CATHOLIC DIOCESE OF ARLINGTON
2023 Lay Employees' Benefit Guide

1/1/2023

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 - 3337438	Cigna	1-800-244-6224	myCigna.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
Health Savings Account (HSA)	HSA Bank	1-800-357-6246	askus@hsabank.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	EBO	703-841-2588	Email: ebo@arlingtondiocese.org
403(b) Plan	Prudential/Empower	1-877-778-2100	prudential.com/online/retirement
	Flagship Financial Partners UBS	1-888-435-6930	—
Pension Plan	EBO	703-841-2588	Email: ebo@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.

New Hire and Open Enrollment enrollments are made exclusively online in Dayforce. You will see an enrollment link on your benefits page when you are eligible to enroll.

Mid-Year Qualified Life Events and Employment Status changes (part-time to full-time) must be made by paper submission to the Employee Benefits Office. The form for these changes is located in the back of this guide. No forms will be accepted for new hire enrollment or open enrollment.

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 date of hire or the date you become a regularly scheduled full-time employee. If you are a new contracted employee, you have 30 days including your contract effective date to enroll – the contract effective date is the 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 received by the Employee Benefits Office (EBO) 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 status change.

During Open Enrollment

Open Enrollment occurs annually in January for an effective date of March 1. Beginning January 1, 2021, open enrollment is offered online in Dayforce.

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 status change.

How much will you pay for benefits?

Health Benefits Premiums are found in the Appendix on page 30. 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.

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

You must submit your Mid-Year Enrollment Change Form to the Employee Beefits Office within 30 days of the status change to make a change to your benefit elections.

Your enrollment period begins on the date your status change occurs.

Contact the Employee Benefits Office at 703-841-2588 if you have any questions.

Medical Plan

The Diocese offers a comprehensive Medical Plan to keep you and your family in good health. **Cigna Choice Fund Open Access Plus** is a high deductible health plan with an associated Health Savings Account (HSA). For information on how the HSA works, please go to page 11.

The table below highlights your coverage under the Medical Plan. Please note that the benefit plan year runs from March 1 to February 28/29.

Need Assistance?

If you have a question about your medical coverage or need assistance with a claim, please call Cigna at **1-800-244-6224**.

You may also access your claims, print temporary ID cards, search for a participating provider, and more at **myCigna.com.**

Plan Features	In-Network Benefits	Out-of-Network Benefits
Annual Deductible *Annual amount you must pay before the health plan begins to pay benefits. The deductible applies to all services unless copay is applied or otherwise noted.*	Individual $1,500 Family $3,000	Individual $2,650 Family $5,300
Annual Out-of-Pocket Maximum	Individual $2,650 Family $5,300	Individual $5,300 Family $10,600
Physician's Office Visit Primary doctor and specialists Allergy testing and injections	80%, after deductible 80%, after deductible	60%, after deductible 60%, after deductible
Preventive Care Routine adult annual physical exams Routine well child physical exams/immunizations Routine gynecological care Routine mammograms and cancer screenings	100%, no deductible	60%, after deductible
Laboratory Services (Diagnostic tests, labs, x-rays)	80%, after deductible	60%, after deductible
Inpatient Hospital Facility (semi-private room, board, tests, medications)	80%, after deductible	60%, after deductible
Outpatient Facility Services	80%, after deductible	60%, after deductible
Emergency Medical Care* Urgent Care Facility Emergency Room	80%, after deductible 80%, after deductible	80%, after deductible 80%, after deductible
Maternity Care (pre-natal and post-natal)	80%, after deductible	60%, after deductible
Mental Health Services Inpatient and Outpatient	80%, after deductible	60%, after deductible
Home Health Care 120 days maximum per plan year 16 hour maximum per day *(includes outpatient private duty nursing days when approved as medically necessary)*	80%, after deductible	60%, after deductible

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

Plan Features	In-Network Benefits	Out-of-Network Benefits
Hospice Care - Inpatient	80%, after deductible	60%, after deductible
Hospice Care - Outpatient	80%, after deductible	60%, after deductible
Skilled Nursing Facility *Limited to 100 days per calendar year*	80%, after deductible	60%, after deductible
Outpatient Short-Term Rehabilitation **Per Plan Year Maximums:** • *Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, and Chiropractic Care - 60 days* • *Cardiac Rehabilitation - 36 days*	80%, after deductible	60%, after deductible
Durable Medical Equipment	80%, after deductible	60%, after deductible
Prescription Drugs **Retail** - *up to 30 day supply* Generic Preferred Brand Non-Preferred Brand **Home Delivery** - *up to 90 day supply* Generic Preferred Brand Non-Preferred Brand	$0 Preventive $10 copay, after deductible $30 copay, after deductible $45 copay, after deductible $20 copay, after deductible $60 copay, after deductible $90 copay, after deductible	Not Covered

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.

Do I need a referral to see a specialist?
No, you do not need a referral to see a specialist.

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 Cigna 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 Cigna ID card.

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

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

- **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.
- **Preferred Brand** is your middle copay option. Use a preferred brand drug if no generic drug is available to treat your condition.
- **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. If a generic equivalent is available, you will pay the non-preferred brand copay plus the cost difference between the non-preferred brand and the generic drug.

Preventive Medications: The deductible and copays are waived for certain preventive medications. For a list of these drugs, please call the number on the back of your Cigna ID card for more information.

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 Cigna's drug list for your routine prescriptions.

Specialty Medications through Accredo Pharmacy: These medications require precertification.

Step Therapy

Step Therapy is a part of the Cigna prescription drug program that requires pre-authorization of certain medications. This means that certain medications will require approval by Cigna 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, Cigna 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, Cigna may ask the doctor if a generic or lower-cost alternative could be prescribed for you before allowing the higher 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.

Are you taking a Step Therapy medication? Go toCigna.com/druglist to look up your medication. If there is an (ST) next to your medication, then it is part of the Step Therapy program.

Cigna 90 Now

For routine maintenance medication, 90 day prescriptions can now be filled at certain 90-day retail pharmacies in Cigna's pharmacy network. Cigna's network of 90-day retail pharmacies includes local pharmacies, grocery stores, retail chains and wholesale warehouse stores. For more information visit Cigna.com/RX90network.

Cigna Home Delivery Pharmacy

If you prefer to have your medication delivered, the Cigna Home Delivery Pharmacy will deliver your maintenance medication to the location of your choice. Standard shipping is free. For more information call customer service at 1-800-835-3784, or visit cigna.com. On the main menu, choose Prescriptions and then Manage Prescriptions.

Cigna Virtual Care - Telehealth Connection

Cigna Virtual Care Telehealth Connection provides access to telehealth services where you can get the care you need—including most prescriptions—for a wide range of minor conditions. Now you can connect with a board-certified doctor via secure video chat or phone, without leaving your home or office. And the cost of a phone or online visit is the same or less than with your primary care provider, and will be applied to your deductible.

MDLive through myCigna	mycigna.com	888-726-3171

Speak with a doctor for help with:

- » sore throat
- » fever
- » rash
- » headache
- » cold and flu
- » acne
- » stomachache
- » allergies
- » UTIs and more

Register today:

- » Step 1 - Set up and create an account with MDLive
- » Step 2 - Complete a medical history using their "virtual clipboard"
- » Step 3 - Download vendor apps to your smartphone/mobile device

When: Day or night, weekdays, weekends and holidays.
Where: Home, work or on the go.
How: Phone or video chat.

Cigna Total Behavioral Health Benefit

If you or your dependent has been diagnosed with a behavioral health condition, it can be hard to know where to turn for help. **Cigna Total Behavioral Health** is a comprehensive program that provides dedicated support, lifestyle coaching, and educational tools. Many of Cigna's mental health services are offered at no additional cost.

Anxiety disorders
Autism spectrum disorders (ASD)
Attention deficit disorder (ADD, ADHD)
Depression
Eating disorders

Mental Health Support

Lifestyle management programs
Parenting, childcare, and adoption
Post-traumatic stress disorder (PTSD)
Stress management
Substance abuse disorders

Call the number on the back of your Cigna ID card for more information.

Cigna Diabetes Prevention Program with Omada

Omada is a lifestyle change program that combines the latest technology with ongoing support, so you can make the changes that help you lose weight and reduce the risks of type 2 diabetes and heart disease.

- » Eat Healthier
- » Increase Activity
- » Overcome Challenges
- » Strengthen Habits

You'll get your own:

- **Interactive Program**
- **Wireless Smart Scale**
- **Weekly Online Lessons**
- **Professional Omada Health Coach**
- **Small Online Group of Participants**

It is covered at the preventive level, so you'll receive the program at no additional cost if you or your covered adult dependents are at risk for diabetes or heart disease, and are accepted into the program. Call the number on the back of your Cigna ID card for more information.

Take Omada's 1-minute health screener to see if you're eligible: **Omadahealth.com/arlingtondiocese**

myCigna.com

myCigna.com is your starting point for answers to questions about your health care, types of treatment, cost of services, and more.

Your online account gives you access to these features:

Find Care and Costs
Search for in-network providers, procedures, cost estimates, and more!

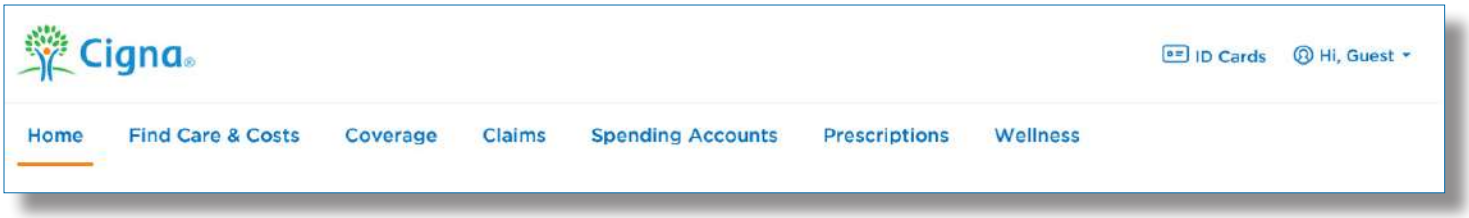
View Claims
See a list of your most recent claims, their status and reimbursements.

Manage Your Prescriptions
Refill & request new prescriptions, and track your orders so you know when they will arrive.

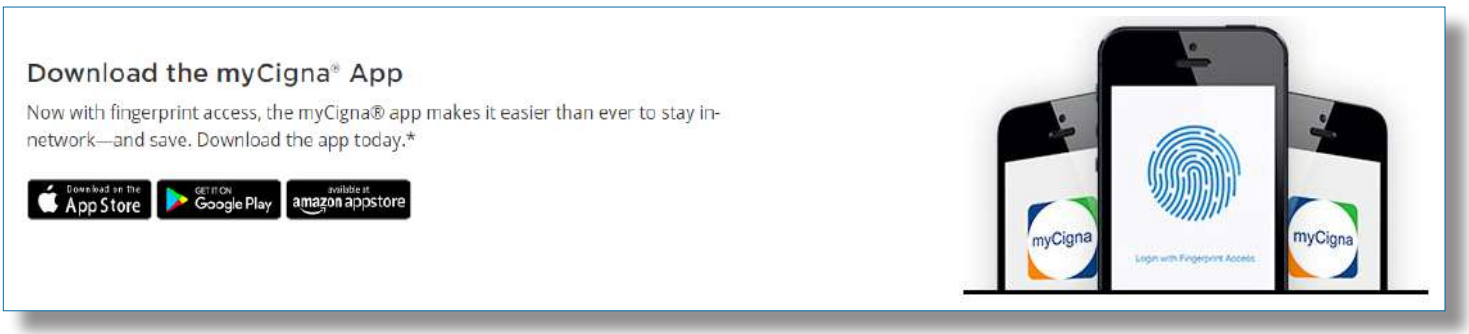
Manage Spending Accounts
Review your spending account balances, contributions, and withdrawals all in one place.

Update Your Profile
Make sure your contact information is up-to-date so you don't miss out on important notifications about your plan.

Use the menus at the top and bottom of the home page to easily move around myCigna:



myCigna® Mobile App



How the HSA Works

What is a Health Savings Account?

A Health Savings Account (HSA) is a savings account designed to help you pay for health care expenses and save on taxes. You have to be enrolled in the Diocesan high-deductible medical plan to participate in the health savings account. Money that is put into an HSA is tax deductible. As long as you use it to pay for eligible health care expenses, you don't pay any taxes when you take the money out. Any money that you don't use can be saved for future health care expenses.

Who may have an HSA?

You may enroll in an HSA if you are enrolled in the Diocesan medical plan and you meet certain IRS eligibility requirements. You are excluded from participation if you: have other health coverage that is not a high-deductible plan; you are enrolled in Medicare; your spouse participates in a Flexible Spending Account; or you can be claimed as a dependent on someone else's tax return.

How do I enroll in an HSA?

You do not need to submit a bank application to open a Health Savings Account. When you are enrolled in the Diocesan medical plan with an HSA, Cigna will forward your information to HSA Bank and your health savings account will automatically be opened. HSA Bank will send you a welcome kit and a debit card.

The USA Patriot Act requires the bank to conduct a Customer Identification Process (CIP). This process, which generally takes 2 to 3 days, involves verifying your name, Social Security Number, date of birth, and address. HSA Bank will contact you directly if it requires additional information to complete its verification. If the bank does not receive the necessary information, your health savings account will be closed.

Using your Medical Benefits

When you go to the doctor, you will need to show the office staff your Cigna Medical ID card. You should not pay anything at the doctor's office at the time of your visit. You should allow Cigna to process your claim before you pay any part of the claims.

How do I put money into my HSA?

There are three ways to fund your HSA:

- Pre-tax payroll deductions – you can choose to contribute funds out of each paycheck, or you may make a "one-time" contribution. You may start, stop, or change your contribution amount at any time or make several "one-time" contributions during the year. If you are a new hire or newly eligible, complete the HSA Payroll Deduction Form found in the Appendix on page 28 and submit to the EBO. Enrollments and changes made during open enrollment are submitted exclusively online through Dayforce and become effective March 1st.
- You (or someone else) can deposit after-tax money directly into your HSA account at the bank and account for the deposit on your tax return. Call the HSA bank for the deposit form.
- Earn money in your HSA by completing Wellness Incentives in our Cigna Wellness plan. A Wellness Program Guide can be found in Dayforce. On your Home Page, click Benefits then scroll down to Files.

How much money can I put in to my HSA?

The IRS limits the amount of funds that can be put into your HSA each year. The limits are tied to your age and the level of medical coverage you have (Individual or Family Coverage). 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 web site.

What can I use my HSA funds for?

You can pay any eligible health care-related expenses with your HSA, such as deductibles, copays, and coinsurance.

How do I pay for these costs with my HSA?

You will be issued a debit card (and checks, if elected) by the bank when your HSA is opened. Once there are funds in your account, you may use your card when paying for prescriptions and copays. You may provide the debit card number on bills received from your doctor or you may use an ATM to reimburse yourself. Be sure to keep your receipts for the IRS and monitor your account balance on myCigna.com; if you have a negative balance, the bank will close your account.

What happens to money that I don't use?

All funds in your account are yours to keep. The funds roll over year to year, and you take the funds with you if you leave the diocese.

Are there additional resources available?

Please refer to IRS Publications 502 and 969 for information about HSAs. You will also want to review Instructions for IRS Form 8889. These resources can be found on the IRS web site.

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 use 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 34.

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. 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.

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 VSP 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 36.

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.

Claims Mailing Address:
VSP
PO Box 385018
Birmingham, AL 35238-0518

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. 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.

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 March 1	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 illness or injury. The Diocese provides this benefit to full-time employees at no cost, through New York Life Group Benefit Solutions (NYL GBS).

Summary of Benefits

Short-Term Salary Continuation under Disability

- Short-term salary continuation begins after seven days of continuous absence (including weekends) due to illness or injury.
- After day seven (7), absence must be reported to NYL GBS in order to be paid available sick leave.
- Beginning day eight (8), accrued sick and vacation leave is used first, then the remainder of short-term salary continuation is paid at the Short-Term Disability (STD) rate of 100% of weekly earnings (not to exceed a maximum benefit of $1,000 per week).
- Benefits are paid through the normal payroll process.
- The maximum short-term disability period is 90 days.
- The date of your disability is the date you are no longer able to perform the duties of your job, whether or not you are scheduled to work (e.g. during summer break for teachers).

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

- Seek appropriate medical attention immediately.
- Tell your manager on or before your first day out of work.
- When you know you will be out of work for more than seven days in a row, please contact NYL GBS as soon as possible at 1-888-842-4462.
- NYL GBS offers Telephonic Claim intake for all employees of Catholic Diocese of Arlington. During this call, an employee will be able to complete the entire portion of his/her claim and give a HIPAA compliant voice signature. The call typically lasts 7-10 minutes and ensures the quickest possible disability turnaround time.
- While we recommend filing your claim telephonically, you can also complete the online claim form at **newyorklife.com/group-benefit-solutions/forms**.

Family Medical Leave

The Family Medical Leave (FML) Act requires employers of a certain size to provide up to 12 weeks of unpaid leave for eligible employees. You are eligible for FML if you have worked for the Diocese for one year, and have worked at least 1,250 hours during the previous 12 months. FML provides you with up to 12 weeks of unpaid, job protected leave annually for certain family and medical reasons. FML protects your job and your benefits for the approved period.

What are the reasons for taking Family Medical Leave?

FML is granted to care for a new baby after birth or adoption; to care for a spouse, son, daughter, or parent who has a serious healthy condition; or to care for yourself if you have a serious health condition. Additionally, you may qualify if you are the next of kin of a service member called to active duty, or who is deployed in support of a contingency operation.

Filing a FML claim

To file a FML claim, call the Employee Benefits Office (EBO) at **703-841-2588** or email the EBO at **ebo@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 the short-term disability plan in most cases. The Employee Benefits Office will send you a letter with additional FML information, including the start and end dates.

Need more information about Family Medical Leave?

To find out about FML, please contact the EBO at 703-841-2588 or via email at ebo@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 38. 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 web site.

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 Prudential's website and create your account. Please visit **prudential.com/online/retirement** and click Register Now to get started.

Please refer to the document titled Guide to Prudential Online Services found on Dayforce in the Benefits/Overview/File section for easy-to-follow instructions for setting up your account.

Contributing to the 403(b) Plan

To initiate a contribution to your 403(b) account through payroll deductions, you must log on Prudential'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. 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 **prudential.com/online/retirement**.

Prudential Retirement Counselors

If you are eligible to participate in the 403(b) Plan, counselors at Prudential are available to provide guidance. See page 2 for the Prudential 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 Prudential —not the Employee Benefits Office.

To enter or update your beneficiary information for your 403(b) account, please log in to your account on Prudential's website by visiting **prudential.com/online/retirement**.

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 eligible employees with a lifetime benefit payment. Your work location makes contributions on your behalf to the Pension Plan. Employees do not contribute to the pension plan.

Eligibility for the Pension Plan

To be eligible for the pension plan, you are required to be a diocesan lay employee and regularly work 20 hours or more per week.

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.

As an eligible employee, you begin to accrue service for this plan effective with your date of hire or the date you become eligible due to a status change. You become a participant in the plan after one year of eligible service. You are vested in the plan after five years of service. At your retirement, your compensation and years of service are used to calculate a monthly payment. This payment continues for the duration of your lifetime. Spousal benefits are offered as well. Spousal benefits do not include coverage for domestic partners or same-sex marriages.

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

***PLEASE NOTE:** Empower has purchased Prudential's retirement business. At this time, we have not transitioned to Empower's computer platform, but you will see their name brand on the Prudential web site.*

Enrollment in the Pension Plan

You will automatically be enrolled in our pension plan when you become eligible.

Vesting in the Pension Plan

When you are vested in the pension plan, you are promised a retirement payment. To be vested, you need to work 20 or more hours on a regular basis for a period of five (5) years or more. You become vested after completing five (5) years of service from your pension service date. Changing your employment status to fewer hours per week or terminating employment can have an effect on your vesting status.

Pension Service Date

The pension service date is the date you become eligible to accrue pension service. This date can be your date of hire or the date you first become eligible for the pension. You will see your pension service date in the upper right hand corner of the pension statement mailed to you each year.

If you leave employment for a period of time or you work in a non-eligible position for a period of time, your pension service date will be adjusted to reflect these breaks in pension eligible service. Certain rules will apply depending on the length of your break in service. In some cases, previously accrued service can be forfeited because the break in service was too long.

If you have any questions about your pension service date, please email the Employee Benefits Office (EBO) to request a review of your service date. These types of reviews can take several weeks because your entire work history and paychecks are reviewed. The EBO will communicate their final decision about your pension service in a letter to your home. This communication will supersede any previous communication on this matter.

Changes in Employment Status & Pension Eligibility

As an eligible employee, working 20 or more hours per week on a regular basis, you will accrue service years in the pension plan. You become vested in the plan when you have continued this level of work hours (or more) for five years. When you are vested, you are promised a retirement payment.

If you decrease your hours worked per week, you will no longer be eligible to participate in the pension plan and continue to build service years. You will want to keep your pension in mind as you make changes to your work schedule.

EXAMPLE: An instructional assistant is hired for 25 regular hours per week. She is enrolled and begins to accrue pension service time. She works these hours every week for four entire school years. In her fifth year of employment, she works as an occasional substitute teacher and works 10 hours every month. The period of time she worked as a substitute teacher is not added to her years of pension service. At the end of five years, she has four years of pension eligible service and she is not vested in the plan.

Please note that the pension calculation is an income average multiplied by a pension plan factor and then multiplied by the years of service. See page 22 for a sample calculation. The years-of-service is an important number in this calculation. It is determined by reviewing your pension eligible periods of work. In other words, it is based on periods when you worked 20 or more hours per week on a regular basis.

Please also note that temporary, occasional and seasonal positions are not pension eligible positions because they are not considered regular hours worked and are arranged on a temporary basis.

Leave of Absence

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

Estimating Your Pension Benefit

The Employee Benefits Office mails pension statements annually during the summer months to all participants in the pension plan. The statement shows your accrued benefit and your projected benefit at retirement, assuming you work until age 65. A sample calculation is provided on page 22. **Please note that EBO cannot do "what if" calculations if you are considering different dates for retirement.**

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.

Normal Retirement - Age 65

If vested, you may begin receiving your retirement benefits at your normal retirement date, which is the first of the month following the date you attain age 65.

Approaching Age 65

The normal retirement age of 65 is also the age of eligibility for Medicare. When you are eligible for Medicare, there are many things to consider. You will receive literature in the mail regarding Medicare and its different parts. You may be wondering if you are ready to retire from the diocese or you may wish to continue to work, but, are unsure if you should enroll in Medicare or stay in the diocese's health plan. To learn more about your options as you approach the age of Medicare eligibility, please refer to "*Appendix B: The World of Medicare*" in the Lay Employees' Retirement Guide.

Retiring Before Age 65

You may retire as early as age 55 if you have 10 years of service. Early retirement benefits are reduced by 5/12% for each month (5% per year) that your retirement precedes age 65. If you have 30 or more years of service at age 60, you may retire with full benefits and no payment reduction.

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…

Before 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 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 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.

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 health plan coverage 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 coverage. You must pay the full cost of the health coverage and, once you make your election, you may not increase coverage levels unless you experience a Qualified Life Event (e.g. marriage). 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 cannot work more than 19 hours per week on a regular basis. If this happens, your retirement payments will stop and your service will resume accruing.

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 Cigna only: 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.

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.

Be mindful of Medicare enrollment deadlines when you decide to enroll later. Medicare will charge you higher premiums if you have a gap in coverage.

Enrolling in Medicare and dropping Cigna: 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 Cigna. 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 Cigna: 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.

If you choose to enroll in Medicare, you will not be eligible to contribute your own money, or accept employer contributions, to a Health Savings Account.

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.

Sample Pension Calculation

Your Pension Plan Benefit payment amount depends on two things:

- Final average compensation (as shown on your W-2)
- Years of service (a minimum of five years is required)

Final Average Compensation is the Lesser of:

- The average of the highest five consecutive calendar years out of the last ten years before termination, or
- The average of completed calendar years after December 31, 2007, if an employee had worked at least five full calendar years after December 31, 2007.

Employee Example:

- Retirement Age = 65
- Years of Service = 20
- Final Average Compensation = $36,000

Pension Calculation Example:

- 1.35% times $36,000 = $486.00
- $486.00 times 20 years of service = $9,720.00 annual benefit
- $9,720.00 divided by 12 = $810.00 monthly benefit

Benefit Payment Options for Sample Calculation:

	Employee Benefit	Spousal Benefit	Certain & Continuous Beneficiary
■ Single Life Annuity	$810.00	None	None
■ Joint & Survivor Annuity			
Joint & Survivor 50%	$769.50	$384.75	n/a
Joint & Survivor 75%	$745.20	$558.90	n/a
Joint & Survivor 100%	$729.00	$729.00	n/a
■ Certain & Continuous Annuity			
Certain & Continuous 5	$801.90	n/a	$801.90
Certain & Continuous 10	$785.70	n/a	$785.70
Certain & Continuous 15	$753.30	n/a	$753.30

Benefit Payment Options

SINGLE LIFE ANNUITY: This option pays a monthly pension to you during your lifetime only. When you die, all payments stop and no further payments are made to anyone else. This option provides you with the highest lifetime monthly benefit.

JOINT & SURVIVOR ANNUITY: This option gives you a monthly income for your lifetime. If you die before the spouse you name as your joint annuitant, your spouse will continue to receive payments for his or her lifetime. Section 1.32 of the Plan Document defines a spouse as "only an individual who is of the opposite sex to the Participant." *Once you have named a survivor annuitant under this option, no other person may be named as your annuitant at a later date, even if you should remarry.*

You may choose to have your surviving spouse receive 100%, 75%, or 50% of the monthly benefit you receive during your lifetime. The benefits under this option are payable for two lifetimes, so the amount of monthly income is always less than if it were payable to you alone under a single life annuity. In addition, the higher the percentage you choose to have paid to your survivor, the lower will be your benefit during your lifetime.

CERTAIN AND CONTINUOUS ANNUITY: This option guarantees a monthly retirement income to your beneficiary for a certain number of years after you retire. You may choose 5, 10, or 15 years as the guaranteed period. If you die before receiving all the payments for the guaranteed period, the remainder is paid to your beneficiary, if living, or to your estate. If you are still alive after the expiration of the guaranteed period, you will continue to receive your retirement benefit for the rest of your life. By guaranteeing a payout period, your monthly benefit will be less than it would be if it were paid to you under a single life annuity. ***Once you have named a beneficiary under this option, no other beneficiary may be named after pension payments have begun. If you are married and choosing this option, you must have your spouse's notarized consent on the Joint and Survivor Annuity Waiver. This form must be completed even if you name your spouse as a beneficiary under this option.***

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.

Health Savings Account

If you had a Health Savings Account (HSA) associated with the medical plan, you will no longer be eligible to make payroll contributions to your account or receive employer funding. You can continue to use the funds in your account for future health care expenses. You will receive a packet from H.S.A. Bank confirming that your account is no longer associated with the Catholic Diocese of Arlington health plan. You may contact H.S.A. Bank customer service via telephone at 1-800-357-6247.

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 Prudential at 1-877-778-2100, or access your account atprudential.com/online/retirement 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

Intent to Remain a Grandfathered Health Plan

The Catholic Diocese of Arlington believes the medical coverage is a "Grandfathered Health Plan" under the Patient Protection and Affordable Health Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **ebo@arlingtondiocese.org**.

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. They are also included on pages 23-24 and in the Appendix of this guide.

Appendix

A. Health Benefits Dependent Eligibility Definition
B. Health Savings Account (HSA) Death Beneficiary Form
C. Health Savings Account (HSA) Payroll Deduction Form
D. IRS Contribution Limits for HSA and 403(b)
E. Plan Year Health Plan Premium Rates
F. ID Card – Cigna Medical Plan and MyCigna.com
G. ID Card – MetLife Dental Plan
H. ID Card – Vision Service Plan (VSP)
I. Travel Intelligence App
J. ID Card – Travel Intelligence
K. Federal Notices
   - Patient Protection for Surprise Billing Notice
   - SBC: Summary of Benefit Coverage
   - Government Marketplace Coverage Notice
   - HIPAA Privacy Notice
   - Wellness Program Privacy Notice
   - Medicare Part D Prescription Creditible Coverage Notice

NOTE:

- Mail HSA Bank Death Beneficiary Form directly to HSA Bank, as the form indicates. Do not send it to EBO.
- Fax all other forms directly to EBO at 703-358-9216.
- For your own personal security, please do not email forms due to the sensitive information on the forms.

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.

Health Savings Account Death Beneficiary Form

hsabank
A Division of Webster Bank, N.A., Member FDIC

Mail to HSA Bank, P.O. Box 939, Sheboygan, WI 53082. Do not send forms to EBO.

Step1: Accountholder Information

*=Required Fields

*Employer Name (If sponsored by an employer plan)

*Accountholder Name (First, MI, Last)

*Social Security Number

*Day Telephone

*Birth Date (MM/DD/YYYY)

Step 2: Designation of Beneficiary(ies)

☐ **New Beneficiary(ies)** -- The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). **If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary.**

☐ **Replace Beneficiary(ies)** -- I designate the individual(s) or entity named below as my primary and/or contingent beneficiary(ies) of this HSA and hereby revoke all prior beneficiary(ies) designations, if any, made by me.

☐ **Add Beneficiary(ies)** -- I designate the individual(s) or entity named below as my primary and/or contingent beneficiary(ies) of this HSA. This list supplements, but does not replace, the beneficiary(ies) previously designated by me on the date specified.
(When adding beneficiaries, if the share % of previously designated beneficiary(ies) changes, restate all beneficiaries and the corresponding share % if the previous percentages are no longer correct.)

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If any primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rata basis. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my HSA.

If you designate your spouse as primary beneficiary or contingent beneficiary of the HSA, the dissolution, termination, annulment or other legal termination of your marriage will automatically revoke such designation.

Name and Address (or of Trust and Trustee)	Date of Birth (mm/dd/yyyy) (creation date, if Trust)	Social Security Number (TIN, if Trust)	Relationship	Primary or Contingent	Share%
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%

Step 3: Marital Status

☐ I Am Not Married - I understand that if I become married in the future, I must complete a new HSA Death Beneficiary Form.

☐ I Am Married - I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below in the presence of a notary public.

I am the spouse of the above-named Accountholder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional. I hereby give the HSA Beneficiary any interest I have in the funds or property deposited in this HSA and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by HSA Bank.

*Spouse Signature | Date | *Signature of Witness (Required. Cannot be spouse. Must be 18 or older.) | Date

*Acountholder Signature | Date | *Signature of Witness (Required. Cannot be spouse. Must be 18 or older.) | Date

State of _____

County of _____

On this, the _____ day of _____, 20____, before me, a notary public, the undersigned officer, personally appeared _____, the spouse of the above named accountholder, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

_____
Notary Public

FORM_HSA_Death_Benificiary_112414

Catholic Diocese of Arlington
Encourage and teach with patience

Health Savings Account (HSA) Payroll Deduction Form

Fax Completed Forms & Documentation To:
(703) 358-9216

INSTRUCTIONS

- COMPLETE THIS FORM TO START, STOP OR CHANGE YOUR PAYROLL DEDUCTION TO YOUR **HSA.**
- PLEASE KEEP THIS FORM FOR YOUR FILES.

A. Account Holder Information

LAST NAME		FIRST NAME	MIDDLE INITIAL
DAYFORCE USERNAME / CLOCK #		PHONE # (DAY)	PHONE # (EVENING)
STREET ADDRESS			
CITY	STATE	ZIP CODE	
WORK LOCATION (E.G. ST. AGNES, BISHOP IRETON HIGH SCHOOL, ETC.)			
EMAIL ADDRESS:			

B. Payroll Deduction Request

☐ I WISH TO AUTHORIZE/CHANGE A BI-WEEKLY CONTRIBUTION TO MY **HSA** IN THE AMOUNT OF: $_____.

☐ I WISH TO MAKE A ONE-TIME CONTRIBUTION TO MY HSA IN THE AMOUNT OF: $_____.

☐ I WISH TO STOP CONTRIBUTIONS TO MY HSA ACCOUNT.

C. Signature

X_____ _____ _____

Signature | Print Name | Date Signed

IRS Contribution Limits for 403(b) and HSA

403(b) Plan IRS Contribution Limits for 2023

The Internal Revenue Service (IRS) has announced 2023 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 $22,500
- The "Catch Up" amount for employees age 50 and older is $7,500.
- The total for calendar year 2023 is $30,000

If you would like to enroll, decrease, or increase your contribution, please complete your transaction on the Prudential/Empower web site. Directions for how to make changes can be found on Dayforce in the Benefits section under Files. Please refer to the Prudential Guide to Online Services for instructions.

Health Savings Account IRS Contribution Limits for 2023

The Internal Revenue Service (IRS) has announced 2023 contribution limits for health savings accounts. The amount of money you can contribute will depend on your level of plan coverage.

- Employee Only Coverage = contribution maximum is $3,850
- Employee + One Coverage = contribution maximum is $7,750
- Family Coverage = contribution maximum is $7,750
- Catch up contribution = Age 55+ only = $1,000

Please note that this maximum must include **ALL** contributions. You will need to consider your employer's contribution and any incentive monies earned in this total.

The payroll department will not monitor your contributions nor will the payroll system stop your deductions when you reach the maximum. You should monitor the year to date contributions. If you exceed the IRS limit in this account, the difference may be taxable income and there may be penalties imposed by the IRS.

If you would like to begin contributing, decrease or increase your payroll contributions, please complete a Health Savings Account Payroll deductions form and fax it to the Benefits Office at 703-358-9216. The payroll deduction form can be found on Dayforce in the Benefits section under Files. Deductions will begin in the next available pay cycle.

Plan Year 2023 Rates - March 2023 through February 2024

Employee Premiums		
Medical Plan with HSA	***Monthly Premiums***	***Per Pay = twice per month***
Individual	$254.00	$127.00
Individual + 1	$509.00	$254.50
Individual + Family	$761.00	$380.50

Medical Plan without HSA	***Monthly Premiums***	***Per Pay = twice per month***
Individual	$233.00	$116.50
Individual + 1	$459.00	$229.50
Individual + Family	$715.00	$357.50

Dental Plan	***Monthly Premiums***	***Per Pay = twice per month***
Individual	$13.70	$6.85
Individual + 1	$27.30	$13.65
Individual + Family	$41.00	$20.50

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). See the following page for a real-life example.

Example:

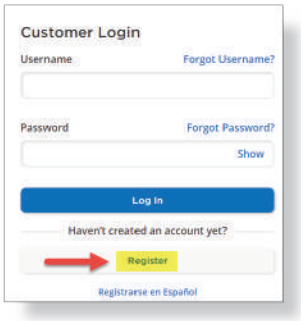
An active school employee does not work or receive pay during the summer. The employee has individual medical coverage, which will remain active during the summer. The employee's medical premium deductions would be as follows for the plan year:

Paycheck Date	Pay Type	Regular Paycheck Premium Due	Regular Paycheck Premium Paid	Premium Placed in Arrears	Arrears Collection = 34% of Regular Premium	Total Premium Paid from Paycheck
March 3, 2023	Reg Pay	$127	$127	$0		$127
March 17, 2023	Reg Pay	$127	$127	$0		$127
April 14, 2023	Reg Pay	$127	$127	$0		$127
April 28, 2023	Reg Pay	$127	$127	$0		$127
May 12, 2023	Reg Pay	$127	$127	$0		$127
May 26, 2023	Reg Pay	$127	$127	$0		$127
June 9, 2023	Reg Pay	$127	$127	$0		$127
June 23, 2023	Reg Pay	$127	$127	$0		$127
July 7, 2023	No Pay	$127	$0	$127		$0
July 21, 2023	No Pay	$127	$0	$127		$0
August 4, 2023	No Pay	$127	$0	$127		$0
August 18, 2023	No Pay	$127	$0	$127		$0
1-Sep-2023	Reg Pay	$127	$127	$0	$43	$170
15-Sep-2023	Reg Pay	$127	$127	$0	$43	$170
13-Oct-2023	Reg Pay	$127	$127	$0	$43	$170
27-Oct-2023	Reg Pay	$127	$127	$0	$43	$170
10-Nov-2023	Reg Pay	$127	$127	$0	$43	$170
24-Nov-2023	Reg Pay	$127	$127	$0	$43	$170
8-Dec-2023	Reg Pay	$127	$127	$0	$43	$170
22-Dec-2023	Reg Pay	$127	$127	$0	$43	$170
5-Jan-2024	Reg Pay	$127	$127	$0	$43	$170
19-Jan-2024	Reg Pay	$127	$127	$0	$43	$170
2-Feb-2024	Reg Pay	$127	$127	$0	$43	$170
16-Feb-2024	Reg Pay	$127	$127	$0	$33	$160
TOTAL		**$3,048**		**$508**	**$508**	**$3,048**

ID Cards – Cigna Medical Plan & MyCigna.com

Enjoy a simple way to personalize, organize and access your important plan information.

Register on myCigna.com. Once you do, you can log in anytime, just about anywhere to:



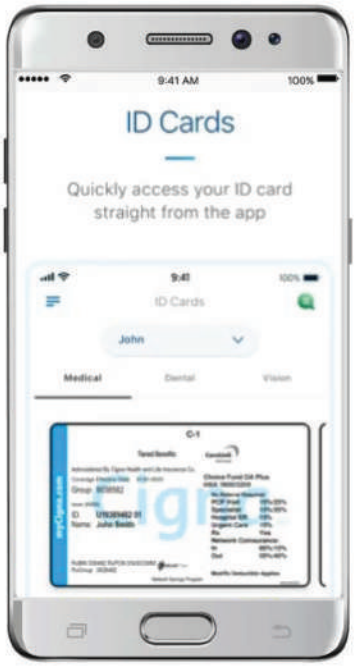
- Manage and track claims
- View ID card information
- Find in-network doctors and compare cost and quality ratings
- Review your coverage
- Track your account balances and deductibles
- Order your Cigna Home Delivery
- Pharmacy℠ prescriptions online and view order history

After you register, you can set up paperless communications. Just log in to myCigna.com and select "Go Paperless".

Register today! Visit myCigna.com or download the myCigna® App.

Mobile App

The Cigna mobile app helps customers like you manage your health, while on the go. Download on the App Store or Get It on Google Play.



iTunes® App Store

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Google Play

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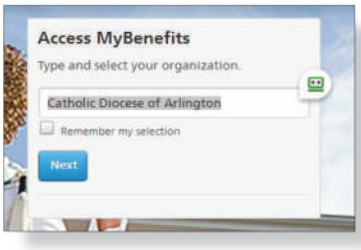
ID Cards – MetLife Dental Plan

Dental ID Cards

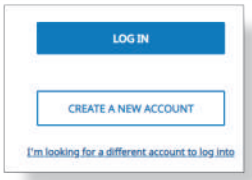
Desktop

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.

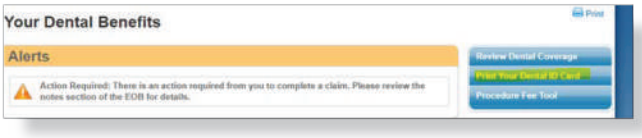


- **Step 1:** Visit www.metlife.com/mybenefits
- **Step 2:** Type Catholic Diocese of Arlington in the Access My Benefits box, select your organization and click Next
- **Step 3:** Select Log In if you have already created an account previously. Enter your Username and Password to access MyBenefits.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

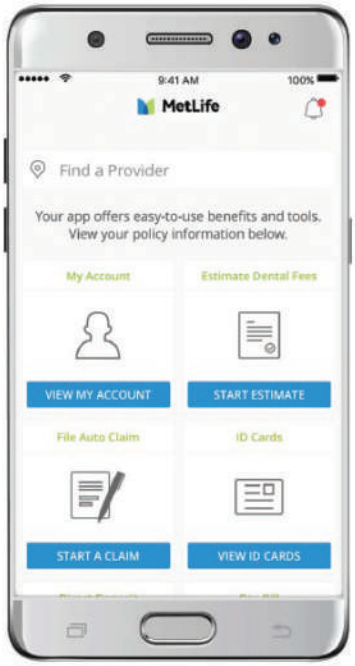
  OR Create a New Account if you are a new user and follow the steps to validate your identity.



- **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 on the iTunes® App Store and Google Play. Download the app, and use it to find a participating dentist, view your claims and to see your ID card.

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

iTunes® App Store

SCAN ME

Google Play

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.

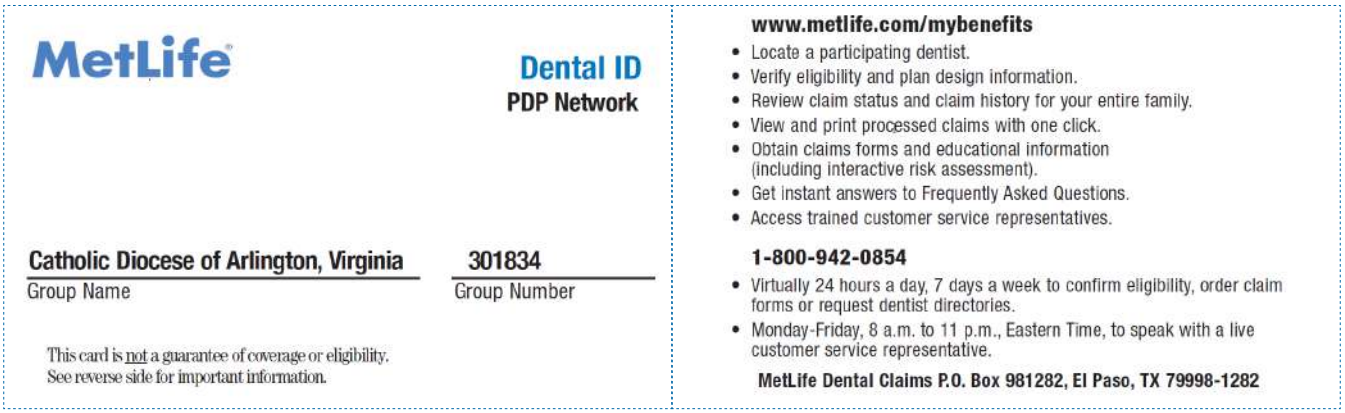
  OR Create a New Account if you are a new user and follow the steps to validate your identity.

- **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

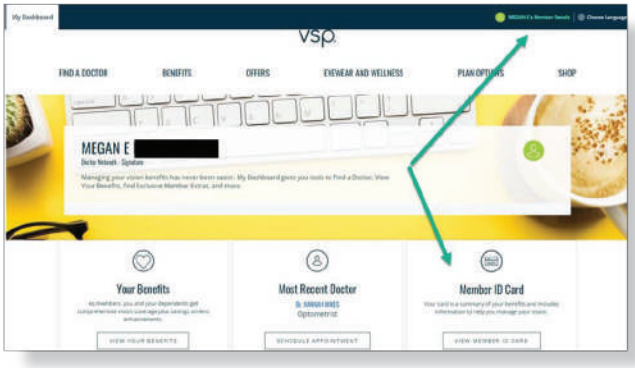
ID Cards – Vision Service Plan (VSP)

Vision ID Cards

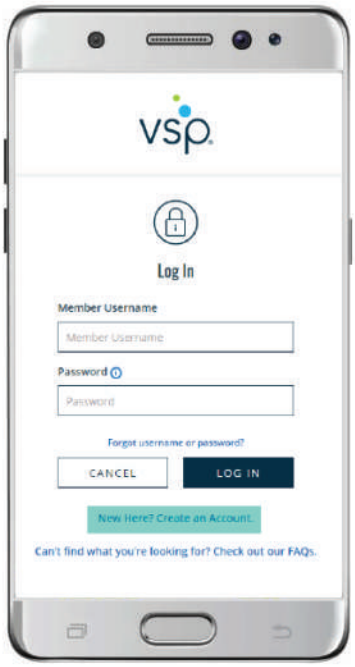
Desktop

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

- **Step 1:** Visit www.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 redesigned VSP® app is available for free in the Apple App store or Google Play store. Updated with a streamlined login process, easier navigation and a personalized member dashboard to mirror the look and feel of your dashboard on vsp.com.

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

iTunes® App Store — SCAN ME

Google Play — 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!

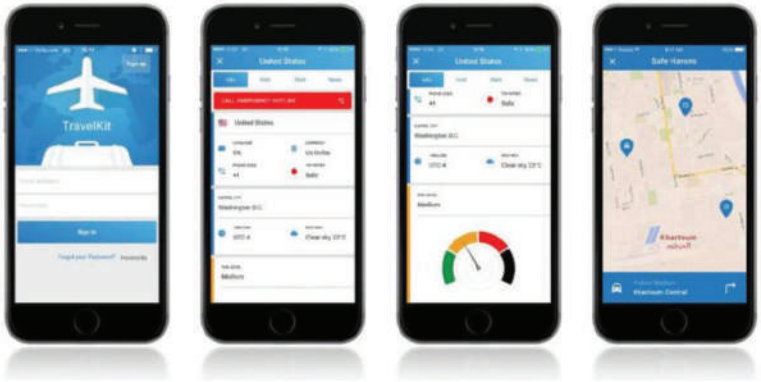
This card isn't required for service and doesn't guarantee benefit eligibility. It's for use by VSP members. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

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 you 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 healthcare 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 "TravelKit" in your mobile app store. Once you have downloaded the app, please enter registration code PRUDENTIALIMG1 to proceed with the setup.

iTunes® App Store

SCAN ME

Google Play

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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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at www.cigna.com/sp. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: $1,500/individual - employee only or $3,000/family maximum For out-of-network providers: $2,650/individual - employee only or $5,300/family maximum Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, in-network preventive drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers: $2,650/individual - employee only or $5,300/family maximum For out-of-network providers: $5,300/individual - employee only or $10,600/family maximum Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance/visit	40% coinsurance	None
	Specialist visit	20% coinsurance/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	40% coinsurance/visit 40% coinsurance/screening 40% coinsurance/ immunizations	None None None You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $20 copay/prescription (retail 90 days); $20 copay/prescription (home delivery 90 days)	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail) and a 90-day supply (home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	$30 copay/prescription (retail 30 days), $60 copay/prescription (retail 90 days); $60 copay/prescription (home delivery 90 days)	Not covered	
	Non-preferred brand drugs (Tier 3)	$45 copay/prescription (retail 30 days), $90 copay/prescription (retail 90 days); $90 copay/prescription (home delivery 90 days)	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services are paid at the in-network cost share and deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	40% coinsurance/office visit 40% coinsurance/all other services	$400 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.).
	Inpatient services	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification. Coverage is limited to 120 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	20% coinsurance/visit	40% coinsurance/visit	$400 penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	20% coinsurance/visit	40% coinsurance/visit	$400 penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	$400 penalty for no out-of-network precertification.
	Hospice services	20% coinsurance/inpatient services 20% coinsurance/outpatient services	40% coinsurance/inpatient services 40% coinsurance/outpatient services	$400 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (combined with Rehabilitation Services)

Your Rights to Continue Coverage:
There are agencies that can help if you want to continue your coverage after it ends. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:
There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-Cigna24. Additionally, a consumer assistance program can help you file your appeal. Contact: Virginia State Corporation Commission at (877) 310-6560.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$1,500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Specialist office visits *(prenatal care)*	
Childbirth/Delivery Professional Services	
Childbirth/Delivery Facility Services	
Diagnostic tests *(ultrasounds and blood work)*	
Specialist visit *(anesthesia)*	
Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$2,670

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$1,500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Primary care physician office visits *(including disease education)*	
Diagnostic tests *(blood work)*	
Prescription drugs	
Durable medical equipment *(glucose meter)*	
Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,920

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$1,500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**
This EXAMPLE event includes services like:	
Emergency room care *(including medical supplies)*	
Diagnostic test *(x-ray)*	
Durable medical equipment *(crutches)*	
Rehabilitation services *(physical therapy)*	
Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,810

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA OAP **Ben Ver:** 27 **Plan ID:** 15836695

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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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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Wellness Program Privacy Notice

Notice for Wellness Program Sponsored By The Catholic Diocese of Arlington and Cigna

Motivate*Me*® Wellness Program is a voluntary wellness program available to OAP HSA medical plan lay employees who participate in the Cigna Choice Fund HSA Open Access Plus medical plan. The program is administered by Cigna according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a biometric screening, which will include a blood test for total cholesterol, glucose, blood pressure, and body mass index (BMI). You are not required to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to $500 for an individual or $1,000 for individual + 1 or family coverage funded in their Health Savings Account (HSA) account for completing the incentive activities. Although you are not required to complete the annual Preventative Exam and the biometric screening, only employees who do so will receive the incentive funding.

Additional incentives of up to $500 for an individual or $1,000 for individual + 1 or family coverage funded in their HSA accounts may be available for employees who participate in certain health-related activities such as completing an online activity, telephonic coaching or working with his/her physician to create an alternative goal and achieve it to improve his/her health or achieve certain health outcomes regarding BMI, blood pressure, cholesterol and blood glucose.

For all participants — If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Cigna at 1-800-244-6224 and they will work with you and, if you wish, with your doctor.

For accommodation requests — If you are unable to participate in any of the program events, activities or goals, you may be entitled to a reasonable accommodation for participation or an alternative standard for rewards. For work-site accommodations please contact The Human Resources Department at 703-841-3857; for accommodations with online, phone or other Cigna programs, please contact Cigna at 1-800-244-6224.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as telephonic coaching or online activities. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Catholic Diocese of Arlington may use aggregate information it collects to design a program based on identified health risks in the workplace, Cigna and Motivate*Me*® Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclose except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The personally identifiable health information that Cigna and Motivate*Me*® receive will only be used in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, and no information you provide as part of the wellness program will be used in making any employment decision. Although no one can prevent all cyber-attacks, Cigna has an information security program consisting of people, process, and technology—including encryption and monitoring tools designed to protect electronic information. We

maintain safeguards intended to protect the security of your information. In the event a data breach, as defined by law, occurs involving information you provide in connection with the wellness program, we will notify you as required by law.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, not may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact The Employee Benefits Office at 703-841-2588.

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 2022"** 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 2022
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.