COURAGEOUSLY
Living the Gospel

Employee Benefits & Enrollment Guide 2021

Retirees

We Reserve the Right to Amend or Withdraw These Plans and Premiums at Any Time

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Welcome

The Diocese of St Petersburg is pleased to offer a comprehensive benefits package to our employees. The benefit package includes medical/pharmacy, dental, vision, short-term disability (STD), long-term disability (LTD), basic life and AD&D, and voluntary (optional) insurance products. This 2021 Employee Benefits booklet provides you with a general summary of the benefits available to you. 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 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 a retiree/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 Descriptions 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 the provisions of the benefit plans.

Sincerely,

Human Resources

Eligibility & Enrollment

Eligible Retirees:

You may be eligible for the Diocese of St. Petersburg Retiree Benefits Program if all the following is true.

- You were enrolled in DOSP benefits on the last day of employment.
- You are collecting your DOSP pension benefits immediately following your last day of work. By pension standards, immediately following is the 1st of the month following the last day of work.
- You are not eligible to enroll in any other outside benefits such as Medicare. The diocese does not offer supplemental benefits to Medicare Benefits.

The Diocese of St Petersburg does not offer supplemental benefits to Medicare. If you are enrolled in Medicare, you will not be eligible for the Diocese plans.

When Coverage Begins:

The effective date for your benefits is the beginning of the following month after retirement. (Retire May 15th benefits start June 1st).

When Coverage Ends:

Coverage will end the date you stop making the required contributions, or the date you are no longer eligible. ***The Diocese reserves the right to amend or withdraw the plans and premiums at any time.***

Enrolling in Benefits

Enrollment is completed through and premiums are paid directly to the Retirement Services office.

Medical - Meritain Health

You have two plan options for healthcare coverage through Meritain Health, including:

POS Plan
High Deductible Health Plan

How to Find a Doctor or Facility Online

- Go to www.aetna.com/docfind/custom/mymeritain
- Enter the geographic information for the area you are looking.
- The 'Select a Plan' dropdown box allows you to choose your provider network; be sure to select **Aetna Choice® POS II**
- Enter in the name of the provider, the type of healthcare professional or facility you wish to find, such as a primary care physician, specialist, or medical hospital OR search by category.
- 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's name.

Member Resources with Meritain Health

Have you registered at www.mymeritain.com yet? There are many member tools that are available to you online!

- Find doctors, pharmacies, and hospitals
- Get an ID card
- Look up a claim
- Check your coverage
- Keep track of health care costs

You can get a summary of your doctor visits, medical tests, prescriptions, and other health activities.

Key Benefit Terms

Deductible
Amount member is responsible for before the plan pays for certain services.

Coinsurance
Percentage of payment shared between the member and the plan for certain services after the deductible has been met.

Maximum Out-of-Pocket
Member total payments for deductible, coinsurance and copays to stated maximum per plan year. Once reached, the plan will pay 100% for eligible expenses for the rest of the plan year.

Copay
Flat dollar amount the member is responsible for at the time of service. The plan usually pays 100% of the remaining balance.

Medical - Meritain Health

	POS Plan (Individual)	High Deductible Plan (Individual)
Calendar Year Deductible (CYD)		
In Network	$1,250	*$1,400
Out of Network	$2,500	*$2,800
Employee Coinsurance (Coins)		
In Network	30%	30%
Out of Network	60%	60%
Maximum Out of Pocket		
In Network	$4,000	*$3,500
Out of Network	$8,000	*$7,000
Physician Charges		
Physician Office Copay - In Network	$40 Copay	Deductible + 30%
Specialist Office Copay - In Network	$90 Copay	Deductible + 30%
Physician Office - Out of Network	Deductible + 40%	Deductible + 60%
Inpatient Hospital (per Admission)		
In Network	$300 Copay + Deductible + 30%	Deductible + 30%
Out of Network	Deductible + 40%	Deductible + 30%
Other Services-In Network		
Preferred Freestanding Lab / Xray	$0 Copay	Deductible + 30%
Complex Radiology ***Precertification is required**	Deductible + 30%	Deductible + 30%
Urgent Care	$200 Copay	Deductible + 30%
Outpatient Surgery	Deductible + 30%	Deductible + 30%
Emergency Room	$300 Copay + Deductible + 30%	Deductible + 30%
Hearing Aids Charges		
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
Prescription		
Rx Copays or Coinsurance	$10 / $60 / $120	Deductible + 30%
Specialty Drugs	30% up to Out of Pocket Maximum	Deductible + 30%
Mail Order- 90 day supply	$20 / $120 / $240; Specialty: N/A	Deductible + 30%; Specialty: N/A
Provider Network	**Choice POS II**	**Choice POS II**

Monthly Premium	**POS Plan** **Individual**	**High Deductible Plan** **Individual**
Due on the 20th of Each Month		
Retiree	$1,087.00	$988.00

*We reserve the right to amend or withdraw these plans and premiums at any time.
**Premium payable to DOSP Insurance Funds Trust
***Premium can be paid using the Bill Pay Option through your bank. Please see your bank for additional details.

Preventive Care Basics

Every year, thousands of people die from chronic diseases in the United States. While that fact may be startling, most chronic conditions can be avoided or better controlled with proper preventive care. Luckily, if you're enrolled in one Diocese of St. Petersburg's medical plans, preventive care services are covered at 100%.

Preventive care consists not only of yearly physical exams, but also routine health screenings, immunizations and maintaining a healthy lifestyle

What is Preventive Care?

While regular medical care focuses on treating illness, preventive care aims to keep you from getting sick in the first place by focusing on helping you maintain good health. Examples of preventive care may include the following:

- Physical examinations
- Health screening
- Lab tests
- Counseling
- Immunizations

Preventive care occurs before you feel sick or notice any symptoms and is designed to prevent or delay the onset of illness and disease. The Centers for Disease Control states that treatment for chronic diseases works best when they are detected early.

Why Should I Use Preventive Care?

Preventive care is important because it helps you stay healthy and access prompt treatment when necessary. For example, many types of screenings and tests can catch a disease before it gets worse. Starting treatment or lifestyle changes before a disease starts or while it's still in its early stages will help you stay healthier or recover more quickly.

Additionally, preventive care can save you money by helping catch problems in the early stages when most diseases are more treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Ultimately, preventive care can improve the quality of your health for years to come. And, when preventive care is combined with leading an overall healthy lifestyle, like eating well and exercising, you can greatly increase your odds of avoiding costly chronic conditions in the first place.

Next Steps

Contact your doctor to discuss your preventive care options. To find an in-network doctor or for details about what preventive care is covered, visit the Meritain Health website www.meritain.com

Become A Savvy Healthcare Consumer

A smart way to save on medication costs is to shop around and look for the best price! The cost of a prescription medication can vary greatly from one pharmacy to another, even within the same store chain. Call ahead or check the pharmacy website to find out the cost.
Ask your doctor and pharmacy for samples and check to see if they have any discount coupons available.

Publix Supermarket:
Certain medications are available at no cost with a prescription. See the Publix Pharmacy website for a current list of free medications. Also offering certain medications at $7.50 for a 90 day supply.
www.publix.com

Wal-Mart, Sam's Club and Neighborhood Market:
$4 generic medications per 30 day supply
$10 generic medications per 90 day supply
www.walmart.com

Winn Dixie
$4 & $10 Generic Drug List
https://www.winndixie.com/pharmacy/generics-list

www.GoodRx.com
This website provides local cost comparisons and also links back to the manufacturers' websites for discounts & coupons.

Generic Drugs

Use a generic drug first, especially when the generic drug is made with the same active ingredients as the original brand-name drug. We don't cover drugs that cost more than similar generics or have not been FDA approved. In order for you to fill a brand-name prescription without paying the cost difference, the prescribing physician must indicate "Medically Necessary" on the prescription.

I Need Care -- Where Should I Go?

Primary Care Doctor's Office
The best place to go for routine or preventive care is your primary care physician (PCP).

Convenient Care Clinic
Generally staffed by nurse practitioners or physician assistants and treats minor medical issues such as cold/flu, rashes, sore throat, minor cuts and burns, earache.

Urgent Care Center
Consider visiting an urgent care center for conditions that are not life threating but requires immediate care, such as cuts, burns, sprains, high fever, chronic lower back pain, urinary tract infections.

Emergency Room (ER)
The ER should be used to obtain immediate care for life or limb threating illnesses or injuries. ER treatment is the highest cost options.

71% of emergency department visits are unnecessary or could have been avoided.

Urgent Care vs. Emergency Room

Urgent Care Center	Emergency Room
Cold, flu, or fever	Chest pain
Strains, sprains, breaks	Abdominal pain
Infections	Stroke
Mild burns	Severe head injury
Allergies	Major trauma

If you are experiencing blurry vision, uncontrolled bleeding, overdose, chest pain, shortness of breath, head injury or major trauma, severe cuts or burns, or similar issues you should call 911 or go to the nearest ER!

Precertification

Key To Your Good Health

You can help make sure you obtain quality healthcare when and where you need it. Meritain Health's Medical Management program is designed to ensure that you 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 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.

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.

MERITAIN®
HEALTH
An Aetna Company

Healthcare Bluebook

Save on Healthcare Costs and Earn Valuable Incentives!

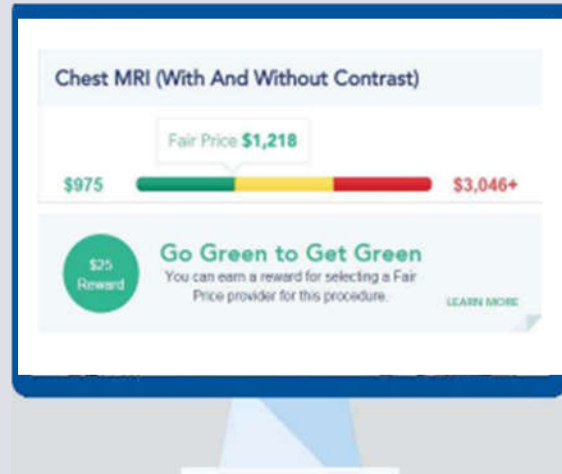
How Healthcare Bluebook™ can help

Want to save money on healthcare services for you, 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:

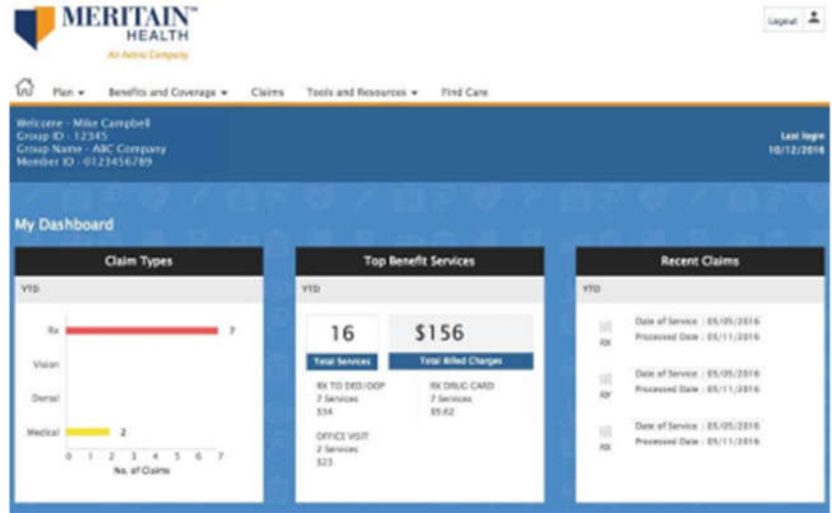
Procedure	Incentive	Procedure	Incentive
Most CT Scans	$25	Lithotripsy	$50
Most MRIs	$25	Removal of adenoids	$50
Transthoracic Echocardigram (TTE)	$25	Sleep Study	$50
TTE with doppler	$25	Tonsillectomy	$50
Cataract Surgery	$50	Colonoscopies	$100
Cholecystectomy (laparoscopic)	$50	Knee arthroscopy	$100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

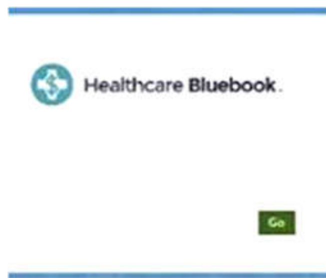
Healthcare Bluebook

How to locate providers using Healthcare Bluebook:

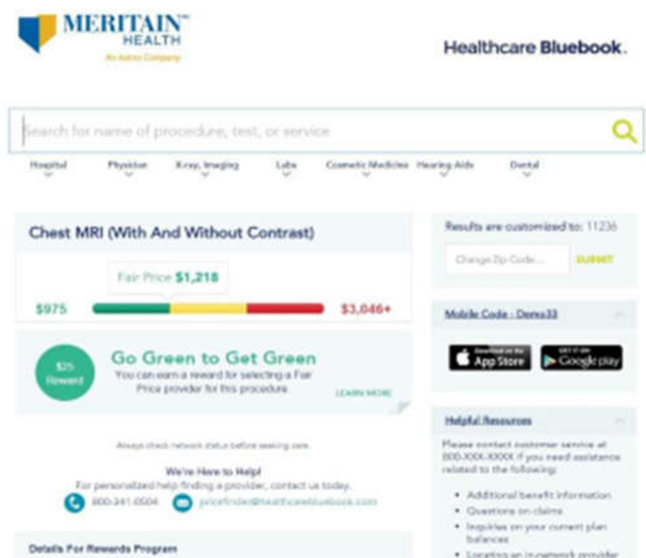
1. First, just log in to your member website at **www.meritain.com**. If you don't have an account, you can create one by following the prompts.

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

Care Management

Taking care of your healthcare needs….

In the interest of enhancing our healthcare benefits, we have partnered with **Practice Management of America, Inc.** "**PMA**". PMA specializes in Clinical Care Management to ensure employees and their families have an advocate to navigate the healthcare maze.

PMA has a team of local care managers that are comprised of Registered Nurses, Pharmacists, Nutritionist, Physicians, Physician Assistants, and patient navigators. You may receive a call from one of these team members to discuss some of the available programs that may benefit you, such as: Diabetes Management, Medication Review, Care Management, setting up your next appointment for an Annual Wellness Visit, Mammography, Colonoscopy, and much more. Their sole focus to helping our members receive the ***Right Care, at the Right Place, at the Right Time.***

This team is accessible to you Monday thru Friday from 8:00am to 5:00pm, please reach out to Patricia Mullarkey, Clinical Care Manager, RN, BSN at 727-308-2859 and Michelle Bonat, Patient Navigator at 727-308-2854 or via email at: DOSPcare@ipany.com

What is Infusion Therapy?

Infusion therapy involves the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Normally those medications are Specialty Medications.

What is a specialty medication?

A medication used to treat chronic, complex conditions like multiple sclerosis, hepatitis C and cancer. Specialty medications can include oral solids, or can be injected, infused or inhaled and may require special handling, such as refrigeration.

Your plan requires most Specialty Medications to be filled through the Diocese of St. Petersburg Plan's Prescription Drug Program. The program is administered by Optum Rx. If you have a specialty medication you must contact them at (877) 656-9604. Optum Specialty Medication Resources will work as a team with your doctor to manage your overall medication therapy.

What are your next steps?

SPECIALTY CLINICIANS ARE YOUR GUIDE

- Optum's specialty-trained pharmacists and nurses are available 24/7 for any questions about your therapy
- You'll receive one-on-one clinical support to help you administer your medication safely and effectively
- Your Optum team helps you manage possible side effects
- For certain conditions, Optum nurses help you administer your medication in the comfort of your home, when appropriate

An easy route for getting your medication

- Free shipping to where you choose, when you choose
- Additional supplies, like syringes and sharps containers, included at no additional charge
- Medication is handled with care, including refrigeration if needed (plus information on how to properly store your medication at home)
- Refill reminders and shipment updates by email or text to make sure you do not run out
- Order refills at optumrx.com, on the mobile app or by calling the number on your prescription label

Navigate insurance and financial assistance

- Get help understanding your insurance coverage and coordinating with your health plan on approvals and eligibility

Real Appeal

Start Your Transformation Today

Real Appeal® is an online weight loss program on Rally Coach™ that delivers real results, and it's available to you for free.*

A program built to help you succeed.

Real Appeal is a proven way to help our members lose weight and live healthier lives by providing:

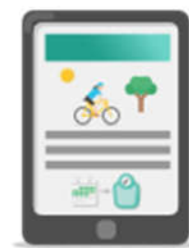
Real Appeal is available to our members at no additional cost. Our approach is based on decades of clinical weight loss research focused on simple steps combined with personalized tools and support.

Ongoing support and guidance

We're committed to keeping you focused on your goals — with online group sessions, support from our coaches, and a passionate community of members rooting for your success.

Small steps for lifelong change

To help you reach your goals, Real Appeal recommends small steps every day — and makes it easy to chart your daily progress with our nutrition and exercise trackers.



Resources to keep you motivated

Throughout your journey, you can access the inspiring stories of other Real Appeal members, blog posts and articles to keep you informed, and simple activities to help you stay on track.

Dental - Guardian

Members may choose to visit in or out-of- network providers. Using in-network providers will results in lower out of pocket costs.

	In-Network (DentalGuard Preferred)	*Out-of-Network*
Annual Deductible - Waived for Preventive Services		
Individual	$125	
Annual Maximum		
Per Person	$2,000 plus Max Rollover	
Preventive Services Exams Cleanings X-Rays	100% No Deductible	
Basic Services Fillings Root Canals Periodontics Extractions	80% After Deductible	
Major Services Crowns Bridges Implants Dentures	80% After Deductible	
Orthodontia		
Benefit Percentage	Not Covered	

Dental Maximum Rollover®

Guardian will roll over a portion of your unused maximum into your personal Maximum Rollover Account (MRA). If you reach your Annual Maximum in future years, you can use money from your MRA. To qualify, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Please see your plan documents for more details on thresholds and MRA limits.

Rollover Threshold: $800
Rollover Amount: $400
Rollover In-Network Amount: $600
Rollover Account Limit: $1500

Monthly Premium	
Due the 20th of Each Month	
Retiree	$41.50

College Tuition Services

It's True. Guardian Dental Can Help Pay For College.

Your employer has worked with Guardian to make College Tuition Benefit services available to eligible members enrolled in a Dental plan. Welcome to the College Tuition Benefits Rewards program! You can now create your Rewards account and start accumulating your Tuition Rewards that can be used to pay up to one year's tuition at SAGE Scholar Consortium of colleges.

You can use your College Tuition Benefits Rewards at over 340 private colleges and universities across the nation. 80% of SAGE colleges have received an "America's Best" ranking by US News and World Reports. Here is how the service works

- You will receive 2,000 rewards for each year you have Guardian Dental Plan benefits
- Each Tuition Reward point equals a $1 tuition reduction
- Tuition Rewards can be given to your relatives including children, nephews, nieces, and grandchildren

To learn more about the program and how to get started, go to: www.Guardian.CollegeTuitionBenefit.com to set up your account. If you have any questions, please feel free to visit the website or contact College Tuition Benefit directly at 215-839-0119.

Register Today!

Guardian's Group Dental Insurance is underwritten by The Guardian Life Insurance Company of America (Guardian) or its subsidiaries. The Tuition Rewards program is provided by College Tuition Benefit. The Guardian Life Insurance Company of America (Guardian) does not provide any services related to this program. College Tuition Benefit is not a subsidiary or an affiliate of Guardian. #2014-15077

(Print and cut out ID Card)

College Tuition Benefits Rewards – ID Card

Register@
www.Guardian.CollegeTuitionBenefit.com
User ID: Is your Guardian Dental Plan Number that can be found on your Dental ID Card
Password: Guardian

fold

The College Tuition Benefit
150 E. Swedesford Road, Suite 100
Wayne, PA 19087
Phone: (215) 839-0119
Fax: (215) 392-3255

Vision - Guardian

The Diocese offers a vision plan through Guardian with VSP Network. This vision plan provides coverage both In-Network and Out-of-Network.

Benefit Coverage		
	In Network Benefits	***Out of Network Benefits***
Exam	$10 Copay	Up to $59
Lenses		
Single	$25 Copay	Up to $30
Bifocal		Up to $50
Trifocal		Up to $65
Frames		
Featured Frame Brands	$150 allowance after $25 copay	Up to $70
Other Frames	$130 allowance after $25 copay	
Costco Frames	$70 allowance after $25 copay	
	20% discount off balance	
Contact Lenses (in lieu of eyeglasses)		
Fitting and Evaluation	$60 Allowance	N/A
Elective contact lenses	$200 Allowance	Up to $120
Medically Necessary	$25 Copay	Up to $210
Frequency - Once Every:		
Exam	Once every 12 Months	
Lenses/Contacts	Once every 12 Months	
Frame	Once every 24 Months	

In-Network Only: Discounts are available for Laser Vision Correction

Monthly Premium	
Due on the 20th of Each Month	
Retiree	$9.81

Pension Plan

Diocese of St Petersburg Pension Plan

Pension Plan Administrators
Gabriel, Roeder & Smith
One East Broward Blvd
Suite 505
Fort Lauderdale, FL 33701-1804
954-527-1616

Value Added Services

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 TicketatWork.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.

Contacts

	Carrier	Phone Number	Website
Medical **Participating Providers** **Precertification**	Meritain Health	(800) 925-2272 (800) 343-3140 (800) 242-1199	www.meritain.com
Case and Disease Management	PMA	Michelle Bonat, Patient Navigator: (727) 308-2854 Patricia Mullarkey, Clinical Care Manager: (727) 308-2859	
Prescription Drug Benefits **Specialty Drugs**	OptumRx	(800) 356-3477 (877) 656-9604	www.optumrx.com
Employee Benefits Hotline **Dental Claims** **Vision Claims**	Guardian	(888) 600-1600 (800) 541-7846 (800) 877-7195	www.guardiananytime.com
Pension Plan	Gabriel Roeder Smith	(954) 527-1616	N/A

Disclosure

NOTE TO ALL EMPLOYEES:
Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

Diocese of St. Petersburg
6363 9th Ave N
St Petersburg, FL 33710
(727) 344-1611

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY
This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS
Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED
Diocese of St. Petersburg reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS
If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

(a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage. However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within 30 days of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within 60 days after either:
(1.) You or your Eligible Dependent's Medicaid coverage under title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of loss of eligibility for such coverage; or
(2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.

(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period). Should you have any questions regarding this information or require additional details, please contact the Plan Administrator.

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

Reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; and Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women’s Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

MEDICARE CREDITABLE COVERAGE NOTICE
Employees Enrolled in the POS or High Deductible Health Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Diocese of St. Petersburg and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.
There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Diocese of St. Petersburg has determined that the prescription drug coverage offered by the Diocese of St. Petersburg Health Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you are an active employee insured under your employers groups health plan and you decide to join a Medicare drug plan, your current **Diocese of St. Petersburg** coverage will not be affected. The **Diocese of St. Petersburg health plan coverage** will provide primary benefits according to standard coordination of benefits guidelines. Please see your current plan design for a description of current coverage. If you do decide to join a Medicare drug plan and drop your current **Diocese of St. Petersburg** health coverage, be aware that you and your dependents will be able to get this coverage back at your next annual open enrollment.

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 **Diocese of St. Petersburg** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Diocese of St. Petersburg** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1, 2021
Name of Entity/Sender:	Diocese of St. Petersburg
Contact--Position/Office:	Human Resources
Address:	6363 9th Ave N St Petersburg, FL 33710
Phone Number:	(727) 344-1611

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

NOTICE REGARDING WELLNESS PROGRAM
Our company may have a voluntary wellness program available to all employees. If available and you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease) or asked to complete a biometric screening, which will include a blood test for cholesterol, glucose, blood pressure, and BMI. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

If incentives were made available for employees who participate in certain health-related activities or achieve certain health outcomes and you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Human Resource Department.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although we may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse or a health coach, so they may provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Human Resource Department.

NOTICE REGARDING MICHELLE'S LAW
On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.
The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

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 below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	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: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Self-Funded or Level-Funded Plan Notice of Privacy

The notice describes how medical information about you may be used and disclosed and how you can get access to this information. The Department of Health and Human Services and the Diocese of St. Petersburg Health Plan ("The Plan") are committed to protecting your health information. The Plan is required by HIPAA law to maintain the privacy of your medical information by the terms of the most current Notice of Privacy Practices, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. The Plan reserves the right to change the terms of this Notice of Privacy and to make any new Notice provisions effective for all Protected Health Information (known as "PHI"). The Plan will inform all participants of changes to this Notice and provide a new and updated Notice of Privacy each time a change in content occurs.

I. Confidentiality Practices and Uses

The Plan may access, use, or share information:

1. **Treatment** During the course of your care, Protected Health Information (known as "PHI") may be disclosed to treatment providers as appropriate/necessary to ensure the quality and continuity of your care. The treatment exception allows doctors to share health information about a patient in order to assure that the patient receives proper care.
2. **Payment** We may use and give your medical information to others to bill and collect payment for the treatment and services provided to you. The Privacy Rule permits The Plan to disclose health information without individual authorization for the purpose of paying a claim.
3. **Regular Health Care Operations** To maintain efficient, quality, and cost effective medical care, PHI is routinely reviewed by authorized personnel to ensure the highest quality standards of patient care are consistently being practiced. For example, PHI may be seen by regulatory agencies that oversee clinical laboratories during routine quality assurance procedures. We may also use PHI for underwriting, premium rating, and other activities relating to Plan coverage such as: submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs. We will not use your genetic information for underwriting purposes.
4. **Information Provided Directly to You or Mailed to You** For example, your medical provider may give you a copy of your lab results or you may receive a bill sent to your address on file for any outstanding balances.
5. **Business Associates** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate contracts with us.

II. Disclosure Not Requiring Your Permission

1. **Notification and Communication with Family** We may disclose your health information to notify or assist in notifying a family member, your emergency contact, or another person responsible for your care about your location, general condition, or in the event of your death. However, if you are able and available to agree or object, we will give you the opportunity to do so prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communication with your family and others.
2. **Required By Law** As required by law, we may use and disclose your health information.
3. **Public Health** As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the FDA problems with products and reactions to medications; and reporting disease or infection exposure.
4. **Health Oversight Activities** We may disclose your health information to business associates, the plan sponsor, health agencies during the course of audits, investigations, inspections, licensure, and other proceedings.
5. **Judicial and Administrative Proceedings** We may disclose your health information in the course of any administrative or judicial proceeding.
6. **Law Enforcement** We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
7. **Deceased Person Information** We may disclose your health information to coroners, medical examiners, or funeral directors.
8. **Organ Donation** We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
9. **Research** We may disclose your health information to researchers conducting research that has been approved.
10. **Public Safety** We may disclose your health information to appropriate persons in order to prevent, lessen, or coordinate a response to a serious and imminent threat to the health/safety of a particular person, the company community, or the general public.
11. **Specialized Government Functions** We may disclose your health information for military, national security, intelligence and/or protective services for the President, prisoner, and government benefits required by law.

12. **Workers' Compensation** We may disclose your health information as necessary to comply with workers' compensation laws.
13. **Marketing** We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.

III. Your Rights To Privacy

Except as described in this Notice of Privacy Practices, The Plan will not use or disclose your health information without your written authorization. If you do authorize The Plan to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. Human Resources has procedures to assist you with your rights to your medical information. You may ask Human Resources staff for a hard copy of this notice at any time.

Personal Representatives We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e.: power of attorney)

NOTE: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse, or neglect by such person;
2. treating such person as your personal representative could endanger you;
3. in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under The Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under The Plan has requested Restrictions or Confidential Communications (see below), and if we have agreed to the request, we will send mail as provided by the request for Restrictions and Confidential Communications.

Authorizations Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes*; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

*Use or disclosure of Psychotherapy Notes. Use or disclosure of psychotherapy notes includes all activities utilizing the notes, including but not limited to research activities.

Any request you may have of The Plan must be submitted in writing, including complaints. All required forms are available at Human Resources. You have the right to:

1. Request restrictions on certain uses and disclosures of your health information. The Plan is not required to agree to the restriction that you requested. Except as provided in the next paragraph, we will honor the restriction until you revoke it or we notify you. Effective January 1, 2019, we will comply with your restriction request if:(1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want us to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply - for example, disclosures to your spouse.

2. Request the Plan to communicate with you in a certain way or at a certain location. For example, you may ask to be contacted only while at work or by email.
3. Right to be notified if we (or a Business Associate) discover a breach of unsecured protected health information.
4. Inspect and receive a copy of certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.
5. Change or add information to your designated records; however, The Plan may not change the "original" documents.
6. An accounting of disclosures of your protected health information made by The Plan. However, The Plan does not have to account for disclosures related to treatment, payment, health care operations, information provided to the patient, specialized government functions, and disclosures authorized by the patient.
7. Right to receive a paper copy of this Notice even if you receive this electronically.

IV. Complaints

1. If you need more information, have complaints, or feel that your privacy rights have been violated, contact us by phone at: (727) 344-1611or by mail at:
   Diocese of St. Petersburg - Human Resources
   6363 9th Ave N, St Petersburg, FL 33710

Remember, any request you may have of The Plan must be submitted in writing, including complaints, to the address above.

2. If you are not satisfied with how Human Resources handles your concern, you may submit a formal complaint to: **Dept. of Health and Human Services Office of Civil Rights 200 Independence Ave. S.W. Room 509F HHH Building Washington, DC 20201**

If you file a complaint, we will not take any action against you or change your treatment in any way.

Form Approved
OMB No. 1210-0149
(expires 06-30-2023)

New Health Insurance Marketplace
Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Diocese of St. Petersburg		4. Employer Identification Number (EIN) 45-3460890
5. Employer address 6363 9th Ave N		6. Employer phone number (727) 344-1611
7. City St. Petersburg	8. State FL	9. ZIP Code 33710
10. Who can we contact about employee health coverage at this job? Faith Eschenfelder		
11. Phone number (if different from above) (727)344-1611 ext 5438	12. Email address fje@dosp.org	

Here is some basic information about health coverage offered by this employer:
As your employer, we offer a health plan to:

- [ ] All employees.
- [X] Some employees. Eligible employees are: Regular Full-Time employees as defined by your employer.

With respect to dependents:

- [X] We do offer coverage. Eligible dependents are: “Spouse and other dependents as defined by your employer”
- [ ] We do not offer coverage.
- [X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

Notes

300 First Avenue South - 5th Floor
St. Petersburg, FL 33701
800.783.5085 • 727.522.7777

Wallace Welch & Willingham is providing this as a service for Diocese of St. Petersburg. The information is solely general guidance on the subjects covered and should not be considered as legal advice.

This is only a highlight of the benefits provided by Diocese of St. Petersburg to use as a quick reference for enrollment purposes. Employees should refer to the plan document or summary plan description for each plan for a more detailed explanation of all plan benefits including any limitations or exclusions.