Archdiocese of Miami
Health Plan Benefits Guide

2019-2020

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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 a major 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.

The Health Plan is funded solely by the monthly contributions of you and your employer. These funds are used to pay all costs of the plan, including claims. In order to maintain our levels of benefits, we ask you to use cost containment services such as the Florida Blue Know Before You Go program, choose generic drugs, and visit an urgent care center rather than the emergency room, when possible.

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 28 for more details.

BENEFIT-ELIGIBLITY

You are benefits-eligible if you are classified as either a full-time regular employee, expected to work 40 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 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

As a newly-hired employee, you have 30 days from your date of hire to enroll in coverage. Coverage will begin on the day following 30 days after your date of hire. To enroll in coverage, you must log on to www.adomhealthplan.org. Detailed instructions are provided on Page 3 of this Benefits Guide.

- Supplemental Life, 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
- 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
- Critical Illness, Accident**:** 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
- Hospital Indemnity 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

Annual Enrollment Period

Annual Enrollment, held each year during the month of May, allows you to review your existing benefit elections and make changes. Any changes made during this time will become effective July 1st.

Special Enrollment Period

A Life Event is a change in family or employment status that allows you to make changes to your existing 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 to your entity administrator 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 child ceases to be eligible as a dependent
- A change in your (or your spouse's) employment status

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

ENROLLING IS EASY

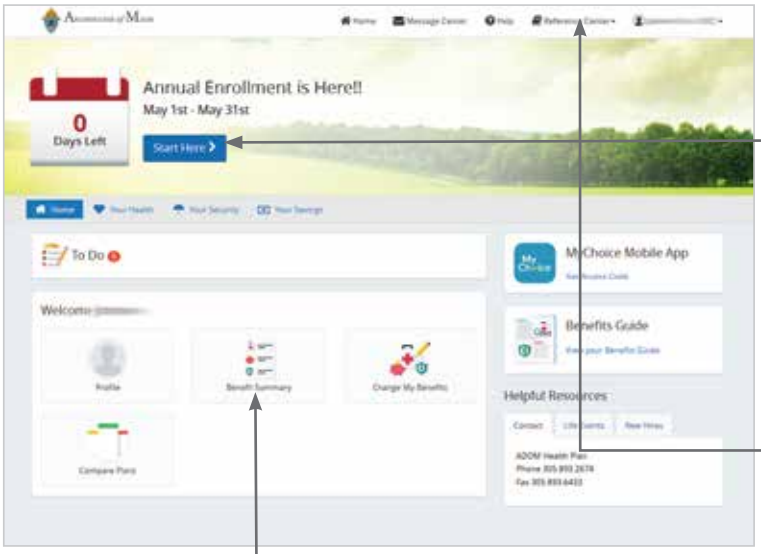
Get started

Visit www.adomhealthplan.org and login by entering your user name and password.

If you are a first-time user, click on 'Register' to set up your user name, password and security questions. Our 'Company Key' is ADOM (note: it's case sensitive).

Forgot your user name or password?

1. Visit www.adomhealthplan.org and click on the 'Forgot your user name or password?' link.
2. Enter your Social Security Number, company key and date of birth.
3. Answer your Security Phrase.
4. Enter and confirm your new password, then click 'Continue' to return to this page and login.



Begin enrollment

Click 'Start Here' and follow the instructions to enroll in your benefits or waive coverage.

You must make your elections by the deadline shown on the calendar. If you miss the deadline you will waive any electable benefit coverage, and have to wait until the next annual enrollment period to enroll.

Looking for more information?

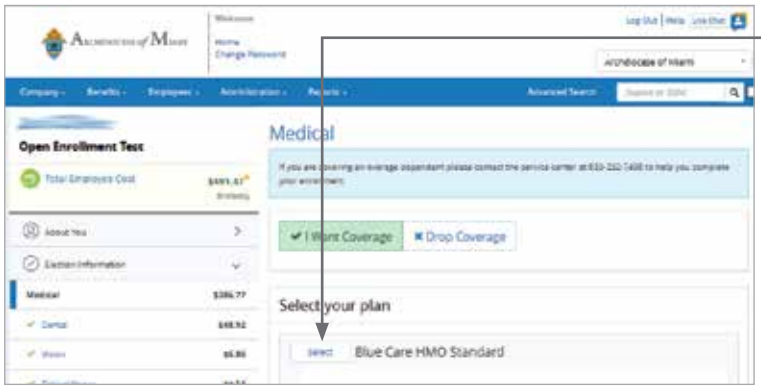
View plan details, carrier specifics and benefit guides by clicking 'Reference Center' in the main navigation.

Want to review your current benefits?

You have year-round access to your benefit summary and specific benefit elections at www.adomhealthplan.org. Click 'Benefits Summary' on the homepage to review your current benefits.

SCAN & ENROLL

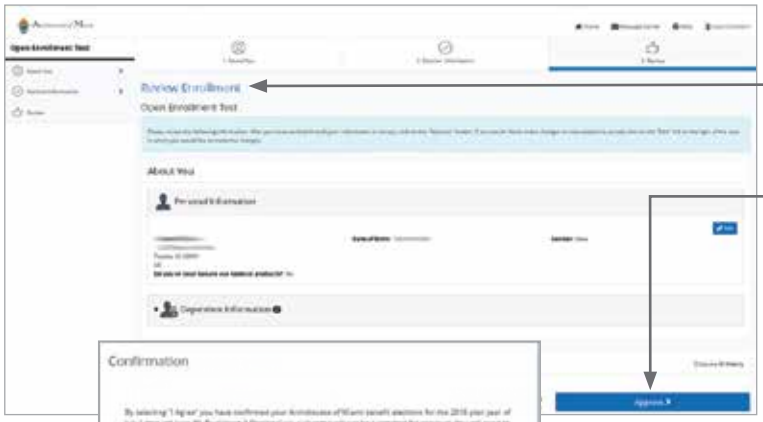
Enroll in your benefits from your mobile device. Visit www.adomhealthplan.org or simply scan this QR code and tap your way through your elections. If you don't already have a QR code reader on your smart phone or tablet, download one from your device's app store.



Make your elections

Review your options as you walk through the enrollment process. Click 'Select' on the plan(s) you would like to choose. Track your choices along the left side which updates with your total cost.

Use the 'Reference Center' to help you make the right elections.



Review your elections

Review, edit and approve your personal information, elections, dependents and beneficiaries.

Approve

Once you have reviewed your elections and they are accurate, click 'Approve' to continue.

Confirm your choices

Your enrollment isn't complete until you confirm your benefit elections and cost.

Print

Print your election information and confirmation number for future reference and save it to your Message Center. Provide a copy to your bookkeeper for payroll deduction purposes.

BASIC LIFE AND AD&D

At no cost to you, the Archdiocese of Miami provides Basic Life/AD&D with The Hartford. Basic Life pays your beneficiary a benefit if you die while you are covered. AD&D (Accidental Death & Dismemberment) pays an additional benefit if you die in an accident or become disabled by losing your eyesight or a limb.

Benefit Amount

$15,000 Term Life and $15,000 AD&D

Benefit Amount Reduction

Your benefit amount will reduce as follows:

- At age 65, $10,000 Term Life and $10,000 AD&D
- At age 70, $7,500 Term Life and $7,500 AD&D

LONG-TERM DISABILITY

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

Benefit	
Coverage Level 1 (no offset):	61% of pre-disability earnings
Coverage Level 2 (with offset):	70% of pre-disability earnings
Maximum Benefit:	$7,000 per month
Minimum Benefit:	$100 per month
Elimination Period:	90 days
Maximum Benefit Period:	Normal retirement age for Social Security

Pre-Existing Condition Clause

Any medical condition for which you are being treated, taking medications, or seek medical advice for 90 days prior to your effective date will not be covered until after a period of 12 months. If during that period of 12 months you go treatment-free for 90 consecutive days, your medical condition will then be covered.

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 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

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 2) 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% 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 Clause

Any medical condition for which you are being treated, taking medications, or seek medical advice for 90 days prior to your effective date will only be covered for up to 4 weeks during the first 12 months of coverage. If during the first 12 months of coverage you go treatment-free for 90 consecutive days, your medical condition will then be covered.

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 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

NEW MEDICAL PLANS FOR 2019-2020

During Open Enrollment you will need to make a new medical plan election. The Archdiocese of Miami is offering you three medical plans to choose from. Medical coverage is available for you, your spouse, and your dependent children. Please note that Quest Diagnostics is the only Laboratory covered by any of the medical plans.

Gold PPO with Blue Options network

- Allows in-network and out-of-network benefits
- Preventive services are covered at 100% (in-network)
- $750 Annual deductible; $2,250 Family Deductible; 20% employee coinsurance in network, 50% coinsurance out of network; copays for prescription drugs
- $4,500 Annual employee Out-of-Pocket; $9,000 Annual Family Out of Pocket

Silver PPO with Blue Options network

- Allows in-network and out-of-network benefits
- Preventive services are covered at 100% (in-network)
- $1,000 Annual deductible; $2,000 Annual Family Deductible; 20% employee coinsurance in network, 50% coinsurance out of network; copays for prescription drugs
- $5,000 Annual employee Out-of-Pocket; $10,000 Annual Family Out of Pocket

Bronze PPO High Deductible Health Plan with Health Savings Account and Blue Options network

- Allows in-network and out-of-network benefits
- Preventive services are covered at 100% (in-network)
- $1,500 Annual deductible; $3,000 Annual Family Deductible; 20% employee coinsurance in network; 50% coinsurance out of network.
- Deductible and coinsurance applies to all covered medical and prescription drug benefits
- $6,000 Annual employee Out-of-Pocket; $12,000 Annual Family Out of Pocket
- No employer contributions to the Healthcare Spending Account in 2019

PLEASE NOTE: Our existing HMO plans will no longer be available. If you are currently enrolled in one of the HMO plans and do not elect a new medical plan during Open Enrollment, you will be automatically enrolled in the Silver PPO Health Plan.

Words to Know

- **Allowed Amount**: The maximum amount an in-network provider is allowed to charge you for a covered service
- **Balance Billing**: An additional amount you may be billed if you seek care from an out-of-network provider
- **Calendar Year Deductible:** The amount per calendar year you owe 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:** Refers to the preferred provider network made up of independent hospitals, physicians, and ancillary providers (i.e., primary physicians, urgent care centers, hospitals) who are participants within your plan's network. You pay less if you receive covered services from in-network providers
- **Out-of-Pocket:** What you pay for health care expenses (i.e., copays, coinsurance, deductible)
- **Out-of-Network:** A provider not in-network; out-of-pocket costs will generally be higher
- **Out-of-Pocket Maximum**: The most you will pay within a calendar year for covered health care expenses (excluding prescription drugs)
- **Provider:** A person or institution licensed to offer health care services (i.e., doctors, specialists, hospitals, labs, etc.)

Bronze PPO High Deductible Health Plan (HDHP)

What is a "High Deductible Health Plan" (HDHP)?

- A high-deductible health plan (HDHP) is a health plan with lower monthly contributions and higher deductibles than a traditional PPO, HMO, or other Plan
- All eligible expenses apply to the deductible and co-insurance; there are no copays for office visits, emergency room or prescription drugs
- If you enroll in the high-deductible health plan, you are eligible for a Health Savings Account (HSA)

Every employee that enrolls in the HDHP will receive a Health Savings Account

- A Health Savings account is a tax-free medical savings account
- HSA Funds can be used to pay for qualified medical, dental, and vision expenses now – and in retirement (e.g., Medicare premiums)
- Unused account balance rolls over year after year, and continues to earn interest tax free. There is no "USE IT OR LOSE IT" rule
- The Health Savings Account is portable and belongs to you, similar to a 403(b) plan
- Annual Tax-free contribution limits are adjusted annually; in 2019 the individual limit is $3,500 and the family limit is $7,000. Couples and single parents fall under the family limit.
- If you are over age 55, you can make an additional contribution of $1,000 per year

Contributions to your HSA

- **Employee Contributions to the HSA are Optional**
    - You can elect additional pre-tax contributions through payroll or change payroll deductions at any time
    - You can make additional post-tax contributions online or by check

Health Savings Account (HSA)

Employee contributions | HSA | Qualified medical expenses

Using the HSA

- Payments can be made with a convenient debit card drawing from the HSA Account
- HSA funds must be in the account before you can access them. In the event the fund balance does not cover the expense at the time of service, you can pay for the service and later reimburse yourself
- You can take advantage of long-term investment options once the account reaches a balance of $2,000
- HSA contributions are deducted pre-tax, funds are withdrawn tax free, and fund interest and investment earnings are also tax-free

Examples of Qualified Medical Expenses

- Health Plan eligible expenses
- Vision and dental expenses
- Prescription Drugs
- COBRA Premiums
- Medicare premiums (for people 65 and older)
- Health Insurance while receiving unemployment
- Long Term Insurance

- Acupuncture
- Cancer Screenings
- Chiropractor
- Crutches, Walkers, Wheelchairs (DME)
- Deductibles, Copays, Coinsurance
- Diabetic Supplies
- First Aid Kits
- Flu Shots
- Hearing aids
- Immunizations
- Laser eye surgery, Lasik
- Lodging at a hospital
- Medical supplies
- Physical, Speech, Occupational Therapy
- Orthodontia
- Radiology
- Stop-smoking programs
- Surgery (non-cosmetic)
- And more….

For a complete list of qualified medical expenses:

Visit Healthequity.com/QME or
Visit the IRS website at **https://www.irs.gov/publications/p969#en_US_2017_publink1000203083**

To contribute to the HSA the following criteria must be met

- You must be enrolled in a qualified High Deductible Health plan (HDHP), such as the one The Health Plan is offering
- You cannot have other health coverage (see IRS Publication 969)
- You (or your spouse, if a tax dependent) cannot be enrolled in any part of Medicare or Medicaid
- Medicare Eligible employees cannot contribute to the HSA fund, but can continue to draw from the account
- You cannot be listed as a dependent on someone else's tax return
- You cannot be active in the military*
    - *Veterans enrolled in a HDHP with no other disqualifying coverage and who have a service-connected disability may make or receive HAS contributions regardless of when they received VA benefits.
- You cannot be enrolled in a full purpose Health FSA through a spouse's plan

Health Equity

HSA Employee Tools and Resources

- Employee Debit card access

- Mobile app or member portal to:
  - Elect your Beneficiary
  - Check account balance
  - Review transactions
  - Review claims
  - Submit new claims or documents
  - Send payments and reimbursements
  - Access tax documents

Health Equity

HSA Phone Support and Member Online Resources

- Telephonic 24/7 Member service
  - Success measured by education of members, not call handle time
  - Insight to help maximize savings
  - Extensive ongoing training

- Online Resources – More information available at:
  - HealthEquity.com/HSAlearn
  - HealthEquity.com/HSAMemberGuide
  - HSAguidebook.com
  - HealthEquity.com/Me
  - HealthEquity.com/Advisor (investments)

Member services available every hour of every day!

Call 866-346-5800

MEDICAL: Benefits at a Glance

	GOLD PPO PLAN		SILVER PPO PLAN		BRONZE PPO PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$750 / $1,500 / $2,250*	$750 / $1,500 / $2,250	$1,000 / $2,000	$2,500 / $5,000	$1,500 / $3,000	$2,500 / $5,000
Out-of-Pocket Maximum (including Deductible)	$4,500 / $9,000	$4,500 / $9,000	$5,000 / $10,000	$10,000 / $20,000	$6,000 / $12,000	$10,000 / $20,000
Co-Insurance	Plan pays 80%	Plan pays 50%	Plan pays 80%	Plan pays 50	Plan pays 80%	Plan pays 50%
Office Visits						
Preventive	Paid at 100%	Coinsurance	Paid at 100%	Co-Insurance	Paid at 100%	Deductible/Co-Insurance
Primary Care	Deductible & Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
TelaDoc	$10 co-pay	$10 co-pay	$10 co-pay	$10 co-pay	Deductible/Co-Insurance	Deductible/Co-Insurance
Specialist	Deductible & Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Urgent Care	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Diagnostic Lab & X-Ray	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Hospital Facility						
In-Patient	Deductible & Co-Insurance	$300 co-pay/Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Out-Patient	Deductible & Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Hospital Physician						
In-Patient	Deductible & Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Out-Patient	Deductible & Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Emergency						
Emergency Room	$50 co-pay/ Deductible/Co-Insurance	$50 co-pay/ Deductible/20% Co-Insurance	Deductible/Co-Insurance	20% Co-Insurance after Deductible	Deductible/Co-Insurance	20% Co-Insurance after Deductible
Mental Health						
In-Patient	Paid at 100%	Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Out-Patient	Paid at 100%	Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Substance Abuse						
In-Patient	Paid at 100%	Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Out-Patient	Paid at 100%	Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance
Home Health Care	20 visit annual maximum	20 visit annual maximum	20 visit annual maximum	20 visit annual maximum	20 visit annual maximum	20 visit annual maximum
Skilled Nursing Facility	60 days per calendar maximum	60 days per calendar maximum	60 days per calendar maximum	60 days per calendar maximum	60 days per calendar maximum	60 days per calendar maximum
In-Patient Therapy	31 day annual maximum	31 day annual maximum	31 day annual maximum	31 day annual maximum	31 day annual maximum	31 day annual maximum
Out-Patient Therapy	35 visit annual maximum	35 visit annual maximum	35 visit annual maximum	35 visit annual maximum	35 visit annual maximum	35 visit annual maximum
Other Services	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance	Deductible/Co-Insurance

* The Gold Plan deductible is per person/per couple or single parent/family. All other plan options are times two on deductible and co-insurance regardless of how many dependents are enrolled.

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

Prescription Drugs

CVS/Caremark

The Prescription Drug benefit is administered by CVS/Caremark. 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.

Comparison of Prescription Drug Plan Benefits

The Prescription Drug Benefit included with all three PPO Plans provides benefits for the purchase of up to 30 days' supply of medication at a retail pharmacy at the following copays (see chart below). Maintenance drugs can be purchased via mail order, up to a 90-day supply, at the following copays (see chart below).

	Gold Plan	Silver Plan	Bronze Plan
Retail Pharmacy	30 day supply	30 day supply	30 day supply
Generic	$10 copay	$10 copay	Deductible, coinsurance
Preferred Brand	$50 copay	$50 copay	Deductible, coinsurance
Non-Preferred Brand	$75 copay	$75 copay	Deductible, coinsurance
Specialty	$75 copay	Deductible, coinsurance $400 maximum	Deductible, coinsurance
Mail Order Pharmacy	90 day supply	90 day supply	90 day supply
Generic	$20 copay	$25 copay	Deductible, coinsurance
Preferred Brand	$100 copay	$125 copay	Deductible, coinsurance
Non-Preferred Brand	$150 copay	$187.50 copay	Deductible, coinsurance
Specialty	$150 copay	Deductible, coinsurance $400 maximum	Deductible, coinsurance

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. Conditions covered include Multiple Sclerosis, Rheumatoid Arthritis, Gaucher's Disease, Allergic Asthma, Osteoporosis, Cystic Fibrosis, Hepatitis C, Crohn's Disease, Pulmonary Hypertension, HIV, Transplants, Psoriasis, and others.

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 for you to receive coverage for them. 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 the criteria standards and still wish to take the medication, you'll be responsible for the entire cost of the drug.

SANITAS is a Florida Blue Provider

- **One-stop shop for medical needs**
  Sanitas provides Primary Care, Specialists, Labs and Diagnostics, Urgent Care, Walk-ins, and more!

- **Extended hours 7 days a week**
  We all know the hassle of needing to request time off from work to go see a doctor. Extended and weekend hours are available at certain locations

- **Shorter wait times and quicker appointments**

Sanitas Medical Centers

Doral
Gateway Center Doral
2000 NW 87th Avenue
Suites 101 and 102
Doral, FL 33172

Kendall
Kendall Value Shopping Center
7135 SW 117th Avenue
Miami, FL 33183

Miami Lakes
Lakes on the Green
18610 NW 87th Avenue
Miami, FL 33015

Sanitas Primary Care Offices

Hialeah
7100 W 20th Avenue
Suite 111
Hialeah, FL 33016

Plantation
180 SW 84th Avenue
Suite B
Plantation, FL 33324

Coral Gables
2601 SW 37th Avenue
Suite 806
Coral Gables, FL 33134

Lauderdale Lakes
4900 W. Oakland Park Blvd.
Suite 105
Oakland Park, FL 33311

Coral Springs
2901 Coral Hills Drive
Bldg. I, Suite 370
Coral Springs, FL 33065

Visit Sanitas.com to learn about services offered at each location and hours of operation.

To set up an appointment today, call 1-844-665-4827

Everything in one place

- **PRIMARY CARE DOCTORS**
  Board-certified Primary Care Doctors and advanced medical support staff who provide comprehensive primary care for the entire family – from infants to seniors. Includes: Family Medicine, Internal Medicine, Pediatrics and Gynecology.

- **HIGH VOLUME SPECIALISTS**
  A wide range of board-certified Specialists to provide comprehensive and timely treatment. Includes: Cardiology, Gastroenterology, Endocrinology, Orthopedics, Dermatology, Ophthalmology, Radiology and Podiatry.

- **URGENT CARE / WALK-IN CLINIC**
  Urgent care facility to treat a wide range of illnesses, injuries, and common conditions. Specially equipped with observation beds to prevent unnecessary visits to the ER.

- **ONSITE LAB & DIAGNOSTIC**
  Onsite lab and diagnostic imaging to help our medical team diagnose and treat diseases or conditions quickly and effectively. Includes: X-Rays, Ultrasound, CT Scan, Electrocardiogram, Echocardiogram, Stress Test, Holter Monitor Test, Mammography, Bone Density Test, Endoscopy and Spirometry.

TELADOC MEDICAL BENEFIT

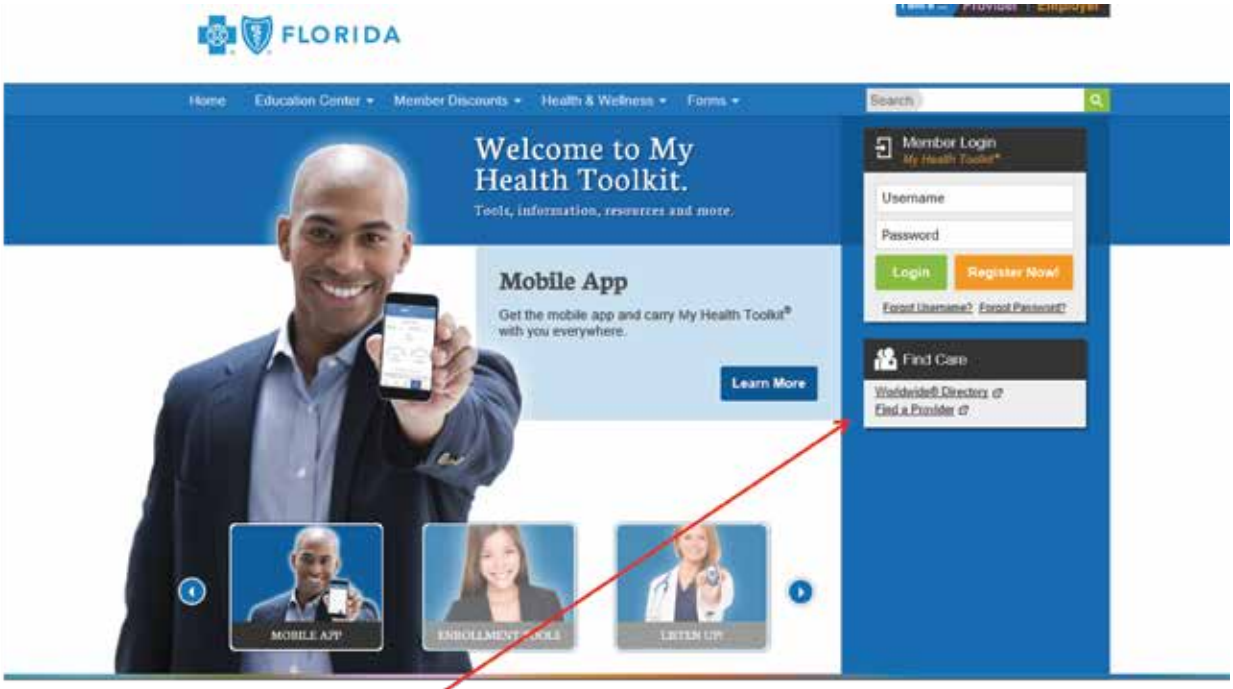
The Health Plan has made Teladoc available to all employees that are enrolled in one of the medical plan options. Here is how it works:

- If you have a medical condition that you feel needs to be treated by your primary care physician and it is either after hours or your doctor is not available, simply call Teladoc at 1-800-Teladoc (1-800-835-2362) and speak to a US board-certified Teladoc physician. They are available 24/7/365
- If they are busy and need to call you back, the average call back will occur in 8 minutes
- The Teladoc physician can diagnose and prescribe medication (if medically necessary) to the pharmacy of your choice
- You can obtain more information at Teladoc.com,Facebook.com/Teladoc or Teladoc.com/mobile
- Always call 911 if you feel that your medical condition is either life threating or a medical emergency

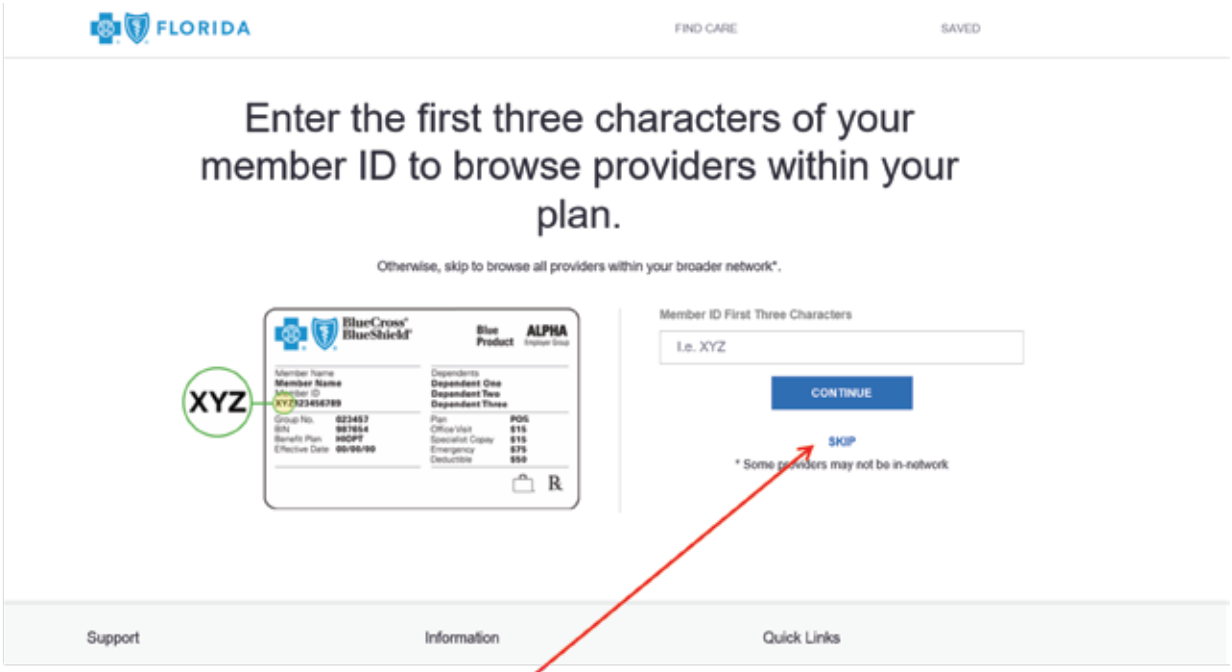
It's quick, easy and can save you time and money!

HOW TO FIND A PROVIDER

Logon to www.myhealthtoolkit.com

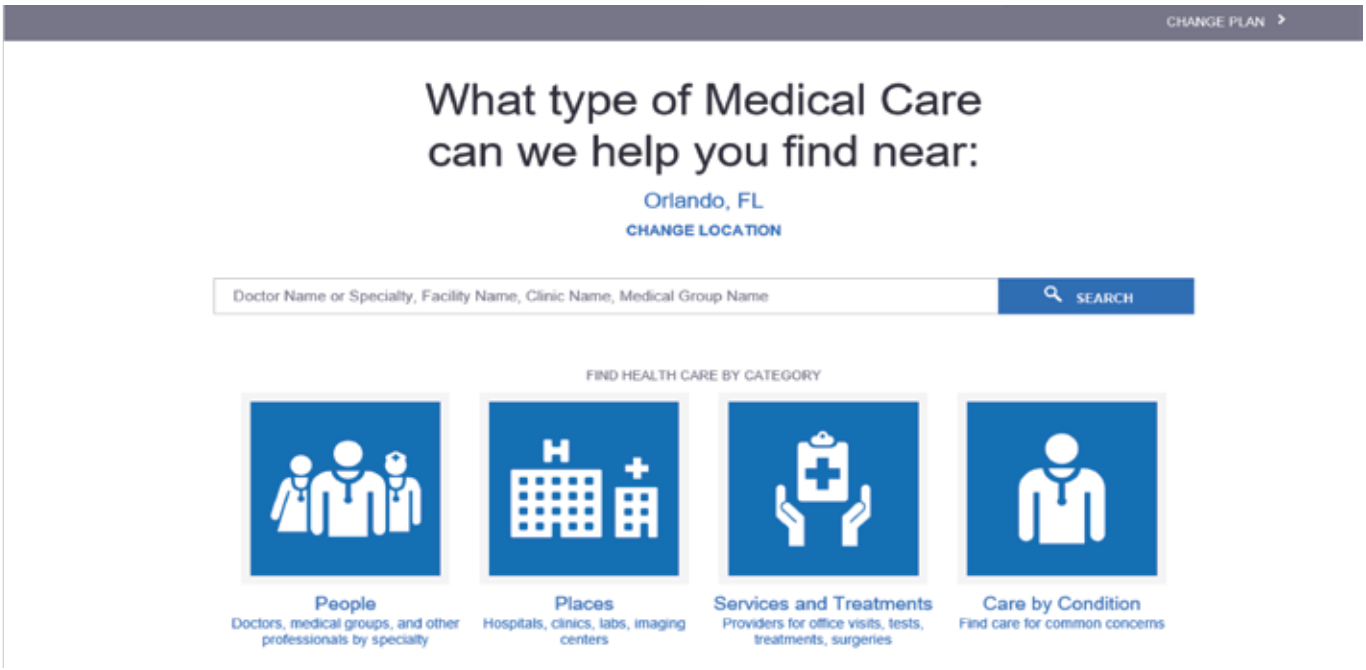


Click on *Find a Provider* link



Enter alpha prefix on your card and click Continue OR click SKIP

HOW TO FIND A PROVIDER



Value Added Features

Know Before You Go

This program is designed to assist you in shopping for the best quality and prices for your medical care. It allows you to shop, compare, and estimate medical costs and prescription drugs. Cost estimates are based on your medical plan, giving you a more personalized experience.

<u>You have three easy ways to compare:</u>

- Online: In your Florida Blue account home page, scroll down until you reach the Know Before You Go section. Then, select the service you need.
- Phone: Contact a Care Consultant at (888) 476-2227
- In Person: Visit a Florida Blue Center near you

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, and 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!

<u>Find a Florida Blue Center</u>

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

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 (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 vison 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

Voluntary Benefits

Voluntary Benefit Options:

- ✓ Accident
- ✓ Critical Illness
- ✓ Hospital Indemnity

Voluntary Benefit Plan Enhancements: CHUBB VOYA

Chubb Will Be the New Carrier for Accident & Critical Illness, Offering:

- ✓ Enhanced Plan Designs
- ✓ Waiver of Pre-existing condition
- ✓ Guaranteed Issue(No Medical Questions)
- ✓ Portable

New Voya Hospital Plan, Offering:

- ✓ Coverage For Out-Of-Pocket Expenses Related to Hospitalization
- ✓ Waiver of Pre-existing condition
- ✓ Guaranteed Issue(No Medical Questions)

Critical Illness Plan: CHUBB

Benefit Amounts:

- Employee Benefit Amounts: $5,000-$30,000
- Spouse Benefit Amounts: $2,500-$15,000
- Children Benefit: 50% of Employee Benefit (No Additional Cost)

Benefit Details:

- Lump Sum Check Sent Directly to you
- Spend the Money however you choose
- Paid regardless of any other coverage you may have

Triple Benefit:

Once we have paid you a benefit, **if you get sick again** with either the same or another covered condition, you're still covered. With Triple Benefit, you can receive **up to 3 times the Face Amount** for each person you choose to cover.

Recurrence Benefit:

If we have paid a critical illness benefit for Benign Brain Tumor, Cancer, Coma, Heart Attack or Stroke, and there is a recurrence, you can receive **up to 100% of your face amount**, as long as you were back to work and treatment free for at least 6 months. The Recurrence Benefit can be paid up to 2 times based on the plan lifetime maximum.

Covered Conditions:

Alzheimer's Disease	**Loss of Sight, Hearing, or Speech**
Benign Brain Tumor	**Major Organ Failure**
Cancer	**Severe Burns**
Coma	**Paralysis or Dismemberment**
End Stage Renal Failure	**Parkinson's Disease**
Heart Attack	**Skin Cancer * ($250)**
Stroke	**Carcinoma In-Situ or Coronary Artery Obstruction *(25%)**

Advocacy:

Chubb offers personal and confidential assistance from professionals. Offering medical advice, doctor referrals , financial advice and travel assistance.

Mortgage and Rent Helper (Employee Only):

Mortgage & Rent Helper pays an extra **$500** per month each month the employee misses 5 or more days of work due to a critical illness for up to 6 months.

Hospital Re-Admission Benefit (Employee Only):

Hospital Admission Benefit pays an extra **$1,500** per admission each time the employee is hospitalized due to a critical illness beginning 6 months after their diagnosis, paid up to 2x each year.

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 (after coverage is in force for 30 days).

Accident Plan: CHUBB 

Accident Plan:

Pays on a schedule of benefits based on services rendered as a result of a non-occupational accidental injury for all employees.

- Pays Directly to you and you choose how to spend the money
- Pays regardless of any other coverage you may have

Coverage Details (extensive indemnity list: below is a snapshot)	
Coverage Type	Off Job
Spouse & Child coverage	Offered
Guaranteed Issue	No medical questions
Pre-Existing Condition	No limitation, will not cover an accident that occurred prior to the effective date.
Portability	Included
Wellness Benefits	$100 after a 90 day waiting period
ER Treatment/Urgent Care	$200/$50
Initial Doctor Visit	$125
Hospitalization/ICU	$1,000 / $2,000
Accidental Death	$50,000 Employee, $50,000 Spouse, $10,000 Child

Additional Information:

First Accident:

Pays you **$100** soon after you report your first claim for covered benefits (once per lifetime)! If you get injured, we can begin processing your claim right over the phone so you can get cash fast.

Accident Plan: CHUBB

Rehabilitation Benefit:

Pays a **$1,000** initial admission benefit and a **$120** per day confinement benefit up to **30 days** when you are admitted into a rehabilitation facility as a result of an accidental injury. Additionally, offers a **$50** recovery benefit up to **7 days.**

Wellness:

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 (after coverage is in force for 90 days).

Sports Package:

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

Claim Example:

If your child breaks a leg at soccer practice, here's how benefits may stack up with **Chubb**

Accident:

First Accident	$ 100
Ambulance	$ 200
Emergency Room Visit	$ 200
X-Ray	$ 30
Fracture	$ 900
Crutches	$ 100
Physical Therapy (x3 visits)	$ 90
Follow-up Visits (x2 visits)	$ 60
Subtotal	**$ 1,680**
PLUS Sports Package	**$ 420**
Total Payment	**$ 2,100**

This is only an example of the benefits that could be payable for the covered loss noted above. Refer to the certificate of insurance for details.

Hospital Indemnity Plan: VOYA

Hospital Indemnity Plan:

Hospital Confinement Indemnity Insurance pays a daily benefit if the insured has a covered stay in a hospital, critical care unit, or rehabilitation facility. The benefit amount is determined based on the type of facility and the number of days they stay.

Features include:

- **Guaranteed Issue:** No medical questions or pre-existing condition limitation
- **Flexible**: Benefits are payable directly to the insured and can be used for any purpose they 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 **(**$50**)** when the covered person completes a health screening test. Child wellness benefit is 50% of the employee benefit, to a maximum of **(**$100**)** for all Children in one calendar year. One wellness benefit is payable per person per year.

Initial Hospital Admission Benefit of a $1,000 per Calendar Year 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 are made pre-tax 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.

If you are scheduled to work more than 1,000 hours per Plan Year 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, however if you do not make a determination within 30 days of hire you will automatically be enrolled with a 3% deferral amount. 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 United Capital manage the investment portfolio, recommending funds that best serve Archdiocesan employees.

To enroll, view, or change your information, please visit the Transamerica website at adom.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 United Capital at 754-200-7600.

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

RETIREMENT BENEFIT

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

Basic Life & Supplemental Life
The Hartford Policy #: **303830**
(888) 563-1124
www.thehartfordatwork.com

Long-Term Disability
The Hartford Policy #: **303830**
(800) 549-6514
www.thehartfordatwork.com

Short Term Disability and FMLA
The Hartford Policy #: **303830**
(800) 549-6514
www.thehartfordatwork.com

Retail /Mail Order Pharmacy
CVS Caremark ADOM #: **0689**
(866) 217-5353
www.caremark.com

Specialty Pharmacy
CVS Caremark ADOM #: **0689**
(800) 237-2767
Fax: (800) 323-2445
www.caremark.com

Teledoc
1-800-Teledoc
www.teledoc.com

Health Savings Account
Health Equity
(866) 346-5800
www.healthequity.com

Medical
Florida Blue
BlueChoice & Blue Options PPO:
(800) 830-1501
www.myhealthtoolkitfl.com

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

Critical Illness & Accident
Chubb Policy #: **BKRC15945**
(866) 445-8874
www.chubbworkplacebenefits.com

Hospital Indemnity
Voya Employee Benefits Policy #: **00705527**
(877) 236-7564
www.voya.com

Archdiocese of Miami Health Plan
Main: (305) 893-0068
Eligibility: (305) 893-2674
Fax: (305) 893-6433
E-mail: healthplan@adomhealthplan.org
www.adomhealthplan.org

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

United Capital
(754) 200-7612
daniel.rodriguez@unitedcp.com

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

BenefitSolver Enrollment
BenefitSolver
Phone: (833) 232-7498
www.benefitsolver.com

Annual Notices

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, 2019 • 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.

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? $ _____
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.

Notes

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.