2023-2024

EMPLOYEE BENEFIT GUIDE

Welcome to the Diocese Benefits Program

At the Diocese of Pensacola-Tallahassee, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health – physical, emotional and financial – is the reason Diocese of Pensacola-Tallahassee offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the end of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to the summary plan descriptions (SPDs) located on the Diocese website at www.ptdiocese.org/benefits

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices beginning on page 19 for more details.

Coverage Eligibility

WHEN DOES COVERAGE BEGIN?

You are eligible for coverage in the employee benefit program on the first day of the month once you have completed 30 days of employment and if you are a full-time employee regularly scheduled to work 30 or more hours per week.

WHO IS ELEGIBLE?

A dependent is a covered employee's legal spouse as defined by the state of Florida or a dependent child of the employee or employee's spouse. Dependent children will be covered on the medical plan until the end of the calendar year in which they turn age26.

A dependent child is defined as:

- A natural child
- A step-child
- A legally adopted child
- A child placed for adoption
- A child for whom legal guardianship has been awarded to the covered employee or the employee's spouse

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

DEPENDENT ELIGIBILITY DOCUMENTATION

Please note that documentation may be required to prove dependent eligibility. Some examples are:

Marriage License, Birth Certificate, Adoption Papers, Court Order.

WHEN CAN I ENROLL?

You must enroll in, or decline, benefits within 31 days of your benefits effective date. ***New employees who do not make an election within 31 days of becoming eligible will automatically be enrolled for single coverage in the High Deductible medical plan.***

Open enrollment for current employees is generally held in late February/early March. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

QUALIFYING FAMILY STATUS CHANGE

Coverage elections made at open enrollment cannot be changed until the next annual open enrollment period. The only exception to this IRS Section 125 Rule is if you experience a "Qualifying Family Status Change." A qualifying event allows you to make a change to your benefit elections within thirty days of the event.

Qualifying events include (but are not limited to):

- Birth, adoption or legal custody of a dependent child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce or legal separation
- Death

If you have a qualified status change, you must contact Human Resources within 30 days to make your change.

Medical- Meritain Group #14182

Meritain, an Aetna Company, continues to be our exclusive medical healthcare provider for the 2023-2024 benefits year. The Diocese offers employees two plans which are open access and do not require you to select a Primary Care Physician (PCP) or obtain a referral to seek care from contracted specialists. However, you will receive maximum levels of benefits when you use the **Aetna Point of Service (POS) Choice II network** preferred providers.

Below are highlights of the Standard and High Deductible plans' features. Please refer to the Summary Plan Descriptions for more detailed information regarding exclusions and limitations and for out-of-network benefits.

	Standard Plan	**High Deductible Health Plan (HSA eligible)**
	In-Network	**In-Network**
Calendar Year Deductible	$2,000 per individual $4,000 family limit	$2,000 employee coverage $4,000 family coverage
Out-of-Pocket Maximum - Medical	$4,000 per individual $8,000 family limit	$4,000 employee coverage $8,000 family coverage
Office Visit Primary Care Specialist	 20% 20%	 20% after deductible 20% after deductible
Preventive Services **Screenings/Immunizations**	No charge Covered at 100%	No charge Covered at 100%
Chiropractic Care	20% after deductible	20% after deductible
Inpatient Hospitalization	20% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	20% after deductible
Urgent Care	20%	20% after deductible
Emergency Room	$300 then 20% coinsurance	20% after deductible

Prescription Drugs

HDHP Plan

Welcome to your new prescription benefit administered by CVS Caremark. Your prescription benefit is designed to bring you quality pharmacy care that will help you save money.

Following is a brief summary of your prescription benefits.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)		**Long-Term Medicines** CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**20%** for one 30-day supply of a generic medicine	**20%** for three 30-day supplies of a generic medicine	**20%** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**20%** for one 30-day supply of a preferred brand-name medicine	**20%** for three 30-day supplies of a preferred brand-name medicine	**20%** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**20%** for one 30-day supply of a non-preferred brand-name medicine	**20%** for three 30-day supplies a non-preferred brand-name medicine	**20%** for a non-preferred brand-name medicine
Preventive Medicines	Your plan has a preventive drug list. Generic medicines on this list bypass the deductible and pay at the coinsurance/copayment level. These medicines will still accumulate towards the Maximum Out-Of-Pocket.		
Annual Deductible	$2,000 for individual / $4,000 for family		
Maximum Out-of-Pocket	$4,000 for individual / $8,000 for family		
Specialty Medicines	20% through CVS Specialty. Visit cvsspecialty.com to get started.		

Standard Plan

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Following is a brief summary of your prescription benefits.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)		Long-Term Medicines CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	**$10** for one 30-day supply of a generic medicine	**$30** for three 30-day supplies of a generic medicine	**$20** for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	**30%** for one 30-day supply of a preferred brand-name medicine	**30%** for three 30-day supplies of a preferred brand-name medicine	**30%** for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	**40%** for one 30-day supply of a non-preferred brand-name medicine	**40%** for three 30-day supplies a non-preferred brand-name medicine	**40%** for a non-preferred brand-name medicine
Specialty Medicines	1-30 day supply 40% Max $150 / 31-90 day supply 40% Max $300 through CVS Specialty. Visit cvsspecialty.com to get started.		
Annual Deductible	$200 per individual		
Maximum Out-of-Pocket	$6,500 per individual / $13,000 per family		

Please Note: When a generic is available, but the pharmacy dispenses the brand-name medication for any reason other than doctor or other prescriber indicates "dispense as written," you will pay the difference between the brand-name medication and the generic plus the brand copayment.

10000

Medical Value-Added Services –
These benefits are paid 100% by the Diocese

- Healthcare Blue Book
- Healthy Merits (wellness plan)
- 98.6 (telemedicine program)

Healthcare Bluebook.

Go Green to Get Green.
Get paid to save on care!

Choose the right path with Healthcare Bluebook and earn rewards.

With **Healthcare Bluebook,** save hundreds to thousands of dollars on medical procedures by choosing **Fair Price** (green) facilities for your care; plus you'll earn rewards. Or you can **overpay** and miss out on rewards. It's up to you! Easy to setup, easy to search, easy to save.

Healthcare Bluebook.

Check It Out:

meritain.com

800-341-0504

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

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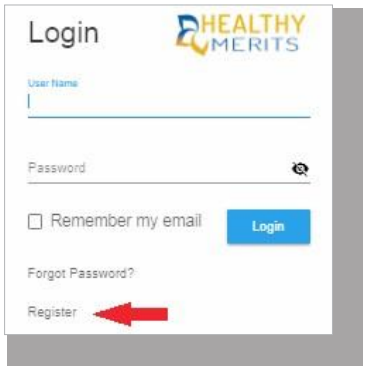
Wellness Portal Registration

Diocese of Pensacola-Tallahassee

How to register for your Healthy Merits portal

To get started with your Healthy Merits Wellness Program, you must first register for your new Healthy Merits wellness portal. This portal gives you tools and resources to help guide you along your wellness journey.

1. Click on or copy and paste the below website: **https://dopt.wellright.com**.
2. Click on *Register.*



3. Enter your information as it is appears on your Meritain Health® medical ID card. Your unique ID isyour member ID found on your ID card.
4. Verify your address via the email you receive. **Please note:** After you register, you will receive an email asking you to verify your email address. Please be sureto check your spam/junk folder for this email. Your registration is not complete until you verify your address through this email.

From here, you'll be able to explore different Healthy Merits topics!

Wellness matters!

When you feel better, you can accomplish more and getmore enjoyment out of doing the things you love.

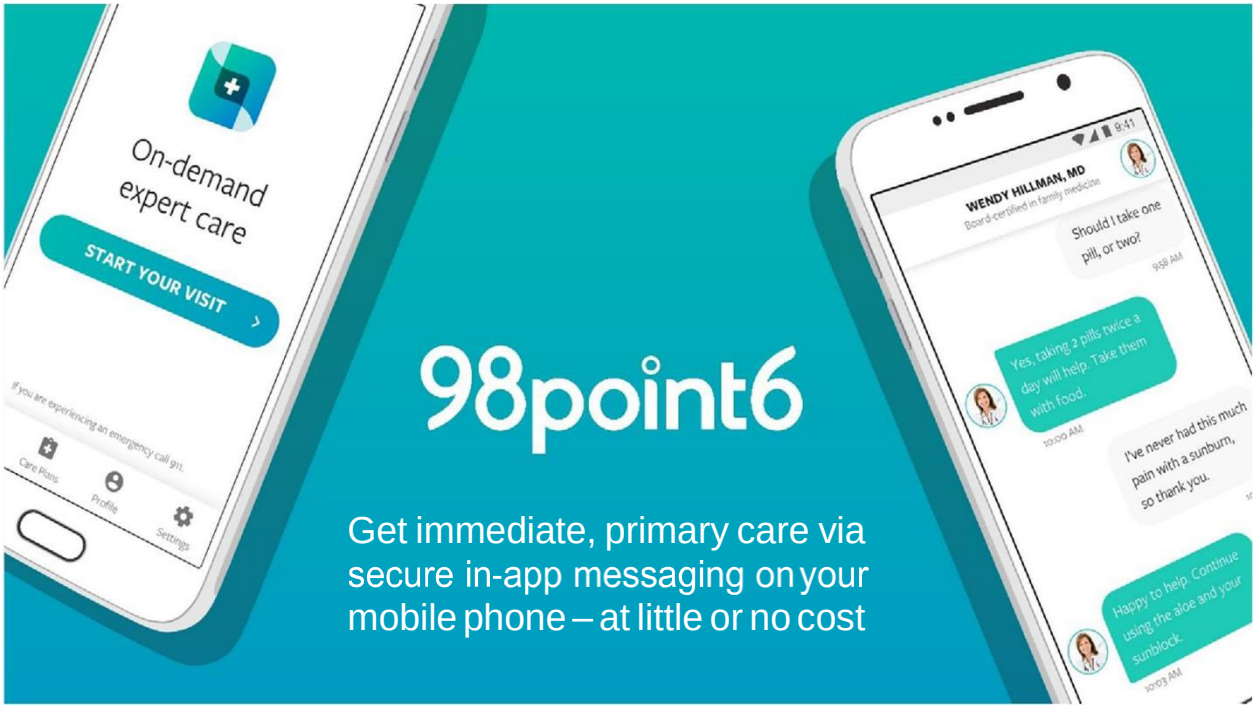
Questions? Just call Healthy Merits Customer Service at 1.877.348.4533 or email healthymerits@meritain.com.

Advocates for Healthier Living

At Meritain Health, we care about your well-being! That'swhy we offer a number of tools and resources to help youon your wellness journey.

MERITAIN® HEALTH
An Aetna Company

98point6 Telemedicine Program



98point6 is a new kind of on-demand primary care delivered through a private and secure in-app messaging, 24/7, experience on your mobile phone.

With 98point6, U.S. based, board-certified physicians answer questions, diagnose and treat acute and chronic illnesses, outline care options and order any necessary prescriptions or lab tests. They can also help you better understand any primary care conditions.

Unlimited primary care through 98point6 is available to benefit-enrolled Diocese employees and dependents ages 18 or older.

Cost per visit is $0 for Standard plan participants and only $5 per visit for High Deductible plan participants.

How does it work?

You simply download the free 98point6 app from the Apple App Store or Google Play, sign in using a mobile phone number and create an account. From there, select the "Employer Benefit" option and then type in "PTDiocese" as your employer.

Visit 98point6.com/ptdiocese for instructions and direct links.

Health Savings Accounts (HSA)

A Health Savings Account (HSA) is a tax-free account you can use to pay for current and future medical expenses (even medical expenses during retirement). If you enroll in the High Deductible Health Plan (HDHP), you will receive an HSA through Benefit Wallet.

What are the tax benefits?	An HSA has triple tax benefits: • Contributions go into the HSA tax-free • The money grows tax free • Your withdrawals for qualified medical expenses, including any earnings, are tax-free
Who is eligible?	You **are eligible** to open an HSA if: • You enroll in the HDHP • Your only coverage is the HDHP and you have not signed up for Medicare coverage You **are not eligible** to open an HSA if: • You're covered under your spouse's plan and that plan is not a high deductible plan • Your spouse contributes to a Healthcare Flexible Spending Account (FSA) • You participate in a medical plan with a Health Reimbursement Account (HRA)
How do I open my account?	If you enroll in the HDHP, you will be notified that an account has been set up and will remain frozen until you go to www.mybenefitwallet.com and open your account with Benefit Wallet. You may choose to make contributions to this account through pre-tax payroll deductions. You may also choose to open your own HSA at any qualified banking institution, however, you will not be eligible to receive the employer contributions if you choose another institution.
Employer contributes to your account.	Contributions each pay period from your employer: • $50.00 per month if enrolled in the HDHP Medical Plan as Employee Only. • $100.00 per month if enrolled in the HDHP Medical Plan if covering dependents.
You can contribute to your account.	You can decide how much you want to contribute up to: • $3,850 less employer contribution if enrolled in employee only medical HDHP coverage • $7,750 less employer contribution if enrolled in family medical HDHP coverage • $1,000 additional if you are age 55 or older You are not required to make HSA contributions, although it is a good idea to add to your account for the tax savings and to help pay for medical expenses. You can contribute with pre-tax payroll deductions or contributions made directly to Benefit Wallet. These amounts are based on IRS limits reduced by your employer's contribution. If you are hired during the year, your contribution limits could be higher or lower than those listed above.
What expenses qualify for HSA use?	Use your HSA to pay for eligible medical expenses, such as your annual deductible and coinsurance. Your HSA can also help pay for vision care, dental care, and prescription drugs. For a complete list of eligible expenses, visit www.irs.gov Each time you have a qualified expense, you decide whether to pay out of your pocket and let your HSA grow, earning interest for future eligible expenses (e.g., medical expenses during retirement) By using an HSA, you can potentially reduce your out-of-pocket costs of your annual deductible by 40%.

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

VSP will continue to be our voluntary Vision carrier for the 2023-2024 Plan Year. The vision plan provides both in-network and out-of-network benefits. However, you will receive maximum benefits when you use a provider within the network. You can locate a participating provider by calling member services at (800) 877-7195 or visiting www.vsp.com. There have been no changes to the benefit features.

	VSP Vision plan	
	In-Network	**Out-of-Network**
Examination		
Benefit	$10 copay	$45 allowance
Frequency	1 x every 12 months from last date of service	1 x every 12 months from last date of service
Lenses (standard)	$25 copay	$30 - $65 allowance
Frames		
Benefit	$130 allowance, then 20% discount	$70 allowance
Frequency	1 x every 24 months from last date of service	1 x every 24 months from last date of service
Contacts		
Benefit	Elective - $130 allowance Medically necessary – covered in full	Elective - $105 allowance Medically necessary – $200 allowance
Frequency	1 x every 12 months from last date of service (in lieu of lenses and frames)	1 x every 12 months from last date of service (in lieu of lenses and frames)

Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to illness elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

The Diocese continues to offer to its employees a Dental Preferred Provider Organization (PPO) plan through Delta Dental during the 2023 - 2024 Plan Year. The PPO plan provides both in-network and out-of-network coverage. However, you will receive the maximum level of benefits when you use a preferred dentist*. You can locate participating Delta Dental Dentists by contacting member services at (800) 521-2651or by visiting www.deltadentalins.com. There have been no changes to the benefit features.

	Delta Dental PPO
	In-Network
Calendar Year Deductible	$50 per individual $150 per family
Annual Plan Maximum	$1,500 per individual
Waiting Period	Late entrant penalty may apply
Diagnostic and Preventive	No charge
Basic Services Fillings, Root Canals, Periodontics	20% after deductible
Major Services **Full or partial dentures, Crowns**	50% after deductible
Child Orthodontia (up to age 19) Benefit Lifetime Maximum	 50% $1,500

*Out-of-network charges are subject to balance billing above the maximum allowable charge.

Life Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

BASIC LIFE AND AD&D

The Diocese provides Basic Life Insurance and Accidental Death & Dismemberment (AD&D), the cost is paid 100% by the Diocese. Your beneficiary will receive a benefit equal to $25,000 if you should pass away while employed with the Diocese.

The Accidental Death & Dismemberment (AD&D) rider is included and will pay a benefit that matches your life insurance coverage when death occurs as a result of an accident or will pay a partial benefit for dismemberment. Please refer to Mutual of Omaha's benefit summary materials for more information.

Please make sure that Human Resources has your most up to date beneficiary designation. You may designate a beneficiary on your annual Benefit Election website and request changes at any time by contacting Human Resources.

VOLUNTARY LIFE AND AD&D

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Mutual of Omaha.

You can purchase voluntary life insurance through payroll deductions for yourself and your dependents through Hartford. In order to elect coverage for your dependent spouse and/or child(ren), you must elect voluntary life coverage for yourself. Employee rates vary depending on your age and benefit amount. Coverage is portable if you leave the company. Please refer to Hartford's voluntary life rate chart to determine your monthly premium deductions for this coverage.

Employee Coverage – As a newly hired employee, you can apply for supplemental life insurance in increments of $10,000, up to a maximum of $500,000 or 5 times your earnings, whichever is less. Evidence of insurability (EOI) will be required if you are applying for insurance coverage for the first time above the Guarantee Issue amount of $180,000.

Spouse Coverage – As an employee, you can apply for additional life insurance for your spouse. The maximum amount you can purchase cannot be more than the lesser of $250,000 or 50% of your voluntary life insurance. Spouse rates and premiums are based on the employee's age, not the spouse's age. Guarantee Issue is up to $50,000. An Evidence of Insurability form is required for amounts over the Guarantee issue.

Child(ren) Coverage – As an employee, you can apply for additional life insurance in the amount of $10,000 for your child(ren).

Voluntary Life coverage is portable and you can "take it with you" should you leave employment. You must contact HR to request portability paperwork.

EVIDENCE OF INSURABILITY

Under certain circumstances, a health questionnaire or Evidence of Insurability (also referred to as EOI) will need to be completed.

Newly Eligible Employee:

- Elections up to Guarantee Issue amount of $180,000 do not require an EOI.
- EOI is required for any $10,000 increment elected over the Guarantee Issue amount of $180,000.
- Maximum of $500,000, not to exceed 5 times salary applies.

Current Employee that IS NOT currently enrolled in Voluntary Life at Annual Enrollment:

- **EOI will be required for any amount at open enrollment, if you are not currently enrolled.**
- Maximum of $500,000, not to exceed 5 times salary applies.

Current Employee that IS currently enrolled at Annual Enrollment:

- If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed the guarantee issue benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). **Amounts over the Guarantee Issue will require evidence of insurability (proof of good health referred to as an EOI).**
- EOI is not required for a $10,000 increment increase.
- EOI **is** required for any $10,000 increment election above $10,000 or over the Guarantee Issue amount of $180,000.
- Maximum of $500,000, not to exceed 5 times salary applies.

Newly Eligible Spouse:

- Elections up to Guarantee Issue amount of $50,000 do not require an EOI.
- EOI is required for any $5,000 increment elected over the Guarantee Issue of $50,000.
- Maximum of $250,000 (Not to exceed 50% of the Employee Supplemental Life election) applies.

Current Spouse that IS NOT currently enrolled at Annual Enrollment:

- EOI is required for any election.
- Maximum of $250,000 (Not to exceed 50% of the in-force Employee Supplemental Life) applies.

Current Spouse that IS currently enrolled at Annual Enrollment:

- EOI is not required for a $5,000 increment, if your spouse is currently enrolled.
- EOI is required for any increment election above $5,000 **or** over the Guarantee Issue amount of $50,000.
- Maximum of $250,000 (Not to exceed 50% of the in-force Employee Supplemental Life) applies.

YOU CANNOT ENROLL A SPOUSE OR CHILD IN COVERAGE UNLESS YOU HAVE COVERAGE ON YOURSELF.

This plan includes the option to select coverage for your spouse and dependent children. Children include those, up to age 26.

VOLUNTARY LIFE AND AD&D COSTS

To help calculate your costs, below you will find a rate table of coverage amounts and the monthly costs based on your age. Please note that rates increase on April 1st after you enter into a new 5-year age band. Additional election amounts and payroll deductions amounts are available on Paycor.

Age Bound **EE & Spouse Rate per $1,000**											
		10000	20000	30000	40000	50000	60000	70000	80000	90000	100000
< 25	0.089	0.89	1.78	2.67	3.56	4.45	5.34	6.23	7.12	8.01	8.9
25-29	0.089	0.89	1.78	2.67	3.56	4.45	5.34	6.23	7.12	8.01	8.9
30-34	0.103	1.03	2.06	3.09	4.12	5.15	6.18	7.21	8.24	9.27	10.3
35-39	0.13	1.30	2.60	3.90	5.20	6.50	7.80	9.10	10.4	11.7	13
40-44	0.148	1.48	2.96	4.44	5.92	7.40	8.88	10.36	11.84	13.32	14.8
45-49	0.211	2.11	4.22	6.33	8.44	10.55	12.66	14.77	16.88	18.99	21.1
50-54	0.337	3.37	6.74	10.11	13.48	16.85	20.22	23.59	26.96	30.33	33.7
55-59	0.58	5.80	11.60	17.40	23.20	29.00	34.80	40.60	46.4	52.2	58
60-64	0.805	8.05	16.10	24.15	32.20	40.25	48.30	56.35	64.4	72.45	80.5
65-69	1.696	16.96	33.92	50.88	67.84	84.80	101.76	118.72	135.68	152.64	169.6
70-74	2.974	29.74	59.48	89.22	118.96	148.70	178.44	208.18	237.92	267.66	297.4
75-79	2.974	29.74	59.48	89.22	118.96	148.70	178.44	208.18	237.92	267.66	297.4
80-84	2.974	29.74	59.48	89.22	118.96	148.70	178.44	208.18	237.92	267.66	297.4
85-89	2.974	29.74	59.48	89.22	118.96	148.70	178.44	208.18	237.92	267.66	297.4
90-100	2.974	29.74	59.48	89.22	118.96	148.70	178.44	208.18	237.92	267.66	297.4

All Children Premium Table (Monthly) - Includes AD&D
$10,000
$2.02

Regardless of how many children you have, they are included in the "All Children" premium amounts shown above.

Disability Insurance

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

LONG-TERM DISABILITY INSURANCE

The Diocese provides you with Long Term Disability (LTD) insurance in the event that you become fully disabled. LTD pays you in the event of a loss of income due to disability either by sickness or injury, after a 90-day elimination period, up to maximum period of 5 years (depending on your age at disability). The LTD program provides a maximum benefit of 60% of your income, up to $6,000 per month.

Monthly Benefit Amount	Plan pays 60% of covered monthly earnings
Maximum Monthly Benefit	$6,000
Benefits Begin After:	
Accident	90 days of disability
Sickness	90 days of disability
Maximum Payment Period*	5th year of disability

*The age at which the disability begins may affect the duration of the benefits.

SHORT-TERM DISABILITY INSURANCE

The Diocese offers you the ability to purchase additional Short-Term Disability coverage. This is voluntary and your premiums are deducted from your paycheck. You can enroll at each annual open enrollment or at your initial new hire enrollment.

Short Term Disability (STD) pays you in the event of a loss of income due to disability either by sickness or injury. If you become disabled, benefits begin on the 15th day (after 14-day elimination period), up to 11 weeks after the elimination period. There is a pre-existing conditions limitation of 3/6 (treatment for any condition 3 months prior to the effective date, that results in the disability in the first 6 months of coverage). The STD program provides a benefit of 60% of your weekly income up to $1,000 per week. There is a $25 minimum weekly benefit.

STD Monthly Rates Per $100 Weekly Benefit
60% of weekly benefit up to $1000 per week
14- day elimination period – accident or off-the-job injury
$0.41 per $10 of weekly benefit – applicable to all ages

Employee Assistance Programs

Mutual of Omaha our disability carrier, offers some other valuable programs that you are eligible to participate in:

- Employee Assistance Program (EAP)
- Travel Assist – Emergency Travel Support Service's
- Will Preparation Services

EMPLOYEE ASSISTANCE PROGRAM

All full-time employees have access to the Employee Assistance Program (EAP). The EAP provides resources to you and your family when dealing with issues such as:

- Marital problems
- Substance abuse
- Workplace conflicts
- Elder and child care
- Healthcare issues
- Legal matters / financial concerns

You can access the program CONFIDENTIALLY, 24 hours a day, seven days a week, by phone **1-800-316-2796** or the web www.MutualofOmaha.com/eap.

The EAP program also allows up to 3 face-to-face consultations per family member per year with a Master's Degreed counselor to assist with personal issues as indicated above. Also included is an on-line library of educational materials and interactive tools that will provide assistance. The EAP program is completely confidential, your privacy is assured. All of the services included in this program are completely free to all employees and their family members.

Cost of Coverage

MEDICAL – Monthly Contributions

Standard Medical Plan		
	YOU PAY	EMPLOYER PAYS
Employee Only	**$120.00**	$636.00
Employee + Spouse	**$730.00**	$670.00
Employee + Child(ren)	**$618.00**	$576.00
Employee + Family	**$1016.00**	$882.00
HDHP Medical Plan		
	YOU PAY	EMPLOYER PAYS
Employee Only	**$74.00**	$650.00
Employee + Spouse	**$504.00**	$822.00
Employee + Child(ren)	**$308.00**	$704.00
Employee + Family	**$520.00**	$1042.00

If you participate in the HDHP, your parish or school will contribute towards your HSA account monthly:

Employee Only	$50.00
Employee + Dependents	$100.00

You may also choose to contribute additional money towards your H.S.A. through payroll deductions.

The total of the employer contributions and your contribution cannot exceed $3,850 for employee only and $7,750 if you are covering a family member.

You must enroll in the BenefitWallet H.S.A. in order to receive the employer contribution. Your account remains in "frozen" status until you've completed all the steps, and the Diocese cannot make contributions while your account is in frozen status*

DENTAL – Monthly Contributions

Dental Plan		
	YOU PAY	EMPLOYER PAYS
Employee Only	**$13.00**	$15.00
Employee + Spouse	**$38.00**	$18.00
Employee + Child(ren)	**$48.00**	$18.00
Employee + Family	**$70.00**	$24.00

VISION – Monthly Contributions

$

Vision Plan		
	YOU PAY	EMPLOYER PAYS
Employee Only	**$6.08**	$0.00
Employee + Spouse	**$10.22**	$0.00
Employee + Child(ren)	**11.54**	$0.00
Employee + Family	**$16.82**	$0.00

Important Plan Notices and Documents

Medicare Part D Notice

Important Notice from the Diocese About Your Prescription Drug Coverage and Medicare

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 Diocese and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

2. The Diocese has determined that the prescription drug coverage offered by the CVS/Caremark plan is, on averagefor all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your Diocese coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under CVS/Caremark is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Diocese prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Diocese and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

Date:	April 1, 2023
Name of Entity/Sender:	Diocese of Pensacola - Tallahassee
Contact-Position/Office:	Cynthia Bean, Benefits Coordinator
Address:	11 North B St., Pensacola, FL 32502
Phone Number:	(850) 435-3556

For more information about Medicare prescription drug coverage:

- Visit **medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 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 **socialsecurity.gov**, or call them at 800-772-1213 (TTY 800-325-0778).

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

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns' and Mothers' Health 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, 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 provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in The Diocese's medical plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in The Diocese's medical plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request medical plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in The Diocese's medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another medical plan.

Michelle's Law

The Diocese Benefits Plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify HR in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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

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

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

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

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

To view a list of participating states that are current as of January 31, 2020 visit:
www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:
U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov1-877-267-2323
Menu Option 4, Ext. 61565

Notice About Non-discrimination and Accessibility Requirements and Nondiscrimination Statement: Discrimination is Against the Law

The Diocese complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Diocese does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Diocese:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Human Resources at 850-435-3556.

If you believe that the Diocese has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2017 for coverage starting as early as January 1, 2018.

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

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

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

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

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

How Can I Get More Information?

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

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

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

Frequently Asked Questions

I went to visit my doctor's office and they said I was not covered by Aetna. Why?

Coverage is provided through Meritain as the Claims Administrator, which utilizes the Aetna POS Choice II network. Please make sure that your doctor is contacting Meritain, and not Aetna to verify your benefits.

What is the In-Network Lab?

Quest Diagnostic

Do I need to get Pre-Certification before I go into the Hospital or have an out-patient procedure?

Yes, the number you need to call is on your Meritain Card. You, your eligible Dependents or a representative acting on your behalf, must call the Medical Management Program Administrator to receive certification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 48 hours in advance of Inpatient admissions or receipt of the non-Emergency Services listed below. If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours or if later, by the next business day after the Emergency Medical Condition admission.

Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

1) Precertification of Medical Necessity. The following items and/or services must be pre-certified before any medical services are provided:
    a. Chemotherapy - all settings including services rendered in a Physician's office
    b. Dialysis - all settings including services rendered in a Physician's office
    c. Durable Medical Equipment – in excess of $1,500
    d. Home health care, including IV home infusion therapy
    e. Hospice care
    f. Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility,
    g. Rehabilitation Facility, and inpatient admissions due to a Mental Disorder or Substance Use Disorder
    h. Radiation - all settings including services rendered in a Physician's office
    i. Imaging, limited to the following: CT/MRA/MRI/PET scans, scintimammography, capsule endoscopy and U.S. bone density (heel)
    j. Transplants, including transportation and lodging
    k. Outpatient Surgical procedures, excluding Surgery rendered in a Physician's office
2) Concurrent Review for continued length of stay and assistance with discharge planning activities.
3) Retrospective review for Medical Necessity where precertification is not obtained or the Medical Management Program Administrator is not notified.

I didn't receive a Vision Card?

Our carrier VSP does not issue vision cards. All you need to do is tell your provider that you have coverage with VSP and they will verify it with your Social Security Number. You can also register at www.VSP.com to view your benefits, print a VSP card and locate a VSP Provider.

Under what circumstances should I go to the Emergency Room vs. Urgent Care vs. Convenience Clinics or Telemedicine?

Emergency Rooms - At the ER, true emergencies are treated first. Other cases must wait—sometimes for hours. And, it will cost you more. If a situation seems life-threatening, take action. Call 911 or your local emergency number right away. Go to the ER for:

- D Heavy Bleeding
- D Major Burns
- D Large open wounds
- D Spinal Injuries
- D Chest pain
- D Difficulty Breathing

Urgent Care - Urgent care centers treat many minor ailments. In most cases, you will not have to wait as long as at the ER. You will pay less, too. An urgent care center can help with:

- D Sprains/ Strains
- D Minor Infections
- D Minor Wounds
- D Rashes

Convenient Care Centers - Convenient care centers offer the fast treatment for colds, flu, strep throat, and minor injuries for the cost of your physician copay. Convenient care centers can be found in select Walgreens and CVS retail locations.

Telemedicine – 98point6 can be used for minor ailments such as cold, flu, allergies, and rashes when you need a doctor to diagnose you over the phone and prescribe treatment.

I want to drop my Husband/Wife/Child from my coverage how can it do that?

During open enrollment, you can drop or add a spouse or child or make any change you want to your coverage. If you want to make the change and the open enrollment period is over, there has to be a qualifying event or qualifying family status change. A qualifying event is Marriage, Divorce, Birth/Adoption of a Child, Involuntary Loss of Insurance, or if your spouse has a new job that provides insurance coverage.

If I have a Qualifying Family Status Change and I need to change my coverage what do I need to do?

When the qualifying event occurs and it is outside of the open enrollment period, you will need to contact the Benefit Coordinator, Cindy Bean at 850-435-3556. She will assist you with answering questions and providing forms to change your enrollment, if necessary. You will also have to provide supporting documentation for the qualifying event.

Where can I get a Summary of Benefits and Coverage?

You can view the summary online at www.ptdiocese.org/benfits or contact Cynthia Bean at (850) 435-3556 or beanc@ptdiocese.org

Important Contact Information

Benefit	Vendor	Customer Service
Enrollment or Benefit Eligibility	Diocese of Pensacola - Tallahassee	Cindy Bean 1-850-435-3556
Human Resources	Diocese of Pensacola - Tallahassee	Robin Jones 1-850-435-3558
Medical	Meritain	1-800-925-2272 www.mymeritain.com
Prescription Drug (Rx)	CVS/Caremark	1-800-565-7091 www.mymeritain.com
Specialty Drug Assistance	CVS/Caremark	1-800-565-7091 www.mymeritain.com
Telemedicine	98point6	www.98point6.com
Healthy Merits	Healthy Merits Meritain	1-877-348-4533 healthymerits@meritain.com dopt.wellright.com/act/auth/login
Dental	Delta Dental	1-800-521-2651 or www.deltadentalins.com
Vision	VSP	1-800-877-7195 or www.vsp.com
Life	Mutual of Omaha	1-888-493-6902 - claims www.mutualofomaha.com
Disability	Mutual of Omaha	1-800-775-1000 - claims www.mutualofomaha.com
Employee Assistance Program	Mutual of Omaha	1-800-316-2796 www.mutualofomaha.com/eap

Questions About…	You May Call:	At This Number:
Medical Benefits	Meritain	1-800-925-2272
Retail Prescription Drug Benefits	CVS/Caremark	1-800-565-7091
Mail Order/Specialty Drugs	CVS/Caremark	1-800-565-7091
Participating Providers	Aetna	1-800-343-3140
Precertification	Meritain	1-800-242-1199

NOTES

THE CATHOLIC DIOCESE of PENSACOLA-TALLAHASSEE

2023-2024