2025-2026 Benefits Guide

Archdiocese of Miami Health Plan

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INTRODUCTION

Benefits designed for you and your family

The Archdiocese of Miami recognizes the importance of providing comprehensive benefits and considers them to be an important part of your compensation package. The Archdiocese of Miami Health Plan (The Health Plan) provides a wide range of benefits designed to support your needs and the needs of your family, particularly as you pay for increasingly expensive medical care.

The Health Plan is funded solely by the monthly contributions made by you and your employer. Those funds pay all costs of the plan, including claims. Therefore, in order to maintain our levels of benefits and to keep your out-of-pocket cost lower, we ask you to:

Take advantage of our Employee Resources programs, such as:

- Know Before You Go to predetermine the cost of services
- Healthy Additions and Next Steps Program for individual health coaching
- Lantern provides you with access to excellent and affordable care for many planned surgical procedures. When using Lantern all costs ot the surgery are paid, including travel expenses.
- Hinge Health, a digital exercise therapy clinic, to support muscle and joint health. Enroll in the Hinge Health program for a free personalized exercise therapy program, unlimited access to a health coach, and physical therapist guidance.

and manage prescription costs by choosing generic and mail order drugs.

This Benefits Guide is an overview of each benefit option available to you as a benefits-eligible employee. It serves as a reference for you and your family, enabling you to receive the most from your benefit plans throughout the year. Whenever you have questions about your benefits, this Benefits Guide is a good place to start. You may also visit www.adomhealthplan.org for more resources and information.

If you have Medicare, or if you will become eligible for Medicare in the next 12 months, a 2006 federal law gives you more choices about your prescription coverage. Please see page 33 for more details.

BENEFIT- ELIGIBILITY

Employee

You are benefits-eligible if you are classified as either a full-time regular employee, expected to work 37.5 hours per week; OR a part-time regular employee, expected to work at least 30 hours per week.

Dependents: Proof of dependent status will be requested for each eligible dependent you enroll.

Spouse:	Your legal spouse.
Children:	Your natural born, adopted, foster, or step children until age 26. There is no age limit for dependent children who are mentally or physically disabled.
Overage Dependent: (age 26-30)	There is a separate charge for your children age 26-30. To be eligible, your Overage Dependent must: • Be a Florida resident or student • Not be covered by or eligible for any other medical coverage • Be unmarried with no dependents of his/her own

ENROLLMENT & CHANGES

Initial Enrollment Period

A newly hired employee has 30 days from the date of hire to enroll in coverage. Coverage will begin on the day following 30 days from your date of hire. To enroll in coverage, you must log on to www.adomhealthplan.org and follow the instructions provided on page 3 of this Benefit Guide. Please note the system will not accept enrollment after the 30-day window has closed.

- Medical, Dental, Vision: Within 30 days of hire, you can enroll or waive coverage. Once you make your elections, you can only make changes or enroll during Annual Enrollment unless you have a Life Event.
- Supplemental Life and Short-Term Disability: Within 30 days of hire, you can enroll without providing medical information. You can always apply for coverage at a later time, but you will need to provide medical information and be subject to carrier approval.
- Critical Illness, Group Accident, Hospital Indemnity, Identity Theft, Gap Plan: Within 30 days of hire, you can enroll or waive coverage. Once you make your elections, you can only make changes or enroll during Annual Enrollment unless you have a Life Event.
- Basic Life and Long-Term Disability automatically enrolled

Annual Enrollment Period

Annual Enrollment, held each year for a period in May, allows you to review your existing benefit elections and make changes. You will be required to provide medical information to enroll in Supplemental Life and Short-Term Disability. To elect or change coverage you must log on to www.adomhealthplan.org and follow the instructions provided on page 3 of this Benefits Guide. Please note the system will not accept changes after the enrollment period has closed. Any changes made during this time will become effective July 1.

Special Enrollment Period

A Life Event is a change in family or employment status that allows you to make changes to your existing medical, dental and vision benefit elections. The changes must be consistent with the event. You have 30 days from the date of the event to submit changes. Changes will become effective on the date of the event. To make a change due to a Life Event, you must log on to www.adomhealthplan.org and follow the instructions provided on page 3 of this Benefits Guide. You must also submit all required documentation (loss or gain of other benefits, birth certificate, marriage certificate, etc.) within 30 days of the event.

A Life Event can be:

- Marriage or divorce
- Birth, adoption or change in custody of an eligible child
- A dependent ceases to be eligible as a dependent
- A change in your (or your spouse's) employment status
- Spouse's Annual Enrollment
- Eligibility for Medicare

Voluntary loss of other coverage, including increased costs or failure to pay, is not considered a Life Event.

Enrollment Selections

Eligible employees may select coverage for themselves and eligible dependents, including the following categories: Employee, Employee Plus One, Employee Plus Child(ren), Employee Plus Family, and Overage Dependants. An Employee Plus One enrollment covers the employee and one designated eligible family member. The definition of eligible family member Includes either a lawful spouse or a child up to age 26.

ENROLLING IS EASY

LOG IN

Visit **www.AdomHealthPlan.org** from any computer or smart device and **Login** with your **User Name** and **Password**.

New users must **Register** and answer security questions. Our case-sensitive company key is **ADOM**.

GET STARTED

Click **Start Here** and follow the instructions to make your benefit choices by the deadline on the calendar. If you miss the deadline you will have to wait until the next annual enrollment period to enroll or make changes.

FIND INFORMATION

View plan details, carrier specifics and resources in the **Reference Center**.

MAKE YOUR ELECTIONS

Using **Previous** and **Next** to navigate, review your options as you move through the enrollment process.

Select plan(s) and who you would like to cover.

REVIEW AND CONFIRM

Make sure your personal and dependent information is accurate, then proceed to your elections.

You will have a chance to review your elections after each section.

FINALIZE

When your enrollment is complete, you will receive a confirmation number and you can **Print Benefit Summary**.

Your **To Do** list will notify you if you have any additional actions needed to complete your enrollment.

REVIEW YOUR BENEFITS

You have year-round access to a benefits summary that shows your personal selections. Click **Benefit Summary** on the homepage to review your current benefits at any time.

Change your benefits

Once approved, your benefit elections will remain in effect until the end of the plan year, unless you have a qualifying life event such as marriage, divorce or having a baby. Find detailed information in the **Reference Center**.

1. Click on **Change My Benefits**.
2. Select **Life Event** and the event type.
3. Review your options and follow the election steps outlined above to complete your changes.

****IMPORTANT:** You must make changes within **30 days** of the event, and provide required documentation.

Change your beneficiary(ies)

1. Click on **Change My Benefits**
2. Select **Life Event/ Beneficiary Update**.
3. Follow the prompts to complete your change.

Beneficiary changes can be made at any time of the year.

Archdiocese of Miami Health Plan

www.adomhealthplan.org
Company Key: ADOM

Need to reset your user name or password?

1. Click **Forgot your user name or password?**
2. Enter your Social Security number, birth date and our company key, **ADOM**.
3. Answer your security phrase.
4. Enter and confirm your new password, then click **Continue** and **Login** with your new credentials.

Download the MyChoice℠ Mobile App

1. Visit your device's app store and download the **MyChoice by Businessolver®** Mobile App.
2. Visit **www.AdomHealthPlan.org** to **Get Access Code**.
3. Activate the app with your access code. (If you don't use the code within 20 minutes, you'll need to generate a new one.)
4. Follow the instructions within the Mobile App to have easy access to your benefits on the go.

Download on the App Store | GET IT ON Google Play

BASIC LIFE AND AD&D

The Archdiocese of Miami provides Basic Group Term Life and Accidental Death & Dismemberment insurance through Hartford at no cost to you. Basic Life and AD&D insurance each pays your named beneficiary* a benefit if you die while covered. Accidental Death & Dismemberment insurance pays a benefit if you suffer an accidental injury.

Basic Life

- The face amount is $15,000; $10,000 at age 65 and $7,500 at age 70
- Accelerated Benefit Provision – pays up to 80% of the face amount if you are diagnosed as Terminally Ill prior to age 60
- Waiver of Premium Provision – insurance remains in force without premiums if disabled prior to age 60
- Convertible or Portable to an Individual policy with Hartford

Accidental Death & Dismemberment – If you die or suffer an injury or an accident

- The face amount is $15,000; $10,000 at age 65 and $7,500 at age 70
- Face amount paid for loss of life; 50% of Face amount paid for loss of limb
- An additional 25% of the face amount will be paid if you die in a motor vehicle accident while wearing a seat belt
- 5% of the face amount will be paid for Day Care, Child Education, and Spouse Education Benefits

LONG TERM DISABILITY

The Archdiocese of Miami provides Long-Term Disability insurance through Hartford at no cost to you. Long-Term Disability pays a portion of your income if you cannot work because of a disabling illness or injury for more than 90 days.

Benefit	
No Offset Income:	61% of Pre-Disability Earnings (excluding overtime and commissions)
With Offset Income:	70% of Pre-disability Earnings (excluding overtime and commissions) Offset income will reduce the monthly benefit amount by the amount of other income, such as disability pension or Social Security
Maximum Benefit:	$7,000 per month
Minimum Benefit:	$100 per month
Elimination Period:	90 Days unable to work
Maximum Benefit Period:	As long as disabled or until Normal Social Security Retirement Age
Survivor Benefit:	6 months Disability Benefit paid to Named Beneficiary

Pre-Existing Condition

Any medical condition for which you are treated, take medications or seek medical advice within 90 days prior to your effective date will not be covered until after a period of 12 months. If during that 12 month period you are treatment free for 90 consecutive days the limitation will not apply.

*A NOTE ABOUT BENEFICIARY DESIGNATIONS: If your beneficiary is a minor child the payment will be held until the child is age 18. If your beneficiary is in another country payment may be delayed.

VALUE ADDED SERVICES FROM THE HARTFORD

As part of the life insurance with The Hartford, you may have access to additional services designed to help you and your loved ones make more informed decisions. Services include:

Funeral Planning and Concierge Services

The Hartford offers a suite of online tools that can help guide you through important decisions before a loss, including detailed local funeral home price comparisons, 24/7 assistance with funeral planning, and the only nationwide database of funeral home prices. After a loss, this service includes family advocacy and professional negotiation of funeral prices with local providers, which often results in significant financial savings.

- Call 1 (866) 854-5429 or
- Visit www.everestfuneral.com/hartford and use the code, HFEVLC

Estate Guidance (create a will online)

The Hartford helps you protect your family's future by creating a customized and legally binding online will using a simple but comprehensive online questionnaire. Estate Guidance also provides an online education center and support from a licensed attorney. Additional services include creating living wills and trusts along with guidance about divorce proceedings and durable power of attorney.

- Visit www.estateguidance.com/wills and use the code, WILLHLF

Beneficiary Assist (help for those coping with a loss)

The Hartford provides expert support to help you or your loved ones cope with the emotional, financial, and legal issues that arise after a loss. This also includes 24/7-unlimited phone contact with professionals, as well as five face-to-face sessions that help with topics such as grief and loss, job pressures, stress, anxiety, depression, and relationship/marital conflicts.

- For more information, call 1 (800) 411-7239

Travel Assistance & ID Theft Protection Service

The Hartford provides pre-trip information that helps you feel safe and secure while traveling. This includes information about whether a visa or passport is required, immunization or inoculation requirements, foreign exchange rates, and embassy referrals. It also provides access to medical professionals across the globe when traveling 100+ miles away from home for 90 days or fewer. In addition, ID theft protection is available 24/7 whether home or away. ID theft protection offers educational materials on how to prevent identity theft and access to caseworkers who can help victims resolve problems that result from it.

- Call 1 (800) 243-6108 or collect (202) 828-5885. Use the travel assistance ID number, GLD-09012

Ability Assist Counseling Services

You can receive professional counseling for financial, legal and emotional issues. This includes three face-to-face sessions per year and unlimited phone access. Services are also available to spouses and dependent children and can include guidance from highly trained master's and doctoral level clinicians to help deal with job pressures, relationship and marital conflicts, stress, anxiety, depression, and substance abuse.

- For more information, call 1 (800) 964-3577

SUPPLEMENTAL LIFE

Supplemental Life is offered as a voluntary benefit with The Hartford. Supplemental Life pays your beneficiary a benefit, in addition to the Basic Life (described on page 5) if you die while you are covered. This insurance is portable or convertible to an individual policy, meaning you can take it with you even if you leave your current employment. Supplemental Life is available for you, your spouse, and your children.

Benefit Amount	
Employee:	In increments of $10,000, up to a maximum of $300,000 Term Life *(combined amount between Basic Life and Supplemental Life is $315,000)* • At age 65, benefit amounts reduce to 65% • At age 70, benefit amounts reduce to 45% • At age 75, benefit amounts reduce to 30% • At age 80, benefit amounts reduce to 20%
Spouse:	Up to 50% of your total life insurance amount in force
Children:	• 15 days to 6 months - $1,000 • 6 months or older - $2,500

Accelerated Benefit Provision

This policy includes an Accelerated Benefit Provision that allows you, under certain circumstances, to access up to 80% of your death benefit if you are diagnosed with a terminal illness.

When can I enroll in Supplemental Life?

A) Within 30 days of hire, you can elect up to $100,000 without providing medical information.
B) To apply at a later time, or for a greater amount, you will need to provide medical information for any amount elected and be subject to carrier approval.

When can I enroll my spouse in Supplemental Life?

A) Within 30 days of your hire, your spouse can elect up to $30,000 without providing medical information.
B) To apply at a later time, or for a greater amount, your spouse will need to provide medical information for any amount elected and be subject to carrier approval.

When can I enroll my children in Supplemental Life?

You can enroll your children when you apply for coverage. Children will never have to provide medical information.

SHORT-TERM DISABILITY

Short-Term Disability is offered as a voluntary benefit with The Hartford. Short-Term Disability pays you a portion of your income if you cannot work because of a disabling illness (including pregnancy/maternity) or injury for a period of time. Short-Term Disability coverage is only available for you.

Benefit	
Coverage Level (with offset):	66.67% of pre-disability earnings
Maximum Benefit:	$600 per week
Minimum Benefit:	$25 per week
Elimination Period:	0 days for an accident; 8 days for an illness
Maximum Benefit Period:	13 weeks

Pre-Existing Condition

Any medical condition for which you are treated, take medications or seek medical advice within 90 days of your effective date of coverage will be limited to a benefit period of 4 weeks during the first 12 months of coverage. If during that 12 month period you are treatment-free for 90 consecutive days the limitation will not apply.

Definitions

- **Pre-Disability Earnings**: Base salary excluding overtime, bonuses, and commission
- **Offset:** The monthly benefit will be reduced by the amount of other income, such as disability pension, sick pay, or Social Security Disability Income
- **Elimination Period:** The period for which you must be unable to work due to a disabling illness or injury before you can receive benefits

What do I need to enroll in Short-Term Disability?

To be eligible for this coverage, you must meet the requirement for benefit-eligibility and be actively at work on the effective date of coverage.

When can I enroll in Short-Term Disability?

A) Within 30 days of hire, you can elect Short-Term Disability without providing medical information
B) To apply at a later time, you will need to provide medical information and be subject to carrier approval

FAMILY MEDICAL LEAVE ACT

The Family Medical Leave Act (FMLA) may entitle you to take up to 12 weeks of unpaid, job-protected leave for specified family and medical reasons.

What are the qualifying reasons for FMLA?

If you have a serious health condition; the serious illness of a family member (spouse, dependent child, or dependent parent); the birth, adoption, or foster care placement of a child; military exigency.

What do I have to do?

If you foresee an absence for more than 3 consecutive days due to an injury, illness, or qualifying reason:

1. Speak with your entity administrator.
2. Call The Hartford at (800) 549-6514 to file a Family Medical Leave application and provide any requested documentation to The Hartford. Your case file may be closed if you fail to respond.
3. Read the entire policy in the Employee Handbook.
4. When returning to work, provide a doctor's note or return-to-work documentation to your entity administrator.

This is an overview of the coverage. It is intended to merely highlight some of the benefits that may be available to you. Consult policy benefit limitations, exclusions, and other provisions online at www.adomhealthplan.org

MEDICAL PLANS FOR 2025-2026

The Archdiocese of Miami offers a choice of three medical plans, Gold, Silver and Bronze. Each Plan has a varying amount of deductible and out of pocket costs, and the Bronze Plan contains a Healthcare Savings Account. Details of each Plan are outlined below and on the next page.

All plans use the Blue Care HMO network through Florida Blue, all Plans cover Preventive Services at 100%, and all Plans cover Quest lab services at 100%. (Please note Quest is the only lab covered by our Plans.)

Primary Care Physicians are not required, referrals to specialists are not required and referrals are not required for treatment, although prior authorization may be required for certain nuclear medicine (MRI, CTscan, etc.), ophthalmology and home healthcare services.

No benefits are provided for providers that are not participating in the Blue Care HMO network except in the case of emergency.

Emergency treatment is care and services provided to stabilize a serious medical condition or injury. It includes those medical services required for immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death. Always go to the nearest Emergency Room if you are having a medical emergency.

Gold Plan

- $10 copay for Teladoc telemedicine visits
- $15 copay for Sanitas Primary Care Physician visits
- $30 copay for Blue Care HMO Primary Care Physician visits
- Calendar Year deductible of $1,750 per employee; $5,250 per family
- Calendar Year Out-of-Pocket of $5,500 per employee; $13,750 per family

Silver Plan

- $10 copay for Teladoc telemedicine visits
- $20 copay for Sanitas Primary Care Physician visits
- $40 copay for Blue Care HMO Primary Care Physician visits
- Calendar Year deductible of $2,500 per employee; $5,000 per family
- Calendar Year Out-of-Pocket of $6,000 per employee; $15,000 per family

Bronze Plan

- Deductible and Coinsurance applies to all covered medical and prescription drug benefits
- Calendar Year deductible of $3,300 per employee; $6,600 per family
- Calendar Year Out-of-Pocket of $4,800 per employee; $9,600 per family
- Automatically receive a Health Savings Account with Health Equity
- See page 13 for details

Allowed Amount: The maximum amount an in-network provider is allowed to charge you for a covered service

Calendar Year Deductible: The amount you owe per calendar year (January 1 – December 31) before your plan begins to pay for covered services; services subject to a copay are separate from the deductible

Copayment (Copay): A set amount you owe at the time of service

Coinsurance: A percentage of total charges you owe at the time of service

Covered Services: Services that are eligible for payment under your plan

In-Network: Physicians, hospitals and ancillary providers who are participating in the Blue Care HMO network through Florida Blue

Out-of-Pocket: What you pay for healthcare expenses (copays, deductibles, coinsurance)

Out-of-Network: Any provider not participating in the Blue Care HMO network through Florida Blue

Out-of-Pocket Maximum: The most you will pay within a calendar year (January 1 – December 31) for covered health care expenses

DEDUCTIBLES, COPAYS AND OUT OF POCKET - HOW DOES IT WORK?

Annual Deductible and Out of Pocket maximums accumulate on a Calendar Year basis, January through December. The dollar amounts applied to copayments, the deductible, and your 20% coinsurance all count toward the annual out of pocket maximum. The illistration below shows how these amounts are applied and added together.

Example: Silver Plan - $2,500 Annual Deductible and $6,000 Annual Out of Pocket

Service - Average Cost	Copay+	Deductible+	Coinsurance+	Out of Pocket
Primary Care Office Visit - $200	$40			$40
Generic Drug	$15			$15
Quest Lab	$0			$0
Emergency Room - avg cost $2,685	$0	$1,200		$1,200
CT Scan - $800		$800		$800
MRI -$1,500		$500	$200	$700
Hospital 5 days - $ 13,000			$2,600	$2,600
Specialist Office Visit - $300	$75			$75
Total	**$130**	**$2,500**	**$2,800**	**$5,430**

GAP PLAN - FIDELITY SECURITY LIFE

Gap insurance is a voluntary, employee paid insurance which pays for employee medical deductible costs.

The FSL Blended GAP Plan provides benefits in tandem with your Fl Blue medical plan, reimbursing you for the costs associated with your annual deductible. Prescription and office visit copays are not eligible for reimbursement.

GAP Plans are specifically designed to "fill the gaps" of your major medical plan by providing coverage for your out-of-pocket deductible expenses. Think of GAP plans as a secondary insurance payor to help alleviate the expensive cost of care burden on you and your family.

If you and your family are enrolled in a medical plan, you are eligible for the GAP Plan without having to answer medical questions. You must be enrolled in a medical plan to participate, and you must enroll in the Gap Plan order to cover your medical plan dependents.

How does the GAP insurance work? Present your Gap card along with your Florida Blue card at the doctor/ medical provider's office to start saving immediately. Due to federal regulations covering the Bronze Plan and the HSA, employees enrolled in that plan must meet a deductible of $1,600 before GAP covers costs.

GAP Plan	Gold Plan	Silver Plan	Bronze HO
Deductible	$0	$0	$1,650
Maximum Annual Benefit	$1,750	$2,500	$1,550
Family Maximum Benefit	$5,250	$5,000	$3,100

MEDICAL: BENEFITS AT A GLANCE

	GOLD PLAN	SILVER PLAN	BRONZE PLAN
Calendar Year Annual Deductible			
Per Individual	$1,750	$2,500	$3,300
Per Family Combined	$5,250	$5,000	$6,600
Co-insurance - Plan pays	80%	80%	90%
Calendar Year Annual Out of Pocket			
Per Individual	$5,500	$6,000	$4,800
Per Family Combined	$13,750	$15,000	$9.600
Out of Pocket includes deductible, coinsurance and copays			
Office Visits			
Preventive	Paid at 100%	Paid at 100%	Paid at 100%
Teladoc Telemedicine	$10 copay	$10 copay	Ded/80%
Primary Care			
Sanitas Provider	$15 copay	$20 copay	Ded/80%
Fl Blue Total Care Providers	$15 copay	$20 copay	Ded/80%
Fl Blue Blue Care Network	$30 copay	$40 copay	Ded/80%
Specialist Visits - no referral needed			
Sanitas Provider	$20 copay	$30 copay	Ded/80%
Fl Blue Total Care Providers	$20 copay	$30 copay	Ded/80%
Fl Blue Blue Care Network	$75 copay	$75 copay	Ded/80%
Urgent Care			
Sanitas Urgent Care	$20 copay	$20 copay	Ded/80%
Fl Blue Blue Care Network	$75 copay	$75 copay	Ded/80%
Emergency Room			
Copay	$100	$0	$0
	Ded/80%	Ded/80%	Ded/80%
Labs			
Quest	Paid at 100%	Paid at 100%	Paid at 100%
Outpatient Hospital	Ded/80%	Ded/80%	Ded/80%
Other	Not covered	Not covered	Not covered
Diagnostic Tests - X-Rays, EKG			
Sanitas Provider	$20 copay	$30 copay	Ded/80%
Fl Blue Total Care Providers	$20 copay	$30 copay	Ded/80%
Fl Blue Blue Care Network	$75 copay	$75 copay	Ded/80%
Facility	Ded/80%	Ded/80%	Ded/80%
Imaging: CT/PET Scans, MRI- Authorization may be required			
Physician Office	$75 copay	$75 copay	Ded/80%
Diagnostic Testing Center	Ded/80%	Ded/80%	Ded/80%
Hospital	Ded/80%	Ded/80%	Ded/80%
Therapy: Physical Therapy, Speech Therapy, Chiropractor			
Outpatient Therapy			
Copay per Visit	$75 copay	$75 copay	Ded/80%
Maximum Annual Visits	35	35	35
Inpatient Therapy			
Copay per Visit	Ded/80%	Ded/80%	Ded/80%
Maximum Annual Visits	31	31	31
Mental Health/Substance Abuse			
Office Visit Copay	$75 copay	$75 copay	Ded/80%
Hospital Inpatient	Ded/80%	Ded/80%	Ded/80%
Hospital Outpatient	Ded/80%	Ded/80%	Ded/80%
Maximum Annual Visits/Days	No max	No max	No max
Skilled Nursing Facility			
Inpatient	Ded/80%	Ded/80%	Ded/80%
Maximum Days per calendar year	60	60	60
Home Health Care			
	Ded/80%	Ded/80%	Ded/80%
Maximum Visits per Calendar Year	20	20	20
Ophthalmology - authorization needed			
Call Eye Management 305 861-1152			

PRESCRIPTION DRUGS

CVS/Caremark

The Prescription Drug benefit is administered by CVS/Caremark. Your prescription Drug Plan coincides with the Medical Plan you have chosen, Gold, Silver or Bronze. A separate CVS/Caremark Pharmacy ID card must be used when purchasing prescription drugs.

Drugs can be purchased at a retail pharmacy or through a mail-order program. You are encouraged to purchase generic drugs when medically appropriate and use mail order purchase for supplies up to 90 days.

To find a retail pharmacy visit the online directory at www.caremark.com or call CVS/Caremark at 1-866-217-5353 for assistance. To enroll in the Mail Order program for your maintenance medication call Caremark's FastStart program at 1-866-217-5353 or visit www.caremark.com for a mail order service form or to order online.

Retail Pharmacy Benefit – fill your 30 day prescription at a Retail Pharmacy

30 Day Supply	Gold Medical Plan	Silver Medical Plan	Bronze Medical Plan
Generic	$15 copay	$15 copay	Deductible, coinsurance
Preferred Brand	$60 copay	$60 copay	Deductible, coinsurance
Non-Preferred Brand	$90 copay	$90 copay	Deductible, coinsurance
Specialty Drugs	Deductible, coinsurance max $400 per prescription	Deductible, coinsurance max $400 per prescription	Deductible, coinsurance
Prudent Rx Specialty Program*	$0 copay	$0 copay	Deductible, Coinsurance

*Must enroll in the Prudent Rx program to qualify for $0 copay. Not all specialty drugs are included.

Mail Order Pharmacy Benefit – fill your 90 day prescription via Mail Order or at a CVS Pharmacy

90 Day Supply	Gold Medical Plan	Silver Medical Plan	Bronze Medical Plan
Generic	$30 copay	$37.50 copay	Deductible, coinsurance
Preferred Brand	$120 copay	$150 copay	Deductible, coinsurance
Non-Preferred Brand	$180 copay	$225 copay	Deductible, coinsurance
Specialty Drugs	Deductible, coinsurance max $400 per prescription	Deductible, coinsurance max $400 per prescription	Deductible, coinsurance
Prudent Rx Specialty Program*	$0 copay	$0 copay	

*Must enroll in the Prudent Rx program to qualify for $0 copay. Not all specialty drugs are included.

Copayments paid under the pharmacy benefit accumulate toward the medical out-of-pocket costs.

Dispense as Written (DAW) Penalty

If you request a brand name drug when a generic equivalent is available, you will be charged the difference between the brand and generic, plus your copay.

PRESCRIPTION DRUGS

CVS/Caremark

Prior Authorization

Prior authorization requires a drug's prescribed use to be evaluated against a predetermined set of criteria before the prescription will be covered.

Certain drugs or drug classes will require prior authorization in order to be covered. If you are taking a drug that requires Prior Authorization, you can avoid delays and interruptions in your therapy by asking your doctor to call the CVS/Caremark Prior Authorization Department. Prescribers may apply for prior authorization electronically, by fax at 1-888-836-0730 or by phone at 1-800-294-5979. The request will be evaluated to determine if you qualify for Plan coverage of the prescribed therapy.

If you fail to obtain Prior Authorization or if you don't meet criteria standards and still wish to take the medication, you'll be responsible for the entire cost of the drug.

Specialty Drugs

CVS/Caremark Specialty Pharmacy Services is a full-service specialty pharmacy that provides specialty injectable and oral drugs for chronic conditions. CVS/Caremark provides these products directly to Covered Persons along with personalized service and educational support for your specific therapy. To learn more about CVS/Caremark Specialty services, visit Caremark.com or call Caremark Connect at 1-800-237-2767.

PrudentRx Copay Program for Specialty Medications

The PrudentRx Copay Program assists our members to enroll in manufacturer copay assistance programs. Copay assistance is financial support provided by drug manufacturers to cover all or most of your costs for certain medications - in particular, specialty medications.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication.

After you have successfully enrolled in the Prudent Rx Program your specialty medication copay will be $0 for each eligible prescription. If you do not successfully enroll in the program you will be responsible for 30% of the cost of the prescription.

All eligible members will be automatically enrolled in the PrudentRx program, but you can choose to opt out of the program by calling 1-800-578-4403. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

The PrudentRx Program Drug List may be updated periodically by the Plan. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

SPENDING ACCOUNTS

The Archdiocese of Miami Health Plan offers three Flexible Spending and Savings Accounts, a Medical Spending Account, a Healthcare Savings Account and a Dependent Day Care Account. Eligibility for each of these accounts is as follows:

All benefit eligible employees (except Bronze Medical Plan participants):

- Health Care Flexible Spending Account (FSA) – deposit up to $3,300 per year, and;
- Dependent Care Flexible Spending Account (DCFSA)– deposit up to $5,000 per year

Bronze Medical Plan participants:

- Health Care Savings Account (HSA) – deposit up to $4,300 for yourself and $8,550 for you and your family, and;
- Dependent Care Flexible Spending Account (DCFSA) – deposit up to $5,000 per year

Employees not otherwise eligible for benefits:

- Dependent Care Flexible Spending Account (DCFSA) – deposit up to $5,000 per year

Health Care Flexible Spending Account

A Health Care FSA is a pre-tax benefit account that's used to pay for eligible medical, dental, and vision care expenses - those not covered by the health care plan or elsewhere. It's a smart, simple way to save money.

With a Health Care FSA, pre-tax dollars are used to pay for qualified out-of-pocket Health Care expenses. The money contributed to a Health Care FSA is not subject to payroll taxes, so less is paid in taxes and more in take home pay.

Per IRS guidelines, up to a maximum of $3,300 can be contributed to a HCFSA during calendar year 2025. Additionally, up to $660 can be carried over into the next calendar year. Account balances over $660 on December 31 will be forfeited. The account is also forfeit when employment ends.

Contributions will be payroll deducted pre-tax and sent to individual Health Equity accounts. Participating employees will have a debit card to pay eligible Health Care expenses, and on-line access to their Health Equity account. The total annual election amount is available on day one of the plan year.

Health Savings Account – Bronze Plan Participants Only

Bronze Plan participants automatically receive a Healthcare Savings Account upon enrollment. A Health Savings Account can be used to pay qualified medical, dental and vision expenses.

With a HSA, pre-tax dollars are used to pay for qualified out-of-pocket Health Care expenses. The money contributed to an HSA is not subject to payroll taxes, so less is paid in taxes and more in take home pay. Per IRS guidelines, up to a maximum of $4,300 per individual or $8,550 per family can be contributed to an HSA during calendar year 2025. There is no “use it or Lose it” rule. Account balances roll over year after year.

Contributions will be payroll deducted pre-tax and sent to individual Health Equity accounts. Participating employees will have a debit card to pay eligible Health Care expenses, and on-line access to their Health Equity account. Account withdrawals, interest and investment earnings are tax-free.

SPENDING ACCOUNTS *(continued)*

Health Care FSA and Health Savings Account Eligible Expenses

- Medical expenses: co-pays, co-insurance, and deductibles
- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services: physical therapy, chiropractor, and acupuncture
- Prescription drugs, insulin, and prescribed over-the-counter medicine
- Over-the-counter health care items: bandages, pregnancy test kits, blood pressure monitors, etc.

Dependent Day Care Flexible Spending Account

A Dependent Day Care Flexible Spending Account a pre-tax benefit account that's used to pay for eligible dependent day care expenses.

Qualifying dependents (Per IRS guidelines)

- Children under 13
- Disabled qualifying relative
- Spouse unable to work or care for themselves
- Adult child unable to work or care for themselves

Qualifying expenses (per IRS guidelines)

- Babysitting, day camp, before- and after-school care, and an au pair or nanny
- Adult daycare and homecare services
- Household services provided by cooks, maids, or cleaners, if the services are part of care
- Applications for care

Not Eligible (per IRS guidelines)

- Date-night babysitter, overnight camp, summer school, tutoring
- Companion care
- Expenses reimbursed by a state social service agency
- Enrichment lessons for recreational activities, such as music and sports

The 2025 dependent care FSA contribution limit is $5,000 for “single” or “married couples filing jointly” households. The amount goes down to $2,500 for married people filing separately.

Account balances on December 31 will be forfeit. The account is also forfeited if employment ends.

Contributions will be payroll deducted pre-tax and sent to individual Health Equity accounts. The total annual election amount is available on day one of the plan year. Logon to www.adomhealthplan.org during your Initial Enrollment to participate.

Once an election is made, the election and payroll deductions cannot be changed until January 1, 2026, unless there is a Life Event (marriage, divorce, birth of a child).

FINDING A PROVIDER

To locate an in-network provider, logon to www.floridablue.com

- Click on Find a Doctor;

    1. Enter your zip code and county

    2. Select a Plan
        a. Medical - Blue Care
        b. Dental PPO - BlueDental Choice
        c. Dental HMO - BlueDental Care Prepaid
        d. Vision - Vision

    3. Search for a provider by name, specialty, facility

When choosing a Provider:

- Consider choosing a Sanitas provider or a provider participating in the **Value Choice** or **Total Care** programs. These providers offer coordinated care and copays for visits are lower.

- **Eye Management** provides ophthalmology network services. If you need to visit an ophthalmologist, you or your optometrist must contact Eye Management at (305) 861-1152 for information and guidance.

- **Care Centrix** provides home health and infusion services, durable medical equipment, medical supplies and orthotic/prosthetic services. Please call CareCentrix at (877) 561-9910 for assistance.

Sanitas Medical Center | For members of Florida Blue

Call 1-844-665-4827
For an appointment
www.mysanitas.com/fl

Why Choose Sanitas Medical Center?

✔ **Everything you need, all in one place**
Primary care and urgent care, lab work and imaging - for the whole family

✔ **Easy and convenient appointments**
Schedule online or by phone. Plus, we're open evenings and weekends at most locations.

✔ **Whole-person care - body, mind and spirit**
Support from care coordinators and nutritionists so that you can live life fully

✔ **The care you want, whenever you need it**
Tap into care from anywhere - chat with us via our app, telehealth care or in-home visits.

Sanitas Medical Clinics	844-665-4827		
Doral 2000 NW 87 th Avenue Doral, FL 33183	**Miami Lakes** 18610 NW 87 th Avenue Miami, FL 33015	**Kendall** 7135 SW117th Avenue Miami, FL 33183	**Plantation** 180 SW 84 th Avenue Plantation, FL 33324
Urgent Care Center Medical Office Dental Office Telemedicine	Urgent Care Center Medical Office Telemedicine	Urgent Care Center Medical Office Telemedicine	Urgent Care Center Medical Office Telemedicine
Primary and Specialty Care Physicians Pediatricians Dentists	Primary and Specialty Care Physicians Pediatricians	Primary and Specialty Care Physicians Pediatricians Specialists	Primary and Specialty Care Physicians Pediatricians
Annual Exams, School and Sports Physicals, Lab and Diagnostic Testing, Blood Work, Urinalysis, X-Rays, Ultrasound, EKGs, Mammograms and Pap Smears, CT Scans, Stress Tests	Annual Exams, School and Sports Physicals, Lab and Diagnostic Testing, Blood Work, Urinalysis, X-Rays, Ultrasound, EKGs, Mammograms and Pap Smears	Annual Exams, School and Sports Physicals, Lab and Diagnostic Testing, Blood Work, Urinalysis, X-Rays, Ultrasound, EKGs Mammograms and Pap Smears, CT Scans, Stress Tests	Annual Exams, School and Sports Physicals, Lab and Diagnostic Testing, Blood Work, Urinalysis, X-Rays, Ultrasound, EKGs Mammograms and Pap Smears

Sanitas Primary Care	844-665-4827	
15600 NW 67 th Avenue Miami Lakes, FL 33014	1313 SW 27 th Avenue Miami, FL 33145	880 NW 13 th Street Boca Raton, FL 33486
1060 W 49 th Street Hialeah, FL 33012	6100 Hollywood Blvd. Hollywood, FL 33024	1501 Congress Avenue Boynton Beach, FL 33426
9736 SW 24 th Street Miami, FL 33165	4850 W Oakland Park Blvd. Lauderdale Lakes, FL 33313	1397 Medical Park Blvd. Wellington, FL 33414
9380 SW 150 th Street Miami, FL 33176	12507 Miramar Parkway Miramar, FL 33027	5960A S Jog Road Lake Worth, FL 33467
7135 SW 117 th Avenue Miami, FL	2150 S Andrews Avenue Ft. Lauderdale, FL 33316	1515 N Flagler Drive West Palm Beach, FL 33401
600 NE 22 nd Terrace Homestead, FL 33033	2901 Coral Hills Drive Coral Springs, FL 33065	3401 PGA Blvd. Palm Beach Gardens, FL 33410
8945 SW 162 nd Avenue Miami, FL 33196	50 W Sample Road Pompano Beach, FL 33064	

Primary Care	$15 copay
Specialist	$20 copay
Urgent Care	$20 copay
Lab	100%

You have access to Teladoc Health virtual care through Archdiocese of Miami

With Teladoc Health, getting care is quick and easy. You can talk to a licensed healthcare provider on your schedule from the comfort of your couch, or even if you're on-the-go.

See a provider fast. It's simple:

1. **Register** through the QR code below.
2. **Share your health information** with your provider
3. **Choose a visit time** that's most convenient for you and meet with a provider by phone or video

You'll get a diagnosis, treatment plan and medication if needed so you can start feeling better, faster. Schedule a visit today.

Get a same-day visit with your 24/7 Care service:

Providers available by phone or video 24/7
- Medical Doctor
- Nurse Practitioner
- Mental Health Therapist
- Dermatologist

Prescriptions sent to your pharmacy of choice if needed

Care for non-emergency needs, such as cold, flu, allergies and more

Gold and Silver Plans
$10 copay per visit

Bronze Plan
Deductible and coinsurance

Your Teladoc Health experience includes:

24/7 Care
Talk to a doctor or nurse practitioner in minutes for non-emergency needs
$10/visit

Mental Health
Talk to a therapist who's right for you by phone or video
$10/therapy visit
$10/first psychiatry visit
$10/ongoing psychiatry visits

Dermatology
Treat skin conditions by sending photos to a dermatologist
$10/online review

Schedule a visit

Scan the QR code with your personal device
Visit TeladocHealth.com
Call 1-800-835-2362
Download the Teladoc Health app

FLORIDA BLUE CENTERS

At the Florida Blue Centers, you can:

- receive assistance with finding a provider
- replace lost ID cards
- review claims
- talk with a health coach
- receive one-on-one customer service

The Florida Blue Centers also host monthly health fairs and free wellness events with guest speakers, fitness classes, nutrition seminars, and more!

Ft. Lauderdale Area
1970 Sawgrass Mills Circle
Located at the
Sawgrass Mills Mall

Miami Area
8895 SW 136th Street
Located across from the
Falls Shopping Center

Palm Beach Area
1501 N. Congress Ave.
Located north of the
Boynton Beach Mall

Find a Florida Blue Center

1. Visit www.floridablue.com
2. Click on *Find a Location* and enter your zip code

VISIT FLORIDA BLUE TO SIGN UP AND LOG IN

If you are already signed up for an account, simply enter your User ID and Password to log in. If you forgot these, click Forgot your User ID or Password. You'll need your Florida Blue Member ID to recover your User ID.

If you have trouble logging in, call 800-352-2583 for help.

Step 1: To Sign up for your Member Account, you'll need your **Member Number** (shown on you ID card)

Step 2: Fill in all of the boxes, and click **NEXT**

Step 3: Choose and type in a User ID (click on User ID suggestion for help on User IDs).

Step 4: Choose and type in a Password. The Password must be typed in twice for security purposes. Click **Next**.

Step 5: Type three different security questions and type an answer to each. Click **Next**.

Step 6: Click **Continue**, and you'll be taken to the member website homepage.

Know Before You Go
Shop, compare and save money.

You have choices when it comes to the cost of your health care.

- The quality and price of medical services can vary depending on where you go for office visits, imaging services, and surgery, including inpatient and outpatient care.
- Compare quality and cost before you go, and then decide what's best for your care.
- Cost estimates are based on your plan and where you stand with your deductible.[1] Your costs are lower after your deductible is met—pay only coinsurance or a copay for in-network services.
- To get cost estimates, simply log in at floridablue.com and select **Compare Medical Costs** under **Tools**.

Check doctor ratings.

- See ZAGAT® patient reviews on important factors like trust, communication, availability and environment.
- To read reviews, log in at floridablue.com. Once you find a doctor using the search tool, click **Details** under the name, then **See Patient Reviews**.

We're here to help:

Click
Log in at **floridablue.com**.

Call
a Care Consultant at **1-888-476-2227**.

Visit
us in person at a **Florida Blue Center** near you. Visit **floridablue.com** for locations.

Florida Blue
In the pursuit of health®

Surgery Cost Example*	
Inpatient or Outpatient Select back, leg, pelvis & more!	**Cost Range** Your actual cost can be estimated by a Care Consultant
Health Care Facility A	$21,710 - $24,423
Health Care Facility B	$17,752 - $19,970
Health Care Facility C	$13,197 - $15,395

Imaging Cost Example*	
MRI, Scan or X-ray Select ankle, back, foot & more!	**Your cost** Before your deductible is met
Imaging Facility A	$797
Imaging Facility B	$689
Imaging Facility C	$1,569

Office Visit Cost Example*	
Primary or Specialist Select allergy, cardiology, dermatology & more!	**Your cost** Before your deductible is met
Health Care Provider A	$181
Health Care Provider B	$326
Health Care Provider C	$177

*On floridablue.com, you'll also see a detailed cost break down, plus the health care provider or facility name, phone number, address, credentials, quality programs, approvals if needed, and patient ratings when available.

[1] you'll be able to compare cost ranges and then speak to our Care Consultants for actual cost estimates based on your plan.

Meet Lantern: Lighting Your Path to the Best Surgical Care

With Lantern, you have access to a personal Care Advocate who can help match you with an excellent surgeon when you need a planned, non-emergency procedure. And you'll save money on the care you need, too.*

The best part is that Lantern is one of your medical benefits, so it is available whenever you need it.

The Care You Need: Lantern covers more than 1,500 planned, non-emergency surgeries. If you need a procedure, we can assist you with finding an excellent surgeon.

The Best Surgeons for You: Lantern surgeons are individually vetted and among the best in their field. Your Care Advocate will work to match you with an excellent surgeon in the Lantern network.

Care Close to Home: Whenever possible, your Care Advocate will match you with a surgeon that's close to your home.

Commonly Covered Procedure Categories

- Spine
- Orthopedic
- Joint
- Ear, Nose, & Throat
- Cardiac
- Gynecology
- General Surgery
- Gastrointestinal
- Spine & Ortho Injections
- Urology
- Bariatrics

Make Lantern Your First Call When You Need to Plan a Surgery

Your Care Advocate is ready to help you understand your benefits, find a surgeon in our network and more. **Call Lantern at (888) 394-1606.**

NEXT STEPS HEALTH COACHING SESSIONS

- Provide assistance in making healthy choices to help you manage:
  - Healthy eating habits
  - A healthy weight
  - Physical activity
  - Stress
  - Cholesterol
  - Blood sugar
  - Blood pressure
- Provide smoking cessation programs by phone or at the work site
- Provide tools and resources to help you reach your wellness goals
- Provide information that empowers you to make informed health care decisions

BetterYou

Next Steps Registered Nurses provide FREE individualized health coaching to assist you in making healthy lifestyle choices. Health coaching sessions are available in English, Spanish and Creole, and are offered by phone or at the work site.

Contact us today for more information or to enroll in Next Steps Program.

Email:
nextsteps@floridablue.com

Call:
1-800-477-3736, ext. 54837
TTY, call 1-800-955-8771 or 711
Monday - Friday, 8 a.m. - 5 p.m. EST

* www.cdc.gov/NCCdphp/index.htm

HEALTHY ADDITION PRENATAL PROGRAM

Program for expecting parents

Every expectant mother wants the best for her baby. Florida Blue has found some great ways to help you give your baby the best health care available, even before he or she is born. Our Healthy Additions Prenatal Program works with you and your health care provider to help you have a healthy pregnancy.

Free for Moms-to-be

The Healthy Addition Prenatal Program and its staff are dedicated to the good health of all mothers and their babies. As a member of Healthy Addition, you will receive the following to encourage good health practices during pregnancy:

- Pregnancy risk screening and monitoring
- Education on healthy lifestyles, nutrition and adequate hydration
- Prenatal education and information
- Emotional support and answers to questions and concerns
- Free prenatal vitamins

Contact us today to find out more!

- Email us at healthyaddition@floridablue.com
- Call us at 1-800-955-7635, option 6 between the hours of 8:00 AM to 5:30 PM EST, Monday through Friday

JOIN BLUE 365 AND START SAVING TODAY!

With Blue 365 great deals are yours for every aspect of your life, like 20% off at Reebok.com, discounted products through Jenny Craig or a gym membership for only $29 per month!

Register now at https://www.blue365deals.com/ to take advantage of Blue 365. It is an online destination featuring healthy deals and discounts exclusively for our members. Make sure to have your Blue Cross and Blue Shield member ID card handy when you log on.

DOWNLOAD THE FLORIDA BLUE MOBILE APP

As Easy as 1, 2, 3...

1 **Download the app –** available through the Apple App Store or Google Play

2 **Get Registered –** log in using your Florida Blue member account User ID and Password

3 **Get Started –** anytime, anywhere with Touch ID

Save time. Save money. Stay healthy.

- Check plan benefits and see the status of your claims
- Find the nearest in-network doctor or Urgent Care Center
- Compare medical costs
- View your member ID card

$0
cost to you

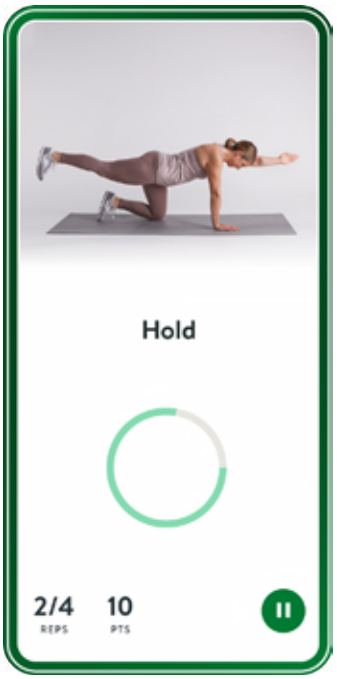
Hinge Health

Personalized pain care that gets you moving

Relieve joint and muscle pain with personalized exercise therapy **at no cost to you**. On average, participants reduce their pain by 68%.[1]

- **Virtual sessions anytime, anywhere**
- **Unlimited 1-on-1 health coaching**
- **Motion-tracking technology for instant form correction**

Your family may be eligible, too!



To learn more and apply, scan the QR code or visit

hinge.health/archdioceseofmiami

Questions? Call (855) 902-2777

Employees and dependents 18+ enrolled in a medical plan through Archdiocese of Miami are eligible.

[1]After 12 weeks, in a study of chronic knee and back program participants. Bailey JF, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. J Med Internet Res 2020;22(5):e18250.

DENTAL

Dental coverage is offered as a voluntary benefit. The Archdiocese of Miami has partnered with Florida Blue to offer you two dental plan options through Florida Combined Life. Dental coverage is available for you, your spouse, and your children.

BlueDental Choice PPO

- You will be able to see any dentist you choose
- You will have In-Network and Out-of-Network benefits. In-Network dentists, or participating providers, in the BlueChoice network cannot charge you more than the allowable amount. Out-of-Network dentists, or non-participating providers, may charge you more than the allowable amount
- Your out-of-pocket costs will include an annual deductible, coinsurance, and an annual maximum benefit

BlueDental Care Prepaid HMO

- You may only see In-Network dentists, or participating providers, in the BlueDental Care Prepaid HMO Network
- You will be required to choose a Primary Care Dentist for yourself and each covered family member upon enrollment (failure to choose a Primary Care Dentist will affect your dental enrollment)
- Your out-of-pockets costs will include copayments per covered service

Benefits at a Glance

	BlueDental Choice PPO		BlueDental Care Prepaid HMO
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK ONLY**
Annual Deductible	$100 per person	$150 per person	No deductible
Maximums			
Dental, *Annual*	$2,000 per person	$1,500 per person	Unlimited
Orthodontia, *Lifetime*	$1,000 per person	$1,000 per person	Unlimited
Office Visit	Deductible + Coinsurance	Deductible + Coinsurance	$5 copay
Specialist Visit	Deductible + Coinsurance	Deductible + Coinsurance	$15 copay
Preventive Services	No charge	No charge	No charge
Basic Services			
Filling, *3 Surfaces*	20% after Deductible	30% after Deductible	$50 copay
Periodontal Scaling, *per quadrant*	20%	30%	$50 copay
Major Services			
Crown	50% after Deductible	60% after Deductible	$280 copay
Dentures	50%	60%	$300 copay + Lab
Orthodontic Services			
Under age 19	50%	50%	$1,800 copay
Adult	Not covered	Not covered	$2,000 copay

How to find a dental provider

1. Visit www.floridablue.com
2. Click on *Find a Doctor* and then choose your dental plan:
   - For BlueDental Choice PPO, choose *Dental-BlueDental Choice & Choice Plus (PPO)*
   - For BlueDental Care Prepaid HMO, choose *Dental-BlueDental Care Prepaid*
3. Then, search by provider name, provider type, or your zip code

This is an overview of coverage. It is intended to merely highlight some of the benefits that may be available to you. Consult policy benefit limitations, exclusions, and other provisions online at www.adomhealthplan.org

VISION

Vision coverage is offered as a voluntary benefit. The Archdiocese of Miami has partnered with Florida Blue to offer you two vision plan options through Davis Vision. Vision coverage is available for you, your spouse, and your children.

Benefits at a Glance

	High Option		Low Option	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
EYE EXAMS				
Frequency	12 Months		12 Months	
Eye Exam	$10 copay	Reimbursed up to $40	$10 copay	Reimbursed up to $30
LENSES				
Frequency	12 Months		12 Months	
Single Vision	$20 copay	Reimbursed up to $40	$20 copay	Reimbursed up to $25
Bifocals	$20 copay	Reimbursed up to $60	$20 copay	Reimbursed up to $40
Trifocals	$20 copay	Reimbursed up to $80	$20 copay	Reimbursed up to $55
Standard Progressive	$50 copay	Reimbursed up to $60	$50 copay	Reimbursed up to $40
FRAMES				
Frequency	12 Months		24 Months	
Non-Collection	$130 allowance plus 20% off balance, after $0 copay; Premier Level subject to $25 copay	Reimbursed up to $50	$130 allowance plus 20% off balance, after $0 copay; Premier Level subject to $25 copay	Reimbursed up to $60
Exclusive	Fashion and Designer Level Exclusive frames covered in full, after $0 copay; Premier Level subject to $25 copay	Reimbursed up to $50	Fashion and Designer Level Exclusive frames covered in full, after $0 copay; Premier Level subject to $25 copay	Reimbursed up to $60
CONTACT LENSES				
Frequency	12 Months		12 Months	
Medically Necessary	$20 copay	Reimbursed up to $225	$20 copay	Reimbursed up to $200
Elective				
Non-Collection	$130 allowance plus 15% off balance, after $20 copay	Reimbursed up to $105	$100 Allowance, after $20 copay	Reimbursed up to $80
Standard Fit & Follow-Up	15% discount	No reimbursement	15% discount	No reimbursement
Premium Fit & Follow-Up	15% discount	No reimbursement	15% discount	No reimbursement
Collection	$20 copay (up to 4 boxes)	Reimbursed up to $105	$20 copay (up to 4 boxes)	Reimbursed up to $80
Standard Fit & Follow-Up	Included	No reimbursement	Included	No reimbursement
Premium Fit & Follow-Up	Included	No reimbursement	Included	No reimbursement

Value Added Discounts

- **Eyewear:** Additional benefits (i.e., Polarized lenses, Anti-Reflective Coating, etc. outlined in schedule of benefits)
- **Lasik:** 25% off U&C or 5% Discount on Network Advertised Special Rate

How to find a vision provider

1. Visit www.floridablue.com
2. Click on *Find a Doctor* and then choose your vision plan:
   - For High Option and Low Option, select *BlueVision*
3. Then, search by provider name, provider type, or your zip code

This is an overview of coverage. It is intended to merely highlight some of the benefits that may be available to you. Consult policy benefit limitations, exclusions, and other provisions online at www.adomhealthplan.org

Allstate Identity Protection Pro+ Cyber

Identity and cyber protection features designed to help you defend yourself from today's risks.

Cyber protection

Device protection tools‡ for up to 5 devices:

- Anti-virus protection
- Missing and stolen device tools**††
- Safe browsing
- Phishing protection†††
- Anti-tracker†††
- Firewall††
- Webcam protection††
- Safe pay
- Android smart watch protection**
- File shredder††

Network security

Military-grade VPN with 4000+ servers to stay safe without slowing down

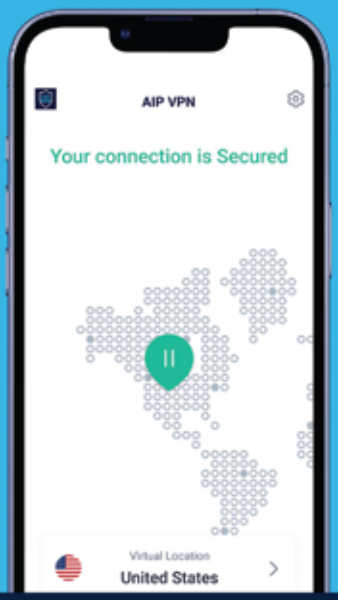
Password manager

- Allstate Digital Footprint‡, our proprietary privacy tool, shows where your data lives online and how it might be exposed‡
- Comprehensive identity and financial monitoring
- Identity Health Status gives you at-a-glance insight into your risk
- Allstate Security Pro* delivers updates and education on scams relevant to you
- Social media account takeover monitoring
- Family digital safety tools that monitor 30+ apps and websites for signs of danger such as cyberbullying△‡
- Robocall blocker‡
- Ad blocker‡
- Tri-bureau credit monitoring with annual reporting and credit score
- Lock your TransUnion credit report in a click and get credit freeze assistance
- Dark web monitoring
- Full-service remediation and resolution support available 24/7
- Up to $1 million in expense reimbursement for stolen funds and out-of-pocket costs due identity theft†, including ransomware* expense reimbursement†

Our broad, inclusive definition of "family" covers everyone under your roof — or under your wallet — no matter their age. Opt for a family plan and get:

- Coverage for your whole household, plus senior family coverage for parents, in-laws, and grandparents age 65+△
- Family mobile and desktop device protection for up to 10 devices△
- Up to $2 million in identity theft and ransomware* expense reimbursement△
- Elder Fraud Center

Allstate℠
IDENTITY PROTECTION



Questions?

1.800.789.2720
or visit myaip.com

* Does not cover cyber ransom payments to hackers.

** Android

†† Windows

††† Windows, macOS, iOS

†††† Windows, Android, iOS

△ Only available with a family plan.

‡ Some features require additional activation. Privacy management features cover up to five email addresses in a family plan. Robocall blocker and ad blocker can only be used by primary subscriber, even in a family plan. Cyber and family digital safety features are managed through the primary subscriber's account in family plans.

† Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Product may be updated or modified. Certain features require additional activation.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

CRITICAL ILLNESS PLAN: VOYA

Voya's voluntary Critical Illness Insurance pays a lump-sum benefit if you are diagnosed with a covered illness or condition that occurs on or after your effective coverage date. No medical questions are required for coverage and you can elect coverage for yourself or yourself and your spouse. Dependent children are automatically covered for 50% of your benefit amount at no additional cost.

You can use the lump sum benefit payment for any purpose you choose- paying deductibles, childcare, transportation costs, loss of income or any financial need. A benefit is paid regardless of any other coverage you may have.

Examples of Covered Conditions:

Alzheimer's
ALS
Aneurysm 10%
Benign Brain Tumor
Bone Marrow Transplant 25%
Cancer
Carcinoma In-Situ 25%
Cardioverter Defibrillator 25%
Coronary Angioplasty 10%
Coronary Artery Obstruction 25%
Coronary Pacemaker 10%
Coronary Valve 25%
End Stage Renal Disease
Heart Attack
Huntington's Disease
Loss of Sight, Hearing or Speech
Major Organ Transplant
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Permanent Paralysis
Severe Burns
Skin Cancer 10%
Stem Cell transplant 25%
Stroke
Transient Ischemic Attack 10%
Type 1 Diabetes

Examples of Covered Conditions for Children:

Cerebral Palsy
Congenital Birth Defects
Cystic Fibrosis
Down Syndrome
Gaucher Disease, Type II or III
Infantile Tay Sachs
Niemann-Pick Disease
Pompe Disease Type IV
Glycogen Storage Disease
Sickle Cell Anemia
Type 1 Diabetes
Zellweger Syndrome

Benefit Amounts:

- Employee Benefit Amounts: You choose the level of coverage between $5,000 and $30,000
- Spouse Benefit Amounts: You choose the level of coverage between $2,500 and $15,000
- Children Benefit: Automatically covered for 50%of the Employee Benefit at no cost

Wellness Benefit:

Health screening tests can help diagnose a condition early or prevent an illness altogether. This benefit pays you $100 after you go for an annual health screening test.

For more information or to file a claim please visit
https://presents.voya.com/EBRC/Home/ArchdioceseofMiami

ACCIDENT PLAN: VOYA

Voluntary Accident Insurance with Voya can help relieve the financial stress that comes with a non-occupational accidental injury. It pays benefits for specific, covered accidents and injuries that happen on or after your coverage effective date. The benefit amount depends on the type of injury you incur, and the treatment you receive. The benefit is paid directly to you and regardless of any other coverage you may have.

Medical questions are not required for coverage and you can elect coverage for yourself, your spouse and your children.

Examples of Benefit Amounts:

Benefit	Benefit Amount
Emergency Room	$325
Initial Doctor Visit	$125
Hospitalization	$1,750
Accidental Death	$100,000 Employee; $50,000 Spouse; $20,000 Child
Wellness Benefit (Annual Physical)	$100 Employee and Spouse; $50 Children
Inpatient Rehab Facility Benefit	$225 per day up to 90 days

Sports Package:

Pays 25% more up to $1,000 per person per year for injuries from participating in organized sports.

Illustrative Example - Your child breaks a leg at soccer practice:

Benefit	Benefit Amount
Ambulance	$550
Emergency Room	$325
X-Ray	$90
Fracture	$5,400
Crutches	$275
Physical Therapy 3 visits	$180
Follow Up Visits	$180
Subtotal	$7,000
PLUS Sports Package	$1,750
Total Payment	$8,750

Voya Travel Assistance::

Offers you and your dependents four types of services when you're more than 100 miles from home, including pre-trip information, emergency personal and transportation services, and medical assistance.

For more information or to file a claim please visit
https://presents.voya.com/EBRC/Home/ArchdioceseofMiami

HOSPITAL INDEMNITY PLAN: VOYA

Hospital Indemnity Plan:

Hospital Confinement Indemnity Insurance pays a daily benefit if you have a covered stay in a hospital, critical care unit, rehabilitation facility, mental health or alcohol addiction facility. The benefit amount is determined based on the type of facility and the number of days you stay.

Features include:

- **Guaranteed Issue:** No medical questions or pre-existing condition limitation
- **Flexible**: Benefits are payable directly to you and can be used for any purpose you choose
- **Payroll Deductions:** Premiums are paid through convenient payroll deductions
- **No Waiting Period**: Coverage available as of coverage effective date
- **No Pre-Existing Limitations**
- **Coverage for Eligible Dependents (Spouse can enroll up to age 69 and Child(ren) up to age 26). Employee must be enrolled to cover dependents**
- **Wellness Benefit:** Provides annual benefit payment of **(**$100**)** when the covered person completes a health screening test. One wellness benefit is payable per person per year.

Initial Hospital Admission Benefit of a $1,100 per Admission in Addition to the Following Daily Benefits		
Hospital	1 X Daily Benefit Amount Duration – up to 30 days	$100
Critical Care Unit	2 X Daily Benefit Amount Duration – up to 15 days	$200
Rehabilitation Facility	½ X Daily Benefit Amount Duration – up to 30 days	$50

403B DEFINED CONTRIBUTION PLAN

A 403(b) Plan is a tax-advantaged retirement savings plan that allows you to defer a portion of your salary into savings for retirement. Your deferrals can be made on a pre-tax basis or on a Roth (post-tax) basis and are allowed to grow tax-deferred. The money is taxed as income when withdrawn from the Plan. All employees of the Archdiocese of Miami are eligible to participate in our Plan.

Your employer will contribute to your 403(b) account by matching 50% of up to the first 6% of your salary which you defer to the 403(b) account. A table below shows how the match is calculated.

You may choose to participate in the 403b Plan at any time. The deferral can be subsequently changed or cancelled at any time.

403(B) MATCH EXAMPLE		
Your Contribution PER PAY PERIOD	**ADOM's Match** PER PAY PERIOD	**Total Contribution** PER PAY PERIOD
2%	1%	3%
4%	2%	6%
6%	3%	9%
10%	3%	13%

The Plan is administered by Transamerica Retirement Solutions, Inc. Our partners at Goldman Sachs Personal Financial Management manage the investment portfolio, recommending funds that best serve Archdiocesan employees.

To enroll, view, or change your information, please visit the Transamerica website at trsretire.com.

Your investment options can be tailored to your investment risk choice. Representatives are available to help with your investment decisions through Transamerica's toll-free number at 1-800-755-5801 Monday through Friday, 8 a.m. to 9 p.m. , or at Osaic Advisor at 561-504-3936.

You are always vested in your own contributions to your 403(b). You become vested in the employer match once you have completed five (5) years of service with the Archdiocese of Miami.

CASH BALANCE PLAN

Employees completing at least 1,500 hours of service each Plan Year are credited a percentage of salary to a cash balance account, which also earns annual interest. This Plan is funded 100% by your employer. Upon retirement, you will receive your vested account balance. Retirement is Normal Retirement Age as defined by Social Security. The Plan is administered by Gabriel, Roeder, Smith and Co.

PENSION PLAN

The Archdiocese of Miami defined benefit Pension Plan was closed on December 31, 2012. Employees with credited years of service under the Plan are eligible for their frozen benefit under the retirement terms and conditions.

CONTACT INFORMATION

Medical
Florida Blue Group # **44637**
Blue Care HMO Network
(800) 664-5295
www.floridablue.com

Teladoc Telemedicine
(800) Teladoc
(800) 835-2362
www.teladoc.com

Sanitas
(844) 665-4827
www.mysanitas.com

Eye Management
Ophthalmology Services
(800) 329-1152

CareCentrix
Home Health Care and
Durable Medical Equipment
(877) 561-9936

Pharmacy Retail and Mail Order
CVS Caremark Group # **0689**
(866) 217-5353
www.caremark.com

Pharmacy Specialty Drugs
CVS Caremark Group # **0689**
(800) 237-2767
(800) 323-2445 fax
www.caremark.com

Prudent Rx Specialty Copay Program
Prudent Rx
(800) 578-4403

Life Insurance – Basic and Supplemental
The Hartford Policy # **303830**
(888) 563-1124
www.thehartford.com/mybenefits

Disability Insurance – Short Term and Long Term
The Hartford Policy # **303830**
(888) 277-4767
www.thehartford.com/mybenefits

Family Medical Leave (FMLA)
The Hartford Policy # **303830**
(888) 277-4767
www.thehartford.com/mybenefits

Critical Illness, Group Accident, Hospital Indemnity
Voya Policy # **705527**
(877) 236-7564
https://presents.voya.com/EBRC/ArchdioceseofMiami

Vision
Davis Vision Group # **44637**
(800) 643-2847
www.floridablue.com

Dental
Florida Combined Life
BlueDental Choice PPO Group # **195L17**
(888) 223-4892
BlueDental Care HMO Group # **29292**
(877) 325-3979
www.floridablue.com

BenefitSolver Enrollment Assistance
Benefit Solver
(833) 232-7498
www.benefitsolver.com

Employee Assistance Program (EAP)
ComPsych
(877) 465-1597
www.guidanceresources.com

CONTACT INFORMATION

HSA - Health Savings Account
FSA - Flexible Spending Account
DCFSA - Dependent Care Flexible Spending Account
Health Equity
(866) 346-5800
www.healthequity.com

403(b) Retirement Plan
Transamerica
(800) 755-5801
www.trsretire.com

403(b) Retirement Plan
Osaic Advisor
(561) 504-3936
daniel.rodriguez@osaicadvisor.com
(305) 609-3990
wilmer.fernandez@osaicadvisor.com

Pension Plan/Cash Balance Plan
Gabriel, Roeder, Smith & Co.
(954) 527-1616
www.grs-plan.com

Lantern
Group ID 686100
(888) 394-1606
www.My.Surgery.Plus.com

Hinge Health
(855) 902-2777
www.hinge.health/archdioceseofmiami

Archdiocese of Miami Health Plan
(305) 757-6241, extension 3000
(305) 893-0068 direct
(305) 893-2674 fax
healthplan@adomhealthplan.org email
www.adomhealthplan.org

Florida KidCare
(888) 540-5437
www.floridakidcare.org

Health Insurance Marketplace
www.HealthCare.gov

Medicare
(800) 633-4227
www.medicare.gov

Social Security Administration
(800) 772-1213
www.ssa.gov

GAP Plan
Fidelity Security Life
Plan Administrator: Amwins
Group #
Customer Service: (925) 278-5601
www.webtpa.com

Identify Theft
Allstate
(800) 789-2720
customercare@aip.com

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

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

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

The Archdiocese of Miami has determined that the prescription drug coverage offered by the Archdiocese of Miami Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for 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 current Florida Blue coverage through the Archdiocese of Miami Health Plan will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits, and this plan will coordinate with Medicare Part D in the same manner as Parts A and B.

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 coverage with the Archdiocese of Miami Health Plan Health Plan 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 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…

Please contact the Health Plan office for further information at (305) 893-0068. NOTE: This notice is updated annually. 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). You may also request a copy of this notice at any time.

For more information about your options under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (seethe inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: July 1, 2025 • Name of Employer: Archdiocese of Miami
Office: Archdiocese of Miami Health Plan • Address: 9401 Biscayne Blvd., Miami Shores, FL 33138
Phone Number: (305) 893-0068

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Archdiocese of Miami Health Plan office at 305.893.0068 or email your inquiries to healthplan@adomhealthplan.org.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application. **Please see your entity administrator for a customized form.**

3. Employer Name		4. Employer Identification Number (EIN)
5. Employer Address		6. Employer Phone Number
7. City	8. City	9. Zip Code
10. Who can we contact about employee health coverage at this job? Archdiocese of Miami Health Plan		
11. Phone Number (if different from above) (305) 893-0068	12. Email Address healthplan@adomhealthplan.org	

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.

Annual Notices

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

- As your employer, we offer a health plan to:
  - ❑ All employees.
  - ☑ Some employees. Eligible employees are:
    All Active Lay Employees directly employed in the regular business of and compensated for services by the Archdiocese of Miami or entities of the Archdiocese and classified as either a Full-time regular employee, whose budgeted scheduled workweek is forty (40) hours; OR a Part-time regular employee, whose budgeted scheduled workweek is less than forty (40) hours but at least 30 hours per week.
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:
    - **Your spouse**
    - **Your natural born, adopted, foster or step child until they attain age 26. There is no age limit for dependent children who are mentally or physically disabled.**
    - **Your unmarried child between the ages of 26 and 30, who are Florida residents or full-time or part-time students and who are not covered by of eligible for any other medical coverage, and do not have dependents of their own.**
  - ❑ We do not offer coverage.
  - ☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
    ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

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

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

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

❑ No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☑ Yes (Go to question 15) ❑ No (STOP and return form to employee)

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

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

16. What change will the employer make for the new plan year?
❑ Employer won't offer health coverage
❑ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much will the employee have to pay in premiums for that plan? $ 68.00
b. How often? ❑ Weekly ❑ Every 2 weeks ❑ Twice a month ☑ Monthly ❑ Quarterly ❑ Yearly

Date of change (mm/dd/yyyy): _____

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Women's Health and Cancer Rights Act Notice

Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy, including lymphedemas.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Please contact the Health plan office at 305 893-0068 for more information.

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).

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 are eligible for health coverage from your employer, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer 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.**

For information on eligibility for premium assistance in the State of Florida, you can contact:

Florida Medicaid • www.flmedicaidyplrecovery.com • 1-877-357-3268

For more information on special enrollment rights, you can contact either:

U.S. Department of Labor • Employee Benefits Security Administration • www.dol.gov/ebsam • 1-866-444-EBSA (3272)
U.S. Department of Health and Human Services • Centers for Medicare & Medicaid Services • www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Use and Disclosure of Protected Health Information

The Archdiocese of Miami Health Plan will use Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to medical care and treatment, payment of medical claims and health care operations for medical care.

Continuation Plan

The Archdiocese of Miami Health Plan offers Laity Medical Plan participants and their covered dependents the opportunity to continue their existing medical coverage in certain instances where coverage under the plan would otherwise end. Coverage can be extended for up to 8 months, or up to 26 months if disabled. The full cost of coverage, employer contributions in addition to employee contributions, is charged. For additional information contact the Health Plan office.

STATEMENT ON MARRIAGE AND SPOUSAL BENEFITS

The Archdiocese of Miami adheres to the belief that the foundation of family life and of the domestic church is the sacramental marriage between a husband and a wife. The Holy Father has affirmed the beauty of marriage as a demanding life-long journey on which a husband and wife are accompanied by Jesus. Through its policies and practices, the Archdiocese of Miami has consistently sought to strengthen marriage as man and woman walking together.

As part of the benefit offerings here, the Archdiocese has expanded the spousal coverage to cover additional eligible members of a household, and therefore now covers a Plus One category. The Archdiocese remains committed to providing legally compliant benefit offerings to its employees, spouses, and eligible dependents.

Archdiocese of Miami Health Plan, 9401 Biscayne Boulevard, Miami Shores, FL 33138

This Benefit Guide is intended to be a convenient and helpful source of information about the benefits offered by the Archdiocese of Miami. The information in this guide is merely an overview of the specific benefit plans available through the Archdiocese of Miami Health Plan Trust which are subject to change at the sole discretion of the Archdiocese, as are all other policies, procedures, benefits or other programs of the Archdiocese. If any of the information contained in this guide conflicts with a particular Benefit Plan or Summary Plan Description, the Benefit Plan or Summary Plan Description will be controlling. This guide is merely intended to summarize each available benefit. This guide, however, does not amend, supersede or expand any of the particular benefits detailed in a Benefit Plan or Summary Plan Description. If you have any questions regarding your benefits, please review those documents or contact the Archdiocese of Miami Health Plan office for assistance.