ARCHDIOCESE OF CINCINNATI

WELFARE BENEFIT PLAN

SUMMARY

Effective July 1, 2023

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SUMMARY

I. INTRODUCTION

This document is a summary of the Archdiocese of Cincinnati Welfare Benefit Plan (the "Plan"). This Plan includes the following benefits: (i) major medical and prescription drug plan ("Health Plan"), dental plan ("Dental Plan"), vision plan ("Vision Plan"), a health care flexible spending account ("Health FSA"), a dependent care flexible spending account ("Dependent Care FSA"), group life insurance coverage ("Group Life"), supplemental life insurance coverage ("Supplemental Life"), accidental death and dismemberment insurance ("AD&D"), and long-term disability benefits ("LTD"). Each of the welfare benefit plans described in this summary is intended to be a "church plan" as defined under §414(e) of the Internal Revenue Code and §3(33) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") which has not made an election under §410(d) of the Internal Revenue Code to become subject to ERISA, and as such, is exempt from the requirements of ERISA.

It is your responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also your responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Individuals being canceled, and such cancellation may be retroactive.

The Employer has the exclusive right, power and authority, in its sole and absolute discretion, to administer and interpret the welfare plans described in this summary, and has all powers reasonably necessary to carry out its responsibilities to the plans including (but not limited to) the sole and absolute discretionary authority to:

- Administer the plans according to their terms and to interpret the plans' policies and procedures;
- Resolve and clarify inconsistencies, ambiguities and omissions relating to the plans; and
- Take all actions and make all decisions regarding questions of coverage, eligibility and entitlement to benefits, and benefit amounts.

The decision of the Employer on any disputes arising under the plans, including (but not limited to) questions of construction, interpretation and administration shall be final, conclusive and binding on all persons having an interest in or under the plans. Any determinations made by the Employer are final and binding and shall be given the highest deference permitted by law.

The Health Plan has been maintained as a "grandfathered health plan" under 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 the law was enacted. If you have questions about grandfathered health plans, you can contact the Employee

Benefit Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthcarereform.

Many words used in this Summary have special meanings. These words appear in capital letters and are defined for you in the "DEFINITIONS" section of this Summary.

II. ELIGIBILITY

A. Eligibility for Life, AD&D and LTD

The Employer provides Group Life, Supplemental Life, and AD&D and LTD to all eligible Employees, with the exception that Diocesan priests and Clergy Members are ineligible for LTD coverage. In order to be eligible for these benefits, you must be an Employee regularly scheduled to work 20 or more hours a week at a participating location or be a board-certified teacher with primary instructional control of a classroom and teach at least 12 classroom hours a week. If you are a teacher at the Athenaeum of Ohio, you are eligible for these benefits if you teach at least 9 semester hours or more per year. If you are a Diocesan priest ordained into the Archdiocese of Cincinnati or a priest on canonical assignment to the Archdiocese of Cincinnati, you are eligible for these benefits at the time of ordainment or assignment to the Archdiocese of Cincinnati, except that you are not eligible for LTD coverage.

You are not eligible for these benefits if you are a full-time member of the armed forces, or a temporary, seasonal or leased employee. Employees who meet this eligibility requirement also have the ability to purchase additional supplemental life insurance coverage.

B. Eligibility for Health, Dental, Vision and FSA Plans

1. General Requirements

The eligibility requirements for the Health, Dental, Vison, Health FSA and Dependent Care FSA Plans vary based on the location and position of your employment. If you are a Seasonal Employee, this Section 1 does not apply to you and please see subsection 3 of this Section II.B.

a. Athenaeum of Ohio – You are eligible if you are an Employee who is employed as a teacher at the Athenaeum of Ohio and you teach fourteen semester hours or more per year.

b. Seminarians – You are eligible for Health Plan coverage only if you are a Seminarian who is enrolled full-time in the Priestly Formation Program of the Archdiocese of Cincinnati and are studying at Mt. St. Mary's Seminary, the Oratory, or any other college seminary as long as you are studying for the Archdiocese of Cincinnati.

c. Teachers at Locations Other Than the Athenaeum – You are eligible if you are an Employee who is employed as a certified teacher in charge of a classroom and you are scheduled at least 15 school day hours per week.

d. Diocesan priests and Clergy Members – You are eligible if you are a Diocesan priest ordained into the Archdiocese of Cincinnati, a priest on canonical assignment to the

Archdiocese or a religious sister or brother who is on assignment to an Archdiocese location.

e. *All Other Employees* – You are eligible if you are an Employee who is regularly scheduled to work at least 30 hours per week. You may also be eligible if you are an Employee who is credited with an average of 30 or more Hours of Service per week during the prior Measurement Period (described below). Substitute teachers fall into this classification and will be given credit for 8 Hours of Service for any day that the substitute teaches at a participating location of the Employer.

If you work for the Employer at multiple participating locations or in multiple positions, your Hours of Service at all participating locations and in all positions will be combined for purposes of eligibility and you will be eligible for coverage only if you average 30 or more Hours of Service per week. If you are a teacher, you will be given credit towards the Hours of Service requirement for 2 Hours of Service for each classroom hour per week that you are scheduled to work.

EXAMPLE: You are a certified teacher in charge of a classroom and you are scheduled to teach 12 classroom hours per week. You also work as a part-time secretary at a participating parish for 10 hours per week. To determine if you are eligible for coverage, the Employer will add the 10 hours you work as a secretary with 24 hours (12 classroom hours x 2) for teaching. Since you will be given credit for 34 hours of service per week, you will be eligible for coverage under the Health, Dental, Vision, Health Care FSA and Dependent Care FSA Plans.

2. Eligibility Calculation for Ongoing Employees

If you fall into the classification of All Other Employees above, you may still be eligible for benefits even if you are not regularly scheduled to work 30 or more hours per week if you were credited with an average of 30 Hours of Service per week over the course of a Measurement Period. This is called the Lookback Method—the Employer looks back at your prior service to determine whether you will be considered full-time and eligible to enroll in coverage during a subsequent Stability Period. The Lookback Method applies to all Ongoing Employees whose hours vary (e.g., substitute teachers) or who are scheduled to work less than 30 hours per week.

You are considered an Ongoing Employee if you have been employed by the Employer for an entire Measurement Period. The Measurement Period is a 12-month period beginning on a date in April and ending 12-months later. If you work an average of at least 30 Hours of Service per week during the Measurement Period, you will be eligible to participate in the Plan during the following Stability Period, even if your hours or wages decrease, so long as you remain an Employee and continue to make any required contributions toward your coverage. Following each Measurement Period, the Employer will inform you if you are eligible for benefits for the subsequent Stability Period. The Stability Period will begin the following July 1st and will last 12-full months until the following June 30th.

EXAMPLE: You work in a non-teaching position for a participating location of the Employer. Over the Measurement Period beginning in April 2022 and ending in April 2023, you average 32 Hours of Service per week. You will be offered coverage for the

Plan Year beginning July 1, 2023 and ending June 30, 2024. If the following Measurement Period (from April 2023 to April 2024) you only average 28 Hours of Service per week, you will not be offered coverage for the Plan Year beginning July 1, 2024 and ending on June 30, 2025.

If you are a school employee, your Measurement Period is calculated without regard to summer break (which is referred to as an Employment Break Period). Further, an Employee is credited for hours they would have worked, but didn't due to a Special Unpaid Leave (which is leave approved under FMLA, USERRA or jury duty).

If your position with the Employer is changed such that you will be regularly scheduled to work 30 or more hours per week, you will be eligible to enroll in the Health, Dental, Vision, Health FSA and Dependent Care FSA Plans effective as of the first day of the calendar month following the switch into your new position.

3. Eligibility Calculation for New Employees

If you are hired as a new Employee, who is not a Seasonal Employee, and you are regularly scheduled to work 30 or more hours per week, you will be eligible for benefits under the Health, Dental, Vision, Health FSA and Dependent Care FSA Plans on the first day of the calendar month following your first Hour of Service. You are considered a new Employee if you did not work for the entire 12-month Measurement Period described in section 2 above or if you were rehired after a period of absence where you were not credited with any Hours of Service for at least 13 consecutive weeks (or 26 weeks for employees working for an educational organization).

If you are hired as a new Employee and are regularly scheduled to work less than 30 hours per week or the number of hours you will work each week is not readily determinable or if you are hired as a Seasonal Employee, the Employer will measure your Hours of Service over an Initial Measurement Period beginning on the first of the calendar month following your date of hire and ending 12 months later. If the Employer determines that you averaged at least 30 Hours of Service per week during your Initial Measurement Period, you will be notified that you are eligible for coverage and given an opportunity to enroll in these plans effective as of the first day of your Initial Stability Period.

Your eligibility for coverage under these plans remains the same until you complete a full Measurement Period. Whether you continue to be eligible for coverage under these plans after your Initial Stability Period will be determined by the next full Measurement Period for all Ongoing Employees. If you become eligible for coverage after this Initial Measurement Period for a Stability Period that spans two Plan Years, you will be given another opportunity to elect coverage or change your coverage election at annual enrollment along with all other eligible Employees.

EXAMPLE: You are hired on August 15, 2023 and it is uncertain how many hours per week you will work due to the nature of the position. Your Hours of Service will be measured from September 1, 2023 – August 31, 2024. If during that Initial Measurement Period you average at least 30 Hours of Service per week, you will be offered coverage in the Health, Dental, Vision, Health FSA and Dependent Care FSA Plans effective as of

October 1, 2024. As long as you timely enroll initially and during the following open enrollment period, your coverage will be effective until September 30, 2025.

If you are credited with an average of less than 30 Hours of Service per week during this Initial Measurement Period, you will not be eligible for coverage under these plans. However, you may become eligible for benefits once you work a full Measurement Period for Ongoing Employees if you are credited with an average of at least 30 Hours of Service per week during that period.

If you are a school employee, your Measurement Period is calculated without regard to summer break (which is referred to as an Employment Break Period). Further, no Employee is penalized for any time of Special Unpaid Leave.

C. Dependent Eligibility for Health, Dental, and Vision Plans

If you are an Employee who is eligible for the Health, Dental and Vision Plans, you may also enroll your Spouse and/or Dependent Child(ren) who are under age 26 in the plans upon your enrollment in the plans. Your Dependent Children are eligible regardless of financial dependency, residency, student status or marital status. If you enroll your Spouse or Dependent Children in the Health Plan, you are required to submit additional documentation, including proof, with your enrollment. A list of the required proof documents is at Appendix A.

If your Spouse has access to group health plan coverage as an employee or your Dependent Child has access to group health plan coverage through the employer of another parent, they are still eligible for coverage under the Health Plan but you will be required to pay 100% of the cost of the Spouse or dependent coverage ("Dependent Surcharge"). In order to enroll a Spouse or dependent, you must submit an affidavit declaring whether they are employed and have other coverage available. If such affidavit is not timely submitted showing no other access to group health coverage, the Dependent Surcharge will be automatically applied regardless of whether your Spouse or Dependent Child has access to other coverage. For additional detail on what type of plans qualify as access to group health plan coverage for purposes of the Dependent Surcharge, refer to the chart in Appendix B.

Any child of an Employee who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to dependent coverage under the Health, Dental and Vision Plans. If the Employee is required to cover a Dependent Child under a QMCSO, the Employee won't be subject to the dependent surcharge even if the Dependent Child has other coverage available. An Employee or other Covered Individual may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Employer.

Eligibility for a Dependent Child in the Health, Dental and Vision Plans will continue past age 26 for a Dependent Child who cannot work to support themselves due to a disability. You must be able to claim this Dependent as a federal tax exemption. The Dependent Child's disability must have started before he or she attained age 26 and the Dependent must have been enrolled in the applicable Employer's plan immediately prior to attaining age 26, or be enrolled at the time you are initially eligible for coverage, if later. You must notify the Employer of the Dependent Child's disability at least 30 days prior to the Dependent Child attaining age 26. The Employer may require you to submit proof of continued eligibility for any enrolled disabled Dependent Child. Your

failure to provide this information could result in termination of the Dependent Child's coverage. You must notify the Employer if the Dependent's disability or tax exemption status changes and they are no longer eligible for continued coverage.

III. ENROLLMENT

A. General Rules

1. New Employees and Newly Eligible Employees

When you are hired or when you become an eligible Employee, you will receive the information you need to assist you in enrolling in the benefits offered under the plans. When you become eligible for Group Life, AD&D and LTD coverages, you will automatically be enrolled in those benefits effective as of the first day of the month following your first day of active employment as an eligible Employee. If you wish to purchase Supplemental Life insurance coverage for yourself or for yourself, Spouse and/or Dependent Children, you must do so within 30 days of becoming an eligible Employee.

For Health, Dental, Vision, Health FSA, and Dependent Care FSA Plans, you must follow the procedures provided by the Employer and complete your initial enrollment electronically within 30 days of becoming an eligible Employee. If you do not enroll in in the Health, Dental, Vision, Health FSA and Dependent Care FSA, or supplemental life coverages by the deadline, you will not be able to enroll until the next open enrollment period, unless you experience a qualifying mid-year event. Similarly, if you do not enroll your Spouse or Dependent Children during open enrollment, you will not be able to enroll them until the next open enrollment period, unless they experience a qualifying mid-year event.

With the exception of new hire teachers, the coverage you elect for you, your Spouse, and any Dependent Child will go into effect on the first day of the month after your date of hire, or the first day of the month after you become an eligible Employee. For brand new hire teachers reporting to work at the beginning of a school year, benefits begin on September 1st.

2. Open Enrollment

Open enrollment is held in the spring each year. The Employer will provide you with instructions for open enrollment, and you must enroll electronically during the time period established by the Employer. During the open enrollment period, you may enroll in coverage, or you may change or drop your current coverage. Your open enrollment elections will go into effect when the new Plan Year starts on July 1st.

You must complete your online enrollment each year to continue receiving benefits under the Plan. With the exception of any Supplemental Life coverage that was previously approved by the Insurer, if you do not complete your online enrollment before the deadline set by the Employer, your prior years' elections will end on June 30th, and you will not be able to enroll in coverage for the next Plan Year, unless you experience a qualifying mid-year change event (see below). Any Supplemental Life coverage that was previously approved by the Insurer will continue until such time as you decline Supplemental Life coverage or otherwise have a termination event.

B. Qualifying Mid-Year Changes

Generally, the elections you make when you enroll in the Plan will remain in effect for the remainder of the Plan Year. However, there are certain events that allow you to make changes to your elections mid-year. For additional details on these mid-year change events, refer to the chart in Appendix C. If a mid-year change permits you to enroll your Spouse and/or your Dependent Children, **the Dependent Surcharge may still apply**.

1. Special Enrollment Events

If you elected not to enroll yourself, your Spouse, or your Dependent Children in the Health Plan, you may be able to enroll yourself, your Spouse, and/or your Dependent Children in the Health Plan during the Plan Year upon the occurrence of the following events:

a. *Loss of Eligibility for Other Group Health Coverage*: If you, your Spouse, or your Dependent Children have other coverage or are covered by a different group health plan and lose eligibility for that coverage (or if the employer offering the other coverage stops contributing towards the other coverage), you may enroll the individual(s) that lose eligibility under the other group health plan in the Health Plan. You must request enrollment within 30 days after the loss of eligibility for other group health coverage (or the date the other employer stops contributing towards the other coverage).

b. *New Spouse or Dependent Child*: If you have a new Spouse or Dependent Child as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself, your Spouse, and any new Dependent Child in the Health Plan. You must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption. See Appendix A for a list of the documents that you must submit to show proof of eligibility.

c. *Eligibility for Medicaid or CHIP*: If you lose eligibility for Medicaid or CHIP coverage, or become eligible for premium assistance through Medicaid or CHIP, you may be able to enroll yourself, your Spouse, and your Dependent Children in the Health Plan. You must request enrollment within 60 days of your Medicaid or CHIP eligibility event.

If you enroll a new Dependent Child in the Health Plan due to birth, adoption, or placement for adoption, coverage will be effective on the date of the Dependent Child's birth, adoption, or placement for adoption. All other elections for special enrollment events will be effective on the first of the month after you request enrollment.

2. Change in Status

You may be able to change your Health, Dental, Vision, Health FSA and Dependent Care FSA elections if you experience a change in status. For most change in status events, you may only change your election if the change in status affects your eligibility for benefits, and your new election is consistent with the event.

These changes in status events include:

a. *Marital Status*: An event affecting your marital status, including marriage, divorce, death of a Spouse, or an annulment.

b. *Number of Eligible Dependents*: An event affecting the number of your Dependent Children, including the birth, death, adoption, or placement for adoption of a child.

c. *Dependent Status*: An event affecting the eligibility of a Dependent Child for coverage.

d. *Employment Status*: An event affecting you, your Spouse, or your Dependent's change in employment status for you or your Spouse, including a termination or commencement of employment or a strike or lockout.

e. *Residence*: A change in the place of residence for you, your Spouse, or a Dependent Child that results in you, your Spouse, or your Dependent Child living beyond the network service area for the Health or Dental Plan.

You may also be able to drop your coverage under the Health Plan following certain events, even when they do not affect your eligibility to receive health coverage. These events include:

f. *Reduction in Hours*: If your hours are reduced and you reasonably expect to work less than 30 hours per week, you may elect to drop health coverage for you, your Spouse, and your Dependent Children, but only if any individual that drops coverage obtains other health coverage that offers minimum essential coverage, as defined by the Affordable Care Act. The new coverage must become effective no later than the first day of the 2nd month after you drop the health coverage.

g. *Enrolling in a Marketplace Health Plan*: If you become eligible to enroll in a public exchange plan during the exchange open enrollment period or during an exchange special enrollment period, you may drop your coverage under the Health Plan for yourself, your Spouse, and your Dependent Children, as long as you intend to enroll yourself, your Spouse, and all Dependent Children who lose coverage in an exchange plan. The exchange plan coverage must become effective no later than the day immediately following the day coverage is lost under the Health Plan.

If you experience a change in status and want to make a change to your coverage, you must notify the Employer and change your elections within 30 days of the event. If you do not notify the Employer and change your elections within the 30-day period, you will not be able to make any changes to your coverage until the next open enrollment period.

Please note that in order to change your benefit elections due to a change in status, you will be required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, divorce decree, etc.).

If you timely elect to enroll in coverage following a change in status, coverage will be effective as of the first day of the month following the date of the event.

3. Additional Events That Allow You to Change Elections

You may also make changes to your elections following eligibility events and specific changes in your coverage or your Spouse's coverage, as follows:

a. *Eligibility or Loss of Eligibility for Medicare or Medicaid*: If you, your Spouse, or your Dependent Children become entitled to, or lose entitlement to, Medicare or Medicaid, or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Health, Dental, Vision, and Health FSA elections. See Section XVIII for more information on coordination with Medicare.

b. *Court Order*: If a Qualified Medical Child Support Order (QMCSO) requires that you provide coverage to your child, then the Employer may automatically change your election to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If a QMCSO requires another person (such as your Spouse or former Spouse) to provide coverage for the child, then you may drop coverage for that child if you provide proof to the Employer that the other person actually provides the coverage for the child.

c. *Significant Change in Cost of Coverage*: If the Employer determines there is a significant increase or decrease in the cost of the Employer's Health, Dental or Vision Plan, you may be permitted to revoke your election in the Employer's Plan and make a new election, even if you previously declined coverage.

d. *Restriction or Loss of Coverage*: If your Health, Dental, or Vision coverage, or the health, dental, or vision coverage offered by your Spouse's employer, is significantly restricted or ceases entirely, you may revoke your health and dental elections and elect coverage under another option that provides similar coverage. Coverage is considered "significantly restricted" if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.

e. *Addition to or Improvement in Coverage*: If the Employer, or your Spouse's employer, adds a health, dental, or vision coverage option or significantly improves a health, dental or vision coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.

f. *Change in Coverage Under Another Employer Plan*: If your Spouse is employed and his or her employer's plan allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change to your Health, Dental or Vision coverage. For example, if your Spouse elects family health coverage during his or her employer's open enrollment period, you may request to end your coverage under the Health Plan.

g. *Change to Dependent Care FSA Elections*: If you experience an increase or decrease in dependent care provider fees (except for increases by a provider who is related to you), or if there is a change in your or your Spouse's regular work schedule that increases or decreases your need for dependent care, you may change your Dependent Care FSA accordingly.

Please note that you will be required to show proof verifying that these events have occurred (e.g., evidence of coverage offered by your Spouse's employer).

If you timely elect to enroll in coverage following an event listed in this section, coverage will be effective as of the first day of the month following the date of the event, with the exception of adding coverage for a birth or adoption, which such change will be effective as of the date of the birth or adoption. An Employee being allowed to make a mid-year change does not impact the decision on whether the Dependent Surcharge applies (see Appendix C for more details on the surcharge).

IV. LEAVES OF ABSENCE

A. FMLA Leave

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact the Employer.

If you take an FMLA leave, you may continue your Health, Dental, Vision, Health FSA and Dependent Care FSA for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of coverage will continue to be deducted from your pay. You also have the option to suspend your coverage for these plans during the leave.

If your health, dental or vision coverage terminates during your FMLA leave due to your non-payment of premiums, your coverage will automatically be reinstated at the same level as prior to the leave as long as you return to work immediately upon FMLA leave being exhausted. If your Health FSA coverage terminates during your leave, you will be automatically reenrolled at the same annual amount you were enrolled in prior to your leave if you return to work in the same year that your leave began. The amount of payments you missed during your FMLA leave will be prorated over the remainder of the Plan Year. No expenses will be reimbursable during the FMLA leave if you opt-out of coverage or fail to make timely payments during the leave.

Your Group Life, Supplemental Life, AD&D and LTD coverages will continue during an FMLA leave. Your supplemental life coverage will continue as long as you continue to pay any applicable premiums. If your coverage is terminated during your FMLA leave, it will be reinstated upon your

return without any evidence of good health or newly imposed waiting period as long as you return to work immediately upon FMLA leave being exhausted.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health FSA coverage amount.)

B. Military Leave under USERRA

If you take a military leave, whether for active duty or for training, you are entitled to extend your Health, Dental, Vision and Health FSA coverage for up to 24 months as long as you give the Employer advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Your total leave, when added to any prior periods of military leave from the Employer, generally cannot exceed five years. There are a number of exceptions. For additional details on the possible exceptions that may extend your USERRA protections, please contact the Employer.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 100% of the cost of coverage.

Your Group Life, Supplemental Life, AD&D and LTD may be continued for up to 12 months during your military leave. Some exceptions do apply. Please see the applicable certificate of coverage. Your Dependent Care FSA will terminate during your military leave.

If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — when you return to work for the Employer, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to Health Plan coverages. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

C. Other Leaves of Absence (Including Unpaid Medical Leaves of Absence)

Generally, a leave of absence that does not qualify under FMLA or USERRA does not impact your eligibility for Health, Dental, Vision, Health FSA or Dependent Care FSA coverage as long as you continue to pay your portion of the applicable premiums. The Employer does not subsidize the cost of the health insurance plan while you are on an unpaid leave of absence, so you will be required to pay the full monthly rate (i.e., both the Employer and employee portion of the premium). If you do not receive sufficient pay during any pay period during your leave, you must send your portion of any premium owed to the Business Administrator at your primary location of employment.

You are able to continue coverage in these plans during the remainder of the current Stability Period, unless your employment is terminated prior to the end of the Stability Period or you fail to pay your premiums on time. If your leave of absence straddles two Stability Periods, whether you

are eligible for coverage during the portion of your leave of absence that is in the second Stability Period depends on whether you are considered a full-time employee during that period's Measurement Period.

Your Group Life, AD&D and LTD coverage will continue for up to 12 months for any leave of absence approved in writing by the Employer. Your Supplemental Life coverage will also continue for up to 12 months as long as you continue to pay any applicable premiums.

V. TERMINATION OF COVERAGE

A. Termination of Employee's Coverage

An Employee properly enrolled in a plan will lose coverage under the applicable plan on the earliest of the followings dates:

a. The date the plan terminates;

b. The date that any required contribution to the applicable plan is not paid;

c. The date in which the Employee is no longer eligible for coverage under the plan;

d. The date of death of the Employee; or

e. The last day of the month following the Employee's date of termination of employment or the July 31st of a year in which an Employee's contract is non-renewed (which includes a voluntary resignation or retirement at the end of the school year), except in the case of the Health FSA and Dependent Care FSA plans, in which case coverages terminates on the date of the Employee's termination of employment.

If you are an Employee whose employment is subject to an employment contract with the Employer and your contract is non-renewed (either by you or by the Employer), your coverage under the Health, Dental and Vision Plans will terminate on July 31st of that year (even if your salary is being paid longer). However, if you are able to secure a position of employment at another location that participates in the Health, Dental and Vision plans prior to the time that your coverage under these plans is terminated, your Health, Dental and Vision plan coverage will be continued at your prior employment location until September 1st when your Health, Dental and Vision plan coverage will go into effect at your new location (assuming that you properly enrolled during open enrollment and have paid your required contributions). It is your responsibility to notify your outgoing Employer if you secure a new contract. If you fail to notify your outgoing Employer by July 31st your coverage will be terminated effective July 31st.

If you terminate employment and are rehired within 90 days, your Supplemental Life coverage will be reinstated on your date of rehire.

B. Termination of Spouse and/or Dependent Child's Coverage

Coverage with respect to any Spouse or Dependent Child that is a Covered Individual will end on the earliest of the following dates:

a. The date that coverage under the plan ceases for the Employee;

b. The last day of the month for the Spouse following the finalization of a divorce from the Employee;

c. The last day of the month that a Dependent Child no longer meets the applicable requirements for eligibility for a plan;

d. The last day of the period that any required contribution to the applicable plan is not paid; or

e. For a Dependent child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.

Coverage under any of the Plans may be retroactively canceled or terminated (rescinded) if a Covered Individual acts fraudulently or intentionally makes material misrepresentations of fact. Any submission of false information or a failure to timely advise the Employer of a change in your Spouse's or Dependent Child's eligibility for other employer group health plan coverage is considered fraud or intentional misrepresentation and your Spouse's or Dependent Child's coverage **will be terminated retroactively** to the date such other coverage became available to them.

If your coverage, your Spouse's, or Dependent Child's coverage is cancelled for fraud or intentional misrepresentation, you will receive a 30-day notice of the rescission, but the cancellation of coverage will be retroactive to the date of the fraud or intentional misrepresentation. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

VI. CONTINUATION COVERAGE

A. Eligibility

The Archdiocese is not subject to federal COBRA laws. However, Ohio law requires that the Employer provide continuation coverage to eligible employees and their eligible dependents for the Health Plan under certain scenarios. The Health Plan not only complies with Ohio law but provides more generous continuation coverage than required. Continuation coverage is only available for the Health Plan and not for other benefits offered by the Employer.

You and any other Covered Individuals are eligible for continuation coverage under the Health Plan if you lose Health Plan coverage as a result of an Involuntary Termination of Employment or

reduction in hours, but only if you are covered under the Health Plan at the time of your termination of employment, and your termination is not due to gross misconduct.

The Employer also offers continuation coverage to Spouses and Dependent Children who were Covered Individuals under the Health Plan at the time of an Employee's death.

Continuation coverage is the same Health Plan coverage available to eligible Employees. Each Covered Individual who elects continuation coverage will have the same rights under the Health Plan as other Covered Individuals.

B. Electing Continuation Coverage and Required Contributions

To elect continuation coverage, you or your family members must complete an election form provided by the Employer or its delegate and furnish it according to the directions on the form.

If you elect continuation coverage, you will be responsible for paying 100% of the required contributions for the Health Plan, which includes any contribution previously made by the Employer while you were an Employee. Your first payment is due within 31 days of losing coverage. You must continue to make the required contributions by the first day of each month for that month's coverage at the location where you (or your spouse) last worked. If your employment is terminated, you will be notified of your right to continuation coverage and the amount of the required contributions. You may also contact the Business Manager/Location Administrator at the location where you last worked to confirm the correct amount of your payment.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. Under federal law, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of a termination of employment or the death of the Employee. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

C. Length of Continuation Coverage

The Employer's continuation coverage is available for up to 12 months from the date you would otherwise have lost coverage under the Health Plan. Continuation coverage may terminate earlier than twelve months if you become eligible for Medicare or other group health plan coverage, you do not make the required contribution in a timely manner, or the Employer terminates the Health Plan. You have an obligation to notify us if you become eligible for other coverage.

D. Address Changes and Additional Information

In order to protect you and your family's rights, you should keep the Business Manager/Location Administrator at your location informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices or election forms you send to the Business Manager/Location Administrator.

If you have any questions concerning the information in this notice or your rights to coverage, you

may contact the Business Manager/Location Administrator at your location, or you may contact:

Director of Benefits
Archdiocese of Cincinnati, Finance Office
100 East Eighth Street
Cincinnati, OH 45202
513-421-3131

For more information about your rights under state law, you may call 1-800-686-1578.

VII. HEALTH & PRESCRIPTION DRUG

You may elect to participate in the Employer's Health Plan, which includes prescription drug coverage. The Health Plan is self-funded and provides affordable coverage for a wide-range of medical services through Anthem Blue Cross Blue Shield ("Anthem") and the prescription drug coverage is self-funded and provides services through OptumRx. The Health Plan is a grandfathered health plan under the Affordable Care Act. For more information on what it means to be grandfathered, please see the Introduction section of this Summary.

The services eligible for coverage under the Health Plan include hospitalization, doctor visits, maternity and newborn care, mental health and substance abuse services, home care, hospice, drugs (but not over-the-counter medications), lab work, chronic disease management, rehabilitation, and wellness services. For the specific benefits provided and coverage levels, please see additional materials provided at https://resources.catholicaoc.org/employee-benefits.

Covered services under the Health Plan received from an in-network provider will generally be at a lower cost than obtaining Covered Services from an out-of-network provider. There is an exception for emergency care. Going out of network to obtain medical services can be very expensive, so you should carefully evaluate your options before making a decision. To assist you with making this decision, you may obtain an estimate of your costs for certain procedures and tests through Anthem's website at www.anthem.com.

If you are prescribed drugs by your doctor, contact OptumRx. Your doctor can assist you with obtaining prior authorization by calling OptumRx at 1-800-797-9791. You can find pharmacies, check the status of your order, view your claims, and submit requests for refills at www.optumrx.com.

The benefits and cost of coverage are subject to change without notice. You should refer to the Health Plan documents and Schedule of Benefits on the Archdiocese's website for detailed information about the cost of coverage and benefits available under the Health Plan. If you have any questions concerning the Health Plan, you may contact the Business Manager/Location Administrator at your location.

VIII. DENTAL

You may elect to participate in the Delta Dental PPO plan. This is a fully insured product offered

by Delta Dental of Ohio. Please see additional materials provided at https://resources.catholicaoc.org/employee-benefits.

The services eligible for benefits include routine exams, cleanings, certain emergency services, office visits, restorative care, oral surgery, orthodontics, and other procedures. For the specific benefits provided and coverage levels, please see the Schedule of Benefits and dental covered services document located at https://resources.catholicaoc.org/employee-benefits.

The annual deductible is $50 for each covered individual limited to a maximum deducible of $150 per family per benefit year. There is no deductible for preventive benefits and such benefits are covered at 100%. After the deductible is met, your Dental Plan will cover 50% for all other covered benefits, up to the $1,000 maximum for each participant each year. Orthodontic services have a $1,000 lifetime maximum per participant.

You are not required to participate in a Dental Plan. If you elect to participate, you cannot discontinue coverage during the Plan Year, unless you experience a Qualifying Event. If you elect to participate in the Dental plan, you will be responsible for the entire cost of coverage and all of your dental expenses.

The benefits and cost of coverage are subject to change. You should refer to the Dental Plan documents and Schedule of Benefits on the Archdiocese's website for detailed information about the cost of coverage and benefits available under the Dental Plan.

IX. VISION

You may elect to participate in the Vision Plan. This is a fully insured product offered by VSP. Please see additional materials provided at https://resources.catholicaoc.org/employee-benefits.

The services eligible for benefits include routine eye exams, prescription glasses and contact lens.

You are not required to participate in the Vision Plan. If you elect to participate, you cannot discontinue coverage during the Plan Year, unless you experience a Qualifying Event. If you elect to participate, you will be responsible for the entire cost of coverage and all of your vision expenses.

The benefits and cost of coverage are subject to change. You should refer to the Vision Plan documents and Schedule of Benefits on the Archdiocese's website for detailed information about the cost of coverage and benefits available under the Vision Plan.

X. LIFE, AD&D AND LTD

The Employer provides eligible employees with $50,000 Group Life & AD&D insurance at no cost to you. If you choose to increase your coverage, beyond $50,000, or insure your Spouse or Dependent Child, you are responsible for the entire cost of any additional or optional coverage. Supplemental Life coverage added after you're first eligible or that exceeds specified amounts is subject to the Standard Underwriting Approval (please see the Certificate for more detail). Before electing additional or optional coverage, you should carefully review the eligibility rules and costs described in the Group Life and AD&D policy document, which is available at

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

The Employer also provides LTD insurance at no cost to you. You are not required to make any contributions towards the cost of LTD insurance. The LTD benefit is 60% of your earnings prior to your disability. The maximum monthly benefit is $5,000. The minimum daily benefit is $100. Your benefits will begin after you have been continuously disabled for 180 days subject to underwriter approval. The period of time for which you receive LTD benefits is determined by your age as described in the Coverage Features section of the LTD policy. You can access the current LTD policy at https://resources.catholicaoc.org/employee-benefits.

XI. HEALTH CARE FSA

You may elect to receive reimbursement of some or all of your uninsured medical expenses through a Health Care FSA, which you may fund with pre-tax salary reduction contributions.

The maximum amount you may elect to defer to the Health Care FSA for the Plan Year is based on the IRS approved amount for the calendar year of the AOC Plan Year starting July 1st (e.g., in 2023 the limit is $3,050). The minimum amount you may elect to contribute to the Health Care FSA each Plan Year is $240. The Employer may change this limit in the future, and will communicate the applicable limit to you at the beginning of each Plan Year. The amount you elect to contribute through salary reductions will be credited to your account at the beginning of each Plan Year and may be used to reimburse your out-of-pocket medical expenses.

While you are a Covered Employee in the Health Care FSA, the expenses eligible for reimbursement include hospital bills, doctor and dental bills, drugs (but not over-the-counter medications), and expenses for medical, dental and vision care which are not reimbursed or otherwise paid by insurance or other sources. No expenses that are contradictory to the beliefs of the Catholic Church (e.g., contraceptives) will be eligible for reimbursement through your Health Care FSA, and the Employer has sole discretion to determine whether an expense is contradictory to the beliefs of the Catholic Church.

Expenses are eligible for reimbursement if incurred by you, your Spouse, or an individual who you may claim as a dependent for income tax purposes, as long as your Spouse or dependent is not contributing to a Health Savings Account or HSA. If your Spouse or Dependent Child contributes to an HSA (or their employer contributes to an HSA on their behalf) during the calendar year, you are still eligible for the Health Care FSA, but the expenses of your Spouse or Dependent Child are not eligible for reimbursement during that period.

To claim a reimbursement, you must follow the procedures established by the Employer. You may only be reimbursed for expenses incurred after you became a Covered Employee in the Health Care FSA plan, and before the end of the Plan Year, or, if earlier, the date of your termination of employment. You must submit all claims and/or supporting documentation no later than September 30th after the Plan Year ends.

If there is any amount remaining in your Health Care FSA after you have been reimbursed for all eligible expenses for the Plan Year, you may carry over up to 20% of the year's annual limit (i.e., $610 for the plan year ending June 30, 2024) to reimburse eligible expenses incurred during the

next Plan Year. You may still elect to contribute up to the maximum limit for the next Plan Year, and the amount you carry over may be used in addition to your election (e.g., if you carry over $610 to new 7/1 – 6/30 Plan Year and also elect to contribute the $3,050 in same Plan Year, you may be reimbursed up to $3,660 in eligible expenses for that Plan Year). **Any unused amount in excess of that year's rollover amount will be forfeited and will not be available to you for future use.**

While the Employer will deny claims that are not eligible for reimbursement under the terms of the Plan, you also have a responsibility to determine if expenses submitted are reimbursable expenses that are excludable from your gross income for federal and state income tax purposes (e.g., are not purely cosmetic in nature). You must notify the Employer if you have reason to believe a reimbursed expense is not permissible.

XII. DEPENDENT CARE FSA

You may elect to receive reimbursement of some or all of your dependent care expenses through a Dependent Care FSA, which you may fund with pre-tax salary reduction contributions.

The maximum amount of reimbursements you may receive from your Dependent Care FSA in any Plan Year or calendar year is the lesser of:

- $5,000 (or $2,500 for a married Covered Employee who files a separate tax return);
- Your earned income; or
- Your Spouse's earned income, or if your Spouse is a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself, your Spouse's deemed earned income ($250 each month if you have one Dependent Child, and $500 per month if you have 2 or more Dependent Children).

Your Dependent Care FSA may be used to reimburse expenses associated with the care of a child under the age of 13 who you could claim as a dependent for income tax purposes, or the care of a dependent for income tax purposes or Spouse who is mentally or physically unable to care for himself or herself. To be eligible for reimbursement, the expense must enable you to be gainfully employed. Expenses incurred while you are on a leave of absence are not reimbursable unless your absence from work is for a period of two consecutive weeks or less.

If the dependent care services are provided outside of your household, the dependent must regularly spend at least 8 hours per day in your household. If those services are provided at a facility that also cares for at least 6 other individuals who do not live there, it must comply with all applicable state and local laws and regulations.

You may not reimburse expenses for services provided by your child who will be under age 19 at the end of the calendar year, or services provided by an individual who you or your Spouse could claim as a dependent for income tax purposes. In addition, you may not be reimbursed for dependent care expenses incurred at a camp where the dependent stays overnight.

To claim a reimbursement, you must follow the procedures established by the Employer. You may only be reimbursed for expenses incurred after you became a Covered Employee in the

Dependent Care FSA plan, and before the end of the Plan Year, or, if earlier, the date of your termination of employment. You must submit all claims and/or supporting documentation no later than September 30th after the Plan Year ends. **If you have a balance remaining in your Dependent Care FSA after you have reimbursed all eligible expenses for the Plan Year, the balance will be forfeited and will not be available to you for future use. In addition, you may not claim any other tax benefit, such as the dependent care tax credit, relative to the tax-free amounts received by you under the Dependent Care FSA plan.**

While the Employer will deny claims that are not eligible for reimbursement under the terms of the Plan, you also have a responsibility to determine if expenses submitted are reimbursable expenses that are excludable from your gross income for federal and state income tax purposes (e.g., an expense that allows you to be gainfully employed opposed to for weekend babysitting). You must notify the Employer if you have reason to believe a reimbursed expense is not permissible.

XIII. EMPLOYEE ASSISTANCE PROGRAM

An Employee Assistance Program ("EAP") is a **free** service that provides access to counselors and resources to help employees and their household members with everyday problems and questions. The EAP is able to assist with a large range of topics including, but not limited to, the following:

- Child and elder care
- Tobacco cessation
- Relationship issues
- Financial planning and budgeting
- ID recovery and credit counseling
- Setting goals for retirement
- Adoption
- Small claims and personal injury
- Grief and loss
- Workplace safety
- Addiction and recovery
- Foreclosures and bankruptcy
- Estate planning
- Career advice
- Car and home buying
- Family health

The EAP covers four free counseling sessions per household member per issue.

You can access the EAP 24 hours a day either online or via phone, and there is never any need to make an appointment first. You can reach the EAP via phone by calling 1- 800-999-7222. EAP counselors are able to assist with setting up one of your four (4) free counseling sessions with a licensed professional. Your call is confidential. They are also able to direct you to professionals and experts able to consult with you on various topics. Online, you have access to articles, checklists, quizzes and other helpful tools. You can also attend webinars or take online classes. Navigate to anthemeap.com and enter the code: AOC.

XIV. CLAIMS

Except for claims decisions that it delegates to a contractual service provider, the Employer has exclusive responsibility for deciding claims for benefits and for deciding any appeals of denied claims. All decisions made by the Employer shall be final and binding to the fullest extent permitted by law.

A. Health, Dental, Vision, Life, AD&D, and LTD Plans

A description of the claims determination process and the details of the appeals process are available in the applicable certificate of coverage, benefits booklet, or insurance contract or policy for each welfare plan described in this summary.

B. Health Care and Dependent Care FSA Plans

If you are a Covered Individual and your claim for a benefit under the Health Care FSA or the Dependent Care FSA plan is denied in whole or in part, you will receive an Explanation of Benefits. If the claim was denied for incomplete information, the Explanation of Benefits will provide step-by-step instructions for resubmitting the claim.

If you disagree with the claims denial, you have 180 days to appeal the claims decision. To appeal a decision, you must send a written, signed letter of appeal to Benefit Allocation Systems, LLC ("BAS") at the following address:

Benefit Allocation Systems
ATTN: Claim Appeal
P.O. Box 62407
King of Prussia, PA 19406

Alternatively, you may fax your appeal to BAS at 1.888.265.2144.

BAS will forward your appeal to the Employer. The review of your denial will not afford deference to the initial determination, and will be conducted by an individual who did not make the original determination and is not the subordinate of such individual. A decision on the review shall be made within 60 days after receipt of your request for review.

XV. SUBROGATION

The Employer has the rights of subrogation and reimbursement in the Health Plan. Subrogation is the Employer's right to pursue your claims for expenses covered by the Employer's Health Plan against another person, entity or organization, and/or your or their insurer. The Employer also has the right to be reimbursed from amounts recovered by a Covered Individual relating to charges covered by the Health Plan. The Employer has the right to be reimbursed from any judgments, settlements or other type of recovery for benefits provided or that will be provided by the Health Plan.

You must repay the Health Plan from any recovery related to the benefits advanced by the Health Plan, whether by lawsuit, settlement or otherwise. The Health Plan's right of subrogation and reimbursement applies to all types of recoveries, including (but not limited to) insurance payments even if it is from your own insurance, reimbursements, cash payments and monies paid by way of judgment, settlement, or to reflect charges covered by the Health Plan. This right of subrogation and reimbursement also applies when you are entitled to recover under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

As a condition of participating in the Employer's Health Plan, you must recognize the Employer's rights to subrogation and reimbursement. Except for claims paid by another Employer sponsored Health or Dental Plan, these rights provide the Plan with first priority over any proceeds (regardless of whether such funds fully or partially compensate you for your losses) paid by or on behalf of any party or any insurance company to you relative to an injury or sickness for which benefits are advanced by the Health Plan, including a priority over any claim for attorney fees, or other costs and expenses. The Health Plan's right to refund shall not be reduced under any common fund or similar claims or theories. In other words, the make-whole doctrine shall not apply.

The Health Plan shall automatically have a first priority equitable lien to the extent the Health Plan paid benefits from any party or insurance company on any amount recovered by you. This equitable lien shall remain in effect until the Plan is repaid in full. The Employer reserves the right to reduce any future benefit payments for you until the obligation to reimburse the Health Plan is satisfied. You shall execute any documents necessary to secure this right.

You shall timely inform the Health Plan of any settlement offers. As an additional condition of participation, you agree to hold in an accessible trust for the Health Plan's benefit under these subrogation provisions any and all proceeds of a settlement, arbitration award or judgment. You agree not to accept any settlement that does not fully compensate or reimburse the Employer without first acquiring the Employer's written consent. Once repayment is made to the Employer, the Employer shall not have any further obligation to pay any expenses relating to the injury or sickness.

As a condition of participating in the Health Plan, you must execute any documents that are determined necessary by the Employer for the Employer to enforce its rights under this section. The Employer may hire an attorney and may recover its attorney fees and any other costs associated with enforcing its rights under this section from you or amounts recovered by you.

XVI. OVERPAYMENTS

If the Employer pays benefits for expenses incurred on account of a Covered Individual, that Covered Individual (or Employee in the case of a Dependent Child), or any other person or organization that was paid, must make a refund to the Employer if any of the following apply:

- All or some of the expenses that should have been paid by the Covered Individual and were not paid by the Covered Individual or did not legally have to be paid by the Covered Individual; or

- All or some of the payment made exceeded the benefits under the Employer's welfare benefit plans.

- The refund equals the amount paid in excess of the amount that should have paid.

If the refund is due from another person or organization, the Covered Individual agrees to help the Employer get the refund when requested as a condition of participation in the Employer's benefit plans.

XVII. COORDINATION OF BENEFITS

A description of the coordination of benefits provisions are available in the applicable certificate of coverage, benefits booklet, or insurance contract or policy for each welfare plan described in this summary.

XVIII. COORDINATION OF BENEFITS WITH MEDICARE

If you are an active Employee, Spouse of an active Employee or Dependent Child of an active employee, you do not lose eligibility for the Health Plan due to either your or anyone else's eligibility for Medicare. In other words, becoming eligible for Medicare does not impact your eligibility in the Health Plan. If you enroll in both the Health Plan and Medicare, Medicare will pay secondary to the Health Plan as long as you remain an active employee (with an exception for individuals with end stage renal disease – explained below). However, an active Employee, age 65 or over, has the option of voluntarily rejecting the employer-sponsored health plan with the result that Medicare becomes the primary payer. Rejection of this employer-sponsored health plan should be submitted in writing to your Benefits Office and must be received within 30 days of the Effective Date of coverage under Medicare. Similarly, an Employee could choose not to enroll their Spouse in the Health Plan (i.e., elect single coverage), if the Spouse prefers to only have Medicare coverage.

If you have end stage renal disease, Medicare is a secondary payer to the Health Plan if you are enrolled in the Health Plan for up to 30 months if you have Medicare solely because of permanent kidney failure. At the end of the 30-month period, Medicare becomes the primary payer until your Medicare coverage for permanent kidney failure ends. If you are eligible for Medicare due to end stage renal disease and do not enroll in Medicare, the Health Plan reduces its benefits for Covered Individuals who are eligible for Medicare, but not enrolled when Medicare would be the primary coverage. Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare. For further information, contact your nearest Social Security office or the Medicare insurance carrier in your area.

XIX. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. The group health plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, health plan administration or as required or permitted by law. A description of the Health Plan uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Health Plan's notice of privacy practices, which is furnished to all Health Plan participants, and is summarized below.

A. Enrollment/Disenrollment Information

The Health Plans and any insurer providing coverage under the plans may disclose information on whether an individual is a Covered Individual or has ceased to be a Covered Individual to the Employer without restriction. In addition, enrollment and disenrollment information created by

the Employer is not considered PHI because the Employer creates the information on behalf of participants and beneficiaries.

B. Summary Health Information

In addition, the Health Plans and any insurer providing coverage under the plans may disclose Summary Health Information requested by the Employer for the purpose of obtaining premium bids for insurance coverage, or modifying, amending, or terminating a plan. Any genetic information contained in the Summary Health Information provided to the Employer will not be used for underwriting purposes.

C. Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in section D, the Health Plans, or a business associate or insurer acting on behalf of a Health Plan, may disclose PHI and Electronic PHI to the Employer, provided that the Employer is permitted to use or disclose PHI and Electronic PHI only for the purpose of administering the Health Plans. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and plan management (including financial and administrative oversight and HIPAA compliance). Plan administration functions do not include functions performed by the Employer for a Health Plan in connection with any other plan, or any employment-related actions or decisions.

Notwithstanding any provisions of this summary to the contrary, the Employer shall not be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with law.

D. Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than PHI disclosed pursuant to a valid signed authorization) disclosed to it by a Health Plan described in this summary, or a business associate or insurer acting on behalf of a Health Plan, the Employer shall:

- Not use or further disclose the PHI other than as permitted or required by the plans or as required by law;
- Ensure that any agent to whom it provides PHI received from the plans agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- Report to the plans any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;
- Make available all PHI necessary for the plans to comply with an individual's right to access PHI, including the right to access electronic copies of PHI, if applicable;
- make available PHI required for the plans to comply with an individual's right to amend PHI, and to incorporate any amendments to PHI;
- Make available PHI required for the plans to comply with an individual's right to request an accounting of disclosures;

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plans available to the Secretary of Health and Human Services for purposes of determining compliance by the plans with HIPAA's privacy requirements;

- If feasible, return or destroy all PHI received from the plans that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure an adequate separation between the plans and the Employer.

The Employer further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than Electronic PHI disclosed pursuant to a valid signed authorization) on behalf of the plans, it will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the plans;

- Ensure that the adequate separation between the plans and the Employer is supported by reasonable and appropriate security measures;

- Ensure that any agent to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

- Report to the plans any security incident of which it becomes aware.

E. Adequate Separation Between Plan and Plan Sponsor

The Employer shall allow certain employees who assist with Health Plan administration access to PHI. No other persons shall have access to PHI. These employees shall have access to and use of PHI only to the extent necessary to perform the administrative functions that the Employer performs for the plans. In the event that an employee does not comply with the provisions of this section, the employee shall be subject to disciplinary action by the Employer for noncompliance pursuant to the Employer's employee discipline and termination procedures. The Employer shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the plans.

F. Availability of Notice of Privacy Practice

The Health Plan and Health FSA Account Plan maintain a Notice of Privacy Practices that provides information to individuals whose PHI will be used or maintained by the Plan. If you would like a copy of the Notice of Privacy Practices, you can find it on our website at https://resources.catholicaoc.org/employee-benefits or you may receive a free paper copy by contacting:

Director of Benefits
Archdiocese of Cincinnati
100 East Eighth Street
Cincinnati, OH 45202
513-421-3131

XX. IMPORTANT NOTICES

A. Women's Health & Cancer Rights Act (WHCRA)

As required by the WHCRA, the Health Plan provides coverage for reconstructive surgery following a mastectomy. Specifically, the plan provides coverage 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 treatments for physical complications for all states of mastectomy, including lymphedemas.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

B. The Newborns' and Mothers' Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Physician obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

C. Special Enrollment Notice

If you are declining enrollment for yourself, your Spouse or your Dependent Children because of other health insurance, you may be able to enroll yourself and your dependents in the Health Plan if you, your Spouse or Dependent Children lose eligibility for that other coverage. You must request enrollment within 30 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, your Spouse and your Dependent Children in the Health Plan. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

The Health Plan includes two additional special enrollment opportunities. These two qualifying events are when:

- You, your Spouse, and/or your Dependent Child(ren) terminate Medicaid or CHIP (Children's Health Insurance Program) coverage as a result of a loss of eligibility; or

- You, your Spouse, and/or Dependent Child(ren) become 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. If you experience a qualifying event and want to enroll in coverage, contact the Business Manager/Location Administrator at your location.

D. Children's Health Insurance Program Reauthorization Act (CHIPRA)

If you, your Spouse, or your Dependent Children are eligible for Medicaid or CHIP and you are eligible for health coverage from the 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, your Spouse, or your Dependent Children are not eligible for Medicaid or CHIP, you will not 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, your Spouse, or your Dependent Children are already enrolled in Medicaid or CHIP and you live in a State that provides assistance, contact your State Medicaid or CHIP office to find out if premium assistance is available. For a list of the states that provide assistance, please review the CHIP notice found in the annual Benefits Guide that can be found at https://resources.catholicaoc.org/employee-benefits.

If you, your Spouse, or your Dependent Children are NOT currently enrolled in Medicaid or CHIP, and you think you or your Dependent Children might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or visit 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, your Spouse, or your Dependent Children are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the Employer's Health Plan, the Employer must allow you to enroll in the Employer's Health Plan if you are not 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 the Employer's plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

E. Notice of Creditable Prescription Drug Coverage

If you or your family members are not currently covered by Medicare and will not be covered by Medicare in the next 12 months, this notice does not apply to you.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Employer 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 the 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 coverage or decide to leave the Employer, you may be eligible for a Medicare special enrollment period.

The Employer has determined that the prescription drug coverage offered by the Health plan is, on average for all Covered Individuals, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered creditable coverage. Because the prescription drug coverage offered under the Health Plan 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 Employee and a Covered Individual, you may also continue your coverage under the Health Plan. In this case, the Health Plan will continue to pay primary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop your health coverage with the Employer, Medicare will be your only payer. An Employee can re-enroll in the Health Plan at open enrollment or if you have a special enrollment event.

You should know that if you waive or cease coverage under the Employer's Health Plan 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 the 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.

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 Employer's Health Plan coverage changes, or upon request.

More detailed information about Medicare plans that offer prescription drug coverage in the "Medicare & You" handbook. Medicare participants will get a copy of the 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 prescription drug coverage.

- 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 and 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:

Director of Benefits
Archdiocese of Cincinnati
100 East Eighth Street
Cincinnati, OH 45202
513-421-3131

XXI. AMENDMENT AND TERMINATION

The Employer intends to continue the welfare benefit plans described in this summary indefinitely, but reserves the right to amend, modify or terminate, in whole or in part, any or all of the provisions of any or all of the plans (including any related documents and underlying policies), at any time and for any reason, by action of the Employer in its sole and absolute discretion. The benefits to be provided under the plans and the eligibility of employee members to participate in the plans are to be determined from time to time under the then-effective provisions of each plan's terms and policies.

XXII. GENERAL LEGAL PROVISIONS

A. Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to benefits. These errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by the Employer or the Employer's designees, in accordance with the terms of the Employer's welfare benefit plans.

B. Unclaimed Funds

If a benefit payment or an administrative expense check is not cashed within a reasonable period

of time, as determined by the Employer, the check shall be voided and shall be used to reduce future contributions by the Employer. However, if the payee later makes a proper claim to the Employer for the amount, it shall be paid to the payee.

C. Governing Law

The Employer's benefit plan documents shall be construed in accordance with the laws of the State of Ohio, except where such laws are superseded by federal law.

D. Invalidity of Certain Provisions

In the event any provisions of the Employer's welfare benefit plans shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts shall be construed and enforced as if such illegal and invalid provisions had never been inserted herein.

E. Limitation of Action

If you want to bring a legal action against the Employer, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action. You cannot bring any legal action against the Employer for any reason unless you first complete all the steps in the appeal process.

F. Policies and Procedures

The Employer may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Employer's welfare benefit plans with which a Covered Individual shall comply.

G. Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Employer's welfare benefit plans or to bind the Employer by making any promise or representation or by giving or receiving any information.

XXIII. GENERAL INFORMATION

Plan Name:	Archdiocese of Cincinnati Welfare Benefit Plan
Employer Name:	Archdiocese of Cincinnati
Employer Address:	100 East Eighth Street Cincinnati, OH 45202
Phone Number:	(513) 421-3131
Agent for Service of Legal Process:	Service of legal process may be made on the Employer.
Benefit Year:	July 1st – June 30th

Effective Date: The effective date of this summary is July 1, 2021.

Benefits: The types of coverage described in this summary are:

Health and Prescription Drug;
Dental;
Vision
Health Care FSA;
Dependent Care FSA;
Life;
Supplemental Life;
AD&D; and
LTD

Funding Method: The Dental, Vision, Life, Supplemental Life, AD&D, and LTD benefits are provided through the purchase of insurance contracts with an insurer, who is solely responsible for payment of benefits and final determinations of benefit eligibility.

The benefits under the Health Plan are funded through the general assets of the Employer and through contributions by Covered Individuals.

Benefits under the Health Care FSA and Dependent Care FSA are funded through contributions by Covered Individuals.

Insurer or Contract Services Provider:

Health
Community Insurance Company dba Anthem Blue Cross and Blue Shield
(800) 887-6055

Prescription Drug
OptumRx
(800) 797-9791

Dental
Delta Dental of Ohio
(800) 524-0149

Vision
VSP Member Services
(800) 877-7195

Health and Dependent Care FSA
Benefit Allocation Systems
(866) 694-6423

Life, Supplemental Life, AD&D, and LTD
The Standard
Life/Supplemental Life/AD&D: (800) 628-8600
LTD: (800) 368-1135

XXIV. DEFINITIONS

"Covered Individual" means an Employee who is properly enrolled in the applicable plan and the Employee's Spouse and/or Dependent Children who are properly enrolled in the applicable plan. A Covered Individual also includes a former Employee and the Spouse and Dependent Children of a former Employee who are enrolled in continuation coverage under the Health Plan.

"Dependent Child" means your biological child, stepchild, foster child, adopted child or a child that is placed with you for adoption.

"Employee" means each individual who is a common law employee maintained on the Archdiocese-wide payroll system and is working at a location that provides for participation in the applicable Plan. An Employee does not include a leased employee or an individual who is paid as an independent contractor. An individual that the Employer determines is not an Employee will not be eligible to participate in the Plans regardless of whether a court, tax or regulatory authority determines that the person is an employee. Solely for purposes of the Plans, any Diocesan priest ordained into the Archdiocese of Cincinnati, priest on canonical assignment to the Archdiocese or a religious sister or brother who is working at a location of the Archdiocese but who is not receiving compensation due to a vow of poverty (each referred to as a "Clergy Member") shall be included as an Employee.

"Electronic Protected Health Information (Electronic PHI)" means PHI that is transmitted by or maintained in electronic media.

"Employer" means the Archdiocese of Cincinnati, including the various schools, parishes, agencies and other organizations belonging to or affiliated with the Archdiocese of Cincinnati and subject to any aspect of supervisory authority of the Archbishop of Cincinnati under Canon Law. The Archdiocese of Cincinnati shall determine which entities are employers based on a reasonable, good faith standard.

"Employment Break Period" means a period of at least four consecutive weeks during which a school employee is not credited with Hours of Service (i.e., summer break). Only full weeks off will be considered in calculating an Employment Break Period.

"Hours of Service" means any hour for which you are paid, or entitled to payment, for the performance of duties for the Employer or for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. An hour of overtime counts as one hour of service, regardless of the rate you are paid. You will not receive credit for Hours of Service for periods during which you are not performing services but are receiving payments in the form of workers compensation wage replacement benefits.

"Initial Administrative Period" means the calendar month following an Employee's Initial Measurement Period during which the Employer calculates the Employee's average Hours of Service during the Initial Measurement Period.

"Initial Measurement Period" means the period beginning on the first of the month following your employment start date and ending 12 months later.

"Initial Stability Period" means the 12-month period beginning immediately after your Initial Administrative Period.

"Involuntary Termination of Employment" means a termination that was not a result of the Employee voluntarily terminating his or her employment. An Involuntary Termination of Employment also includes the non-renewal of a teacher's contract where the teacher is permitted to resign or a non-teacher who is permitted to resign due to a non-renewal of the individual's contract.

"Lookback Method" a method that is prescribed by the Affordable Care Act that permits an employer to look back at an employee's prior service to determine whether the employee is considered full-time and eligible for health plan coverage.

"Measurement Period" means a 12-month period that will begin each year sometime in April and end 12 months later.

"Ongoing Employee" means an Employee who has been employed by the Employer for an entire Measurement Period, regardless of whether the Employee has changed positions or moved between participating locations within the Employer.

"Plan Year" means each July 1 to June 30.

"Protected Health Information (PHI)" means information that is created or received by a health plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe that the information can be used to identify the individual. PHI includes information of persons living or deceased. PHI does not include health information about an employee that is held in the Plan Sponsor's employment records in its role as an employer.

"Seasonal Employee" means an Employee who is hired into a position for which the customary annual employment is six months or less and that period begin each calendar year at approximately the same time of the year (e.g., every summer).

"Special Unpaid Leave" means unpaid leave that is subject to the FMLA, USERRA, or on account of jury duty.

"Spouse" means a person of the opposite-sex to whom the Covered Employee is married in a legal union between one man and one woman as husband and wife.

"Stability Period" means the Plan Year immediately following the end of each Measurement

Period.

"Summary Health Information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan, and from which 18 specific identifiers have been removed in accordance with applicable regulations.

APPENDIX A
REQUIRED PROOF DOCUMENTS FOR DEPENDENT COVERAGE

Legal Marriage – One of the following:

- Marriage certificate (clarify that it must be from local government vs. a non official church certificate
- First page of Federal income tax return (dollars may be redacted)

Biological Child – One of the following:

- Birth certificate listing Employee as parent
- Documentation on hospital letterhead indicating the birth date of child(ren) under 6 months old
- Federal income tax return

Adopted Child - One of the following:

- Official court/agency papers (initial stage)
- Official Court Adoption Agreement (mid-stage)
- Birth certificate (final stage)
- Federal income tax return

Foster Child

- Official court or agency placement papers

Stepchild – All of the following:

- 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

Other Child

- Court papers demonstrating legal guardianship, including the person named as legal guardian

Court-Ordered Health **Coverage – One of the following:**

- Qualified Medical Child Support Order (QMCSO)
- National Medical Support Notice (NMSN)

APPENDIX B
OTHER GROUP HEALTH PLAN COVERAGE

In Section II.B.3.D of the this Summary, it explains that Spouses and Dependent Children will be required to pay 100% of the cost of family coverage for Health Plan coverage if the Spouse or Dependent Child has access to "other group health plan coverage." The following chart is a summary of various types of plans and whether those types of plans are considered "other group health plan coverage" for this purpose. The chart is not all-inclusive, so if your Spouse or Dependent Child is eligible for another type of coverage, please check with your Business Manager in advance of enrolling your spouse or dependent child to determine if the surcharge would apply.

Type of coverage	**Considered "other group health plan coverage"**
PPO medical plan	Yes
HMO medical plan	Yes
Network-only medical plan	Yes
High-deductible health plan (with or without HSA)	Yes
Multiple Employer Welfare Arrangement ("MEWA")	Yes
Health Reimbursement Arrangement (HRA)	Yes
Medical Reimbursement Arrangement (MERP)	Yes
Medicare	No
Medicaid	No
Tricare	No
Individual insurance policy	No
Vision	No
Dental	No
Drug Discount Card	No
Employee Assistance Program	No
Health FSA	No

APPENDIX C
QUALIFYING MID-YEAR CHANGE EVENTS

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Marriage	Election form must be received within 30 days of the date of marriage to opposite sex individual. Coverage must become effective no later than first of the month following receipt of completed form.	Employee may enroll or increase election for new Spouse. Employee may revoke or decrease coverage only if coverage for the Employee becomes effective or increased under Spouse's plan.	Employee may enroll or increase election for new Spouse. Employee may decrease election if Employee becomes eligible for coverage under Spouse's plan. Mid-year decrease can be limited to the amount the Employee has already spent YTD.	Employee may enroll or increase to accommodate newly eligible dependent. Employee may cease coverage if new Spouse is not employed or if making a Dependent Care FSA election under Spouse's plan. Mid-year decrease may be limited to the amount the Employee has already spent YTD.
Divorce	Election form must be received within 30 days of divorce date. Coverage will end on the date of divorce. Paycheck changes effective with first payroll following receipt of election form. If election form is received more than 30 days after divorce, coverage will still be cancelled back to the date of divorce but paycheck changes will not go into effect until the start of the new benefit year.	Employee may decrease election to reflect loss of Spouse's eligibility. Employee may enroll or increase election for Dependent Child's coverage if the Employee or dependents lost coverage under other plan (see Loss of Other Coverage).	Employee may decrease election to reflect loss of Spouse's eligibility. Employee may enroll or increase election where coverage is lost under Spouse's plan. Mid-year decrease is limited to the amount the Employee has already spent YTD.	Employee may decrease coverage if eligibility lost for Dependent Children (e.g., dependents now reside with ex-Spouse). Mid-year decrease is limited to the amount the Employee has already spent YTD.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Spouse or Dependent Child's Death	Election form must be submitted within 30 days of the date of death. Any coverage changes allowable will be effective as of the first of the month following date of death. Paycheck changes will be effective first payroll following coverage change effective date.	Employee may only drop coverage for the deceased Spouse or Dependent Child. Employee may add coverage for themselves and other eligible dependents if a loss of other coverage occurs due to the death (see Loss of Other Coverage).	Employee may decrease election amount to account for deceased Spouse or Dependent Child. Mid-year decrease is limited to the amount the Employee has already spent YTD.	Employee may decrease election amount if deceased dependent was the individual who required child care. Mid-year decrease is limited to the amount the Employee has already spent YTD.
Death of Employee	Notification of Employee's death must be received within 30 days from the date of death.	Coverage ceases on the date of death of the Employee.	Claims incurred on or before date of death may be submitted but coverage ceases on date of death.	Claims incurred on or before date of death may be submitted but coverage ceases on date of death.
Adoption, Birth, Placement for Adoption	Election form must be received within 30 days of the date of birth, adoption, or placement for adoption. Coverage is effective on the date of birth, adoption, or placement for adoption. Paycheck changes first paycheck after birth, adoption, or placement for adoption, or first paycheck following receipt of election form, if later.	Employee may add coverage (or change coverage) for themselves, Spouse and for the new Dependent Child. Employee may also drop coverage if enrolling in family coverage elsewhere.	Employee may enroll or increase election amount to cover expenses of new Dependent Child.	Employee may enroll or increase election amount to cover expenses of new Dependent Child.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Dependent Ages Out	Election form must be received within 30 days of the date of the Dependent Child's birth date. Coverage will be terminated on the last day of the month of the Dependent Child's birth date. Paycheck changes effective with first payroll following receipt of the form or birth date (whichever is later). If election form is submitted more than 30 days after the Dependent Child's birth date, coverage will still be cancelled retroactively to last date of birthday month but paycheck changes will not be effective until the beginning of the next benefit plan year.	Employee may only drop coverage for the Dependent Child.	Employee may decrease election amount to account for loss of Dependent Child. Mid-year decrease is limited to the amount the Employee has already spent YTD.	Employee may decrease election if the Dependent Child ages out of the Dependent Care FSA plan (age 13) if paying for child care for that dependent previously. Mid-year decrease is limited to the amount the Employee has already spent YTD.
Employee/ Dependent Gains Other Coverage	Election form must be submitted within 30 days of the date other coverage is effective. Any allowable coverage changes will be effective as of the first of the month following date election form received. Paycheck changes with first payroll following coverage change effective date.	Employee may drop coverage only for those individuals who are enrolled in other coverage. However, if Employee drops coverage for themselves, coverage for Spouse and Dependent Children ceases too.	Employee may decrease or increase election amount to take into account other coverage. Mid-year decrease is limited to the amount the Employee has already spent YTD.	Employee may decrease election amount if other coverage gained was Dependent Care FSA coverage. Mid-year decrease is limited to the amount the Employee has already spent YTD.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Loss of Other Coverage (Employee, Spouse, or Dependent Child)	Election form must be submitted within 30 days of the date of the loss of other coverage. Coverage changes effective the first of the month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Employee may add coverage (or change coverage) for themselves and for Spouse and Dependent Child if Spouse or Dependent Child lost other coverage.	Employee may enroll or increase election amount.	Employee may enroll or increase election amount if other coverage lost was Dependent Care FSA coverage.
Employee Eligible to Enroll in Exchange Plan During Exchange Open Enrollment Period or Special Enrollment Period	Election form must be submitted within 30 days of eligibility for an Exchange plan. Benefit coverage will cease on the last day of the month in which the election form is submitted. Paycheck changes effective with first payroll of the month following the loss of coverage	Employee may drop coverage for themselves, Spouse, and Dependent Children, but only if each individual that drops coverage obtains coverage through an Exchange plan	No change is permitted based on Exchange enrollment rights	No change is permitted based on Exchange enrollment rights
Rehired by Employer After Termination of Employment Within 13 Weeks for a Non-School Employee or 26 Weeks for a School Employee	Employee will be eligible to enroll in the same manner as if Employee had not terminated employment. Election form must be submitted within 30 days of benefits eligible effective date. Paycheck changes effective with first payroll following coverage effective date.	Employee may make an election to enroll in plan or may choose not to enroll.	Employee may make an election to enroll in plan or may choose not to enroll. Total amount elected for both periods of employment in the same year may not exceed annual limit.	Employee may make an election to enroll in plan or may choose not to enroll. Total amount elected for both periods of employment in the same year may not exceed annual limit.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Rehired by Employer After Termination of Employment After 13 or More Weeks for a Non-School Employee or 26 or more Weeks for a School Employee	Employee will be treated as a newly hired employee for purposes of enrollment. If eligible to enroll, election form must be submitted within 30 days of benefits eligible effective date. Paycheck changes effective with first payroll following coverage effective date.	If Employee meets the eligibility requirements as a new hire, Employee may make an election to enroll in plan or may choose not to enroll.	If Employee meets the eligibility requirements as a new hire, Employee may make an election to enroll in plan or may choose not to enroll. Total amount elected for both periods of employment in the same year may not exceed annual limit.	If Employee meets the eligibility requirements as a new hire, Employee may make an election to enroll in plan or may choose not to enroll. Total amount elected for both periods of employment in the same year may not exceed annual limit.
Employee Change to Benefits Eligible	Election form must be submitted within 30 days of benefits eligible effective date. Benefit coverage will become effective the first of the month following 30 days in a benefits eligible position and receipt of a election form. Paycheck changes effective with first payroll following coverage effective date.	Employee may elect to enroll in coverage for themselves, Spouse and Dependent Children.	Employee may enroll in FSA.	Employee may enroll in Dependent Care FSA.
Employee Determined to be Full-Time During Initial Measurement Period	Benefit coverage will begin on the first day of the stability period. Paycheck changes effective with first payroll following coverage effective date.	Employee may elect to enroll in coverage for themselves, Spouse and Dependent Children.	Employee may enroll in FSA.	Employee may enroll in Dependent Care FSA.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Reduction in Employee's Hours to Less than 30 Hours Per Week	Election form must be submitted within 30 days of the reduction in hours. Benefit coverage will cease on the last day of the month in which the election form is submitted. Paycheck changes effective with first payroll of the month following the loss of coverage.	Employee may drop coverage for themselves, Spouse, and Dependent Children, but only if each individual that drops coverage obtains coverage through an Exchange plan	No change is permitted	No change is permitted
Promotion, Demotion, or Position Change with No Change in Benefits Eligibility	N/A	No change is permitted.	No change is permitted.	No change is permitted.
Employee Changes Locations Within the Archdiocese	N/A	No change is permitted.	No change is permitted.	No change is permitted.
Commence FMLA Leave	Election form must be submitted within 30 days from beginning of leave (or 30 days from beginning of unpaid portion of leave, if later). Coverage changes effective with the first payroll following receipt of the form. Paycheck changes, if applicable, effective with first payroll following coverage change effective date.	Coverage will continue during paid FMLA leave. Employee may discontinue coverage during unpaid portion of FMLA leave.	Elections will continue during paid FMLA leave. Employee may stop/discontinue contributions during unpaid portion of FMLA leave. Employee will not be able to submit for reimbursement any claims incurred during gap period and total amount available will be reduced by missed contributions.	Elections will continue during paid FMLA leave. Employee may stop/discontinue contributions during unpaid portion of FMLA leave. Employee will not be able to submit for reimbursement any claims incurred during gap period and total amount available will be reduced by missed contributions.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Return from FMLA Leave	Election form must be submitted within 30 days from return from leave if Employee wants to change pre-leave benefit levels. Coverage changes effective on date of return, or if election form submitted after return to work the first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Coverage will automatically be reinstated at pre-FMLA leave levels. Employee may choose to enroll in coverage for themselves or change coverage upon return from FMLA leave.	Elections will be reinstated at pre-FMLA leave levels if the Employee discontinued coverage at beginning of leave and returns immediately following FMLA protected leave. Employee may increase contributions to make up for missed contributions during FMLA leave.	Elections will be reinstated at pre-FMLA leave levels if the Employee discontinued coverage at beginning of leave and returns immediately following FMLA protected leave. Employee may increase contributions to make up for missed contributions during FMLA leave.
Return from USERRA (Military) Leave	Election form must be submitted within 30 days from return from military leave. Coverage change will be effective on date of return, or if election form submitted after return to work the first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Employee can elect to enroll themselves, Spouse, and Dependent Children in coverage. If it is a Spouse or Dependent Child returning from military leave, Employee can increase coverage to include returning individual.	Employee can enroll or increase elections.	Employee can enroll or increase elections.
Commence Other Unpaid Leave of Absence	Mid-year changes are not permitted for this reason under the terms of the Cafeteria Plan.	No change is permitted. Employee must continue to send in payments or coverage will be terminated.	No change is permitted. Employee must continue to send in payments or coverage will be terminated.	No change is permitted. Employee must continue to send in payments or coverage will be terminated.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Return from Other Unpaid Leave of Absence	Mid-year changes are not permitted for this reason under the terms of the Cafeteria Plan.	No change is permitted. If Employee's coverage was cancelled during leave due to failure to pay premiums, Employee must wait until next open enrollment to re-enroll.	No change is permitted. If Employee's coverage was cancelled during leave due to failure to pay contributions, Employee must wait until next open enrollment to re-enroll.	No change is permitted. If Employee's coverage was cancelled during leave due to failure to pay contributions, Employee must wait until next open enrollment to re-enroll.
Significant Increase in Cost of Coverage of Archdiocese's Plan	Election form must be submitted within 30 days of coverage cost increase change. Coverage change effective first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Employee may increase payroll withholding or revoke coverage. Employee may also add coverage for themselves,	No change permitted.	May increase election to take into account significant cost change; however, no change can be made when cost change is imposed by dependent care provider who is relative of Employee.
Change in Coverage Under Other Employer's Plan	Election form must be submitted within 30 days of change in other coverage. Coverage change effective first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Employee may add coverage for themselves, Spouse, and Dependent Children if other coverage changes. Employee may also drop coverage for themselves, Spouse, and Dependent Children.	No change permitted.	May increase or decrease election to take into account change. Mid-year decrease is limited to the amount the Employee has already spent YTD.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Entitlement to Medicare	Election form must be submitted within 30 days of change in other coverage. Coverage change effective first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Employee may drop coverage for individual who is eligible for Medicare. If Employee drops coverage for themselves, coverage for a Spouse and Dependent Children ceases too.	No change is permitted.	No change is permitted.
Eligibility for Medicaid/CHIP Subsidy	Election form must be submitted within 60 days of state determination of eligibility. Coverage effective first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Employee may drop coverage for themselves, Spouse and/or Dependent Children, if now eligible for state plan. Employee may add, change or increase coverage to cover themselves, Spouse, and Dependent Children if now eligible for subsidy.	Employee may increase election.	No change is permitted.
Loss of Medicaid/CHIP Coverage	Election form must be submitted within 60 days of state determination of loss of eligibility. Coverage effective first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	Employee may change or add coverage for themselves, Spouse, and Dependent Children.	Employee may increase or decrease election. Mid-year decrease is limited to the amount the Employee has already spent YTD.	No change is permitted.

Event	Timing	Health Insurance (medical, dental, and vision)	Health FSA	Dependent Care FSA
Change in Child Care Provider or Child Care Rates	Election form must be submitted within 30 days of change in other coverage. Coverage change effective first of month following receipt of election form. Paycheck changes effective with first payroll following coverage change effective date.	No change is permitted.	No change is permitted.	Employee can increase or decrease election amount. Mid-year decrease is limited to the amount the Employee has already spent YTD.
Receipt of Medical Support Order	Coverage begins first of month following receipt of Medical Support Order.	Order will specify which benefit plans child(ren) are to be enrolled in. Employee will also be enrolled in Court ordered benefit plans, if Employee is not already enrolled.	Employee may enroll or increase election.	No change is permitted.
Termination of Medical Support Order	Election form must be submitted within 30 days of Medical Support Order coverage end date. Coverage ends as of end of month of election form, or date specified in Court Order, or date Court Order received - whichever is later.	Employee may drop coverage for child(ren) and/or Employee	No change is permitted.	No change is permitted.