DIOCESE OF ST. PETERSBURG

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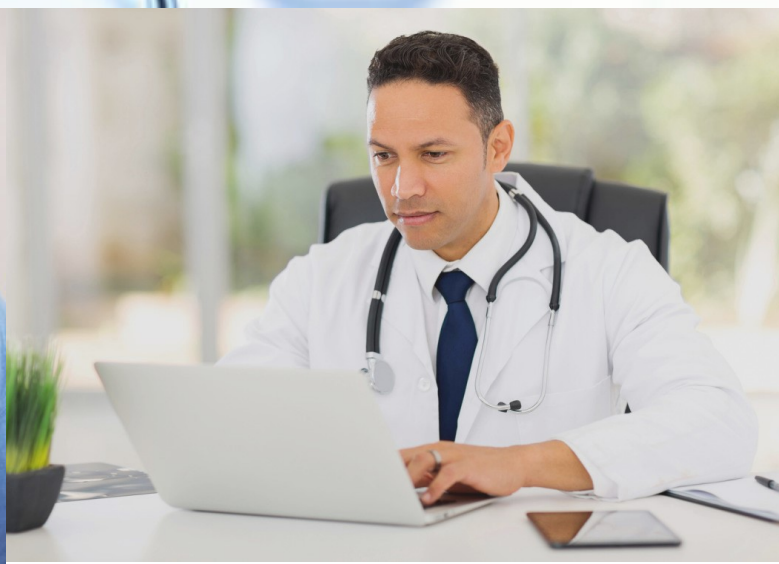
Employee Benefits & Enrollment Guide 2022



This is only a highlight of the benefits 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.

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Welcome

At the Diocese of St. Petersburg, we believe that you, our employees, are our most important blessing. Helping you and your families achieve and maintain good health – physical, emotional and financial goal– is the reason that the Diocese of St. Petersburg offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided in the booklet. While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to the benefits resources located on the Diocesan website at:

https://www.dosp.org/humanresources/benefits/

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 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.

You can also view overviews of our benefit plans by going to www.Paylocity.com.

- Sign in using your company ID (12xxx)
- Your username
- And your password

(If you are missing any of the information above, please reach out to the payroll administrator at your entity)

- Near the top left of the page you will see a gray square that reads “HR & Payroll”
- Please click on this and you will see a menu slide in from the left
- Click on the last option, the heart and cross which reads Bswift Benefits.
- You will be brought to a welcome screen
- You can then go to the library and access information on all our benefit plans
- Each year you must update your FSA / HSA contribution amount
- Be sure to confirm your beneficiary designation
- Print and retain your confirmation statement

Sincerely,
Human Resources

Eligibility & Enrollment

Eligible Employees:
You may enroll in the Diocese of St. Petersburg Employee Benefits Program if you are a Full-Time employee working at least 30 hours per week.

Eligible Dependents:
If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children, and children obtained through court - appointed legal guardianship.

Spouse Eligibility:
If your spouse is eligible for other coverage through his / her employer, they are not eligible for coverage under the Diocese of St Petersburg plan.

When Coverage Begins:
Newly hired employees and dependents will be effective in Diocese of St Petersburg's benefits programs on the first of month following 30 days of employment. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status change.

Enrolling in Benefits
Enrollments are processed through the online enrollment system.

Please log onto https://logion.Paylocity.com

If you need your login or password reset, please contact the payroll administrator at your location, or Faith Eschenfelder (727) 344-1611 ext. 5438, or fje@dosp.org

Changing Your Benefit Elections

Changes to benefits may generally only be made at annual open enrollment, unless you experience a qualifying event. A qualifying event needs to be reported to Human Resources within 30 days of the event. Examples of qualifying events include:

Change In Family Status	Change In Cost or Coverage
Marriage or Divorce	Addition or elimination of benefit options
Death of dependent	Spouse's employment begins or ends
Birth or adoption of child	Relocation in or out of plan's service area
Dependent eligibility status change	Plan covering a spouse or dependent holds an annual enrollment at a different time than the plan covering the employee.
Medicare Eligibility **(60 day special enrollment)**	
Medicaid Eligibility **(60 day special enrollment)**	

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.

MERITAIN® HEALTH
An Aetna Company

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	High Deductible Plan
Calendar Year Deductible (CYD)		
In Network	$1,250	*$1,400
Out of Network	$2,500	*$2,800
Family Deductible Maximum	$2,500 In / $5,000 Out	$2,800 In / $5,600 Out
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
Family Maximum Out of Pocket	$8,000 In / $16,000 Out	$7,000 In / $14,000 Out
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**

***Aggregate** - The entire family deductible must be satisfied by one or a combination of family members. The family out of pocket maximum is also aggregate .

Payroll Deductions - (Monthly)	POS Plan	High Deductible Plan
Employee	$108.00	$0.00
Employee & Spouse	$722.00	$521.00
Employee & Child(ren)	$511.00	$376.00
Employee & Family	$919.00	$681.00

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. **Ask your doctor and pharmacy for samples and check to see if they have any discount coupons available.**

Publix Supermarket:
Publix Pharmacy offers 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

www.GoodRx.com
This website provides local cost comparisons and also links back to the manufacturers' websites for discounts & coupons. Download the free mobile app or use the card - good for the entire family including pets!

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

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??

WALK-IN CLINIC	URGENT CARE CENTER	EMERGENCY ROOM
Allergies	Cold, flu, or fever	Chest pain
Bladder infections	Strains, sprains, or breaks	Abdominal pain
Cold sores	Infections	Stroke
Ear infections	Mild burns	Severe head injury
Eye infections	Allergies	Major trauma
Immunizations	Diagnostic services (X-rays, lab tests)	Compound fractures
Sinus infections	Minor broken bones (e.g., toes, fingers)	Deep knife cuts or animal bites
Strep throat	Severe sore throat or cough	Moderate or severe burns
Colds	Skin rashes and infections	Poisoning or suspected poisoning
Head lice	Urinary tract infections	Seizures or loss of consciousness
Diabetes	Vomiting, diarrhea or dehydration	Serious head, neck or back injuries
Blood pressure management	Controlled bleeding, cuts that require stitches	Uncontrollable bleeding
LOWEST cost applies	**LOWER** cost applies	**HIGHER** cost applies

If you or your dependent is experiencing uncontrolled bleeding, overdose, chest pain, shortness of breath, head injury, blurry vision, major trauma, or similar life or limb threatening issues you should call 911 or have someone take you to the nearest emergency room.

Health Savings Account (HSA)

A Health Savings Account (HSA) works with a qualified health plan and allows you to pay for health care expenses not covered by insurance using pre-tax dollars. Your HSA is funded through payroll deductions on a pre-tax basis into a personal account. The funds carry over from year to year and remain yours even if you change employers.

The **HSA Plan** is a qualified HSA health plan. The IRS governs Health Savings Accounts and has established the following rules for who can open a HSA:

- You must enroll in a qualified HSA plan (High Deductible Health Plan)
- You cannot have any other "first dollar coverage" (i.e.: a spouse's copay plan)
- You are not a dependent on someone else's tax return
- You are not enrolled in Medicare
- Your spouse cannot participate in a Flexible Spending Account (FSA)

Diocese of St. Petersburg has partnered with Paylocity to administer the HSA. Paylocity will provide a debit card that allows you to pay for qualified medical expenses (deductibles, etc.) directly from your HSA account. Paylocity will automatically send a replacement card near the renewal date printed on your card.

2022 Contribution Limits:	Self Only Coverage	$3,650
	Family Coverage	$7,300

When planning your contribution, remember to include the employer contribution amount so the combined total does not exceed the limits stated above.

Participants age 55 and over and not on Medicare may contribute the maximum annual amount and add a $1,000 "catch up" contribution.

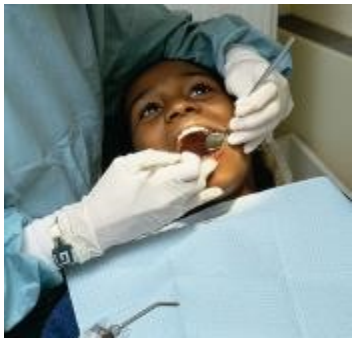
*Employees age 65 and over may not contribute to an HSA.

Employer Contribution
To help offset your High Deductible Health Plan out of pocket costs, Diocese of St. Petersburg will contribute towards your HSA of $350 to an individual or $700 to a family for 2022.

All employees enrolled in the HSA qualified medical plan must log in to Paylocity and set up their HSA account in order to receive the Diocese contribution, even if you are not going to make any contributions to the HSA.

Examples of Qualified Expenses

Deductibles	Bandages
Copayments	OTC meds
Dental Copays	Splints
Prescription Copays	Braces
Eyeglasses	Wheelchair
Contact Lenses	Crutches



HSA participants are responsible for annually reporting HSA contributions and distributions to the IRS as an attachment to their IRS Form 1040. If there is an audit of your tax return, to avoid a penalty, you will need to substantiate the expenses were qualified by producing receipts or an Explanation of Benefits (EOB).

HSA Frequently Asked Questions

How does an HSA work?

To be eligible to contribute to an HSA, you must be covered by a qualified high-deductible health plan (HDHP) and have no other first dollar coverage (insurance that provides payment for the full loss up to the insured amount with no deductibles).

You may use your HSA to help pay for medical expenses covered under a high-deductible health plan, as well as for other common qualified medical expenses.

Unused HSA funds remain in your account for future expenses and may be able to be invested in a choice of investment options, providing the opportunity for funds to grow. Check with your financial institution to see if this is an option for your account.

HSAs work in conjunction with an HDHP. The money you (or your employer) deposit into your HSA up to the maximum annual contribution limit is 100% tax-deductible from federal income tax, FICA (Social Security and Medicare) tax, and in most states, state income tax. This makes HSA dollars tax-free. You can use these tax-free dollars to pay for expenses not covered under your HDHP until you have met your deductible.

The insurance company pays covered medical expenses above your deductible, except for any coinsurance; you can pay coinsurance costs with tax-free money from your HSA. In addition, you can use your HSA tax-free dollars to pay for qualified medical expenses not covered by the HDHP, such as dental, vision, and alternative medicines.

Contributions

Tax-free contributions to your HSA can be made in a variety of ways, including:
1. Pre-tax payroll contributions, if available through your employer.
2. Online payment transfers — transfer funds directly to your HSA from your linked personal savings or checking account.
3. Rolling over or making a transfer from an existing IRA (Individual Retirement Account) to an HSA, but only once in your lifetime.

Distributions

Distributions from your HSA are used to pay for qualified medical expenses. This can be done by the following methods:
1. Paying for purchases and medical services using your Debit Card.
2. Using online bill pay through your online Paylocity HSA Employee Portal.
3. Requesting self-reimbursement through the online portal when you have already paid out-of-pocket for qualified expenses.

How It Works

Your Health Savings Account allows you to save pre-tax income that you can use to pay for qualified short and long-term medical expenses. It complements your High Deductible Health Plan, giving you an additional method to save specifically for healthcare costs.

Who can have an HSA?

You must be:
1. Covered by a qualified high deductible health insurance plan;
2. Not covered under other health insurance;
3. Not enrolled in Medicare; and
4. Must be a taxed dependent; and
5. Spouse cannot participate in a Flexible Spending Account

Exceptions: Other health insurance does not include coverage for the following: accidents, dental care, disability, long-term care, and vision care. Workers' compensation, specified disease, and fixed indemnity coverage is permitted.

How do HSAs differ from Health Care Flexible Spending Accounts (FSAs)?

Both HSAs and FSAs allow you to pay for qualified medical expenses with pre-tax dollars. One key difference, however, is that HSA balances can roll over from year to year, while FSA money left unspent at the end of the year is limited to a $500 carryover to the following plan year OR a grace period. Your spouse's employer may provide the option to enroll in a Limited Purpose FSA. You may choose to use a Limited Purpose FSA to pay for eligible dental and vision expenses and save your HSA dollars for future health care needs. You may use Limited Purpose FSA dollars to reimburse yourself for expenses not covered by your high deductible health plan, such as:

1. Vision expenses, including glasses, frames, contacts, prescription sunglasses, goggles, vision copayments, optometrists or ophthalmologist fees, and corrective eye surgery.

2. Dental expenses, including: Dental care, deductibles and copayments, braces, x-rays, fillings, and dentures.

Why is my employer offering an HSA in conjunctions with a qualified HDHP?

Offering an HSA is an excellent way to help you save for future medical expenses and pay for current expenses with tremendous tax advantages.

HSA Frequently Asked Questions

What are the tax advantages of owning an HSA?

Triple tax savings:
• Contributions are tax free.
• Earnings are tax free.
• Withdrawals are tax free when made for eligible medical care expenses.

Three kinds of tax-favored contributions:

• Employee contributions that are deductible over-the-line (i.e. deductible even by non-itemizers).
• Employer contributions that are excluded from income and employment taxes.
• Salary reduction contributions made through a section 125 cafeteria plan.

All three forms of contributions are exempt from federal income taxes. Employer and salary reduction contributions (Section 125 cafeteria plan) are exempt from FICA and FUTA as well.

May I have more than one HSA?

Yes, you may have more than one HSA and you may contribute to them all, if you are currently enrolled in an HDHP. However, this does not give you any additional tax advantages, as the total contributions to your accounts cannot exceed the annual maximum contribution limit. Contributions from your employer, family members, or any other person must be included in the total.

Can I get an HSA even if I have other insurance that pays medical bills?

You're only allowed to have medical, dental, vision, disability, and long-term care insurance at the same time as an HDHP. You may also have coverage for a specific disease or illness if it pays a specific dollar amount when the policy is triggered.

Can my HSA be used to pay premiums?

No, this would be a non-medical withdrawal, subject to taxes and penalty.

Exceptions. No penalty or taxes will apply if the money is withdrawn to pay premiums for:

1. Qualified long-term care insurance; or
2. Health insurance while you are receiving federal or state unemployment compensation; or
3. Continuation of coverage plans, like COBRA, required under any federal law; or
4. Certain Medicare premiums after age 65.

Can I use the money in my HSA to pay for medical care for a family member?

Generally, yes. Qualified medical expenses include unreimbursed medical expenses of the account holder, his or her spouse, or dependents.

What is a qualified medical expense?

A qualified medical expense is one for medical care as defined by Internal Revenue Code Section 213(d). The expenses must be primarily to alleviate or prevent a physical or mental defect or illness, including dental and vision. Most expenses for medical care will fall under IRC Section 213(d). HSA money cannot generally be used to pay your insurance premiums.

However, some expenses do not qualify. A few examples are:
• Surgery for purely cosmetic reasons
• Health club dues
• Illegal operations or treatment
• Maternity clothes
• Toothpaste, toiletries, and cosmetics
*See IRS Publications 502 ("Medical and Dental Expenses") and 969 ("Health Savings Accounts and Other Tax-Favored Health Plans") for more information.

What happens to my HSA if I quit my job or otherwise leave my employer?

Your HSA is portable. This means that you can take your HSA with you when you leave and continue to use the funds you have accumulated. Funds left in your account continue to grow tax-free. If you are covered by a qualified HDHP you can even continue to make tax-free contributions to your HSA.

Distributions from your HSA used exclusively to pay for qualified expenses for you, your spouse, or dependents are excluded from your gross income. Your HSA funds can be used for qualified expenses even if you are not currently eligible to make contributions to your HSA.

How and when can money be taken out of an HSA?

Account holders may make a withdrawal (also known as a distribution) at any time. Distributions received for qualified medical expenses not covered by the high deductible health plan are distributed tax-free. Distributions can be requested via your online account.

Unless individuals are disabled, age 65 or older, or die during the year, they must pay income taxes plus an additional percentage (determined by the IRS) on any amount not used for qualified medical expenses. Individuals who are disabled or reach age 65 can receive non-medical distributions without penalty but must report the distribution as taxable income

HSA Frequently Asked Questions

How are distributions from my HSA taxed after I am no longer eligible to contribute?

If you are no longer eligible to contribute because you are enrolled in Medicare benefits, or are no longer covered by a qualified HDHP, distributions used exclusively to pay for qualified medical expenses continue to be free from federal taxes and state tax (for most states) and excluded from your gross income.

What happens to the money in my HSA after I reach age 65?

At age 65 and older, your funds continue to be available without federal taxes or state tax (for most states) for qualified medical expenses; for instance, you may use your HSA to pay certain insurance premiums, such as Medicare Parts A and B, Medicare HMO, or your share of retiree medical coverage offered by a former employer. Funds cannot be used tax-free to purchase Medigap or Medicare supplemental policies.

If you use your funds for qualified medical expenses, the distributions from your account remain tax-free. If you use the monies for non-qualified expenses, the distribution becomes taxable, but exempt from the 20 percent penalty. With enrollment in Medicare, you are no longer eligible to contribute to your HSA. If you reach age 65 or become disabled, you may still contribute to your HSA if you have not enrolled in Medicare. Note that for some people, Medicare enrollment is automatic.

How do I make investments?

Please refer to the HSA Investment Options document for a listing of investments available to you along with their return rate. Via your investment portal, you may choose which mutual funds you wish to purchase and sell. You may use your investment portal to review your investments as well as update the percentage allocated to each mutual fund you have chosen.

Are You Eligible for a Health Savings Account?

Are you covered on a Qualified High Deductible Health Plan? (QHDHP)

- ☑ YES → **Have you been enrolled on Medicare, Tricare, VA or HIS non-Preventive Medical/Rx plan within the last 3 months?**
  - ☒ NO → **Are you claimed as a dependent on another person's tax return?**
    - ☒ NO → **Do you (OR YOUR SPOUSE) have a Flexible Spending Account (FSA)?**
      - ☒ NO → ☑ YES
      - ☑ YES → **Is it a Limited Purpose FSA?**
        - ☑ YES → ☒ NO
        - ☒ NO
    - ☑ YES
  - ☑ YES
- ☒ NO

SORRY!
Unfortunately, you are not eligible for a Health Savings Account.

An HSA is a tax benefit that is heavily regulated by the IRS. There are certain requirements to be considered qualified to contribute pre-tax dollars.

You are still eligible to participate in the QHDHP, but you are not eligible to fund a HSA to pay for out-of-pocket expenses.

CONGRATULATIONS!
You are eligible to make pre-tax contributions into a Health Savings Account!

Flexible Spending Account

Flexible Spending Accounts are a great way to help you save money on certain Health Care and Dependent Care costs. A portion of your pay can be set aside pre-tax to save on medical, prescriptions, dental, vision and daycare expenses.

There are three types of FSA accounts:

Health Care FSA - this account is used to pay for eligible out of pocket medical expenses not covered by insurance.

Dependent Care FSA - this is used to pay for eligible child or elder care expenses including daycare, before and after school care and summer day camp.

How do I use my FSA?

When you enroll in the Healthcare FSA you will automatically receive a spending account card. The card is used like a credit card to pay for eligible health care purchases. The funds are automatically deducted from your FSA account. This helps to reduce the number of reimbursement claims to file and gives you immediate access to your funds. Dependent Care expenses must be submitted with the appropriate receipts or documentation for reimbursement.

What happens to the funds if I don't use them?

Because FSAs have tax benefits, the IRS places guidelines on them. An Account Balance up to $550 may be rolled over into the next plan year but beware that any amount over the $550 rollover threshold will be forfeited. It's important to plan carefully when determining how much you want to contribute.

How do I enroll?

By electing the FSA during your annual open enrollment period. Once you have determined your annual FSA election, your employer deducts the amount from your pay on a pre-tax basis throughout the year.

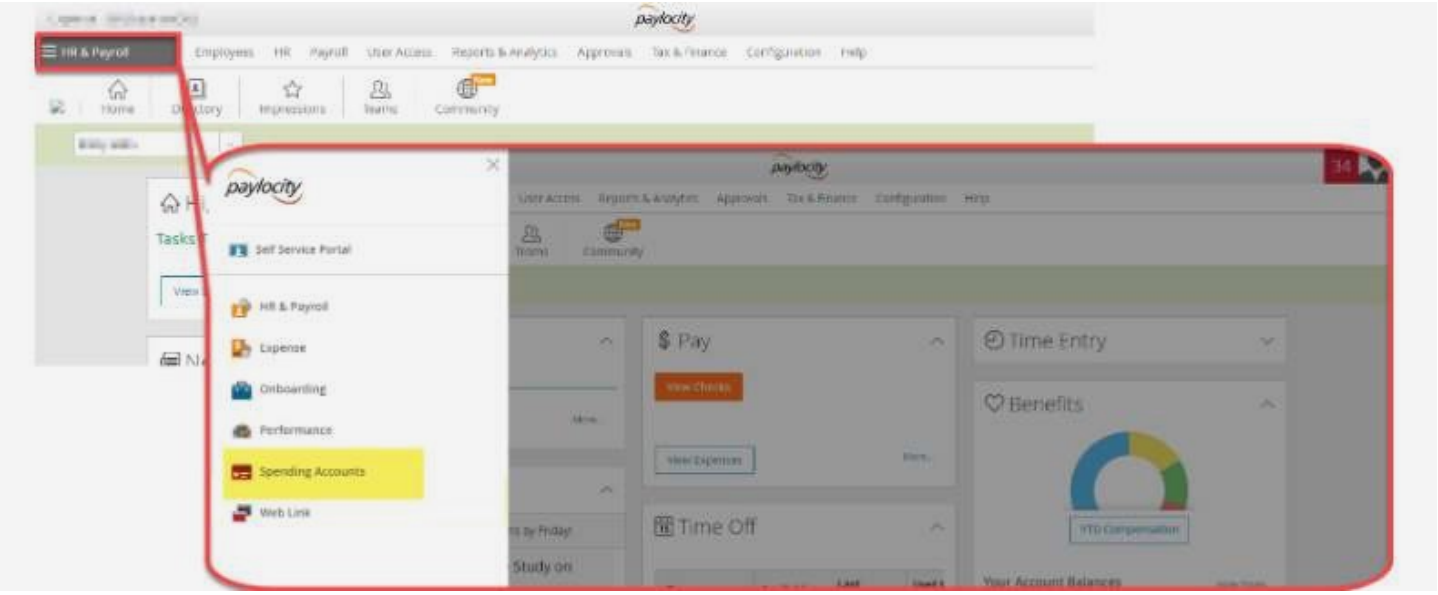
Can I participate in the FSA if I am enrolled in the High Deductible Health Plan and in the HSA?

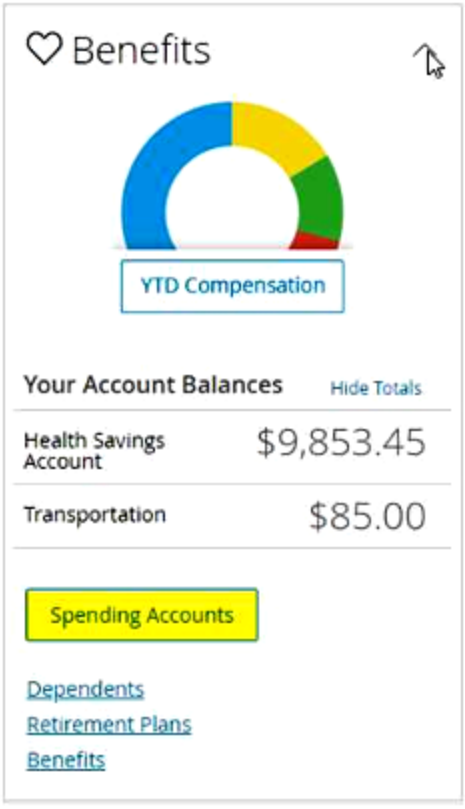
Yes, you can still elect to participate in the FSA, however you must enroll in the **Limited Purpose FSA**, which means that funds can only be used to cover qualified dental and vision expenses.

2022 Maximum Annual Election	
Health Care FSA	$2,750
Dependent Care FSA	$5,000

Access Spending Accounts via Self Service Portal

1. Navigate to the Self-Service Portal
2. Review the **Benefits** tile for account and balance information.
3. Select **Spending Accounts** to display **Overview** tab of Your **Spending Accounts**. Or navigate to **Spending Accounts** from the main menu.





Precertification

Key To Your Good Health

You can help make sure you and your family obtain 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 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.

For assistance in obtaining the pre-certification please contact PMA at 727-308-2854

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
An Aetna Company

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.

ADVOCATES FOR HEALTHIER LIVING

Healthcare Bluebook

Save on Healthcare Costs and Earn Valuable Incentives!

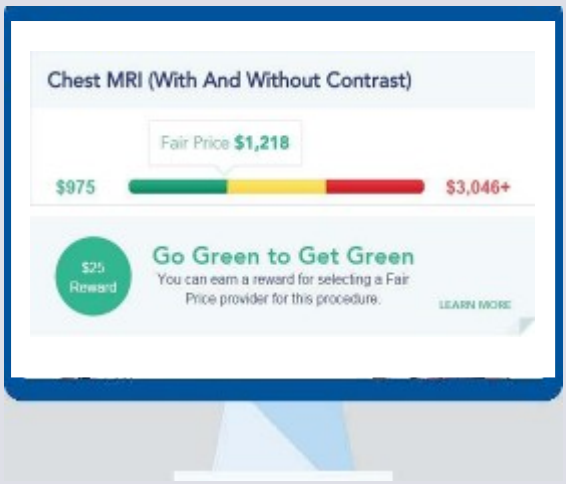
How Healthcare Bluebook™ can help

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:

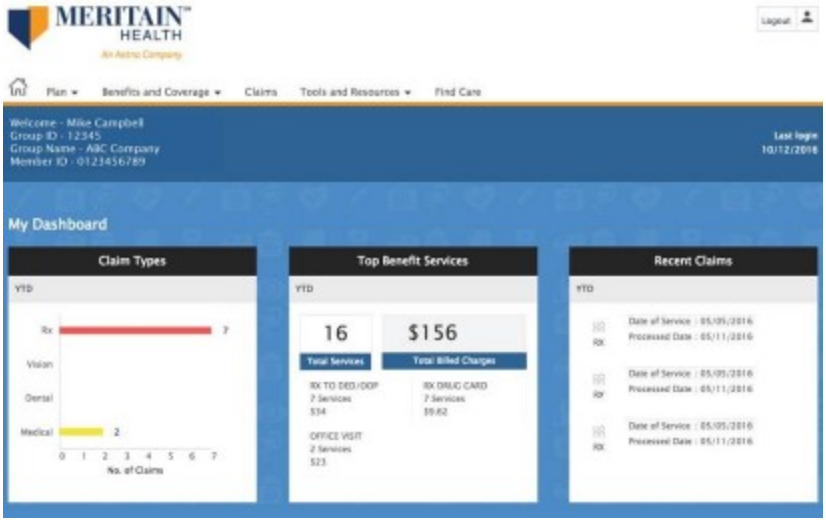
Procedure	Incentive	Procedure	Incentive
Most CT Scans	$25	Lithotripsy	$50
Most MRIs	$25	Removal of adenoids	$50
Transthoracic Echocardigram (TTE)	$25	Sleep Study	$50
TTE with doppler	$25	Tonsillectomy	$50
Cataract Surgery	$50	Colonoscopies	$100
Cholecystectomy (laparoscopic)	$50	Knee arthroscopy	$100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

Healthcare Bluebook

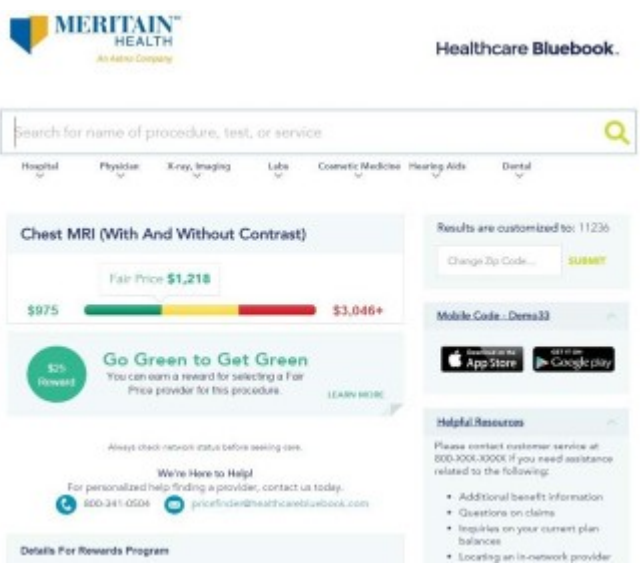
How to locate providers using Healthcare Bluebook:

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:

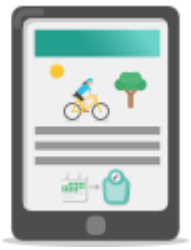
Real Appeal is available to our members at no additional cost. Our approach is based on decades of clinical weight loss research focused on simple steps combined with personalized tools and support.

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	
Family Limit	Up to $375	
Annual Maximum		
Per Person / Family	$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	
Late Entrant Wait Period		
Basic Services	6 Months	
Major Services	12 Months	

Late Entrant Wait Period: a late entrant is someone who previously declined dental coverage and enrolls at a future open enrollment. Late Entrants must wait 6 months to receive Basic Services and 12 months to receive Major Services under the plan.

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

Dental Payroll Deductions - (Monthly)	
Employee	$41.50
Employee & Spouse	$68.14
Employee & Child(ren)	$59.21
Employee & Family	$75.35

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

Guardian

Vision Payroll Deductions - (Monthly)	
Employee	$9.81
Employee & Spouse	$16.10
Employee & Child(ren)	$13.49
Employee & Family	$17.78

Life and Disability - The Hartford

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 and AD&D Insurance
You can purchase supplemental life and AD&D insurance through payroll deductions for yourself and your dependents through The 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.

Guarantee Issue: $100,000

Spousal Life Insurance - The employee can choose 50% of Employee's Optional Life amounts in increments of $1,000. Spouse optional life coverage may not exceed 50% of the employee's coverage.

Guarantee Issue: $50,000

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).

During the **2022 open enrollment,** all employees may enroll or increase their current amount up to the Guarantee Issue amount without completing an Evidence of Insurability form.

Voluntary Offerings

24-Hour Group Voluntary Accident – H.S.A. HDHP Compatible

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 or fracture, initial hospital confinement, hospital confinement, intensive care, ambulance service, medical expenses and Outpatient Physician's Treatment.

Employee	$14.52
Employee & Spouse	$26.88
Employee & Child(ren)	$24.60
Employee & Family	$36.96

Group Whole Life Insurance

Group Whole Life insurance gives you simplified and straightforward coverage for your final expenses. With a variety of additional riders available, this coverage can help ease your concerns about the cost of care due to possible future chronic illnesses. As the policy builds value, you can achieve your financial goals or borrow against the policy if the need arises. With Group Whole Life insurance from Allstate Benefits, you can secure protection for the future while building peace of mind right now. Please be sure to review your certificate/brochure when received to learn all of your benefits and options.

Group Voluntary Critical Illness with Cancer – H.S.A. HDHP Compatible

Group Voluntary Critical Illness coverage helps offer financial support with a 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 State Renal Failure, Alzheimer's Disease and Cancer.

$10,000 Benefit	Non-Tobacco	Tobacco
Employee	$34.60	$59.67
Employee & Spouse	$51.48	$88.62
Employee & Child(ren)	$35.15	$60.21
Employee & Family	$52.04	$89.13
$20,000 Benefit	**Non-Tobacco**	**Tobacco**
Employee	$67.20	$117.35
Employee & Spouse	$99.71	$173.98
Employee & Child(ren)	$68.29	$118.43
Employee & Family	$100.83	$175.02

Group Hospital Indemnity Benefit

Unexpected hospital visits lead to unexpected expenses. Statistics show that most people aren't prepared to handle the financial burden that comes with such expenses. Group Hospital Indemnity insurance can help cover some of the 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 product is HSA-compatible, so it works well with high deductible health plans (HDHP) and traditional major medical plans to close gaps in coverage. This plan has no waiting period for pregnancy or pre-existing conditions.

Refer to the plan document for additional details.

HSA & HDHP Compatible Plans	Option 1	Option 2
Employee	$17.16	$34.32
Employee & Spouse	$48.10	$96.20
Employee & Child(ren)	$19.89	$39.91
Employee & Family	$50.57	$101.01
POS Compatible Plans	**Option 3**	**Option 4**
Employee	$31.59	$39.26
Employee & Spouse	$69.03	$89.83
Employee & Child(ren)	$54.60	$67.86
Employee & Family	$78.26	$100.62

Group Hospital Indemnity Benefit	Option 1	Option 2	Option 3	Option 4
1st Day Hospital Confinement Benefit - One Per Year	$1,000	$2,000	$500	$1,000
Daily Confinement Benefit - 10 days maximum	$100	$200	$50	$100
Intensive Care Benefit - 10 days maximum	$100	$200	$50	$100

Legal and ID Theft

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 committed a crime, got a job, opened an account or used medical benefits in YOUR name?

What is LegalShield?

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 at home)

- **Legal Advice** – unlimited issues include 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 T**rusts**
- **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 Shield℠ 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.**

- **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	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

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 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.

- Benefits through **Allstate** Insurance - Group Critical Illness, Accident Insurance, Indemnity Medical

TicketsatWork.com
Fun. With benefits.

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 Administrator.

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.

Helping you make Moves

You're just a few steps away from MassMutual's RetireSmart website, where you can:

- Access information about your retirement account.
- Raise your financial awareness with our online tools and educational articles.
- View messages related to your plan, and much more!

To get started, log in to **www.retiresmart.com** and click **Create Account**, located in the upper right corner. Follow the instructions and answer a few validation questions, then you can create your username, password and PIN.

Access the RetireSmart website review and update your beneficiary information.

If you need assistance, contact our Participant Information Center at **1-800-743-5274** Monday – Friday between 8 a.m. and 8 p.m. ET. .

Diocese of St Petersburg Pension Plan

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

http://www.grs-plan.com/

Gabriel Roeder Smith

954-527-1616

Access the GRS plan website review and update your beneficiary information.

	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	(855) 524-0381 (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
Health Savings Account (HSA) **Flexible Spending Account (FSA)**	Paylocity	(800) 631-3539	www.paylocity.com
Voluntary Term Life Insurance **Short and Long Term Disability**	Hartford	(888) 563-1124 (800) 549-6514	www.hartford.com
Employee Assistance Program (EAP)	Hartford Guidance Resources	(800) 327-1850	www.guidanceresources.com Organization: HLF902
Accident **Critical Illness** **Group Indemnity Medical** **Whole Life**	Allstate	(800) 521-3535	www.allstatebenefits.com
Legal and ID Theft	Legal Shield	(800) 654-7757	www.legalshield.com
Pension Plan	Gabriel Roeder Smith	(954) 527-1616	www.grs-plan.com/
401(k)	Retiresmart Chris Chiaro John Benitoa (UBS) Ryan Brannon (UBS)	(800) 743-5274 (941) 953-7452 (813) 903-6694 (813) 903-6690	www.Retiresmart.com cchiaro@kbgrp.com John.benitoa@ubs.com Ryan.brannon@ubs.com

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, 2022
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 July 31, 2021. Contact your State

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/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
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 July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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