CATHOLIC DIOCESE OF ARLINGTON
Lay Employees' Benefit Guide
Effective March 2025- February 2026

Have a question about your benefits?

If you have general questions about your benefits, including enrollment and eligibility questions, please contact the Employee Benefits Office (EBO) at:

Phone: 703-841-2588
Fax: 703-358-9216
Email: ebo@arlingtondiocese.org

You may also obtain information by contacting our benefit providers directly.

If you have questions about...	Contact	Phone Number	Website or Email
Medical Group Plan Number - CDA933	Edison Health Solutions	1-855-205-8460	members@edisonehs.com
Dental Group Plan Number - 0301834	MetLife	1-800-942-0854	metlife.com
Vision Group Plan Number - 12204637	VSP	1-800-877-7195	vsp.com
Pharmacy	DisclosedRx	1-888-589-3340	disclosedrx.com
Life Insurance Policy Number - 52141	Prudential	Customer Service 1-888-598-5671 Life Claims 1-800-524-0542 Portability & Conversion 1-800-778-3827	prudential.com ComPsych (Will Preparation): estateguidance.com Web ID: EGP311
Short and Long Term Disability	New York Life Group Benefit Solutions	1-888-842-4462	newyorklife.com/group-benefit-solutions/forms
Employee Assistance & Wellness Support		1-800-344-9752	guidanceresources.com Web ID: NYLGBS
Financial, Legal & Estate Support			
Family Medical Leave	HR	703-841-3857	Email: loa@arlingtondiocese.org
403(b) Plan	Empower	1-833-961-5273	participant.empower-retirement.com/participant/#/login
Pension Plan	EBO	703-841-2588	Email: ebo@arlingtondiocese.org
Leave of Absence Office	LOA Specialist	703-841-3857	Email: loa@arlingtondiocese.org

What's Inside

Catholic Diocese of Arlington
Employee Benefits Office

200 North Glebe Rd
Suite 205
Arlington, VA 22203

Email: ebo@arlingtondiocese.org
Phone: 703-841-2588
Fax: 703-358-9216

Introduction

The purpose of the **Lay Employees' Benefit Guide** is to provide a summary of the benefits offered to lay employees of the Catholic Diocese of Arlington and Catholic Charities. Please read through the guide to learn about the benefits for which you are eligible and how they work for you.

For questions about employment and other policies, please refer to the Employee Policy Manual, which can be found on your Dayforce home page.

Personal changes such as name, address, contact information, etc. can be made directly by you in Dayforce using the forms in the Forms section. Your payroll processor at your work location is your point of contact should you have any questions about making these changes.

If you are a new employee, your date of hire is your first day at work, unless you are a contracted employee. If you are a contracted employee your date of hire is your contract effective date.

Eligibility and Enrollment

Who is Eligible

Employees

Regularly scheduled full time employees (30 or more hours per week) are eligible for the full menu of benefits.

Regularly scheduled part time employees (20-29 hours per week) are eligible to participate in the 403(b) and Pension Plans. Enrollment in the Pension Plan is automatic and you may enroll in the 403(b) plan at any time.

If you are temporary, on call, or part-time limited (working fewer than 20 hours per week on a regular basis) you are not eligible for benefits.

All enrollments and changes to benefit plans are made online in Dayforce; paper forms are not provided or accepted. You will receive a message in your Dayforce Message Center and an enrollment link on the Dayforce Benefits Overview page when you are eligible.

Generally, benefits will begin the first of the month following your hire date or eligibility date.

Dependents

In addition to enrolling yourself, you may also enroll your eligible dependents in the Medical, Dental and Vision plans. A complete list of eligible dependents is included in the Appendix section of this guide.

When to Enroll

When First Eligible

You must enroll in your benefit plans within 30 days of your date of hire or the date you become a regularly scheduled full-time employee. If you are a newly hired contracted employee, you have 30 days, including your contract effective date to enroll – your contract effective date is your date of hire. If you miss this initial eligibility period, you will be required to wait until the next Open Enrollment period, unless you experience a qualified life status change, as defined by the IRS. (See blue box at right.)

Your enrollment in benefits must be submitted online in Dayforce on or before the 30th day of your enrollment period. The EBO cannot make an exception to this deadline. The enrollment period begins with your hire date or the date you became eligible for benefits.

The benefits you choose when you are first eligible will remain in place until the next Open Enrollment period following your eligibility date, unless you experience a qualified life event status change.

During Open Enrollment

Open Enrollment is done exclusively online in Dayforce; paper form enrollments are not provided or accepted.

During Open Enrollment you may enroll or change current
benefit elections. This coverage will remain in place until the next Open Enrollment period, unless you have a qualified life event status change.

How much will you pay for benefits?

Health Benefits Premiums are found in the Appendix on page 32. Paycheck premiums are deducted from the first two (2) paychecks of each month of the year. The rates are the same for all employees, regardless of work schedule. Missed premium deductions, such as those that occur during the summer for school employees who do not receive pay or for those on an unpaid leave of absence, will be placed into arrears and collected upon return to active pay status.

Making Changes Changes in Status

Your benefit elections will stay in place until the next Open Enrollment period unless you have a qualified life status change.

Examples of qualified life status changes are:

- Marriage, divorce, or annulment
- Birth or adoption of a child
- Change in eligibility of a child
- Death of a dependent
- Change in your employment status
- You lose or gain insurance in another health plan

Changes to benefits for Mid-Year Life Events such as marriage, gain of new coverage, loss of coverage and birth of a baby are made online in Dayforce with a two-step process. First, submit a Life Event Declaration Form (found on the home page under forms) and attach proof of the life event. Once the form is approved by the benefits office, you will be offered an enrollment link in the Dayforce Benefit Overview screen to make the enrollment change you need. Generally, life event changes must be completed within 30 days of the event. For more information, please refer to the Mid-Year Life Event Benefit Change document found in Dayforce on the Benefits Overview screen.

Contact the Employee Benefits Office at EBO@arlingtondiocese.org, if you have questions.

Medical

The Diocese offers a comprehensive Medical Plan to keep you and your family in good health. The Lay Medical Plan is a high performing PPO plan with nurse navigation and DPC (Direct Primary Care) program options.

The table below highlights your coverage under the Medical Plan. Please note that your benefit plan year runs from March 1st, 2025 to February 28, 2026.

Need Assistance?

If you have a question about your medical coverage or need assistance with a claim, please call Edison Health Solutions at the number on the back of your ID card.

You may also access your claims, print temporary ID cards, search for a participating provider, and more at **https://gateway.edisonehs.com.**

Plan Features	In-Network	Concierge Care Options	Out-of-Network
Annual Deductible (Individual/Family)	$1,600 | $3,200	**$0 Deductible & $0 Out-of-Pocket Options with Nurse Navigation**	$2,650 | $5,300
Annual Out-of-Pocket Maximum (Individual/Family)	$2,650 | $5,300		$5,300 | $10,600
Coinsurance	20%	**$0 with Nurse Navigation**	40%
Primary Care Physician Office Visit (office visit only, other services rendered will be subject to applicable benefit)	$20 Copay only	**$0 with Direct Primary Care**	Deductible & Coinsurance
Specialist Office Visit (office visit only, other services rendered will be subject to applicable benefit)	$40 Copay only	N/A	Deductible & Coinsurance
Telehealth Visits	$0 with MyCatholicDoctor	**$0 with Direct Primary Care**	N/A
Routine Prevention Care Routine adult annual physical exams	100% Covered	**100% Covered**	Not Covered
Chiropractic Care (30 visit limit per plan year)	$30 Copay only	N/A	Deductible & Coinsurance
Labs	Deductible & Coinsurance	**$0 at in-network independent lab**	Deductible & Coinsurance
Imaging	Deductible & Coinsurance	**$0 with Nurse Navigation**	Deductible & Coinsurance
Inpatient Hospital Facility	Deductible & Coinsurance	**$0 with Nurse Navigation**	Deductible & Coinsurance
Outpatient Hospital Facility	Deductible & Coinsurance	**$0 with Nurse Navigation**	Deductible & Coinsurance
Emergency Room	$300 Copay, then deductible & coinsurance (ded & coins waived if admitted)	N/A	$300 Copay, then deductible & coinsurance (ded & coins waived if admitted)
Urgent Care Facility	$75 Copay only	**$0 with Direct Primary Care or MyCatholicDoctor**	Deductible & Coinsurance
Mental Health Outpatient Services	$20 Copay only	**$0 with MyCatholicDoctor**	Deductible & Coinsurance
Outpatient Rehabilitation PT, OT, ST (30 visit limit per plan year) Cardiac Rehabilitation - 36 days	$20 Copay only	N/A	Deductible & Coinsurance
Maternity	$30 Copay only	**Pay Deductible only, $0 Coinsurance with Nurse Navigation**	Deductible & Coinsurance

* Non-urgent use of Urgent Care provider or non-emergency care in an Emergency Room is not covered.

Prescription Drugs	In-Network	Out-of-Network
Retail - up to 30 day supply	$0 Preventive	Not Covered
Tier 1	Lesser of $10 copay or actual cost	
Tier 2	Lesser of $50 copay or actual cost	
Tier 3	Lesser of $75 copay or actual cost	
Tier 4	Coordinated through Nurse Navigation	
Mail Order- up to 90 day supply		
Tier 1	Lesser of $30 copay or actual cost	
Tier 2	Lesser of $150 copay or actual cost	
Tier 3	Lesser of $225 copay or actual cost	
Tier 4	Coordinated through Nurse Navigation	

Please note these are only highlights. The specific terms of coverage, exclusions, limitation and maximums are contained in the Benefit Plan Booklet. To the extent there may be differences, the terms of the Benefit Plan Booklet control.

Do I need to choose a Primary Care Physician? No; you do not need to select a Primary Care Physician. However, if you elect to participate in Direct Primary Care (DPC), you will need to select a direct primary care physician in order to take advantage of those free services. See pages 15 - 16 for details.

Do I need a referral to see a specialist? No; you do not need a referral to see a specialist. You are encouraged, however, to contact the Nurse Navigator before selecting a specialist or scheduling your first appointment. See page 13 for details.

Precertification

Our medical plan requires Precertification for certain procedures, treatments, and services. Your coverage may be reduced or denied if you don't get Precertification. Services that require Precertification include, but are not limited to:

- All Inpatient Admissions such as hospital admissions, skilled nursing facilities, rehabilitation facilities, and hospice care
- High-tech radiology (MRI, CAT Scans, PET scans, nuclear cardiology)
- Injectable drugs (other than self-injectable)
- Durable medical equipment (insulin pumps, specialty wheelchairs, etc.)
- Home Health Care
- Speech Therapy
- Sleep management
- Radiation Therapy
- External prosthetic appliances
- Dialysis (to direct to a participating facility)

For in-network services, your doctor will call Edison for the Precertification.

For out-of-network services, you are responsible for the Precertification. To request Precertification, call the toll-free number on the back of your Medical ID card (855-205-8460) .

Medical Necessity Review: The Right Care for Your Health & Budget

Medical Necessity Review (MNR) is a process where certain services (like physical therapy & chiropractic care) are reviewed to determine if they are necessary and will be covered. This helps you get the care and services you need and avoid surprise bills.

Prescription Drugs - DisclosedRx

The Lay Medical Plan includes prescription drug coverage through DisclosedRx.
You can purchase prescription drugs from a retail pharmacy or DisclosedRx Home Delivery Pharmacy. Your prescription drug benefit divides medications into four tiers:

- **Tier 1 (Generic)** is your lowest copay option. For the lowest out-of-pocket expense, you should consider generic drugs if you and your physician agree that they are appropriate for your treatment.
- **Tier 2 (Preferred Brand)** is your middle copay option. Use a preferred brand drug if no generic drug is available to treat your condition.
- **Tier 3 (Non-Preferred Brand)** is your highest copay option. The drugs that are a non-preferred brand are usually more expensive. Sometimes there are generic and preferred brand alternatives available.
- **Tier 4 (Specialty Medications)** These medications require precertification through Concierge Nurse Navigators for coverage. You MUST call the nurse.

Preventive Medications: The copays are waived for certain preventive medications. For a list of these drugs, please call DisclosedRx or Edison.

Covered Drugs: Prescription drug plan lists for covered drugs can change from year to year. Some prescriptions will move from one drug tier to another and some will no longer be covered. It is always a good idea to review DisclosedRx's drug list for your routine prescriptions.

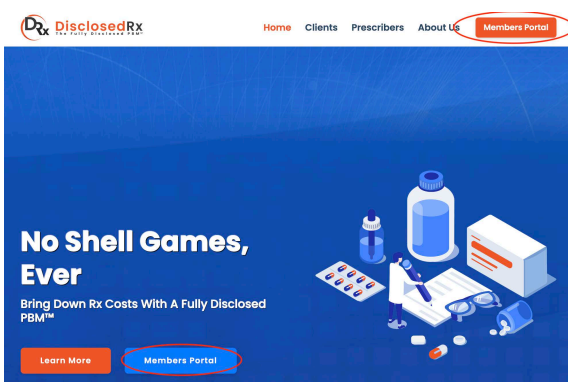
Step Therapy

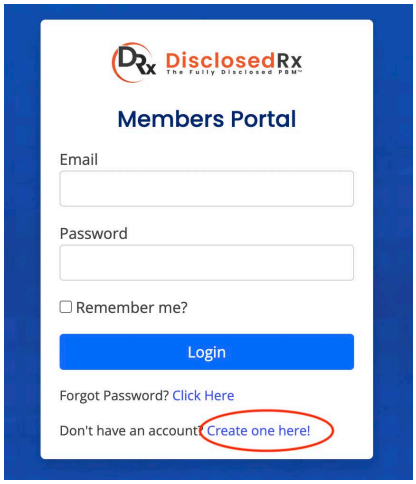
Step Therapy is a part of the DisclosedRx prescription drug program that requires pre-authorization of certain medications. This means that certain medications will require approval by DisclosedRx before they are covered. If you have a prescription that is part of the Step Therapy program, you may be asked to try the most cost-effective and appropriate medications available, typically a generic or lower cost brand, before more expensive brand name medications are approved for coverage.

How Step Therapy works: When you fill a prescription that is part of the Step Therapy Program, DisclosedRx will allow the prescription to be filled one time before sending you and your doctor a letter describing the steps needed before you refill your medication. In some cases, DisclosedRX may ask the doctor if a generic or lower-cost alternative could be prescribed for you before allowing the high er cost medication. If your doctor believes an alternative medication isn't right for you for medical reasons, he or she can request prior authorization for continued coverage of a Step Therapy medication.

Member Portal

Visit **disclosedrx.com** and select "Members Portal" - two different locations on the page (either upper-right or middle of the page). Login by entering your email & password. If you have not registered for a member account, select "**Don't have an account? Create one here!**". After you register or login, you will see your DisclosedRx Dashboard. This dashboard makes it easy to access the tools and features designed to help you manage your medications and health. You can view your claims history in the "Claims History" tab, find pharmacy options in your area with the "Pharmacy Locator", use the "Price Calculator" to find information about drug prices, and submit a request for reimbursement using the "Member Reimbursement" tab. Questions can be directed to the **member services number 24/7 at 1.888.589.3340**





SAMPLE Medical ID Card

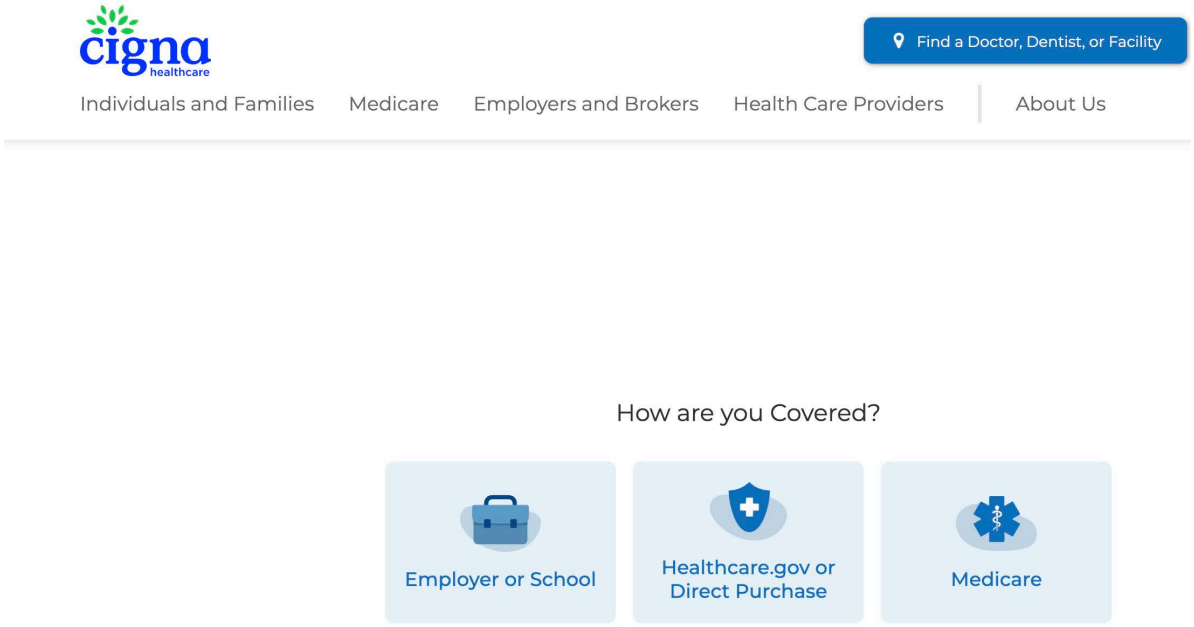
Finding a Health Care Provider

1. Visit Cigna.com and click on “Find a Doctor, Dentist or Facility” (upper right).
2. Choose “Employer or School.”
3. Enter the geographic location you want to search and select the search type.
4. Choose **“Continue as guest.”**
5. Fill in the “I Live in” field and choose “Continue.”
6. Select the **PPO option** that appears on your screen.***

Call Edison or Concierge Nurse Navigators during business hours

Edison: 855.205-8460 (Monday-Friday, 9am-6pm ET)

Concierge Nurse Navigators: 703.637.3580, 703.637.3593 (Monday-Friday, 9 am-5 pm ET)



A good way to avoid unexpected medical bills is to know how your plan works. Certain choices you make can affect what you’ll pay out of pocket.

In-network vs. out: what’s the difference?

To help you save money, your health plan provides access to a network of providers. These include:

- o Doctors
- o Hospitals
- o Labs
- o Radiology centers
- o Surgical centers

Member Portal

Login to your Edison employee portal to view your explanations of benefits, ID cards, policy documents, and see claims activity.

EDISON

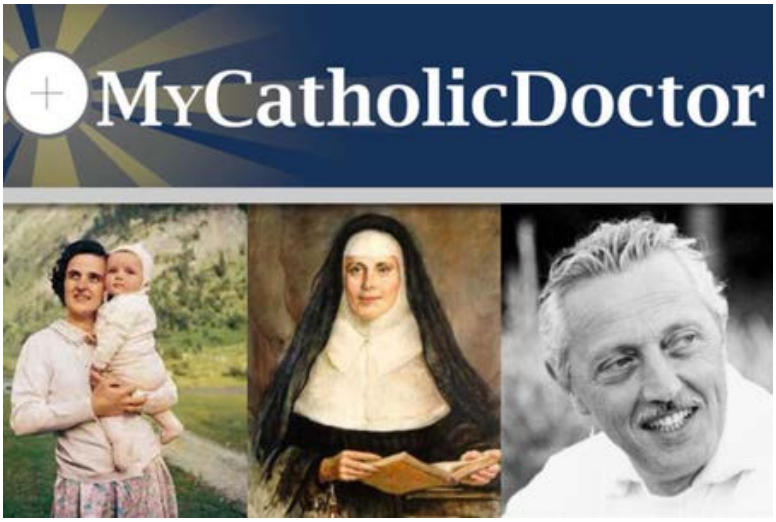
HOW TO **GET STARTED ONLINE**

1. Go to **https://gateway.edisonehs.com/** in your web browser (Google Chrome or Internet Explorer)
2. Click **"Register"**
3. Select **"Member"** from the drop down menu and complete all the requested information, then click **"SUBMIT"**
4. You will then receive a confirmation email; open and click on the **"Confirmation Link"**
5. Once the words **"Login was successful"** show in your browser, your personal information should begin to load in your dashboard and your personalized member portal will take shape

HOW TO **GET STARTED WITH THE MOBILE APP**

1. Open the App Store (on iOs or Android) on your mobile device, and search for "**EdisonGateway**"
2. Download the app to your device
3. On the Welcome Screen, you'll have two options:
4. If you've already registered for EHS Gateway, use the same login info for this EdisonGateway App, or
5. If you have not yet registered, please click on the blue text "**Register for Gateway**", complete all requested information, then click "**SUBMIT**"
6. You will then receive a confirmation email; open and click the "**Confirmation Link**" to complete registration
7. That should trigger the EHS Mobile app screen to read "**Login was successful**" and your personal information will begin to load in your app's dashboard

MEMBERS@EDISONEHS.COM • 855.205.8460



MyCatholic Doctor - Telehealth

MyCatholicDoctor is a nationwide organization that brings a network of faithful medical professionals to you through video appointment (telehealth), at NO COST to you. We offer rapid access urgent care 24/7/365, as well as appointment- based visits. Appointment based visits will have NO COPAY and include both primary care and specialty care.
We can initiate your medical care virtually, order any necessary labs or imaging, and send prescriptions to any pharmacy of your choice. We practice evidence-based scientific medicine from a Catholic perspective and integrate Catholic spirituality into our care as appropriate to the situation.

No Password Required, No Special App

$0 for all members

to get started, visit
https://mycatholicdoctor.com/arlington

When can I use MyCatholicDoctor?

Choose our rapid access urgent care when:

- You need care now
- If you are considering the ER or urgent care center for a non-emergency issue
- You are traveling
- You need care during non-business hours

Smartphone access appointments by video or phone. Confidential visits available during evenings, weekends, and holidays.

Nurse Navigators

Nurse Navigation Available to All Enrolled Members of the Medical Plan

NURSE NAVIGATION - Let's find the highest-quality doctors for YOU!

- Choosing facilities that deliver proven high-quality care
- Choosing doctors and facilities that gladly accept your health plan
- Help maximizing your benefits and reducing your out of pocket
- Understanding your diagnosis and treatment options
- When is a second opinion appropriate?

Call BEFORE you schedule care.

$0 DEDUCTIBLE and $0 COINSURANCE

WHY SEEK QUALITY FIRST?

- **Less Misdiagnosis**
- **Lower Infection Rates**
- **Fewer Complications**
- **Lower chance of returning to hospital after being discharged.**
- **Reduced patient harm and death**
- **Less Cost**
- **Right Care, Right Time, Right Place.**

What qualifies for "WAIVED DEDUCTIBLE & COINSURANCE" under the Nurse Navigator program:

•**Imaging** – CT Scan, MRI, Ultrasound, Echocardiogram, etc.

•**Scheduled Inpatient/Outpatient Surgeries** – Hip Replacement, Heart Bypass Surgery, Knee Replacement, etc.

•**Scheduled Outpatient Procedures** – Colonoscopy, Heart Catheterization, etc.

•**Second Opinions** – with a highly qualified physician or Center of Excellence (i.e. cancer diagnosis or treatment, spine surgery or fusion, complex surgeries)

Contact your local Nurse Navigators

for assistance navigating the complex healthcare system.

CONCIERGE NURSE NAVIGATORS

Jen Cala, RN
703.637.3580 voice/text (HIPAA secure)
Jen@mynursenavigators.com

In an emergency, always call 911

Kendra Wagner, RN
703.637.3593 voice/text (HIPAA secure)
Kendra@mynursenavigators.com

Medical & Diabetic Supplies

Medical Products and Services

ConnectDME is the leading provider of supplies direct to home. We are committed to caring and providing you solutions that make it easy to choose and receive the products needed to live your best life. We help keep life simple: from product awareness and order status, to insurance coverage details, we are advocates through the complexities of healthcare. For over 90 years, customers have trusted us to get supplies easily, urgently, and accurately.

- CPAPs, BiPAPs
- CPAP Supplies
- Nebulizers
- Joint & Back Braces
- Boot Walkers
- Knee-Wheelers
- Catheters
- Sleep Study
- Bone Stimulators
- TENS Units
- Cold/Heat Therapy
- Breast Pumps
- Compression Therapy

ZERO COPAY 100% BENEFIT

FREE Shipping & handling and Next-day shipping
FREE In-home setup and training

NO COST to you or your family
Contact your Nurse Navigators today
703-637-3580 or 703-637-3593

Diabetic Supplies

Diathrive opened in 1928 as a small corner pharmacy in Ohio and has grown to become a leading nationwide provider of medical supplies. Our decades of experience enable us to offer you the largest selection of products and brands, comprehensive insurance coverage and hassle-free ordering.

QUALITY DIABETES TESTING SUPPLIES

Supplies delivered straight to your door at NO COST to you.

- Test Strips
- Glucose Monitors
- Insulin Needles
- Lancets
- FDA-approved
- Accurate and reliable
- Delivered every 3 months

ZERO COPAY 100% BENEFIT

FREE Shipping & handling and Next-day shipping
FREE In-home setup and training

Direct Primary Care

NEXTERA HEALTHCARE

You will love this new health benefit

You now have the benefit of personalized, ongoing care from a primary care doctor virtually or in-person at a designated clinic near you!

Local doctor, $0 copays, $0 deductibles, Unlimited Visits

All NEW next-level Primary Care program means more time with your doctor for a better YOU!

Use Direct Primary Care for:

Prevention & Wellness
Check in on your current health and make a personalized plan to stay healthy and strong.

Mental Health Services
Help for depression, anxiety and more

Disease Management
Support managing asthma, diabetes, hypertension, obesity, high cholesterol, smoking, COPD and more.

Urgent Care Issues
Talk to your doctor in minutes for sinus infection, UTI, cold, flu rash, headache and more.

Referrals, Tests and More
Our doctors can:

- Order labs, tests and screenings
- Provide sick notes and documentation
- Work with your Nurse Navigator for referrals to High-Quality specialists

Care on your time.

- direct access to your doctor
- text/consult your doctor directly
- convenient video/image consults
- schedule appointments directly via app

No Copays, No Hassles

This care & service is available 24/7/365 with a concierge physician who works for YOU. Primary care, disease management and urgent issues for adults.

*In an emergency, always call 911.

As published by the *International Journal of Health Sciences, "*Primary Care is by far the most significant variable related to better health status, correlating with lower mortality, fewer deaths from cancer and heart disease, as well as a host of other beneficial outcomes"

NEXTERA HEALTHCARE

Primary Care Redefined

Affordable
Accessible
Exceptional

Embracing the Direct Primary Care Model

Nextera Healthcare's direct primary care membership offers you and your family members a convenient and cost-effective solution. Direct primary care eliminates insurance hassles by providing unlimited access to your doctor, extended appointment times, and a focus on pro-active care, delivering enhanced value from your primary care coverage.

What Nextera Healthcare Offers You:

$0 Primary Care/ Urgent Needs

With Nextera Healthcare, enjoy quick access to comprehensive primary care services like check-ups, physicals, urgent needs, and chronic disease management, for example asthma and mental health care. Our direct primary care membership provides convenient, no cost access to personalized healthcare, ensuring you receive the best and time appropriate care for your health needs.

$0 After Hours, Holidays and Weekends Care

At Nextera Healthcare, your well-being is our priority, even after regular office hours. Our after-hours urgent care service allows you to connect with a doctor on call for immediate assistance, ensuring you receive timely and expert care whenever you need it most.

Secure App

Experience seamless healthcare with Nextera Healthcare's HIPAA secure app. Accessible 24/7, our app allows you to request appointments, seek after-hours help, stay connected to your care team and communicate directly with your physician. Enjoy peace of mind with healthcare that's always within reach.

Our Services:

- Acute care and chronic disease management
- Allergy management
- Dermatology
- Mental health Management
- Sleep assessment and support
- Stress management
- Sprains, lacerations and broken bones
- Weight management and health risk assessment
- Women's and Men's Health
- Pediatric Care

In addition to the services above, Nextera Healthcare membership offers patients:

- After-hours care for more urgent medical needs (non-life threatening emergencies)
- Remote or virtual access to physicians via email or phone if you are busy or traveling
- Deeply discounted imaging and laboratory services
- Same Day/ Next Day appointments
- No Copays or Deductibles

Ready to Use Your Nextera Healthcare Membership?
Call us today at 303-501-2600 for your first appointment

Dental Plan

The Dental Plan is administered by MetLife and is separate from the Medical Plan. You can go to any dentist you choose (even those who do not participate with MetLife), but the plan will pay more for covered services if you can u se a MetLife dentist.

Using the Dental Plan

When you go to the dentist, they will need the group number and your social security number to process your claim. You do not need an ID card to participate. The Group Number is **0301834**.

Claims Mailing Address:
MetLife Dental Claims
PO Box 981282
El Paso, TX 79998-1282

MetLife Dental ID Card

See the Appendix for directions about printing MetLife Dental ID cards on MetLife's website, and how to download the MetLife Mobile App.

There is also a standard ID card available for your use in the Appendix on page 33.

How to Locate an In-Network Dentist

1. Visit metlife.com
2. I want to Find a MetLife Dentist (right side of home page)
3. Enter your zip code
4. Select a network: PDP
   Click - Submit

Need Assistance?

When you need help with...	Contact MetLife at:
Claims or coverage questions	1-800-942-0854
If the dentist wants to verify coverage	1-800-474-7371

Benefit Highlights

Plan Features	In-Network	Out-of-Network
Annual Deductible	$50 per individual; $150 per family	
Annual Maximum	$1,500 per person	
Diagnostic and Preventive Care	100%, no deductible	100%, no deductible
Basic Restorative Fillings	90%, after deductible	70%, after deductible
Major Restorative Single crowns, inlays, onlays	60%, after deductible	50%, after deductible
Orthodontics For eligible dependents up to age 26	60%, after deductible	50%, after deductible
Orthodontic Maximum	$1,500 lifetime maximum per person	

Please note these are only highlights. For specific terms of coverage, exclusions, limitation and maximums contact MetLife.

List of Primary Covered Services and Limitations

Type A - Preventive	How Many/How Often
Prophalaxis (cleanings)	Two cleanings per plan year
Oral examinations	Two examinations per plan year
Topical fluoride application	One fluoride treatment per plan year for dependent children up to 15th birthday
Bitewing x-rays	One set per plan year for adults; two sets per plan year for children
Space maintainers	Space maintainers for dependent children up to 15th birthday
Sealants	One application of sealant material every 60 months for each non-restored, non-decayed first and second molar of a dependent child up to 19th birthday
Type B - Basic Restorative	**How Many/How Often**
Fillings	One per 24 months per tooth surface
Non-Bitewing x-rays	Full mouth x-rays; one per 60 months
Simple extractions	
Crown, denture and bridge repair/ recementations	
Endodontics	■ Pulp cap ■ Pulpotomy
Periodontics	■ Periodontal scaling and root planning once per quadrant; every 24 months ■ Total number of periodontal maintenance treatments and prophylaxis cannot exceed four (4) treatments in a calendar year
Type C - Major Restorative	**How Many/How Often**
Implants	Once per tooth per 84 months
Bridges and Dentures	■ Initial placement to replace one or more natural teeth, which are lost while covered by the Plan ■ Dentures and bridgework replacement: one every 84 months ■ Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns/Inlays/Onlays/Post & Cores	Replacement: once per tooth per 84 months
Endodontics	Root canal treatment limited to once per tooth per 24 months
Periodontics	Periodontal surgery once per quadrant, every 36 months
General Anesthesia	When medically necessary in connection with oral surgery, extractions or other covered dental services
Oral Surgery	

Type D - Orthodontia

- Your children, up to the end of the months of their 26th birthday, are covered while Dental insurance is in effect. All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia.
- Payments are on a repetitive basis.
- 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary.
- Orthodontic benefits end at cancellation of coverage.

Vision

Your Vision coverage includes a full range of vision care services provided through a network of preferred vision providers, the Vision Service Plan (VSP) vision network. You may receive care from any provider you wish, but your benefits are greater when you see a participating provider. (The Vision plan is not part of the Medical plan.)

Using Your Vision Benefits

When you use a VSP provider, a copay is due at the time of service and an ID card is not needed. Many vision centers in the area (ex: My Eye Dr., Hour Eyes) commonly participate. If you use a non-VSP provider, you pay all the expenses at the time of service and you file for reimbursement later.

If the doctor wants to verify your coverage, call Vision Service Plan Customer Service at **1-800-877-7195** and provide the Group #: **12204637**.

VSP Vision ID Card

See the Appendix for directions about printing VSP Vision ID cards on VSP.com, and how to download the VSP app.

There is also a standard ID card available for your use in the Appendix on page 35.

Filing Claims

In-network VSP providers will file any claims for you and be reimbursed for allowable charges directly from VSP.

If you use an out-of-network provider, you are responsible for payment at the time of service. To receive reimbursement up to the allowed amount, submit an itemized bill along with your name, address, phone number, Social Security number, date of birth and the name of our group, Catholic Diocese of Arlington. Please make sure the bill lists the charges for the eye exam and materials, including the lens type as well as the name and address of the provider.

VSP In-Network Claims Mailing Address:
VSP
PO Box 495907
Cincinnati, OH 45249-5907

VSP Out-of-Network Claims Mailing Address:
VSP
PO Box 495918
Cincinnati, OH 45249-5918

Finding a VSP Provider

To locate a participating in-network provider, call the Vision Service Plan at **1-800-877-7195** or search online at **vsp.com**. Under the Members section of the website, click on **"Find the Right Doctor for You"**.

Benefit Highlights

Covered Services	In-Network	Out-of-Network
Comprehensive Eye Exam every 12 months	$10 copay	Reimbursed up to $35 after $10 copay
Frames and Lenses every 12 months	$200 Allowance; no copay plus 20% off remaining costs	Reimbursed up to $200
Contact Lenses (in lieu of glasses) - Cosmetic every 12 months	$200 Allowance; no copay plus 15% off remaining costs (including fitting and evaluation)	Reimbursed up to $200
Laser Vision Correction	Average 15% off regular price or 5% off a promotional offer Discounts only available from contracted facilities	

Please note these are only highlights. For specific terms of coverage, exclusions, limitation and maximums, please contact VSP.

Life Insurance

Company-paid Basic Employee Coverage

Life insurance helps protect your family from a sudden loss of income in the event of your death. The Diocese pays the full cost for basic employee coverage. To be eligible for this benefit, you must be an active lay employee who is regularly working at least 30 hours each week. Enrollment is automatic upon becoming eligible.

Eligible employees receive a benefit equal to two times annual base salary (rounded up to the nearest $1,000) up to a maximum benefit of $500,000.

Age Reduction Schedule

Your Basic Life insurance benefit will be reduced to a percentage of your pre-age 65 amount upon reaching the following ages:

Age	Reduced Benefit % of Pre-Age 65 Benefit
65	65%
70	50%
75	35%

Supplemental Coverage for you or your Dependents

If you are eligible for Basic Life, you may also apply for Additional Life coverage to supplement your Basic Life amount.

For you: As a newly hired or newly eligible employee, you have 30 days to purchase additional life insurance in multiples of $10,000 up to a maximum benefit of $1,000,000. Evidence of Insurability (EOI) will be required if you elect an amount in excess of $150,000.

For your dependents: As a newly hired or newly eligible employee, you are also eligible to purchase additional life insurance for your spouse and dependent children. You may purchase supplemental life insurance for your spouse in multiples of $10,000 up to a maximum benefit of $250,000 (benefit amount may not exceed the employee's life coverage). Evidence of insurability will be required if you elect an amount in excess of $50,000.

You may purchase supplemental life insurance for your children in the amount of $10,000. Evidence of Insurability is not required.

Note: You must purchase supplemental life insurance in order to elect supplemental life insurance for your spouse and/or dependent children. The combined amount of your Basic Life benefit plus your Additional Life coverage must be greater than or equal to your total dependent coverage.

If you and your spouse are both employed by The Catholic Diocese of Arlington, you may not elect supplemental life insurance for your spouse. Additionally you and your spouse may not both cover your dependent children.

Evidence of Insurability

If you wish to purchase supplemental life insurance for you or your spouse, you may be required to complete an Evidence of Insurability (EOI) form online with the insurance carrier. Any changes or elections after your initial enrollment period as a newly hired or newly eligible employee will require evidence of insurability. Please contact the Employee Benefits Office for the link to the EOI Online Form.

Cost for Supplemental Life Insurance

The costs for you and your spouse are based on your individual ages and the amount of coverage elected, as indicated in the chart below. Paycheck premiums are deducted from the first two (2) paychecks of each month of the year. The rates are the same for all employees, regardless of work schedule. Missed premium deductions, such as those that occur during the summer for school employees who do not receive pay or for those on an unpaid leave of absence will be placed into arrears and collected upon return to active pay status.

The cost for children is $0.090 per $1,000 of coverage.

Age as of the first of the month	Monthly Rates per $1,000
<25	$0.050
25-29	$0.060
30-34	$0.080
35-39	$0.100
40-44	$0.110
45-49	$0.180
50-54	$0.275
55-59	$0.480
60-64	$0.710
65-69	$1.300
70+	$2.100

Accelerated Benefits

If you become terminally ill, you may be eligible to receive up to 75 percent, to a maximum of $650,000, of your combined Basic and Additional Life Insurance coverage before your death. Please refer to your Additional Life Employee Brochure for further details.

Don't forget to designate a beneficiary!

You are automatically enrolled in the basic employee Life coverage as soon as you become eligible. However, you must submit your beneficiary designation form on Dayforce. Login to your Dayforce account and choose Forms.

Disability Insurance

Short and Long-Term Disability benefits provide income while you are unable to work for an extended period of time due to a non-work illness or injury. The Diocese provides this benefit to full-time employees at no cost, through New York Life Group Benefit Solutions (NYL GBS), on the first of the month following 3 months of consecutive full-time employment.

Summary of Benefits

Short-Term Salary Continuation under Disability

- You must submit a claim to NYL GBS if you have a non-work health-related absence of more than 14 consecutive days. Failure to submit a claim prevents payment of the benefit as well as available leave—FML, sick, and annual —beyond day 14 of absence.
- The maximum short-term disability period is 90 days from the date of disability.
- The date of disability is the date at which you could no longer perform the duties of your position, irrespective of whether you were scheduled to work at that time.
- Short-term salary continuation payments begin after a 14-day elimination period. You must use your own leave —sick and/or annual—in order to receive pay during the elimination period.
  - » If you are not eligible and/or approved for FML, your elimination period begins on your first day of approved absence; your short-term salary continuation payments begin on week 3 of your absence.
  - » If you are approved for FML, your elimination period follows your 8 weeks of paid FML; your short-term salary continuation payments begin on week 11 of your absence.
- Short-term salary continuation payments are paid at 100% of your regular weekly earnings and through the normal payroll process.

Long-Term Disability Insurance

- If you are unable to work after 90 days, the STD benefit transitions to Long Term Disability (LTD).
- The LTD Benefit pays 60% of your monthly earnings to a maximum benefit payment of $12,500 per month.
- Benefits are paid by NYL GBS on a monthly basis.
- The maximum benefit duration is Social Security Normal Retirement Age.

Claim Filing Procedures

How to report a Disability claim

- Contact NYL GBS as soon as you know you will need to be out of work for more than 14 consecutive days.
  - » NYL GBS offers a Telephonic Claim intake at 1-888-842-4462. During this 7-to-10-minute call, you will be able to complete your portion of the claim and give a HIPAA compliant voice signature.
  - » While we recommend filing your claim telephonically, you can choose the option of submitting the claim online at: www.newyorklife.com/group-benefit-solutions/forms
- Advise your manager of your need for absence as soon as the need is known. Keep your manager updated during your absence.

Family Medical Leave

The Family Medical Leave (FML) Act requires employers of a certain size to provide up to 26 weeks of job and benefit protected leave to eligible employees. You are eligible for FML if you have worked for the Diocese for one year, have worked at least 1,250 hours during the previous year, and you have a qualifying reason.

What are the reasons for taking Family Medical Leave?

FML is granted to care for a new child after birth, adoption, or foster care placement; to care for a spouse, child, or parent who has a serious health condition; or to care for yourself if you have a serious health condition. Additionally, you may qualify if you are the spouse, child, parent, or next of kin of a service member called to active duty and need leave for a qualifying "exigency".

Filing a FML claim

To file a FML claim, call the Leave of absence specialist (LOA specialist) at 703-841-3857 or email the LOA specialist at **loa@arlingtondiocese.org**. Please also notify your direct supervisor of your need to be absent.

When does FML start?

FML begins on the first day of absence and runs concurrently with other paid leave benefits, including short-term disability, workers' compensation, and use of your own paid time-off leave. The Employee Benefits Office will send you a letter with additional FML information, including start and end dates and required documentation.

Need more information about Family Medical Leave?

To find out about FML, please contact the LOA office at 703-841-3857 or via email at loa@arlingtondiocese.org.

Employee Assistance & Wellness Support

Our Employee Assistance & Wellness Support program, provided through New York Life Group Benefit Solutions, provides professional, confidential counseling visits, as well as referrals and other information at no additional cost to you.

Our suite of value-add resources includes:

Life Assistance Program

- You and your family members have access to various counseling services including legal, financial, and work-life balance assistance.
- All counseling calls are answered by a Master's or PhD-level counselor who will collect some general information and will discuss your needs.
- This program provides a maximum of three sessions, per issue, per year.

GuidanceResources®

- Visit **guidanceresources.com** for resources and tools on topics such as health and wellness, legal regulations, family and relationships, work and education, money and investments, and home and auto.
- Also includes access to articles, podcasts, videos, slideshows, on-demand trainings and "Ask the Expert" which provides personal responses to your questions.

Well-being Coaching

- Get the help you need with personal challenges and physical issues that can be overwhelming, such as burnout, time management, and coping with stress.
- You have access to five sessions per year and all sessions are conducted telephonically.

FamilySource®

- Help resolve the everyday concerns of home, work and family.
- This resource provides access to family care service specialists that provide customized research, educational materials and prescreened referrals for child care, adoption, elder care, education, and pet care.

Getting Help

You don't have to handle your problems alone. Get the help you need by calling toll-free at 1-800-344-9752 or go online at guidanceresources.com. (Web ID: NYLGBS)

Financial, Legal & Estate Support

New York Life Group Benefit Solutions offers a suite of value-add resources, including:

FinancialConnect®

- You and your family members have unlimited access to a team of qualified experts to help guide you. If additional help is needed, you can request referrals to financial professionals in your local community.
- In addition, **guidanceresources.com** includes access to financial information on a wide range of topics including debt management, estate planning, family budgeting and tax planning as well as interactive tools and financial calculators.

LegalConnect®

- This program gives you access to unlimited phone consultations with a staff of attorneys who can provide guidance on issues such as divorce, adoption, estate planning, real estate, and identity theft.
- If needed, you can be referred to a local attorney for a free 30-minute consulation and a 25% reduction in fees thereafter.
- You can also find information on low and no cost legal options along with referrals to consumer advocacy groups and governmental organizations if needed.

EstateGuidance®

- This user-friendly online tool allows you and your family members to write a last will and testament, a living will and documents outlining your wishes for final arrangements quickly, easily and cost effectively.
- Access is available anytime, anywhere via tablet, desktop, or mobile app.

guidanceresources.com (Web ID: NYLGBS)

Call 1-800-344-9752, Monday through Friday from 9:00 a.m. to 6:00 p.m. ET (6:00 a.m. to 3:00 p.m. PT) to speak with a representative.

All you'll need to give is the name of your employer. You can also visit guidanceresources.com (Web ID: NYLGBS) for more information, or to register and access online tools and educational resources and create legal documents.

Travel Assistance Program

What if I...

- Forget my prescription medication when I am traveling?
- Become sick or injured while I'm traveling?
- Lose my passport?
- Need a physician referral during my holiday?
- Need information about visa & passport requirements?
- Need information about local customs?
- Need an emergency cash transfer?
- Need to evacuate due to a natural disaster or political unrest?

Your Travel Assistance Program can help!

Travel Assistance is an invaluable service that is provided and administered by International Medical Group Travel Assistance Services. IMG offers full-time employees (regularly scheduled to work 30 hours per week) medical, travel financial and legal services, 24 hours a day, 365 days a year, if traveling 100 or more miles from home, up to 180 days.

How do I access Travel Assistance?

Your ID card is included on page 37. IMG Assistance Services can be accessed 24/7/365 via the following:

Phone:	Email:
US: 1-855-847-2194 International: 1-317-927-6881	assist@imglobal.com

Before you travel, see page 37 in the appendix for instructions on downloading the IMG App.

Retirement

The Diocese recognizes our shared responsibility in planning your future. The organization shares this important responsibility with you by providing a foundation of retirement income as well as opportunities to supplement that income through your own savings.

The Diocese provides two plans to help you reach your retirement goals: The 403(b) Tax Deferred Savings Plan (403(b) Plan) and the Lay Employees' Retirement Plan (Pension Plan).

403(b) Plan

The Catholic Diocese of Arlington provides a 403(b) plan that is 100% funded by you, the employee. There is not a company match in the 403(b) plan. We consider the 403(b) plan as your contribution to your retirement. The 403(b) plan provides you with a mechanism to save for your retirement on a pre-tax basis.

You may contribute up to 92% of your pay to your 403(b) account. Please consider your benefit deductions before you set a percentage contribution. Please keep in mind that the IRS limits
the amount of pre-tax money you can set aside annually. The IRS contribution limits can be found in the back of this guide for the current year, or you may review them on the IRS website.

Eligibility for the 403(b) Plan

To be eligible to participate in the 403(b) Plan, you must be scheduled to regularly work 20 hours or more per week.

Enrolling in the 403(b) Plan

To enroll in the 403(b) Plan, you must log on to Empower's website and create your account.

Please visit **https://participant.empower-retirement.com/participant/#/login** and click Register to get started.

Registration will be available the week after you receive your first paycheck.

Contributing to the 403(b) Plan

To initiate a contribution to your 403(b) account through payroll deductions, you must log on Empower's website and select a contribution rate. Please keep in mind that the IRS limits the amount of pre-tax money you can set aside annually. Please see page 29 for these contribution limits. Exceeding the IRS limits may result in fines.

You may elect a flat dollar contribution or a percentage contribution. You may increase, decrease, stop and re-start contributions at any time by visiting

https://participant.empower-retirement.com/participant/#/login

Empower Retirement Counselors

If you are eligible to participate in the 403(b) Plan, counselors at Empower are available to provide guidance.

See page 2 for the Empower phone number.

403(b) Plan Required Minimum Distributions (RMDs)

As long as you are working 20 or more hours per week on a regular basis you will be eligible to continue contributing to your 403(b) account. You will not be required to begin distributions out of your 403(b) account until after you have terminated all employment with the Diocese and you are age 73.

403(b) Account Beneficiaries

It is very important that you provide beneficiary information for your 403(b) account in the event of your passing. Beneficiary information for your 403(b) account is maintained by Empower — not the Employee Benefits Office.

To enter or update your beneficiary information for your 403(b) account, please log in to your account on Empower's website by visiting **participant.empower-retirement.com/participant/#/login.**

Pension Plan

The Catholic Diocese of Arlington provides a pension plan that is 100% funded by the Diocese. The pension plan is the Diocese's contribution to your retirement. The pension plan provides vested employees with a lifetime benefit payment. At your retirement, your compensation and years of eligible service are used to calculate a monthly payment. This payment continues for the duration of your lifetime. Spousal benefits are offered as well. Note, however, that spousal benefits do not include coverage for domestic partners or same-sex marriages.

Your work location makes contributions on your behalf to the Pension Plan. Employees do not contribute to the pension plan.

Employees of Catholic Charities (CCDA) have a separate retirement plan. CCDA employees should visit ccda.net or contact the CCDA HR office to learn more.

For detailed information regarding the pension plan, including a sample calculation, please see the Retirement Guide in Dayforce in the Benefits/Overview/File section.

Eligibility for the Pension Plan

Eligibility is based on eligible paid hours in the fiscal year, July 1 - June 30. You must have at least 800 eligible paid hours in the fiscal year to receive a year of service.

Years of service for the plan will be determined in two parts: Part A (prior to July 1, 2024) and Part B (July 1, 2024 and after). Service completed under the former provisions of the plan will be "frozen" as of June 30, 2024 and remain credited to you. Part B, beginning July 1, service will be earned for each fiscal year in which you are paid at least 800 eligible hours. No fractional years of service are credited.

Enrollment in the Pension Plan

As a diocesan lay employee, you don't need to do anything. You will automatically be enrolled in our Pension Plan when you become eligible.

Vesting in the Pension Plan

You are vested in the plan after five years of eligible service.

Changes in Employment Status & Pension Eligibility

You will earn a year of service if you have 800 eligible paid hours in the fiscal year. Your classification of employment will not affect your pension status.

Leave of Absence

A paid or unpaid leave of absence can have an impact on your service accrual.

Disability

If you become disabled and have completed at least five years of pension eligible service, you continue to accrue service in the pension plan as long as you are receiving benefits from our diocesan disability plan.

Estimating your Pension Benefit

The Employee Benefits Office mails pension statements annually to all participants in the pension plan. The statements show your accrued benefit and your projected benefit at retirement, assuming you work until age 65. A sample calculation is provided in the Lay Employees' Retirement Guide.
Please note that EBO cannot do "What if" calculations if you are considering different dates for retirement.

Normal Retirement - Age 65

Age 60 with 30 years of pension service: If you are an active employee with 30 or more years of pension service at age 60, you may retire with full benefits and no payment reduction.

Age 55 with 10 years of pension service: If you are at least age 55 with 10 or more years of pension service, you may begin your pension benefit early. Early retirement benefits are reduced by 5/12% for each month (5% per year) that your retirement precedes age 65.

Note: If you are not in either category above, you are not eligible to begin your pension payments early.

If You Die Before You Retire

If you are vested (have five or more years of service) and die before you retire, and you are married or have dependent children, your surviving spouse/children may be eligible for a benefit from the Plan.

Terminating Employment

If you terminate employment after July 1, 2024, and you have...

Less than 5 years of eligible service: You are not entitled to a benefit from the plan because you have not satisfied the plan's five-year vesting requirement. Should you be rehired within five years from your date of termination, this period of employment may count towards your pension eligible service.

5 years of eligible service: You are entitled to a benefit from the plan. Depending on the value of your accrued benefit, you may be eligible for an immediate lump sum payment, or you may have to defer receiving your benefit. Benefits are normally payable at age 65. The Employee Benefits Office will send you a final Deferred Vested Benefit Statement of your pension benefit 120 days after you terminate. You will no longer receive annual statements from EBO as your final statement will not change. Please notify the EBO if you have a change of address.

If You Are Rehired

If you terminate employment after at least one year of pension eligible service and are rehired later, your past service may be included in calculating your benefit, depending on the length of your break in service.

Health Benefits After Retirement

You are eligible to continue your medical, dental, vision, and life insurance coverage for yourself if you retire directly from active employment and have been enrolled in the diocesan health plans for a minimum of 36 consecutive months. Your dependents must have been enrolled in coverage a minimum of 12 consecutive months in order to continue their coverage. You must pay the full cost of the health coverage. Once you make your election, you may not increase coverage levels unless you experience an eligible Qualified Life Event (restrictions apply). Eligible dependents must be added within 30 days of the event. Premiums will increase to the appropriate coverage level.

Actively Working at Age 65 and Beyond

Pension Benefit

You have many options to consider as you approach age 65 if you are currently working. One of the decisions you may make is whether to continue working beyond age 65. If you decide you want to continue working, your years of service and compensation will continue to accrue and apply to your pension benefit. You may, however, decide that you want to be able to enjoy retirement, but you are not ready to stop working altogether. Many people will decide to work a few hours a week. If you reduce your work schedule to fewer than 20 hours per week, you will be offered retirement options, and your pension payments will start. Please keep in mind that once your pension payments start, you must limit your total paid hours in the fiscal year (July 1st to June 30th) to a maximum of 799. If you exceed 799 hours, your pension will be recalculated at the end of the fiscal year and appropriate adjustments made.

Medical Coverage

As long as you are actively working full-time, you and members of your family may defer enrolling in Medicare and continue to be covered by the Diocesan medical plan, regardless of age. However, you may want to consider the following to help you make your decision.

Enrolling in the Diocesan Medical Plan only:

Medicare will not penalize you for not enrolling in Medicare at age 65 as long as you are actively working and covered by your employer's group health plan and the health plan is deemed to provide creditable coverage. See the Medicare Part D Notice of Credible Coverage included in the appendix of this guide.

Enrolling in Medicare and Dropping the Diocesan Medical Plan: To replace diocesan medical coverage you must enroll in Medicare Part A (Hospitalization), Part B (Medical Insurance), and Part D Prescription Drug).

Please notify the EBO of your intent to enroll in Medicare and drop the diocesan medical plan. There is a 60 day deadline from the effective date of your Medicare coverage to end your diocesan medical plan.

Enrolling in Medicare and keeping the Diocesan Medical Plan: If you choose to enroll in Medicare and maintain your medical coverage through the diocese, your diocesan medical plan will continue to be the Primary insurance (Primary Payor) for you and your dependents.

Medicare will charge you a premium for your enrollment in Part B (Medical Insurance) and it will be a secondary Insurance (Secondary Payor) for you and your dependents. This means that claims will be processed through your diocesan medical plan first, and then it will be processed by Medicare.

If you do enroll in Medicare part A (Hospitalization), Part B (Medical Insurance) or Part C (Medicare Advantage), you need to notify the Employee Benefits Office so that we can adjust your medical plan to show Primary Payor and Secondary Payor correctly.

Leaving the Diocese

If your employment with the Catholic Diocese of Arlington ends, your benefits will terminate. You will receive a letter from the Employee Benefits Office outlining what happens to any benefits you may have such as health, life insurance, 403(b) Tax Deferred Savings, and the Pension Plan.

Medical, Dental, and Vision Benefits

Your benefits will end on the last day of the month in which your employment ends. We provide employees the option to enroll in our Continuation Coverage program in which you can elect to continue your medical coverage for up to 18 months. Vision and dental benefits may not be continued.

Continuation of medical benefits is NOT subject to the terms and conditions of COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended) since the Diocese's plan is a church-sponsored plan (26 CFR 54, 4980B-2).

You will have 60 days from your date of separation to enroll in the Continuation Coverage program.

Life Insurance

If you were a full-time employee, you participated in the life insurance plans and these plans will end at the end of the month in which you terminate employment.

As a result of your employment and Group Life Insurance coverage ending, you may be eligible to convert your basic coverage and port or convert your optional life coverage(s) with Prudential. To be eligible to port coverage, you must have been actively at work on the date employment ended. You must complete an application and apply for these options within 31 days of your coverage termination. To obtain an application, please contact Prudential at 1-800-778-3827.
Please provide the policy number (52141) when calling.

If you are using a telecommunications device for the hearing impaired (TDD), please call 1-800-496-1214. Representatives are available to assist you Monday through Friday between 8:00 a.m. and 8:00 p.m. ET.

403(b) Plan

If you were a full or part-time employee that participated in the 403(b) plan, please contact Empower at 1-833-961-5273, or access your account at **participant.empower-retirement.com/participant/#/login** to learn about your options.

Pension Plan

If you terminate employment…

Before one (1) year of service: You are not yet a participant in the plan. Should you be rehired at a later date, this period of employment will not count towards your pension eligible service.

Before five (5) years of service: You are not entitled to a benefit from the plan because you have not satisfied the plan's five year vesting requirement. Should you be rehired within five years from your date of termination, this period of employment may count towards your pension eligible service.

After five (5) years of service: You are entitled to a benefit from the plan. Depending on the value of your accrued benefit, you may be eligible for an immediate lump sum payment, or you may have to defer receiving your benefit. Benefits are normally payable at age 65. The Employee Benefits Office will send you a final Deferred Vested Benefit Statement of your pension benefit 120 days after you terminate. You will no longer receive annual statements from EBO as your final statement will not change. Please notify the EBO if you have a change of address.

Federal Notices and Provisions

Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the Catholic Diocese of Arlington to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. A copy of the HIPAA Privacy Notice is included in the appendix of this guide.

Special Enrollment Rights for Medical Insurance

The following rules apply under the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

- If you do not enroll in the medical plan at the time you are eligible because of other health insurance coverage, you may be eligible to enroll yourself or your dependents at a future date, provided that you request enrollment within 30 days after your other coverage ends.
- In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and/or your qualified dependents, provided that you request enrollment within 30 days after marriage, birth, adoption, or placement for adoption.

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

Effective April 1, 2009, if you or your dependent lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or you become eligible for a state's premium assistance program under Medicaid for CHIP, then you may be able to enroll yourself and/or your qualified dependent. You will have 60 days — instead of 30 — from the date of the Medicaid / CHIP event to request enrollment under the Plan. Note that this new 60-day extension does not apply to enrollment opportunities other than the Medicaid/CHIP eligibility change. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Newborn and Mother's Health Protection Act Notice

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicare Part D Notice of Creditable Coverage

The Catholic Diocese of Arlington has determined that the prescription drug coverage offered under its Cigna plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug plan will pay and is considered Creditable Coverage. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

A copy of the Medicare Part D Notice of Credible Coverage is included in the appendix of this guide.

Women's Health and Cancer Rights Act of 1998

Your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for an appropriate mastectomy and related services (including reconstruction and surgery) to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call Cigna Member Services at the number on your ID card for more information.

A Note about Legal Notices

A complete set of Federal Legal Notices can be found on Dayforce in the Benefits/Overview/File section.

Appendix

A. Health Benefits Dependent Eligibility Definition
B. IRS Contribution Limits for 403(b)
C. Plan Year Health Plan Premium Rates
D. ID Card – MetLife Dental Plan
E. ID Card – Vision Service Plan (VSP)
F. Travel Intelligence App
G. Federal Notices
   - Patient Protection for Surprise Billing Notice
   - SBC: Summary of Benefit Coverage
   - Government Marketplace Coverage Notice
   - HIPAA Privacy Notice
   - Medicare Part D Prescription Creditable Coverage Notice

Catholic Diocese of Arlington
Encourage and teach with patience

Dependent Eligibility Definition

ELIGIBLE DEPENDENT CATEGORY
Spouse "Marriage" means only a legal union between one man and one woman as husband and wife, and the word "spouse" refers only to a person of the opposite sex who is a husband or a wife. Common law spouses and domestic partners are not covered. If your spouse is also an employee of the diocese, you may enroll in individual coverage or as a dependent on your spouse's coverage. You may not enroll as an individual and a dependent.
Child(ren) Age 0 to 26 Dependent children, **until the end of the month in which they turn 26**, *without regard to marital status, student status, or financial dependency,* include: • A son, daughter, stepson, or stepdaughter of the employee; or • An eligible foster child of the employee (eligible foster child means an individual who is placed with the employee by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction); or • An adopted child of the employee (a legally adopted individual of the employee, or an individual who is lawfully placed with the employee for legal adoption by the employee, shall be treated as a child); or • A grandchild for whom the employee has been awarded guardianship or custody by a court of competent jurisdiction; or • Children under the legal guardianship of employee; or • Children under a recognized qualified medical child support order (QMCSO). If your child under age 26 also works for the Diocese and is eligible for enrollment in the health plans, he or she may enroll as an employee or as a dependent child. You cannot be covered as an employee while also covered as a dependent of an employee.
Disabled Child(ren) Over Age 26 Your unmarried children who are primarily supported by you and are incapable of self-sustaining employment by reason of a mental or physical disability that began before the child reached age 26 while covered under this plan or while covered under another plan with no break in coverage. This category may require the completion of certain forms with the insurance carrier within 31 days. Please contact EBO for the form.

By adding a dependent to the benefit plans, you have confirmed that you understand the definition of an eligible dependent. The Diocese reserves the right to randomly audit dependent eligibility and require documentation. If ineligible dependents have been added to the plans and documentation cannot be provided, the enrollment for this person will be reversed and the financial responsibility for all incurred claims will be reversed from the benefit plans and will become the responsibility of the employee.

IRS Contribution Limits for 403(b)

403(b) Plan IRS Contribution Limits for 2025

The Internal Revenue Service (IRS) has announced 2025 contribution limits for tax deferred plans under Section 403(b) of the Internal Revenue Tax Code (IRC). The amount of money you can contribute will depend on your age.

- The general limit for employees under age 50 is $23,500
- The limit for employees ages 50 to 59 is $31,000 (includes a catch-up contribution of $7,500)
- The limit for employees ages 60 to 63 is $34,750 (includes a catch-up contribution of $11,250)
- The limit for employees age 64 and older is $31,000

If you would like to enroll, decrease, or increase your contribution, please complete your transaction on the Empower web site at **participant.empower-retirement.com/participant/#/login**. Directions for how to make changes can be found on Dayforce in the Benefits section under Files. Please refer to the Guide to Empower On-line Services for instructions.

Plan Year Rates

Employee Premiums March 01, 2025 - February 28, 2026		
Lay Medical Plan	***Monthly Premiums***	***Per Pay = twice per month***
Individual	$ 253	$126.50
Individual + 1	$ 505	$ 252.50
Individual + Family	$ 765	$ 382.50

Dental Plan	***Monthly Premiums***	***Per Pay = twice per month***
Individual	$14.00	$7.00
Individual + 1	$28.00	$14.00
Individual + Family	$42.00	$21.00

Vision Plan	***Monthly Premiums***	***Per Pay = twice per month***
Individual	$11.02	$5.51
Individual + 1	$20.00	$10.00
Individual + Family	$29.00	$14.50

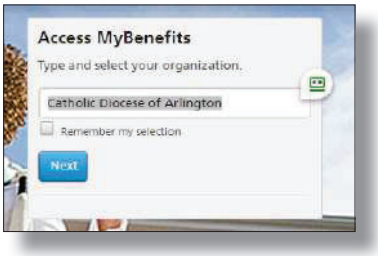
Insurance premiums are the same for all employees, regardless of work or payment schedule. Missed insurance premiums (during the summer or otherwise) will be placed into arrears when an employee does not receive pay or have enough pay to cover the entire deduction. Upon return to active pay, a percentage of the arrears will be collected in addition to the standard premium until paid in full. The arrears collection will not exceed 34% of the regular premium per paycheck. Employees who separate from employment with an arrears balance will have the balance deducted automatically from their final paycheck(s).

ID Cards – MetLife Dental Plan

How to Access Dental ID Cards

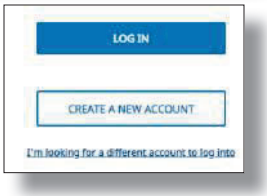
Desktop

Dental ID cards are available online for you to download and print at your convenience. Cards contain your name, employer's name and group number. Also included are MetLife's claims submission address, website address, and customer service telephone number.

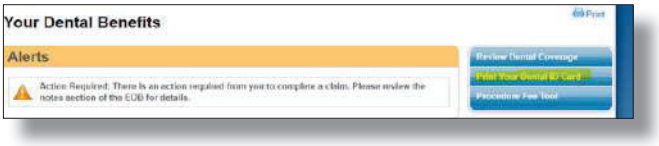


- **Step 1:** Visit metlife.com/mybenefits.
- **Step 2:** Type Catholic Diocese of Arlington in the Access My Benefits box, select your organization and click Next.
- **Step 3:** Select Log In if you have already created an account previously. Enter your Username and Password to access MyBenefits. You also have the ability to recover/reset your Username and Password from this screen.

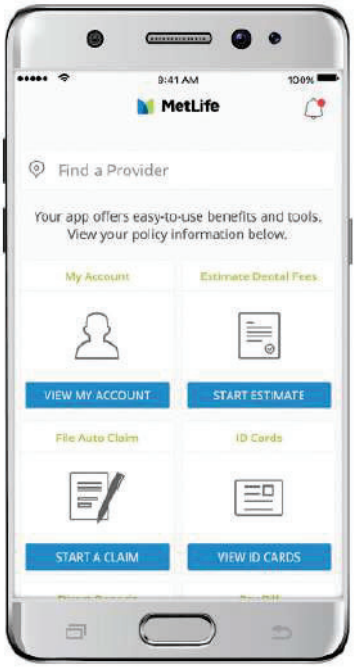
  OR Create a New Account if you are a new user and follow the steps to validate your identity.



- **Step 4:** Once logged into MyBenefits, your Dental coverage will be available to view. Click on the Dental Plan link or use the drop down to Print a Dental ID card.



Mobile App



With MetLife's Mobile App, employees who prefer a digital service experience can securely and easily view and manage their benefits information on their mobile device and view ID cards. The MetLife Mobile App is available for free in the Apple App Store or Google Play Store. Download the app, and use it to find a participating dentist, view your claims and to see your ID card.

- **Step 1:** Go to the Apple App Store or Google Play Store and search for MetLife US App or scan the QR below:

Apple App Store

SCAN ME

Google Play Store

SCAN ME

- **Step 2:** Once the Mobile App is downloaded, select Log In if you have already created an account previously. Enter your Username and Password to access MyBenefits. You also have the ability to recover/reset your User Name and Password from this screen.

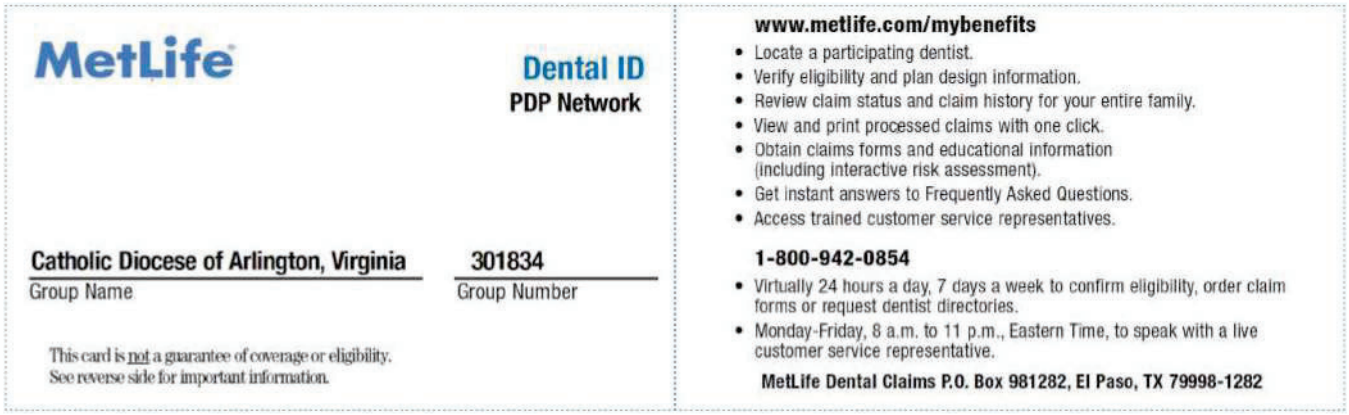
  OR Create a New Account if you are a new user and follow the steps to validate your identity.

- **Step 3:** Click View ID Cards

Available 24 hours a day, seven days a week.

Dental ID Card

Dental ID Card


MetLife

Dental ID
PDP Network

Catholic Diocese of Arlington, Virginia
Group Name

301834
Group Number

This card is not a guarantee of coverage or eligibility.
See reverse side for important information.

www.metlife.com/mybenefits

- Locate a participating dentist.
- Verify eligibility and plan design information.
- Review claim status and claim history for your entire family.
- View and print processed claims with one click.
- Obtain claims forms and educational information (including interactive risk assessment).
- Get instant answers to Frequently Asked Questions.
- Access trained customer service representatives.

1-800-942-0854

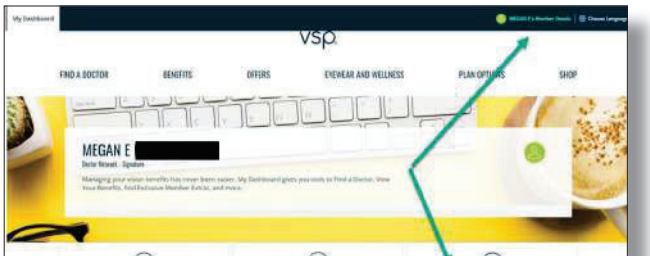
- Virtually 24 hours a day, 7 days a week to confirm eligibility, order claim forms or request dentist directories.
- Monday-Friday, 8 a.m. to 11 p.m., Eastern Time, to speak with a live customer service representative.

MetLife Dental Claims P.O. Box 981282, El Paso, TX 79998-1282

ID Cards – Vision Service Plan (VSP)

How to Access Vision ID Cards

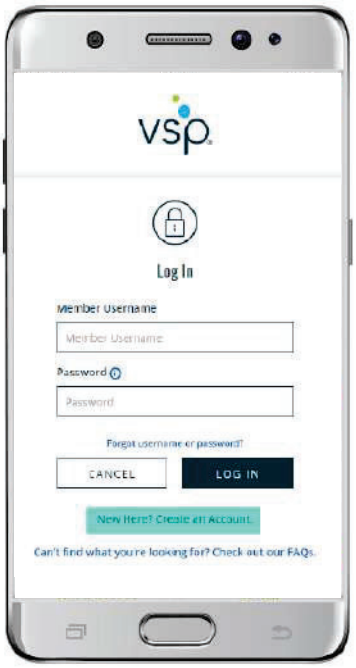
Desktop



It's easy to create an account on vsp.com. Just follow these steps:

- **Step 1:** Visit vsp.com.
- **Step 2:** Click on CREATE AN ACCOUNT at the top of the page
- **Step 3:** Enter the last 4 digits of the primary member's Social Security Number or Member ID Number, continue to complete all required fields and click on CREATE AN ACCOUNT to complete the process.
- **Step 4:** When you log-in, click the View Member ID Card under the Member ID Card tile, or select Member Details in the top right corner and select which plan member you want to view. Once you click, you will see a preview of your Member ID Card. To print your card, select the link to the right. If you want to save the card to access on your smartphone, select Save under Member ID Card.

Mobile App



The VSP® app is available for free in the Apple App Store or Google Play Store. Updated with a streamlined login process, the app features easier navigation and a personalized member dashboard to mirror the look and feel of your dashboard on vsp.com.

- **Step 1:** Go to the Apple App Store or Google Play Store and search for VSP Vision Care or scan the QR below:

Apple App Store

SCAN ME

Google Play Store

SCAN ME

- **Step 2:** Once the Mobile App is downloaded, select Log In if you have already created an account previously. Enter your Username and Password. You also have the ability to recover/reset your User Name and Password from this screen.

  OR click New Here? Create an Account if you are a new user and enter the last 4 digits of the primary member's Social Security Number or Member ID Number. Continue to complete all required fields and click Create an Account.
- **Step 3:** Click Member ID Card

Available 24 hours a day, seven days a week.

Vision ID Card

Vision ID Card

Client Catholic Diocese of Arlington
Doctor Network VSP Signature
Group ID 12204637
Copays
Exam $10
Materials $0

To find a VSP provider near you, visit **vsp.com** or call **800.877.7195**.

See the difference great vision can make.

Let us help you:

- find the right provider for you,
- keep your eyes healthy with a WellVision Exam®,
- love how you look in great eyewear,
- save money!

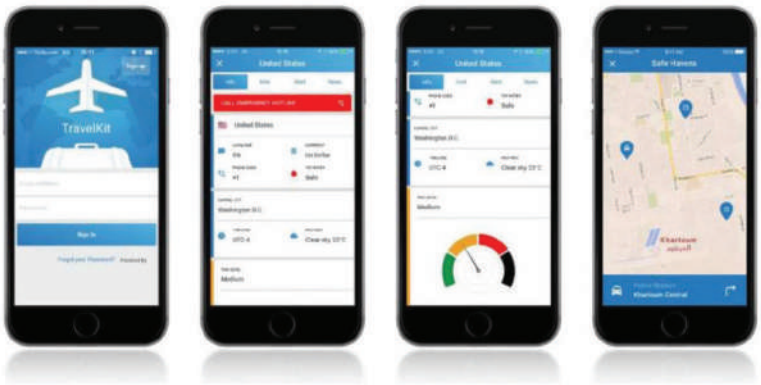
This card isn't required for service and doesn't guarantee benefit eligibility. It's for use by VSP members. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

VSP Vision care for life and WellVision Exam are registered trademarks of Vision Service Plan.

Travel Intelligence App

Keeping You Safe with IMG's Travel Intelligence App

Full-time employees (regularly scheduled to work 30 hours or more per week) can stay informed of safety and security issues worldwide, or reach out for help, all from TravelKit, the IMG Travel Intelligence mobile app. TravelKit provides you with detailed threat intelligence and security advice on locations and territories globally and alerts you to security incidents or disruptions so you can avoid risks and minimize threats. This standalone mobile app allows you to minimize your exposure to risks, avoid threats and easily connect with emergency contacts if necessary. Due to the app's geolocation capabilities, it is as beneficial when at home or abroad, notifying you of risks and disruptions in your area.



Benefits of the App Include:

Country Intelligence: Immediate access to intelligence for over 200 countries and territories that includes informative quick-reference risk indicators and in-depth information on topics such as security issues, transportation, cultural factors, and environmental concerns.

Alerts: Be promptly notified of any safety, security and travel-related incidents in your location, for any other locations on your itinerary, or for countries to which you have subscribed.

Emergency Hotline: Request assistance at any time by calling an emergency hotline via a single click.

Itinerary: Load your itinerary and flight numbers into the app and be notified of any major delays or cancellations regarding your travel.

Health Intelligence: Research your destination before traveling so you can be informed of health risks, recommended inoculations and the level of health care infrastructure and support.

Pre-trip Checklist: With the itinerary added, you are automatically prompted to ensure your passport and insurance documentation is in place for your trip.

Download and Access

TravelKit, the IMG Travel Intelligence App, is available from the Apple App Store and on Google Play for Android. Search and download "TraveKit" in your mobile app store. Once you have downloaded the app, please enter registration code PRUDENTIALIMG1 to proceed with the setup.

Apple App Store

SCAN ME

Google Play Store

SCAN ME

IMG Travel Assistance ID Card

IMG Travel Assistance ID Card

Federal Notices

Patient Protection for Surprise Billing Notice

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for the service. This is called **"balance billing"**. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. The document is intended only to provide clarity to the public regarding existing requirements under the law.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the federal government for information and complaints. The phone number is 1-800-985-3059.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

SBC – Summary of Medical Benefit Coverage

Government Marketplace Coverage Notice

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 201 3 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 EMPLOYEE BENEFITS OFFICE: ebo@arlingtondiocese.org or (703) 841-2588.

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name: **CATHOLIC DIOCESE OF ARLINGTON**		4. Employer Identification Number (EIN)
5. Employer Address: **200 NORTH GLEBE ROAD, SUITE 205**		6. Employer Phone Number: **(703) 841-2588**
7. City: **ARLINGTON**	8. State: **VIRGINIA**	9. Zip Code: **22203-3728**
10. Who can we contact about employee health coverage at this job? **EMPLOYEE BENEFITS OFFICE**		
11. Phone number (if different from above)		12. Email Address: **ebo@arlingtondiocese.org**

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:

    Employees regularly scheduled to work 30 or more hours per week
- With respect to dependents:
  - √ We do offer coverage. Eligible dependents are:

    Wife, husband, children under age 26, children over age 26 if financially dependent due to handicap, legally adopted children, eligible foster children, children for whom employee has legal guardianship and children under a qualified medical child support order.
  - □ 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.

HIPAA Privacy Notice

Catholic Diocese of Arlington
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information (PHI), includes virtually all individually identifiable health information held by the Plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the following plans: **Group Medical, Dental, and Vision Care Plans.** The plans covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It is important to note that these rules apply to the Plan, not the Diocese as an employer — that is the way the HIPAA rules work. Different policies may apply to other Diocese programs or to data unrelated to the health plan.

How the Plan may use or disclosure your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one (1) or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*

- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing, as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

- **Health Care Operations** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs.*

The amount of health information used, disclosed, or requested will be limited and, when needed, restricted to the "Minimum Necessary" to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes (generally, eligibility determinations, premium computations, application of pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of health benefits), the Plan will not use or disclose PHI that is your genetic information for such purposes. Genetic information includes information regarding genetic tests for you and your family members, information regarding the manifestation of a disease or disorder in you or your family members, and any request for (or receipt of) genetic services, including participation in clinical research trials that involve genetic services. The Plan may contact you to provide appointment reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest to you, as permitted by law.

How the Plan may share your health information with the Diocese

The Plan, or its Health Insurer or HMO, may disclose your health information without your written authorization to **the Diocese** for plan administration purposes. The Diocese may need your health information to administer benefits under the Plan. The Diocese agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. **Authorized Employee Benefits, Human Resource, Chancery, and Fiscal Management Office employees** are the only Diocese employees who will have access to your health information for plan administration functions.

Here is how additional information may be shared between the Plan and the Diocese, as allowed under the HIPAA rules:

- The Plan, or its Claims Administrator, Insurer or HMO, may disclose "summary health information" to **the Diocese** if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information have been removed.

- The Plan, or its Claims Administrator, Insurer or HMO, may disclose to the Diocese information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that the Diocese cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the Diocese from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is *not* protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization, including any use or disclosure of any psychotherapy notes or PHI for marketing purposes. The Plan also will not accept any remuneration, direct or indirect, for the use or disclosure of your PHI without your authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Effective February 17, 2010, an entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment of health care operations if you have paid for the item or service, in full out of pocket.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set" (including obtaining electronically maintained information in an electronic format). This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You also may request that copies of your health information be sent to another entity or person, so long as that request is clear, specific and directs where the copies are to be sent. Any charge that is assessed to you for providing copies, if any, must be

reasonable and based on Plan costs.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes, or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;
- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures. " You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request. You do not have a right to receive an accounting of any disclosures made:

- for treatment, payment, or health care operations;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a "limited data set", (health information that excludes certain identifying information).

In addition, if the Plan maintains electronic health records, you may, to the extent required by law, receive an accounting of disclosures made for treatment, payment, or health care operations, during the three years before the date of your request. For this purpose, an "electronic health record" is generally a record that contains health-related information for an individual which is gathered and consulted by authorized health care clinicians and staff.

Your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to receive notice of breaches of unsecured protected health information

You have the right to receive notice from the Plan of any unauthorized access, use, or disclosure (called a "breach") of your unsecured PHI within 60 days of the discovery of the breach. If the breach affects more than 500 individuals in a state or other jurisdiction, notice also will be provided through one or more prominent media outlets in the area. The notice will describe what happened (including the date of the breach and the date the breach was discovered), the type of PHI involved, steps you should take to protect yourself, and steps the Plan will take to mitigate any harmful effects from the breach and to protect against future breaches.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the Privacy Notice currently in effect. This notice takes effect on **September 23, 2013**. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised Privacy Notice, which **will be mailed to you at your home address.**

Complaints

If you believe your privacy rights have been violated, or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint, **you must do so in writing and direct it to the Complaint Manager: Director of Human Resources, Catholic Diocese of Arlington, Employee Benefits Office, 200 N. Glebe Road, Suite 205, Arlington, VA 22203**.

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, including your rights to restrict disclosure of, receive confidential communications of, inspect or copy, amend, or receive an accounting of disclosure of your health information, contact: **Director of Human Resources, Catholic Diocese of Arlington, Employee Benefits Office, 200 N. Glebe Road, Suite 205, Arlington VA 22203**.

Additional Contacts

The following is a list of key persons or offices you may need to contact to exercise your rights under the HIPAA privacy rule for different benefit plans offered by the Diocese.

	Restricted Disclosures	Confidential communications	Access to or copies of your health information	Amendment of your health information	Accounting of disclosures
Catholic Diocese of Arlington Group Health Care Plan	*For all inquiries, please contact:* **Catholic Diocese of Arlington** **Employee Benefits Office** **200 North Glebe Rd. Suite 205** **Arlington, VA 22203** **703-841-2588**				
Catholic Diocese of Arlington Group Dental Care Plan					
Catholic Diocese of Arlington Group Vision Care Plan					

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Medicare Part D Prescription Drug Creditable Coverage Notice

REQUIRED FEDERAL NOTICES

LAY EMPLOYEES/RETIREES OF THE CATHOLIC DIOCESE OF ARLINGTON

NOTICE OF CREDITABLE COVERAGE

Important Notice from the Catholic Diocese of Arlington about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Catholic Diocese of Arlington and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. There is also information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans with prescription drug coverage. All Medicare prescription 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 Catholic Diocese of Arlington has determined that the prescription drug coverage offered under its Cigna plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug plan will pay and is considered **Creditable Coverage. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.**

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year between October 15th and December 7th. Beneficiaries leaving employer coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should carefully compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Please review the following categories:

- If you are a Lay retiree age 65 or older, your prescription drug coverage under the diocesan group plan will terminate the last day of the month prior to your retirement. You must enroll in a Medicare prescription drug plan.
- If you are a Lay retiree under age 65, your prescription drug coverage under the diocesan group plan will terminate the last day of the month prior to your 65th birthday, which corresponds to your Medicare eligibility date. When first eligible, you must enroll in Medicare Parts A and B and a Medicare prescription drug plan.
- If you are an active Lay employee age 65 or older, you do **not** need to enroll in a Medicare prescription drug plan until you retire or terminate from employment. As long as you are actively employed, your diocesan group plan is primary for you and, because our coverage is deemed "Creditable," you will not pay a premium penalty when you do enroll in a Medicare prescription drug plan.

You should also know that if you cancel or lose your coverage with the Catholic Diocese of Arlington and are eligible for Medicare and do not enroll in a Medicare prescription drug plan after your current coverage ends, you will pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's standard prescription drug coverage, your monthly premium will increase at least 1% per month for every month that you did not have

coverage. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next open enrollment in November to enroll.

For more information about this notice or your current prescription drug coverage: Call our office at (703) 841-2588. NOTE: You may receive this notice at various times in the future: annual open enrollment, prior to your Medicare eligibility, and if the diocesan plan changes. You may request a copy.

For more information about your options under Medicare prescription drug coverage: More detailed information about Medicare plans that offer prescription drug coverage is available in the **"Medicare & You 2023"** handbook. You can also get more information from these places:

- Visit www.medicare.gov,
- Call your State Health Insurance Assistance Program
  (See your copy of the **Medicare & You** handbook for their telephone number), or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users, call 1-877-486-2048.

For people with limited income and resources, help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) on-line at www.socialsecurity.gov, or by phone at 1-800-772-1213 (TTY users call 1-800-325-0778).

Remember: KEEP THIS NOTICE. When you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium.

Date:	October 2023
Sender:	Catholic Diocese of Arlington
Contact:	Employee Benefits Office
Address:	200 North Glebe Road, Suite 205, Arlington, VA 22203-3728
Phone:	(703) 841-2588
E-mail:	ebo@arlingtondiocese.org

This communication highlights some of the benefit plans available at Catholic Diocese of Arlington. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. The Diocese reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.