 for each child up to age 19 years old (or 25 years if a full-time student).

Legal and ID Theft Insurance

Have You Ever:

- Needed your Will prepared or updated?
- Wanted to know your options for mortgages?
- Received a moving traffic violation?
- Needed help with insurance claims?
- Have teenage drivers or kids in college?
- Been pursued by a collection agency?
- Been overcharged for a repair or paid an unfair bill?
- Had trouble with a warranty or defective product?
- Signed a contract of any kind?
- Had concerns regarding child support?
- Been treated unfairly?
- Lost a security deposit?
- Wanted to know what your rights are?
- Been a victim of IDENTITY THEFT or worried about it?
- Had someone commit a crime, get a job, open an account or use medical benefits in YOUR name?

What is LegalShield?

Know your rights in any situation. LegalShield gives you the ability to talk to an attorney on any matter without worrying about high hourly costs. Everyone deserves legal protection. And now, with LegalShield, everyone can access it. No matter how trivial. No matter how traumatic. Welcome to LegalShield. Worry less. Live more.

The Legal Services membership includes: (For Member; Member's spouse; never married dependent children under age 26 living at home.

- **Legal Advice** – unlimited issues incl Pre-Existing
- **Letters/calls** made on your behalf- unlimited
- **Unlimited Contracts & documents reviewed** up to 15 pages each
- Attorneys prepare your **Will, Living Will, Healthcare Power of Attorney** & Minor **Trusts**
- **Moving Traffic Violation** Representation-15-day wait
- **IRS Audit Defense**
- **Trial Defense**, includes Pre-Trial and Trial hours.
- **Uncontested Divorce, Uncontested Separation, Uncontested Adoption and Uncontested Name Change** (90-day wait) Also includes **Residential Loan Document Assistance** (for Primary Residence)
- **Preferred Member Discount** – other legal matters. (i.e. bankruptcy, foreclosure, divorce, criminal charges, child custody)
- **24/7 Emergency Access** for covered situations
- **Online legal forms, video law library & consumer discounts at several HUNDRED retailers.**

The ID ShieldSM membership includes (for member, or member, spouse/domestic partner & dependents up to age 18 for Consultation, Monitoring and full Restoration, and Dependents up to age 26 for Consultation and full Restoration, **including Pre-Existing ID Theft**)

Covering all types of Identity Theft such as **Medical, Driver's License, Criminal, Financial, Social Security Fraud.**

- 24/7 Continuous Credit Monitoring with Activity Alerts
- **Comprehensive Restoration Service** by licensed experts at **Kroll Advisory Solutions** for all areas of ID Theft, including a tri-merged credit report after your identity is restored AND a background check to check for criminal warrants, multiple
- **Unlimited Identity Theft Consultation, including 24/7/365 Emergency Access to licensed investigators at KROLL**
- **Web Watcher** - Daily web monitoring for unauthorized use of your personal information
- **Public Persona** - Monthly monitoring of any changes to SSN or address history associated with your name
- **Lost Wallet Assistance** - Help with canceling and replacing cards & IDs, and placing fraud alerts for a lost wallet or purse.
- **Social Security Number Skip-Trace** - SS # search through 34 billion public records to detect potential fraud.
- **Sex Offender Search** - Search of sex offender Registry Reports
- **Quarterly CREDIT SCORE TRACKER**, Bank Account Number Monitoring, Credit Monitoring and Credit Card Number Monitoring. **Court Record** Monitoring. **Public Persona** Monitoring.
- **Credit Inquiry Alerts, Black Market Website Surveillance, Minors Monitoring and Restoration.**
- **Payday Loan Monitoring, Passport Number Monitoring, Medical ID Number and Drivers License Monitoring**
- **$5 Million Service Guarantee**: If your identity gets breached, we will do whatever it takes- as long as it takes- to restore it!

Individual Legal	Family Legal Plan	IDShield-Individual	IDShield-Family	Legal + IDShield Individual	Family Legal + Family IDShield
$14.95/mo	$15.95/mo	$8.45/mo	$15.95/mo	$23.40/mo	$28.90/mo

LegalShield® Worry Less. Live More.

Value Added Services

Hartford, our Life and Disability Insurance provider, offers several value added services at no cost to you, which includes:

- **Employee Assistance Program (EAP)**
- **Travel Assist - Identify Theft Protection**
- **Beneficiary Assist ***
- **Estate Guidance ***
- **Funeral Planning and Concierge Services ***

Employee Assistance Program (EAP) All full-time employees have access to the Employee Assistance Program (EAP) offered through Compsych. This program is called **Ability Assist**, and provides resources to you and your family when dealing with issues such as:

- Marital
- Substance Abuse
- Workplace Conflicts
- Elder and Child Care
- Health Care Issues
- Legal Matters / Financial Concerns

You can access the program CONFIDENTIALLY, 24 hours a day, seven days a week, by phone **1 -800-327-1850**

or the web at **www.GuidanceResources.com.** When entering the website for the first time, provide the following: Company
Organization field is **HLF902**; Company name is **Diocese of St Petersburg**.

The Ability Assist EAP program also allows up to 6 face-to-face consultations per family member per year with a Master's Degree counselor to assist with personal issues as indicated above. Also included is an on-line library of educational materials and interactive tools that will provide assistance. The EAP program is completely confidential, your privacy is assured. All of the services included in this program are completely free to all employees and their family members.

- **Tickets at Work** - exclusive discounts, special offers and access to preferred seating, and tickets to top attractions, theme parks, shows, sporting events, movie tickets, hotels and much more. Company Code: DOSP
    - **How to Sign Up!**
        1. Go to TicketsatWork.com
        2. Click on “Become a Member”
        3. You will then be prompted to create an account with your email address and company code (DOSP)
- Discounted Membership to **YMCA** of Pinellas, Hillsborough, Citrus, Hernando and Pasco counties.
- Benefits through **Allstate** Insurance - Group Critical Illness, Accident Insurance, Indemnity Medical

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Diocese of St Petersburg 401(k) Retirement Plan & Pension Plan

Diocese of St. Petersburg 401(k) Retirement Plan

Employee Pre-Tax Contributions:	Participants are eligible to defer a portion of their compensation as pre-tax contributions to the Plan. You may elect to defer from 1% to the maximum allowable by law to your account.
Roth 401(k):	This option defers post-tax contributions, but earnings and withdrawals are not taxed.
Eligibility for Participation:	Full-time and part-time employees who have attained age 21. Completion of three months of service.
Investments:	You can direct where your account is invested. There are a variety of investment choices offered. Information on your choices will be provided to you in the enrollment package sent to you by our Plan Admministrator.
In-Service Withdrawals:	In the event of a defined financial hardship or attainment of age 59½, you may be eligible to take a distribution from your account. In addition, you may take an In-service withdrawal from your Rollover Account, if any, one time during any Plan Year.
Loans:	You are able to borrow money from your 401k. See your 401k administrator for details.

Diocese of St Petersburg Pension Plan Overview

- Lay employees' benefit:
  - 1.50% of Final Average Earnings (FAE) times highest ten years of credited services, maximum 50% of FAE
  - Payable as a life annuity, with other forms of payment available
- Normal Retirement Age: age 65 with 5 years of service
- Early Retirement: age 55 with 10 years of service at a reduced benefit amount. Please see Pension Plan for additional information
- Employees are 100% vested in the plan once they have completed five years of credited services
- Year of Service
  - 1,000 hours for year of service vesting and eligibility benefits
- Year of Credited Service
  - 1,500 hours for one year of credited service for benefit accrual
  - 1,000 – 1,499 hours for one-half year of credited service for benefit accrual

Required Annual Employee Disclosure Notices

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 than 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.

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.

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 requires Diocese of St Petersburg to notify you, as a participant or beneficiary of the Diocese of St Petersburg 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.

Patient Protection:

Meritain Health generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Meritain Health at 800-925-2272.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Meritain Health 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 our network who specializes in obstetrics or gynecology. The health care professional, 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, contact Meritain Health at 800-925-2272.

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.

Required Annual Employee Disclosure Notices - Continued

HIPAA Privacy Policy for Self-Funded Plans with Access to PHI

The group health plan is a partially self-funded 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). HIPAA privacy requirements are in place and a copy of the Privacy Policy is available from the Human Resource Department.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:
coverage is lost under Medicaid or a State CHIP program; or
you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 30 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, please contact the Human Resources Department..

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. 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 on the following page, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer 's plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Required Annual Employee Disclosure Notices - Continued

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, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	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
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531
To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:	
US Department of Labor Employee Benefits Security Administration **www.dol.gov/ebsa** 1-866-444-EBSA (3272)|	US Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext 61565

Required Annual Employee Disclosure Notices - Continued

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 Meritain Health 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. Meritain Health has determined that the prescription drug overage offered by the Welfare Plan for Employees of Diocese of St Petersburg under the Meritain Health 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 Meritain Health 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 Meritain Health 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 Meritain Health 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 Meritain Health and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up 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 Meritain Health changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see 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:	July 1, 2018
Name of Entity/Sender:	**Diocese of St Petersburg**
Contact--Position/Office:	Human Resources
Address:	6363 9th Avenue North St. Petersburg, FL 33710
Phone Number:	**(727)344-1611**

Frequently Asked Questions

I went to visit my doctor's office and they said I was not covered by Aetna. Why?
Coverage is provided through Meritain as the Claims Administrator, which utilizes the Aetna Choice POS II network. **Please make sure that your doctor is contacting Meritain, and not Aetna to verify your benefits.**

What is the In-Network Lab?
Quest Diagnostic

I didn't receive a Vision Card?
Our carrier VSP does not issue vision cards, but your health card contains info on VSP. All you need to do is tell your provider that you have coverage with VSP and they will verify it with your Social Security Number. You can also register at www.VSP.com to view your benefits, print a VSP card and locate a VSP Provider.

Do I need to get Pre-Certification before I go into the Hospital or have an out-patient procedure?
Yes, the number you need to call is on your Meritain Card. You, your eligible Dependents or a representative acting on your behalf, must call the Medical Management Program Administrator to receive certification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 48 hours in advance of Inpatient admissions or receipt of the non-Emergency Services listed below. If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours or if later, by the next business day after the Emergency Medical Condition admission.

Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied.

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

1. **Precertification of Medical Necessity. The following items and/or services must be pre-certified before any medical services are provided:**
    a) **Chemotherapy - all settings including services rendered in a Physician's office**
    b) **Dialysis - all settings including services rendered in a Physician's office**
    c) **Durable Medical Equipment – in excess of $1,500**
    d) **Home health care, including IV home infusion therapy**
    e) **Hospice care**
    f) **Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility,**
    g) **Rehabilitation Facility, and inpatient admissions due to a Mental Disorder or Substance Use Disorder**
    h) **Radiation - all settings including services rendered in a Physician's office**
    i) **Imaging, limited to the following: CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel)**
    j) **Transplants, including transportation and lodging**
    k) **Outpatient Surgical procedures, excluding Surgery rendered in a Physician's office**

2. **Concurrent Review for continued length of stay and assistance with discharge planning activities.**

3. **Retrospective review for Medical Necessity where precertification is not obtained or the Medical Management Program Administrator is not notified.**

Frequently Asked Questions

Under what circumstances should I go to the Emergency Room vs. Urgent Care or Convenience Clinics?
Emergency Rooms - At the ER, true emergencies are treated first. Other cases must wait—sometimes for hours. And, it will cost you more. If a situation seems life-threatening, take action. Call 911 or your local emergency number right away. Go to the ER for:

- Heavy Bleeding
- Major Burns
- Large open wounds
- Spinal Injuries
- Chest pain
- Difficulty Breathing

Urgent Care - Urgent care centers treat many minor ailments. In most cases, you won't have to wait as long as at the ER. You will pay less, too. An urgent care center can help with:

- Sprains/ Strains
- Minor Infections
- Minor Wounds
- Rashes

Convenient Care Centers - Convenient care centers offer the fast treatment for colds, flu, strep throat, and minor injuries for the cost of your physician copay. Convenient care centers can be found in select Walgreens and CVS retail locations.

How do I use mail order pharmacy?
Enjoy the convenience and cost-savings of Express Scripts Mail Order Pharmacy! To start using mail service you can:

- Call the toll-free number at **800-903-6219**, or
- Log onto www.express-scripts.com and fill out and send a mail service order form.

I want to drop my Husband/Wife/Child from my coverage how can it do that?
During open enrollment, you can drop or add a spouse or child or make any change you want to your coverage. If you want to make the change and the open enrollment period is over, there has to be a qualifying event or qualifying family status change. A qualifying event is Marriage, Divorce, Birth/Adoption of a Child, Involuntary Loss of Insurance, or if your spouse has a new job that provides insurance coverage

If I have a Qualifying Family Status Change and I need to change my coverage what do I need to do?
When the qualifying event occurs and it is outside of the open enrollment period, you will need to complete a paper enrollment form and submit to lsb@dosp.org. You will also have to provide supporting documentation for the qualifying event.

Where can I get a Summary of Benefits and Coverage?
You can get a copy online at www.Meritain.com or you can get paper copy by calling Human Resources at 727-344.1611, ext 5397.

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the 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: