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Employee Benefits and Enrollment Guide 2024

Inside the Guide

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 – 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. 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. 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.

Two Ways To Enroll

We have two options for you to enroll in your benefit plan. Guided Enrollment, or Self Service. We strongly encourage you to take advantage of our guided enrollment option, which provides you with free access to a personal enrollment counselor to review your plans, costs, and assist with entering the information in Paylocity,

OPTION 1: GUIDED ENROLLMENT RECOMMENDED OPTION

Our recommended method for your enrollment is for you to set an appointment with a dedicated specialist at Enrollment Alliance.

You set a time that works for you during the day, in the evening or on Saturday.

Your Enrollment Alliance Specialist will review your options and enter your selections for you in Paylocity—No need for you to remember your user name and password!

Click the QR code to the right to set your appointment.

OPTION 2: SELF SERVICE ENROLLMENT

If you prefer to enroll on your own, you will do so at www.Paylocity.com.

- Sign in using your company ID (12xxx)
- Enter 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 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

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 www.paylocity.com

If you need your login or password reset, please contact the payroll administrator at your location.

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 - Regenexx & Optum

Regenexx

WHAT IS REGENEXX?

Regenexx is an innovative treatment for orthopedic injuries that enhances your body's natural healing processes. To treat damaged tendons, ligaments, muscle, bone, and cartilage, our physicians draw your blood platelets and bone marrow aspirate and process them in our advanced orthobiologics laboratories. We then inject them precisely at the site of your injury using image guidance. Regenexx procedures provide a lower-risk, lower-cost, minimally invasive alternative for up to 70 percent of elective orthopedic surgeries.

Regenexx is covered as an in-network benefit
within the Diocese of St. Petersburg health plans.

Under the POS and HDHP plans, the patient is responsible for 30% after meeting the deductible.

LEARN MORE
To find out more about your Regenexx benefit and whether Regenexx is an option for you, contact their education center.
To register for one of their weekly webinars, visit regenexxbenefits.com/webinar?mailer
Call them today at **727-361-9626** or visit regenexxbenefits.com/dosp to learn more.

Optum Rx®

The Optum Rx website and app are fast, easy and secure ways to get the information you need to make the most of your pharmacy benefit. Register for an online account and you can:

- Check drug prices
- Place a home delivery order
- Track home delivery order status
- Access and print your ID card

Register now

To set up your online account:
1.Go to OptumRx.com
2.Select Register on the home page
3.Enter the information from your member ID card
4.Create a username and password
5.Complete your profile
If you already have an account, sign in using your username and password.

Medical - Meritain Health

	POS Plan	High Deductible Plan
Calendar Year Deductible (CYD)		
In Network (Individual / Family)	$1,500 / $3,000	*$1,600 / $3,200
Out of Network (Individual / Family)	$2,500 / $5,000	*$3,200 / $6,400
Employee Coinsurance (Coins)		
In Network	30%	30%
Out of Network	60%	60%
Maximum Out of Pocket		
In Network (Individual / Family)	$4,000 / $8,000	*$4,000 / $8,000
Out of Network (Individual / Family)	$8,000 / $16,000	*$8,000 / $16,000
Physician Charges		
Physician Office Copay - In Network	$40 Copay	30% After Deductible
Specialist Office Copay - In Network	$90 Copay	30% After Deductible
Physician Office - Out of Network	60% After Deductible	60% After Deductible
Inpatient Hospital (per Admission)		
In Network	$300 Copay + Deductible + 30%	30% After Deductible
Out of Network	60% After Deductible	30% After Deductible
Other Services-In Network		
Preferred Freestanding Lab / Xray	$0 Copay	30% After Deductible
Complex Radiology ***Precertification is required**	30% After Deductible	30% After Deductible
Urgent Care	$100 Copay	30% After Deductible
Outpatient Surgery	30% After Deductible	30% After Deductible
Emergency Room	30% After Deductible + $300 Copay	30% After Deductible
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	30% After Deductible
Specialty Drugs	30% up to $350 per month	30% After Deductible $350 cap applies after deductible is met
Mail Order- 90 day supply	$20 / $120 / $240; Specialty: N/A	30% After Deductible Specialty: N/A
Provider Network	**Choice POS II**	**Choice POS II**

***Aggregate** - For employees covering family members, the entire family deductible and out-of-pocket maximum apply to the family as one "unit". It may be satisfied by one family member or a combination of family members.

Employee Payroll Deductions - (Monthly)	POS Plan	High Deductible Plan
Employee	$111.00	$0.00
Employee & Spouse	$744.00	$521.00
Employee & Child(ren)	$526.00	$376.00
Employee & Family	$947.00	$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 stagmedical es 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.**

Supermarket Savings:

www.publix.com
www.winndixie.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!

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.

Telemedicine - My Catholic Doctor

MyCatholicDoctor is a NEW telehealth/virtual care organization that brings a team of faithful medical professionals to patients through video-based health consultation on almost any smartphone, computer or tablet. MyCatholicDoctor practices evidence-based scientific medicine and also integrates Catholic spirituality into their healthcare as appropriate to the situation and their abilities.

MyCatholicDoctor is continually recruiting physicians and other healthcare professionals that desire to integrate the Catholic faith into their practice.

Why Choose MyCatholicDoctor?

- Direct access to compassionate and faithful healthcare providers using your smartphone or computer
- Providers who integrate Catholic spirituality into your care as needed
- Labs and tests ordered and scheduled locally
- Your prescriptions sent electronically to your local pharmacy
- Visits are convenient, private, and secure
- Avoid the high costs and inconvenience of urgent care centers and emergency rooms. We accept most insurance plans and healthshares.

List of Services*

- Telehealth Platform
- Rapid Access Urgent Telehealth**
- Virtual Primary Care
- $0 Copay on POS and HDHP plans
- Specialty Consultation
- Natural Family Planning / Fertility Awareness Education
- Puberty Education for Adolescents and Parents
- Mental Health Care
- Non-local Coverage
- Laboratory Services

*POS - Copays, Deductible and Coinsurance apply
HDHP - Deductible and Coinsurance apply

Visit mycatholicdoctor.com to get seen immediately by a clinician through a virtual telehealth visit, browse a full list of medical professionals in your state, schedule an appointment, or learn more about MyCatholicDoctor.

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 High Deductible Health Plan offered by the Diocese of St. Petersburg is a qualified 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.

2024 Contribution Limits:	Self Only Coverage	$4,150
	Family Coverage	$8,300

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 over age 65 who are participating in Medicare Part A or B may not have an HSA bank account

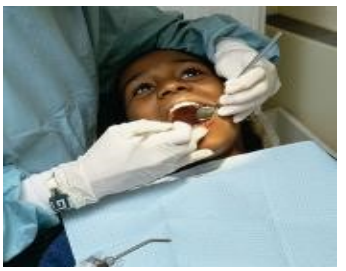
Employer Contribution
To help offset your High Deductible Health Plan out of pocket costs, the Diocese of St. Petersburg will contribute towards your HSA on the following schedule:

New Hire Date	Employee Only	Employee & Dependents
Jan 1 - June 30	$650	$1,300
July 1 - Dec 31	$325	$650

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?
HSAs work in conjunction with an HDHP. The money you 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
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.

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.

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.

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.

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.

What are the tax advantages of owning an HSA?
Triple tax savings:
• Contributions and earnings are tax free.
• Withdrawals are tax free when made for eligible medical care expenses.

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.

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.

HSA Frequently Asked Questions

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.

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

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.

Are You Eligible for a Health Savings Account?

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

YES → **Have you been enrolled in Medicare, Tricare, VA or HIS non-Preventive Medical/Rx plan within the last 3 months?**

NO → **Have you been enrolled in 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 → **Is it a Limited Purpose FSA?**

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

NO → **Is it a Limited Purpose FSA?**

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.

YES → 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.

YES → **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.

NO → **CONGRATULATIONS!**
You are eligible to make pre-tax contributions into a Health Savings Account!

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YES → **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.

Why choose the HSA?

To assist you with determining if an HSA is right for you, we have put together some illustrations that compare the financial implications of various healthcare scenarios. Note that these are for illustrative purposes only, and not a guarantee of expense.

Employee 1: Single Coverage - Low Utilizer	HDHP Participant	POS Participant	Notes
PCP Office Visit - Annual Physical	$0.00	$0.00	Never a charge for physicals
PCP Office Visit - 2 Sick Visits Per Year	$150.00	$80.00	Assumes contracted rate of $75
Generic Monthly Prescription - Atrovastatin	$105.00	$120.00	HDHP plan cost based on GoodRx
Annual Premium (Payroll Deduction)	$0.00	$1,332.00	
Annual HSA deposit from the DOSP	$650.00	$0.00	
Total Annual Spend	-$395.00	$1,532.00	

Employee 2: ES Coverage - Moderate Utilizers	HDHP Participant	POS Participant	Notes
PCP Office Visit - Annual Physical	$0.00	$0.00	Never a charge for physicals
PCP Office Visit - 2 Sick Visits Per Year	$150.00	$80.00	Assumes contracted rate of $75
X-Ray	$200.00	$0.00	Assumes contracted rate of $200
MRI - neck with contrast	$600.00	$600.00	Assumes contracted rate of $600
Generic Monthly Prescription - Nadolol	$204.00	$120.00	HDHP plan cost based on GoodRx
Generic Monthly Prescription - Atrovastatin	$105.00	$120.00	HDHP plan cost based on GoodRx
Annual Premium (Payroll Deduction)	$6,252.00	$8,928.00	
Annual HSA deposit from the DOSP	$1,300.00	$0.00	
Total Annual Spend	$6,211.00	$9,848.00	

Employee 3: FAM Coverage - Spouse Has Hospital Stay	HDHP Participant	POS Participant	Notes
Spouse Hospital Stay ($50,000)	$7,000.00	$4,000.00	Spouse's Out of Pocket Max
PCP Office Visit - Annual Physical x 4	$0.00	$0.00	Never a charge for physicals
PCP Office Visit - 6 Sick Visits Per Year (2 for spouse)	$0.00	$160.00	No cost for HDHP as family max out of pocket has been met.
X-Ray (Est $200) for Child	$0.00	$0.00	No cost for HDHP as family max out of pocket has been met.
MRI (Est $600) for Spouse	$0.00	$0.00	No cost for HDHP as family max out of pocket has been met.
Generic Monthly Prescription - Nadolol (for EE)	$0.00	$120.00	No cost for HDHP as family max out of pocket has been met.
Generic Monthly Prescription - Atrovastatin (for Spouse)	$0.00	$120.00	No cost for HDHP as family max out of pocket has been met.
Specialty Medication for Child / Humira ($6,000 per month)	$0.00	$3,600.00	Capped based on family max out of pocket
Annual Premium (Payroll Deduction)	$8,172.00	$11,364.00	
Annual HSA deposit from the DOSP	$1,300.00	$0.00	
Total Annual Spend	$6,872.00	$15,364.00	

Flexible Spending Account

Flexible Spending Accounts are a great way to help you save money on certain HealthCare 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 two types of FSA accounts:

HealthCare 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 healthcare 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 $640 may be rolled over into the next plan year but beware that any amount over the 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.

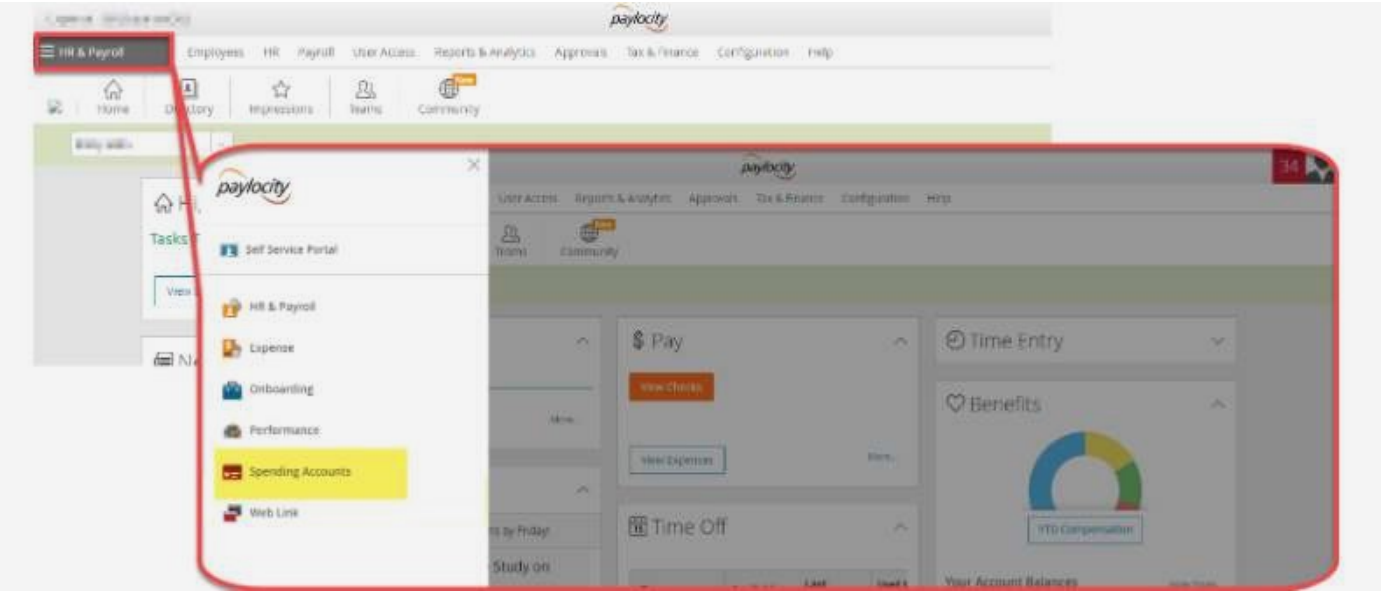
Can I participate in the FSA if I am enrolled in the High Deductible Health Plan and in the HSA?

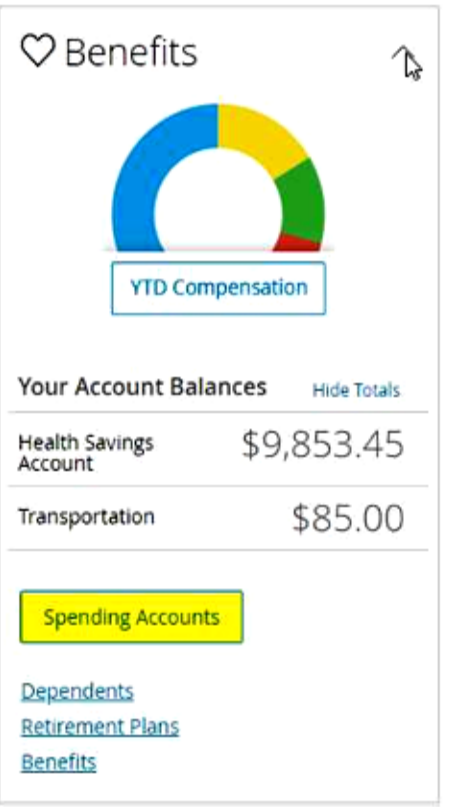
No, if you have an HSA, you may not also have an FSA

2024 Maximum Annual Election	
Health Care FSA	$3,200
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. Quantum 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.

Quantum HEALTH

Download the Mobile App and have access to your medical benefits and Care Coordinator at your fingertips!

- **Schedule a call**
- **Live Chat**
- **Contact Your Care Coordinators**
- **Health Coaching**
- **Much More!**

MYDOSPBenefits.com 844-460-2787
Mon-Fri 8:30am - 10pm EST

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 Quantum 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.

Healthcare Bluebook

Healthcare Bluebook Reward Details
Go Green to Get Green

How do I know if I am eligible to participate in the Go Green to Get Green rewards program?
If you are a current employee with active health insurance coverage at the time of the rewardable healthcare service, then you and your covered dependents are eligible to participate in the Go Green to Get Green rewards program.

How do I qualify for a reward?
Qualifying for a reward is an easy two-step process.

1. Use Healthcare Bluebook to shop for your healthcare service on or before the day of the service. You can shop with Healthcare Bluebook any of the following ways:
   - Login and search the Healthcare Bluebook website
   - Login and search the Healthcare Bluebook mobile app
   - Call Healthcare Bluebook member services at 800-341-0504
   - Contact Healthcare Bluebook member services by logging in and selecting contact us
2. Use a Fair Price™ (green-rated) facility, specifically:
   - For reward-eligible outpatient services, use a facility with a green price ranking to qualify for the reward.
   - For reward-eligible inpatient services, use a facility with a green quality ranking and a green price ranking to qualify for the maximum reward amount. Alternatively, use a facility with a green quality ranking and a yellow price ranking to qualify for a lesser reward amount.

It's that simple!

How can my family members qualify for a reward?
You, the enrollee, can use Healthcare Bluebook to shop for medical services for your covered dependents. If they use a Fair Price™ (green-rated) facility, then the reward will be issued to you.
If your covered dependents have access to Healthcare Bluebook, they can shop for you and each other as well. However, the reward is always issued to you, the enrollee.

Do I have to shop separately for multiple services? No. You can shop for multiple services at the same time. For example, if you view an MRI and a shoulder surgery during one visit to the Healthcare Bluebook website, you get shopping credit for each. Then, if you use a Fair Price™ (green- rated) facility for both of those services, you will get a reward for each.

Can I receive a reward regardless of when I shop?
No. You must use Healthcare Bluebook within 12 months prior to receiving your service, even as late as the same day of the service. However, if you use Healthcare Bluebook and then delay a service more than a year, be sure to use Healthcare Bluebook again before receiving that service.

What if my service is already scheduled at a Fair Price™ (green-rated) facility?
That's great news! Now all you need to do is use Healthcare Bluebook before receiving that service to qualify for a reward.

Is my health information kept private?
Yes. Healthcare Bluebook does not share information about healthcare services received by you, the enrollee, or your dependents with your employer. All healthcare information is kept confidential.

About the Go Green to Get Green rewards program:
- Rewards will be processed on a monthly basis. Rewards may be delayed due to the time it takes for claims to be billed and processed.
- Rewards are mailed to your home address and will be addressed to the employee, regardless of which family member receives care.
- Rewards are accompanied by a letter of explanation.
- You may receive multiple rewards for procedures rendered on the same day. For example, sometimes a patient may need a knee MRI and a hip MRI on the same day. In this case, the patient would receive a separate reward for using a high value provider for both of the services.
- Your employer reserves the right to modify or discontinue the rewards program at any time.

Healthcare Bluebook

1 ACCESS HEALTHCARE BLUEBOOK

On your PC, laptop and tablet:
meritain.com

On your mobile phone: Download the app.

Mobile Code: MERITAIN

2 SEARCH IN BLUEBOOK BEFORE SCHEDULING

You must search for your procedure using Healthcare Bluebook on or up to 12-months prior to date of service and use a **Fair Price™** facility for your procedure to qualify.
Always check network status before scheduling.

3 QUALIFY FOR A REWARD!!!

1. Prior to scheduling, shop for your procedure using **Healthcare Bluebook**
2. Use a **Fair Price™** facility of your choice
3. Earn up to a **$1,500** reward on eligible procedures

No forms or extra steps required. It's automatic!

Dependents also eligible for rewards. Please allow 60-90 days for processing. Active engagement is required to get rewards.

Up to a $1,500 Reward per procedure

List of Common Reward Procedures

See the full list at healthcarebluebook.com/cc/MERITAINDOSP/rewards

MRI's - $100
CT's - $100
Colonoscopy - $150
OP Knee Surgery - $350
OP Shoulder Surgery - $350
Sleep Study - $125
Cataract Surgery - $150
Joint Replacements - $1000 Spinal Fusions - $1500
Ultrasounds - $35
Upper GI Endoscopy - $150

Check It Out!

meritain.com

800-341-0504

Download the App: App Store | Google play Mobile Code: MERITAIN

Healthcare Bluebook.

Care Management

When you don't know where to begin, start with your Quantum Health Care Coordinator.

Q: Can someone explain my medical bill?
A: Your Quantum Health Care Coordinators are experts at explaining your employer's health plans and helping you understand even the most complex medical bills.

Q: How do I replace my medical ID card?
A: Just give your Care Coordinators a call or visit your member website: gettelbenefits.com to request a new one and we will get a replacement in the mail to you right away. You can also request a replacement and download one to your phone with the Quantum Health - Care Coordinators mobile app.

Q: Is my doctor in the network?
A: A great way to avoid surprise fees is to verify that your doctor is in your plan's network prior to your appointment. We can help you find out with just a tap, click, or call via your mobile app, member portal, or toll-free Care Coordinator phone number.

Q: What if I have questions about my treatment plan??
A: It is ok to have questions about your diagnosis or treatment plan. Get help and guidance from a Quantum Health Nurse Care Coordinator whenever you are uncertain about your care.

Q: Can anyone help me manage my chronic condition?
A: We'll work with you and your doctor to manage your chronic condition. Contact us for help with your prescriptions, referrals, insurance eligibility, and claims as well as useful resources for nutrition, exercise, and more.

Q: How do I know if my MRI or other test is covered?
A: Many procedures and services require pre-certification to verify coverage. Contact your Care Coordinator to ensure in network coverage from your health plan prior to your appointment.

Q: How can I save on prescriptions?
A: We can help you find lower prices on your prescriptions by investigating alternatives, utilizing savings programs, and engaging our in-house pharmacy team, if necessary.

Download the Mobile App and have access to your medical benefits and Care Coordinator at your fingertips!

- **Schedule a call**
- **Live Chat**
- **Contact Your Care Coordinators**
- **Health Coaching**
- **Much More!**

MYDOSPBenefits.com 844-460-2787

Mon-Fri 8:30am - 10pm EST

Download on the App Store

GET IT ON Google Play

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 (Member Responsibility) Exams Cleanings X-Rays	0% No Deductible 2x Per 12 Months	
Basic Services (Member Responsibility) Fillings Root Canals Periodontics Extractions	20% After Deductible	
Major Services (Member Responsibility) Crowns Bridges Implants Dentures	20% After Deductible	
Orthodontia		
Benefit Percentage	Not Covered	
Late Entrant Wait Period		
Basic Services	6 Months	
Major Services	12 Months	

*Out of Network dentists may balance bill for charges over reasonable & customary.

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	$0.00
Employee & Spouse	$29.94
Employee & Child(ren)	$19.90
Employee & Family	$38.04

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		
Frames	$130 allowance after $25 copay	Up to $70
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
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	$0.00
Employee & Spouse	$6.59
Employee & Child(ren)	$3.85
Employee & Family	$8.35

Life and Disability - Guardian

Basic Life Insurance and Accidental Death and Dismemberment

1 times (1x) your annual salary up to $150,000

Additional coverage available.
Age Reduction: 35% by age 70

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 15 for qualified disability. Maximum benefit period is 11 weeks.

Long-Term Disability Plan

Provides income replacement of 60% up to $5,000 per month. Benefits for qualified disability begin after 90 days, or the end of the STD maximum benefits period, whichever is later. Coverage continues until Social Security Normal Retirement age. Preexisting condition limitations apply.

Voluntary Supplemental Life and AD&D Insurance

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

Spouse premium is based on the employee's age.

Life Insurance - The employee can choose an amount between $10,000 and $500,000 in increments of $10,000.

Guarantee Issue: $100,000

Spousal Life Insurance - The employee can choose Spouse Supplemental Life amounts in increments of $1,000 up to $50,000. Spouse life coverage may not exceed 50% of the employee's coverage. Spouse coverage terminates at spouse age 70.

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 26 years if a full-time student). The benefit from birth to 14 day is $500. The premium covers all eligible children.

Guardian

Important Note For Employees Who Purchase Supplemental Life

During this open enrollment, all employees who are currently enrolled may purchase or increase their coverage to the guarantee issue amount without answering medical questions on the Evidence of Insurability (EOI) form.

- **Employees that are currently enrolled can increase their Voluntary Life amount by 50k or up to the guarantee issue amount of 100k without EOI. EOI is needed for any amount if enrolling as a late entrant.**
- **Spouses require EOI for any increase and if enrolling as a late entrant.**
- **EOI not required for children.**

Complete EOIs online by going to www.guardiananytime.com/eoi.
You will need to enter your group number: 561322

Voluntary Offerings - Worksite - Guardian

Worksite - Guardian

Group Voluntary Accident – H.S.A. HDHP Compatible

Group Voluntary Accident Insurance pays benefits for 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.

Though the benefit amounts differ, these plans provide direct payment to you when unexpected accidents occur for things like burns, lacerations, fractures, dislocations, hospital confinements, ambulance services and more. The plan also provides an accidental death benefit.

Monthly Deductions	Low Plan	High Plan
Employee Only	$ 9.93	$13.26
Employee + Spouse	$16.64	$22.00
Employee + Child(ren)	$17.51	$22.70
Employee + Family	$24.22	$31.44

Group Hospital Indemnity Benefit - H.S.A. HDHP Compatible

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.

Monthly Deductions	Plan 1	Plan 2
Employee Only	$ 8.99	$17.55
Employee + Spouse	$16.81	$32.82
Employee + Child(ren)	$13.78	$26.91
Employee + Family	$21.60	$42.18

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 such as Heart Attack, Stroke, Heart Transplant, Coronary Artery Bypass Surgery, Major Organ Transplant, Paralysis, End State Renal Failure, Alzheimer's Disease and Cancer.

Employee may choose a lump sum benefit of $10,000, $20,000, or $30,000. Employee can elect coverage for their spouse for a lump sum benefit of $10,000, $20,000, or $30,000, not to exceed employee's lump sum benefit. Employee can elect coverage for their child (to age 26) for 50% of the employee's lump sum benefit. Example, if employee elects $20,000 to cover him/her self and would also like to cover their child. The child would have a $10,000 lump sum benefit.

Premiums are for Issue Age and will not increase due to an insured aging. The cost per employee and spouse is based on the employee's age. The cost for child(ren) is included with the employee rate. Monthly deductions:

Benefit Amount		<30	30-39	40-49	50-59	60-69	70+
Non-Tobacco	$10,000	$3.50	$5.80	$10.60	$18.80	$27.80	$49.90
	$20,000	$7.00	$11.60	$21.20	$37.60	$55.60	$99.80
	$30,000	$10.50	$17.40	$31.80	$56.40	$83.40	$149.70
Tobacco	$10,000	$4.20	$7.60	$16.20	$33.70	$54.90	$92.40
	$20,000	$8.40	$15.20	$32.40	$67.40	$109.80	$184.80
	$30,000	$12.60	$22.80	$48.60	$101.10	$164.70	$277.20

Benefits reduce to 50% at age 70

Voluntary Offerings - Legal and ID Theft

NewBenefits - Legal Bundle

Legal Services

- Attorneys help with traffic tickets, bankruptcy, divorce, and spousal and child support
- Free services include one-on-one consultations. Attorney-made phone calls, help with legal documents, assistance with welfare and INS, representation in small claims court, and a Simple and Living Will
- Attorneys only charge $125 and hour or 40% off their hourly rate, whichever is greater
- Receive 10% off all contingency-based cases
- You'll be referred to attorneys based on location, language, and area of law

LawAssure Enhanced

- Access and create high-quality, personalized legal documents, saving hundreds of dollars in attorney's fees
- Available legal documents include wills, living trusts, healthcare directives, lease agreements, complaint letters, and divorce paperwork
- Deal with legal matters wherever it's most convenient for you, even on your tablet or phone
- Securely share you documents with trusted advisors or an attorney
- Safely store and edit your documents, or export them for printing and signature

Tax Hotline

- Let the experts handle your tax return preparation for free, giving you a painless and frustration-free experience
- Get advice from tax attorneys, financial analysts,
- CPAs, former auditors, and/or Enrolled Agents certified by the IRS, including unlimited advice on federal taxes
- Tax experts provide advice, planning, and audit assistance to help you avoid mistakes, penalties, and interest
- Receive discounts on other tax forms and schedules
- Access tax tips, tax law changes, advice, and more through an online portal

Aura - DigitalGuard (ID Theft)

- **Financial Fraud Protection -** Aura keeps you a step ahead of threats with credit monitoring, credit lock, and financial tools to help keep your assets safe.
- **Identity Theft Protection -** We alert you if we detect threats to your identity, SSN, online accounts and more. Plus, we help protect your personal info from data brokers that may sell you info on the Web.
- **WiFi Security (VPN) and Online Privacy** - With one tap, Aura's VPN keeps hackers at bay and keeps youronline activities private–so you can shop, bank and work onlineconfidently wherever you go.
- **Password Manager** - We'll help you store important digital assets and passwordssecurely. Plus, we'll alert you if there's a password breach so youcan protect your online accounts.
- **ParentalControls(FamilyPlansOnly)** - Block harmful content and manage how much time your kidsspend online–all in one app.

Each Plan Comes with $5M Identity Theft Insurance for Each Enrolled Adult

Legal Bundle Individual or Family	ID Theft (Aura Digital Guard) Individual	ID Theft (Aura Digital Guard) Family	Combo (both Legal Bundle & ID Theft) Individual	Combo (both Legal Bundle & ID Theft) Family
$4.20/mo	$6.05/mo	$12.00/mo	$8.25/mo	$12.50/mo

EAP & Value Added Services

Employee Assistance Program (EAP) Consultative Services

ComPsych Eff 4/1/2024 (formerly with Uprise)

Confidential Emotional Support

3 face-to-face or virtual sessions per person, per issue, per year

Life can be stressful. Your EAP provides short-term counseling services for you and your dependents to help you handle concerns constructively, before they become serious issues. Call anytime about topics such as marital, relationship and family problems; stress, anxiety and depression; grief and loss, job pressures and substance misuse disorders.

Work and Lifestyle Support

Too much to do, and too little time to get it all done? Work-life specialists can do the research for you and provide qualified referrals and customized resources for topics such as child and elder care, moving, pet care, college planning, home repair, buying a car, planning an event, selling a house and more.

Legal Guidance

With your GuidanceResources® program, you have an attorney “on call” whenever you have questions. They can help with legal concerns such as divorce, custody, adoption, real estate, debt and bankruptcy, landlord or tenant issues, civil and criminal actions and more. If you require representation, you can be referred to a qualified attorney for a complimentary 30-minute consultation and a 25 percent reduction in customary legal fees.

Financial Information

Everyone has financial questions. Get answers about budgeting, debt management, tax issues and other money concerns from on-staff accountants, financial professionals and other specialists, simply by calling the toll-free number.

Digital Support

Go to GuidanceResources® Online to connect to counseling, work and lifestyle support and other services, such as child care and legal services search tools. Tap into an array of articles podcasts, videos and slideshows on thousands of topics or improve your skills with On-Demand trainings, self-assessments and more.

ComPsych GuidanceResources® Worldwide | Guardian

Online Will Preparation

Drafting a will and a living will can be a complicated and expensive process. With EstateGuidance® from your GuidanceResources® benefit, we eliminate the hassle and high costs with a complimentary, simple and secure online tool. Log on to GuidanceResources® Online to get started.

Wellness Support

Flexible 3-5 coaching session model

Your well-being is precious. We can help you maintain it. Take advantage of online self-guided programs or work one-on-one with a well-being coach to make improvements. Programs include tobacco and nicotine cessation, weight management, sleep improvement, self-motivation, back care, diabetes prevention and more.

Assistance is available 24 hours a day,7 days a week.

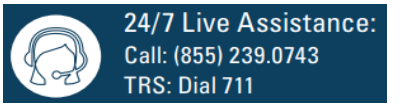
To access GuidanceResources® services:

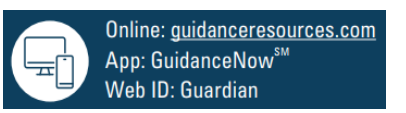
•Call your toll-free number. You’ll speak with a highly trained, caring professional who can listen to your concerns and guide you to the appropriate services.

•Visit GuidanceResources®Online at www.guidanceresources.com and enter your company ID.

Remember, assistance from the GuidanceResources® program is strictly confidential. To view the ComPsych® HIPAA privacy notice, please go to www.guidanceresources.com/privacy.

We hope you will take some time to explore all the benefits the GuidanceResources® program has to offer.





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. Entry into the plan is first of the month following 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 the Empower My Retirement 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.empowermyretirement.com** and click **Register**, 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 EmpowerRetirement 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.

Contact Us

	Carrier	Phone Number	Website
Medical **Participating Providers** **Precertification**	Meritain Health	(800) 925-2272 (800) 343-3140 (800) 242-1199	www.meritain.com
Care Management	Quantum Health	(844) 460-2787	MYDOSPBenefits.com
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	Portal access: www.paylocity.com Email for customer service: batinfo@paylocity.com
Voluntary Term Life Insurance **Short and Long Term Disability**	Guardian	(800) 541-7846	www.guardiananytime.com
Employee Assistance Program (EAP)	ComPsych/Guardian	(855) 239-0743	www.guidanceresources.com
Accident **Critical Illness** **Group Indemnity Medical**	Guardian	(800) 541-7846	www.guardiananytime.com
Legal **ID Theft**	New Benefits New Benefits/Aura	(800) 800-7616 (888) 664-2708	mybenefitswork.com/login www.aura.com
Pension Plan	Gabriel Roeder Smith	(954) 527-1616	www.grs-plan.com/
401(k)	Chris Chiaro John Benitoa (UBS) Ryan Brannon (UBS)	(800) 743-5274 (941) 953-7452 (813) 903-6694 (813) 903-6690	www.empowermyretirement.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, 2024
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, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecove ry.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MASSACHUSETTS-Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program- reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA-Medicaid	**MINNESOTA-Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programsservices/other-insurance.jsp Phone: 1-800-657-3739
IOWA-Medicaid and CHIP (Hawki)	**MISSOURI-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://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS-Medicaid	**MONTANA-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY-Medicaid	**NEBRASKA-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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA-Medicaid	**NEVADA-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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE-Medicaid	**NEW HAMPSHIRE-Medicaid**
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	Website: https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY-Medicaid and CHIP	SOUTH DAKOTA-Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK-Medicaid	**TEXAS-Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA-Medicaid	**VERMONT-Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA-Medicaid and CHIP	**VIRGINIA-Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	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
OREGON-Medicaid	**WASHINGTON-Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND-Medicaid and CHIP	**WISCONSIN-Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA-Medicaid	**WYOMING-Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2022, 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.

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? Giselle Gillis		
11. Phone number (if different from above) 727-317-4563	12. Email address ggillis@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.

☒ Some employees. Eligible employees are: Regular Full-Time employees as defined by your employer.

With respect to dependents:

☒ We do offer coverage. Eligible dependents are: “Spouse and other dependents as defined by your employer”

☐ We do not offer coverage.

☒ 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.

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

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