ARCHDIOCESE OF
CINCINNATI

2023-2024 Enrollment Guide

Active Employees must complete Open Enrollment during
May 2 – May 16, 2023

Partners in Value

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

Contents

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

Effective December 31, 2016, the Archdiocese of Cincinnati terminated its Supplemental Retiree Health Insurance Plan and Retiree Dental Plan for Post-65 lay retirees. Effective September 1, 2016, the Pre-65 Retiree Health Plan and Pre-65 Retiree Dental Plan were frozen and no longer accept any new participants.

The Archdiocese of Cincinnati reserves the right, in its sole discretion, to amend, modify, or terminate the Plan at any time and for any reason.

ARCHDIOCESE OF CINCINNATI

Welcome to Open Enrollment

In this guide you will find an overview of the benefits available to you through The Archdiocese of Cincinnati (AOC). Open Enrollment will take place between: **May 2 – May 16th** for Plan Year July 1, 2023-June 30, 2024.

The only time outside of open enrollment that an employee can **add/drop or make changes** to their coverage is when a qualifying event is experienced such as marriage/divorce, birth/adoption, loss/gain eligibility, loss of other coverage, etc., your local administrator has been notified within 30 days of that qualifying event, and the qualifying life event is initiated in MyEnroll. For further details refer to the Summary Document online: resources.catholicaoc.org/employee-benefits

What Makes the Archdiocese of Cincinnati (AOC) Plan Different?

The AOC Welfare Benefit Plan is a non-ERISA group health plan that maintains grandfather status under the ACA. Our employees are offered single coverage with a low employee premium charge. Family coverage is available to include the spouse and children, but with a surcharge if the dependents have other group health plan coverage available to them. This surcharge can be waived if it is determined the spouse is not eligible for other group health plan coverage.

The 2023-2024 plan year medical/prescription premium for single coverage is $813 per month. For eligible employees, the parish/school location pays $773 and the employee's portion of the premium is $40 per month. This is an annual expense for the parish/school location of $9,276.

The 2023-2024 plan year medical/prescription premium for family coverage is $1,896 per month. The additional expense to a location for an employee's family premium over the single premium is $1,083 per month or an annual difference of $12,996. The employee may be subject to a surcharge of $1,123 for this additional cost. The surcharge can be waived when the employee provides evidence that their dependents have no access to other group coverage. **Example: $1,896 - $813 = $1,083 + $40 = $1,123. $1,123 cost to employee per month if dependent surcharge isn't waived.**

Waiver request letters are provided during the enrolment process and available at: resources.catholicaoc.org/employee-benefits

Any change in the status of other available Group Health coverage during a plan year may be considered a Life Event and changes the waiver status for dependent surcharge during the plan year.

Any false or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be retroactively terminated (to the extent permitted by law). Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Eligibility

For active employees and their dependents who are deemed eligible for benefits as outlined below, benefits will begin the first of the month following the employee's date of hire.

Employee Eligibility for Medical, Dental, Vision and FSA Plans

- Full-time employees who work 30+ hours per week or teach 15+ classroom hours per week (certificated teacher in charge of the classroom).
- Variable-hour employees who have worked an average of 30+ hours per week or have taught an average of 15+ classroom hours per week during the prior 12-month measurement period (certificated teacher in charge of the classroom).
- Teachers who are employed by Athenaeum of Ohio and teach 14+ semester hours per year (or have taught an average of 14+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

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

- All employees who are regularly scheduled to work 20+ hours per week or teach 12+ classroom hours per week.
- Teachers who are employed by Athenaeum of Ohio and teach 9+ semester hours per year (or have taught an average of 9+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

Eligible Dependents*

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

Proof Documents to Enroll Dependent(s)

Legal Opposite Sex Marriage (one of the following)	**Biological Child** (one of the following)	**Adopted Child** (one of the following)
➢ Marriage license ➢ Federal income tax return	➢ Birth certificate of biological child ➢ Documentation on hospital letterhead indicating the birth date of child(ren) under 6 months old ➢ Federal income tax return	➢ Official court/agency papers (initial stage) ➢ Official Court Adoption Agreement (mid-stage) ➢ Birth certificate (final stage) ➢ Federal income tax return
Foster Child (one of the following)	**Step Child** (**ALL** of the following)	**Court-Ordered Medical coverage** (one of the following)
➢ Official Court or agency placement papers **Other Child** ➢ Court papers demonstrating legal guardianship, including the person named as legal guardian	➢ Child's birth certificate showing the child's parent is the employee's spouse ➢ Marriage certificate showing legal marriage between the employee and the child's parent ➢ Court document showing that the employee's spouse has custody of the child or is required to cover child	➢ Qualified Medical Child Support Order (QMCSO) ➢ National Medical Support Notice (NMSN)
Surcharge Waiver	Other Employer Letter, whether for spouse or eligible dependents	

***Anthem requires a Social Security number for the newborn within 30 days of birth or coverage is terminated. When adding a new baby to the plan, you must call MyEnroll/Benefit Allocation Systems (BAS) 1.866.694.6423 within 30 days of the birth, with the Social Security Number to ensure that Anthem does not drop the baby's coverage.*

Enrolling in Benefits

Step 1: Review your benefits package and understand the options available to you.

Step 2: Gather proof documents for new dependents. Scan in necessary proof documents and save the documents to your desktop as **one PDF per dependent**.

- You will need to submit these during the online enrollment process by attaching the scanned documents to your MyEnroll benefit profile when prompted.
  You can also fax your proof documents to 1.888.265.2144

Step 3: Enroll

- Log on to www.myenroll.com using your User Name and password**
- Select the "Enroll" button drop down and select "Enrollment Wizard" to access your open enrollment
- When prompted, submit the necessary proof documents for new dependents
- Review the summary and signature page and click Accept and Finalize

MyEnroll Customer Service Contact Information: 1.866.694.6423 or AOCBenefits@basusa.com

** *If you haven't previously logged into MyEnroll or forgot your username/password, go to www.myenroll.com and click on the "First Time Users" under the Sign-in button and step through the screens. Please reach out to the MyEnroll client services team at 866-694-6423 service if you have any issues retrieving a password.*

*****Deadline to complete Open Enrollment (OE) is 11:59 PM on May 16, 2023. You will need to log on to MyEnroll during the Open Enrollment period to select your current health, dental, vision and flexible spending account selections. Double check to make sure your selections are correct by carefully reviewing the Summary & Signature page. If you are happy with your selections, click Accept and Finalize. Print a copy of the Summary & Signature page for your records.***

Employer Paid Benefits

BASIC LIFE AND AD&D INSURANCE
The Standard

Eligibility:
- All employees who are regularly scheduled to work 20+ hours per week or teach 12+ classroom hours per week (certificated teacher in charge of the classroom).
- Teachers who are employed by Athenaeum of Ohio and teach 9+ semester hours per year (or have taught an average of 9+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

Benefit: $50,000 of Group Life and $50,000 Accidental Death and Dismemberment (AD&D) insurance.
*Age reduction may apply

LONG-TERM DISABILITY
The Standard

Eligibility:
- All employees who are regularly scheduled to work 20+ hours per week or teach 12+ classroom hours per week.
- Teachers who are employed by Athenaeum of Ohio and teach 9+ semester hours per year (or have taught an average of 9+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

Benefit: 60% of the first $8,333 of monthly pre-disability earnings. The maximum monthly benefit is $5,000 and the minimum monthly benefit is $100. Benefits begin after a benefit waiting period of 180 days.

Optional Benefits

MEDICAL & PHARMACY
Anthem

Please reference https://resources.catholicaoc.org/employee-benefits

- *Summary of Benefits — a detailed description of your coverage*
- *Understanding online tools available to you — register at* anthem.com
- *Download the Anthem Sydney Health app*

Eligibility: Reference Eligibility section on page 4

Premium Rates:

Monthly			
	Total Cost	*Employer Contribution*	*Employee Contribution*
Single	*$813*	*$773*	*$40*
Family	*$1,896*	*$1,802*	*$94**

Annual			
	Total Cost	*Employer Contribution*	*Employee Contribution*
Single	*$9,756*	*$9,276*	*$480*
Family	*$22,752*	*$21,624*	*$1,128*

*The 2023-2024 plan year medical/ prescription premium for family coverage is $1,896 per month. The additional expense to a location for an employee's family premium over the single premium is $1,083 per month or an annual difference of $12,996. The employee may be subject to a surcharge of $1,123 for this additional cost. The surcharge can be waived when the employee provides evidence that their dependents have no access to other group coverage.

Any change in the status of other available group health coverage during a plan year may be considered a qualifying life event and changes the waiver status for dependent surcharge during the plan year.

Benefit: Please remember that your deductible and your out-of-pocket limit reset every calendar year on January 1st.

Medical Plan Benefit		
Plan Payment Levels	**In-Network**	**Out of Network**
Annual deductible (Indv. / Family)	$550 / $1,100	$1,100 / $2,200
Coinsurance – AOC pays	80%	60%
Annual out-of-pocket limit (Indv. / Family)	$2,800 / $5,600	$5,600/ $11,200
Physician Services		
Preventive Visits	100%	60%
Primary Care office visits	$30 copay	60%
Specialty office visits	$45 copay	60%
Online LiveHealth Physician visits	$10 copay	N/A
Inpatient Hospital – Facility Services	80%	60%
Outpatient Care	80%	60%
Emergency/Urgent Care		
Not Admitted	80%	80%
Admitted	Charges Waived	Charges Waived
Ambulance services	80%	80%

OptumRx

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

Prescription Co-pays			
	Retail-30 days	Retail-90 days*	Mail Order-90 days
Generic	$17	$42.50	$42.50
Formulary	$39	$97.50	$97.50
Non-Formulary	$75	$187.50	$187.50

Formulary brand refers to brand drugs with no generic available.
Non-formulary brand primarily refers to brand drugs that have other alternatives available.

NOTE: Retail 90 day prescriptions may only be filled at Kroger pharmacies

THE CHRIST HOSPITAL CENTER OF EXCELLENCE

Hip and Knee Replacement

The Archdiocese of Cincinnati has partnered with The Christ Hospital Joint and Spine Center to offer surgery benefits through the Center of Excellence program for hip and knee replacement.

The Archdiocese of Cincinnati's health plan offers a significant savings, exceptional outcomes and an outstanding patient experience when you use The Christ Hospital Center of Excellence for hip and/or knee surgical replacement procedures.

Members covered under the Archdiocese of Cincinnati health plan that utilize the Center of Excellence Program through The Christ Hospital for hip and knee replacement procedures are eligible to have their **deductible and coinsurance waived** for the procedure.

You will also receive only one bill and explanation of benefits that includes:

- facility fees
- surgeon fees
- fees for other ancillary costs during the hospital stay

In addition, you can communicate with dedicated nurse navigators that are available to guide you through every step of the process.

For more information about the Center of Excellence Program for Joint Replacement, please call The Christ Hospital's Nurse Navigator at 513-557-4882.

FLEXIBLE SPENDING ACCOUNT (FSA)

Benefit Allocation Systems (BAS)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using pre-tax dollars. The annual amount you elect for the July 1, 2023–June 30, 2024 plan year is deducted each pay check before taxes are withheld, which lowers your taxable income. You are only able to carryover up to $550 to the next year in your Health Care FSA, so plan carefully.

If you decide to contribute to a healthcare FSA, you will receive a Benny card in the mail. The Benny card is similar to a debit card and is linked directly to your FSA. You should always save your receipts when you have used the Benny card, as you will need to **SUBSTANTIATE** the charge to BAS. To substantiate means to provide proof that the purchase was an eligible expense per the IRS. Please know the Benny Card may be suspended temporarily if charges not substantiated.

If you pay for an expense without the Benny card, you can request reimbursement from your FSA. To do so, you submit a claim to MyEnroll by filling out necessary forms and providing required substantiation (receipts, invoices, etc.).

The dependent care FSA does not have a Benny card. All expenses are paid by the employee up front and then employee submits receipts to MyEnroll for reimbursement.

Account Type	*Use it for:*	*How much can I contribute for 2023?*	*Does it rollover?*
Health Care FSA	***Medical, dental, and vision expenses***	***$3,050 (minimum is $240)***	***You can rollover up to $550 to the next plan year***
Dependent Care FSA	***Dependent care for children under the age of 13 or a disabled spouse or parent***	***Annual Maximum Contribution = $5,000 per couple for married filing jointly and single head of household or $2,500 per individual for married filing separately***	***No***

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

DENTAL

Delta Dental of Ohio

The plan is 100% paid by the employee. For more details see the Dental page on the https://resources.catholicaoc.org/employee-benefits website.

Eligibility: Reference Eligibility section on page 4

Dental Plan	
This plan allows you to select the dentist of your choice by offering both in and out of network benefits	
Individual Max benefit year 7/1 to 6/30	$1,000
Annual Deductible (single/family) basic & major only	$50/$150
Preventive (exams, cleanings)	100%
Basic (fillings)	50%
Major (crowns, implants)	50%
Child Orthodontia	50%
Ortho Lifetime Max	$1,000

Monthly Employee Cost	Dental
	$26.34 – Single / $76.24 - Family

VISION

VSP – Choice Network

Eye Exams are an important part of overall health care for the entire family. The Vision Benefits Summary below may help you decide if the vision plan fits the needs of you and your family. The vision carrier VSP offers a large network of providers. When you use a contracting network provider, the care is considered “in-network” and your expenses will be paid using in-network rates. If you select a provider outside of the network, the care is considered “out-of-network.” Coverage is still provided, but the out-of-pocket expenses will be significantly higher.

Eligibility: Reference Eligibility section on page 4

	In-Network	**Out-of-Network**
Exam	$10 Copay	Reimbursed up to $45
Lenses		
Single	$0 Copay	Reimbursed up to $30
Bifocal		Reimbursed up to $50
Trifocal		Reimbursed up to $65
Lenticular		Reimbursed up to $100
Frames	20% off balance over $150 allowance; $200 allowance for any featured frame	Reimbursed up to $70
Contact Lenses		
Medical Necessity	Covered in Full	Reimbursed up to $210
Elective	$130 allowance	Reimbursed up to $105
Frequency Limitation *(exam/lens/frames)*	**You can get an Eye Exam every 12 months / Lenses *or* contacts every 12 months / Frames every 24 months**	
Monthly Premium		
Monthly Employee Cost	$5.26 – Single / $14.50 – Family	

SUPPLEMENTAL LIFE INSURANCE

The Standard

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

Eligibility: Reference Eligibility section on page 4
Spouse — Employee's legal opposite sex spouse
Children — Eligible dependent children from live birth to age 26

Benefit: In addition to the $50,000 Core Life paid for by the location where you work, you have the option to apply for, and if approved by the Standard Underwriters, purchase Supplemental Life Insurance for yourself, your spouse and your child(ren).

	Employee	Spouse	Child(ren)
Increments	$10,000	$10,000	$2,500, $5,000, $7,500, or $10,000
Maximum Benefit Amount	$500,000	Not to exceed the employee's benefit amount	

Eligible children may be covered from birth to age 26.

If an employee or spouse elects or increases coverage during annual enrollment, an Evidence of Insurability (EOI)* form must be completed, submitted by June 1, 2023 to The Standard Insurance Co., and approved by The Standard. This form is available within the MyEnroll system during the Open Enrollment process.

The basic core life and supplemental life insurance benefits are subject to the following age reduction schedule: reduction by 35% at age 65, 58% at age 70 and 70% at age 75.

Premium per $10,000 increments:

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

Your rates are based on your age at your last birthday.
Your spouse's rates are based on their age at their last birthday. They will change on the plan anniversary date coinciding with, or next following, your last birthday as you advance to a higher age bracket.

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

CONSIDERING RETIREMENT

Medicare and Group Health Plan Coverage
When you retire and are Medicare-eligible, you have a number of important decisions to make prior to your Archdiocesan health benefits ending. These may include whether to enroll in Medicare Part B, join a Medicare Prescription Drug Plan, or buy a Medigap policy.

Understanding your choices

To help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's

best for you, you can visit http://www.medicare.gov and select “Compare Medicare Prescription Drug Plans” and “Compare Health Plans and Medigap Policies in Your Area.” You can also call your State Health Insurance Assistance Program. To get the telephone number for your state’s program, call 1.800. MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

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

RetireMed is an additional source of information. They are an independent health plan advisory service that offers guidance to individuals in need of insurance options upon retirement. Their goal is to give retirees information and guidance to choose the insurance plan that best meets their retirement budget, needs and life-style - at no cost to the retiree. RetireMed can be reached at 1.877.268.2863 or www.retiremed.com

401(k) PLAN
Empower Retirement

Open Enrollment is a perfect time to review another important benefit – your 401(k)! Take a moment to log into your account at https://participant.empower-retirement.com/participant/#/login

Action items:
- Increase personal deferral percentage amount
- Review investment fund choices
- Review beneficiary. It is important to note that your beneficiary for life insurance in MyEnroll does NOT apply to the 401(k) portal. You must designate a beneficiary for your 401(k) account at https://participant.empower-retirement.com/participant/#/login

CONTACT INFORMATION

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

Benefit	Administrator	Phone	Website/Email
Medical	Anthem	1.844.995.1752	www.anthem.com
Prescription	OptumRx	1.800.797.9791	www.optumrx.com
Life & AD&D/LTD/Voluntary Life	The Standard	Life 1.800.628.8600 LTD: 1.800.368.1135	www.standard.com
Voluntary Dental	Delta Dental	1.800.524.0149	www.memberportal.com
Voluntary Vision	VSP	1.800.877.7195	www.vsp.com
Flexible Spending Account (FSA)	BAS	1.866.694.6423	AOCBenefits@basusa.com
Benefits Customer Service (MyEnroll)	BAS	1.866.694.6423	AOCBenefits@basusa.com
401(k)	Empower Retirement	1.866.467-7756	www.empowermyretirment.com
The Christ Hospital Center of Excellence	The Christ Hospital	513.557.4882	www.thechristhospital.com

AOC BENEFITS WEBSITE

Find a wealth of information about your benefits and explore helpful decision- making tools.
At home or on the road you can go to: https://resources.catholicaoc.org/employee-benefits

Here's just a small sampling of what you'll find:

- Open enrollment information
- Benefit plan information
- Links to providers such as Anthem, OptumRx, Delta Dental, VSP Vision
- Helpful decision-making tools
- Health news
- Find specific information and summaries of the benefits offered by the Archdiocese of Cincinnati

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

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

LEGAL NOTICES

Grandfathered Health Plan under the Patient Protection and Affordable Care Act

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

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

Rescission of Coverage

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

Women's Health & Cancer Rights Act (WHCRA)

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

» Reconstruction of the breast on which the mastectomy has been performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance, and;

» Prostheses and treatment for physical complications for all stages of mastectomy, including lymphedemas.

The Newborns' Act

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

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

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

Military Leave Employees

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

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

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

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

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

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

Health Insurance Portability & Accountability Act (HIPAA)

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

If you are declining enrollment for yourself or your dependents (including your spouse or child(ren)) because of other health insurance, you may be able to enroll yourself and your dependents in an Archdiocese of Cincinnati plan if you or your dependents lose eligibility for that other coverage. You must request enrollment within 31 days of the date the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days of the date the other coverage ends.

Notice of Availability

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

Children's Health Insurance Program Reauthorization Act New Special Enrollment Period for Health Coverage

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

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

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

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

Should you have a qualifying event and want to enroll in health coverage, contact your location administrator. If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs.

Notice of Creditable Prescription Drug Coverage

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescript ion drug coverage with the Archdiocese of Cincinnati and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare drug plan when you first become eligible, and each year from October 15 through December 7. If you lose your current creditable prescription drug coverage or decide to leave the Archdiocese of Cincinnati you may be eligible for a Medicare Special Enrollment Period. Archdiocese of Cincinnati has determined that the prescription drug coverage offered by the Notice of Archdiocese of Cincinnati Health Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because Archdiocese of Cincinnati's coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

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

Visit www.medicare.gov for personalized help.

» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number).

» Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

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

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

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

Name of Entity: Archdiocese of Cincinnati
Contact: Charlotte Carpenter
Address: 100 East Eighth Street, Cincinnati OH 45202
Phone Number: (513) 421-3131

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

ALABAMA Medicaid	ALASKA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS Medicaid	**CALIFORNIA Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	INDIANA Medicaid
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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	KANSAS 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: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY Medicaid	LOUISIANA 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: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE Medicaid	MASSACHUSETTS Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
MINNESOTA Medicaid	MISSOURI Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA Medicaid	NEBRASKA Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA Medicaid	NEW HAMPSHIRE Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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	NEW YORK 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: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	NORTH DAKOTA Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	OREGON Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	RHODE ISLAND Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA Medicaid	SOUTH DAKOTA Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS Medicaid	UTAH Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT Medicaid	VIRGINIA Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	**WEST VIRGINIA Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)
WISCONSIN Medicaid and CHIP	**WYOMING Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and- eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2023)

New Health Insurance Marketplace Coverage 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 Benefits Office.

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.

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 Archdiocese of Cincinnati		4. Employer Identification Number (EIN) 31-0538501
5. Employer address 100 E 8th Street		6. Employer phone number 513-421-3131
7. City Cincinnati	8. State Ohio	9. ZIP code 45202
10. Who can we contact about employee health coverage at this job? Benefits Office		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

✓ All employees. Eligible employees are:

- Full-time employees who work 30+ hours per week or teach 15+ classroom hours per week (certificated teacher in charge of the classroom).
- Variable-hour employees who have worked an average of 30+ hours per week or have taught an average of 15+ classroom hours per week during the prior 12-month measurement period (certificated teacher in charge of the classroom).
- Teachers who are employed by Athenaeum of Ohio and teach 14+ semester hours per year (or have taught an average of 14+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

☐ Some employees. Eligible employees are:

- With respect to dependents:

✓ We do offer coverage. Eligible dependents are:

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

☐ 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

[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.

** 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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
(mm/dd/yyyy) (Continue)

☐ **No**

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard[2] offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan?
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan?
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly