ARCHDIOCESE OF
CINCINNATI

2024/2025 Benefit Guide

Eligible employees must complete their elections within 30 days from date of hire or date of life event change.

Partners in Value

At the Archdiocese of Cincinnati, we do all we can to mitigate the effect of rising healthcare costs. We look at the design of our benefit programs, the providers we work with and the role you can play in keeping our plans affordable. We're asking you to partner with us to control costs by learning about your coverage and how to use it most effectively. The Archdiocese of Cincinnati provides you with a number of tools and resources, but it's up to you to stay informed, make the right choices and then make the most of the benefits you have.

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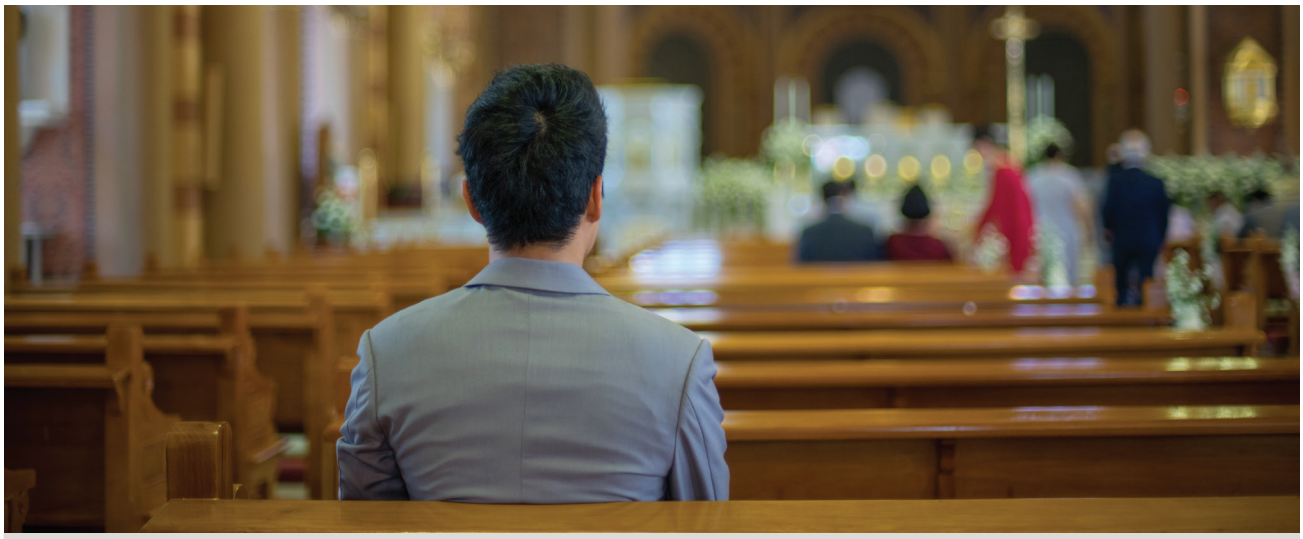

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Welcome to The Archdiocese of Cincinnati

In this guide you will find an overview of the benefits available to you through The Archdiocese of Cincinnati (AOC).

The only time outside of your election period that an employee can add/drop or make changes to their coverage is when a qualifying event is experienced such as marriage/divorce, birth/adoption, loss/gain eligibility, loss of other coverage, etc., your local administrator has been notified within 30 days of that qualifying event, and the qualifying life event is initiated in MyEnroll. For further details refer to the Summary Document online: resources.catholicaoc.org/employee-benefits

What Makes the Archdiocese of Cincinnati (AOC) Plan Different?

The AOC Welfare Benefit Plan is a non-ERISA group health plan that maintains grandfather status under the ACA. Our employees are offered single coverage with a low employee premium charge. Family coverage is available to include the spouse and children, but with a monthly surcharge if the dependents have other group health plan coverage available to them. This monthly surcharge can be waived if it is determined the spouse or other parent is not eligible for other group health plan coverage.

The 2024-2025 plan year medical/prescription premium for single coverage is $869 per month. For eligible employees, the parish/school location pays $826 and the employee's portion of the premium is $43 per month. This is an annual expense for the parish/school location of $9,912.

The 2024-2025 plan year medical/prescription premium for family coverage is $2,028 per month. The additional expense to a location for an employee's family premium over the single premium is $1,159 per month or an annual difference of $13,908. The employee may be subject to a monthly surcharge of $1,202 for this additional cost. The surcharge can be waived when the employee provides evidence that their dependents have no access to other group coverage. **Example: $2,028 - $869 = $1,159 + $43 = $1,202. $1,202 cost to employee per month if dependent surcharge isn't waived.**

Affidavit request letters are provided during the enrollment process and are available at this address: https://resources.catholicaoc.org/employee-benefits

Any change in the status of other available Group Health coverage during a plan year may be considered a Life Event and changes the waiver status for the dependent surcharge during the plan year.

Any false or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be retroactively terminated (to the extent permitted by law). Non-compliance is considered fraud and can result in recouping surcharge, claims paid and dismissal of those complicit in the fraud.

Eligibility

For active employees and their dependents who are deemed eligible for benefits as outlined below, benefits will begin the first of the month following the employee's date of hire.

Employee Eligibility for Medical, Dental, Vision and FSA Plans

- Full-time employees who work 30+ hours per week or teach 15+ classroom hours per week (certificated teacher in charge of the classroom).
- Variable-hour employees who have worked an average of 30+ hours per week or have taught an average of 15+ classroom hours per week during the prior 12-month measurement period (certificated teacher in charge of the classroom).
- Teachers who are employed by Athenaeum of Ohio and teach 14+ semester hours per year (or have taught an average of 14+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

Employee Eligibility for Life, AD&D and Long-Term Disability Insurance

- All employees who are regularly scheduled to work 20+ hours per week or teach 12+ classroom hours per week.
- Teachers who are employed by Athenaeum of Ohio and teach 9+ semester hours per year (or have taught an average of 9+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

Eligible Dependents

The plan allows coverage for your legal opposite-sex spouse and/or your child(ren) (biological, adopted, step or foster) from birth to the end of the month that your child attains age 26.

Proof Documents to Enroll Dependent(s)

Legal Opposite Sex Marriage (one of the following)	Biological Child (one of the following)	Adopted Child (one of the following)
» Marriage license » Federal income tax return	» Birth certificate of biological child » Documentation on hospital letterhead indicating the birth date of child(ren) under 6 months old » Federal income tax return	» Official court/agency papers (initial stage) » Official Court Adoption Agreement (mid-stage) » Birth certificate (final stage) » Federal income tax return
Foster Child (one of the following)	**Step Child (ALL of the following)**	**Court-Ordered Medical coverage (one of the following)**
» Official Court or agency placement papers	» Child's birth certificate showing the child's parent is the employee's spouse » Marriage certificate showing legal marriage between the employee and the child's parent » Court document showing that the employee's spouse has custody of the child or is required to cover child	» Qualified Medical Child Support Order (QMCSO) » National Medical Support Notice (NMSN)
Other Child	**Surcharge Waiver**	
» Court papers demonstrating legal guardianship, including the person named as legal guardian	» Other Employer Letter, whether for spouse or eligible dependents	

**Anthem requires a Social Security number for the newborn within 30 days of birth or coverage is terminated. When adding a new baby to the plan, you must call my enroll (1.866.694.6423), within 30 days of the birth, with the Social Security Number to ensure that Anthem does not drop the baby's coverage.

Enrolling in Benefits

Step 1: Review your benefits package and understand the options available to you.

Step 2: Gather proof documents for new dependents. Scan in necessary proof documents and save the documents to your desktop as one PDF per dependent.

» You will need to submit these during the online enrollment process by attaching the scanned documents to your MyEnroll benefit profile when prompted. You can also fax your proof documents to 1.888.265.2144.

Step 3: Enroll

» Log on to www.myenroll.com using your User Name and password**

» Select the "Enroll" button drop down and select "Enrollment Wizard" to access your open enrollment

» When prompted, submit the necessary proof documents for new dependents

» Review the summary and signature page and click Accept and Finalize

MyEnroll Customer Service Contact Information: 1.866.694.6423 AOCBenefits@basusa.com

**If you haven't previously logged into MyEnroll or forgot your username/password, go to www.myenroll.com and click on the "First Time Users" under the Sign-in button and follow through the screens. Please reach out to MyEnroll customer service if you have any issues retrieving a password.

Employer Paid Benefits

Basic Life and AD&D Insurance

The Standard

Eligibility:

» All employees who are regularly scheduled to work 20+ hours per week or teach 12+ classroom hours per week (certificated teacher in charge of the classroom).

» Teachers who are employed by Athenaeum of Ohio and teach 9+ semester hours per year (or have taught an average of 9+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

Benefit: $50,000 of Group Life and $50,000 Accidental Death and Dismemberment (AD&D) insurance.

» *Age reduction may apply

Long-Term Disability

The Standard

Eligibility:

» All employees who are regularly scheduled to work 20+ hours per week or teach 12+ classroom hours per week.

» Teachers who are employed by Athenaeum of Ohio and teach 9+ semester hours per year (or have taught an average of 9+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

Benefit: 60% of the first $8,333 of monthly pre-disability earnings. The maximum monthly benefit is $5,000 and the minimum monthly benefit is $100. Benefits begin after a benefit waiting period of 180 days.

Optional Benefits

Medical & Pharmacy

Anthem

Please reference https://resources.catholicaoc.org/employee-benefits

» Summary of Benefits — a detailed description of your coverage

» Understanding online tools available to you — register at anthem.com

» Download the Sydney Health app

Eligibility: Reference Eligibility section on page 3

Monthly			
	Total Cost	Employer Contribution	Employee Contribution
Single	$869	$826	$43
Family	$2,028	$1,927	$101*

Annual			
	Total Cost	Employer Contribution	Employee Contribution
Single	$10,428	$9,912	$516
Family	$24,336	$23,124	$1,212

*The 2024-2025 plan year medical/ prescription premium for family coverage is $2,028 per month. The additional expense to a location for an employee's family premium over the single premium is $1,159 per month or an annual difference of $13,908. The employee may be subject to a monthly surcharge of $1,202 for this additional cost. The surcharge can be waived when the employee provides evidence that their dependents have no access to other group coverage.

Any change in the status of other available group health coverage during a plan year may be considered a qualifying life event and changes the waiver status for dependent surcharge during the plan year.

Benefit: Please remember that your deductible and your out-of-pocket limit reset every calendar year on January 1st.

Medical Plan Benefit		
Plan Payment Levels	In-Network	Out of Network
Annual deductible (Indv. / Family)	$550 / $1,100	$1,100 / $2,200
Coinsurance – AOC pays	80%	60%
Annual Out-of-Pocket Limit (Indv. / Family)	$2,800 / $5,600	$5,600/ $11,200
PHYSICIAN SERVICES		
Preventive Visits Primary Care Office Visits	100% $30 copay	60% 60%
Specialty Office Visits	$45 copay	60%
Online LiveHealth Physician Visits	$10 copay	N/A
Inpatient Hospital – Facility Services	80%	60%
Outpatient Care	80%	60%
EMERGENCY/URGENT CARE		
Not Admitted	80%	80%
Admitted	Charges Waived	Charges Waived
Ambulance services	80%	80%

OptumRx

IMPORTANT: Your OptumRx prescription benefit is separate from your Anthem medical benefit and is accessed using a separate OptumRx ID card.

Optum RX 07/01/2024-6/30/2025			
	Co-Pay Retail 30 day mail order	Co-Pay 90 day mail order	Specialty Optum RX
Tier 1	$17	$42.50	$17
Tier 2	$39	$97.50	$39
Tier 3/4	$78	$195	$78

Tier 1	$ Lower cost medications	Brand name and generic medications can be found in any of the 4 tiers
Tier 2	$$ Low cost medications	
Tier 3/4	$$$ Mid and $$$$ High cost medications	
Excluded Drugs	Clinical Equivalents in other tiers Discuss with your doctor and OptumRX	

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NOTE: Retail 90 day prescriptions may only be filled at Kroger pharmacies

Flexible Spending Account (FSA)

Benefit Allocation Systems (BAS)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using pre-tax dollars. The annual amount you elect for the 2024 – 2025 plan year is deducted each pay check before taxes are withheld, which lowers your taxable income. You are only able to carryover up to $640 to the next plan year in your Health Care FSA, so plan carefully.

If you decide to contribute to a healthcare FSA, you will receive a Benny card in the mail. The Benny card is similar to a debit card and is linked directly to your FSA. You should always save your receipts when you have used the Benny card, as you will need to **SUBSTANTIATE** the charge to MyEnroll. To substantiate means to provide proof that the purchase was an eligible expense per the IRS. Please know the Benny Card may be suspended temporarily if charges are not substantiated.

If you pay for an expense without the Benny card, you can request reimbursement from your FSA. To do so, you submit a claim to MyEnroll by filling out necessary forms and providing required substantiation (receipts, invoices, etc.).

The dependent care FSA does not have a Benny card. All expenses are paid by the employee up front and then the employee submits receipts to MyEnroll for reimbursement.

Account Type	Use it for:	How much can I contribute for 2024?	Does it rollover?
Health Care FSA	Medical, dental, and vision expenses	$3,200 (minimum is $240)	You can rollover up to $640 to the next plan year
Dependent Care FSA	Dependent care for children under the age of 13 or a disabled spouse or parent	Annual Maximum Contribution = $5,000 per couple for married filing jointly and single head of household or $2,500 per individual for married filing separately	No

Important Note: *Should your employment terminate, your FSA participation will end on your last day of employment. Per the Internal Revenue Code, any funds remaining in your account, against which claims have not been incurred, by or prior to, your date of termination will be forfeited.*

Dental

Delta Dental of Ohio

The plan is 100% paid by the employee. For more details see the Dental page on the https://resources.catholicaoc.org/employee-benefits website.

Eligibility: Reference Eligibility section on page 3. Dental benefit year: 7/1/2024-6/30/2025

Dental Plan	
This plan allows you to select the dentist of your choice by offering both in and out of network benefits	
Individual Max benefit year 7/1 to 6/30	$1,000
Annual Deductible (single/family) basic & major only	$50/$150
Preventive (exams, cleanings)	100%
Basic (fillings)	50%
Major (crowns, implants)	50%
Child Orthodontia	50%
Ortho Lifetime Max	$1,000

	Dental
Monthly Employee Cost	$28.78 – Single / $83.28 - Family

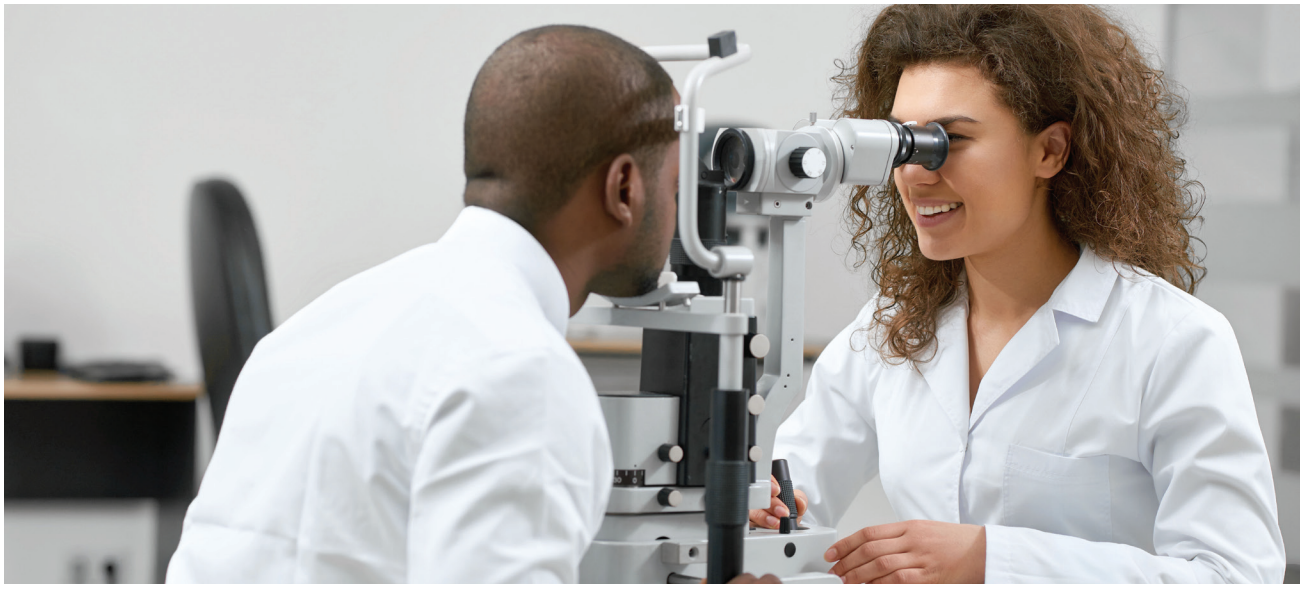
Vision

VSP – Choice Network

Eye exams are an important part of overall health care for the entire family. The Vision Benefits Summary below may help you decide if the vision plan fits the needs of you and your family. The vision carrier VSP offers a large network of providers. When you use a contracting network provider, the care is considered "in-network" and your expenses will be paid using in-network rates. If you select a provider outside of the network, the care is considered "out-of-network." Coverage is still provided, but the out-of-pocket expenses will be significantly higher.

Eligibility: Reference Eligibility section on page 3.

	In-Network	Out-of-Network
Exam	$10 Copay	Reimbursed up to $45
LENSES		
Single	$0 Copay	Reimbursed up to $30
Bifocal		Reimbursed up to $50
Trifocal		Reimbursed up to $65
Lenticular		Reimbursed up to $100
Frames	20% off balance over $150 allowance; $200 allowance for any featured frame	Reimbursed up to $70
CONTACT LENSES		
Medical Necessity	Covered in Full	Reimbursed up to $210
Elective	$130 allowance	Reimbursed up to $105
Frequency Limitation (exam/lens/frames)	You can get an Eye Exam every 12 months / Lenses or contacts every 12 months / Frames every 24 months	
MONTHLY PREMIUM		
Monthly Employee Cost	$6.48 – Single / $17.87 – Family	



Supplemental Life Insurance

The Standard

The Archdiocese of Cincinnati recognizes that different individuals have varying comfort levels and needs in regards to life insurance. It is important that you analyze a variety of factors to determine where you and your family may need expanded coverage (e.g., risk factors, age, wellness, and medical history).

Eligibility: Reference Eligibility section on page 3

Spouse — Employee's legal opposite sex spouse

Children — Eligible dependent children from live birth to age 26

Benefit: In addition to the $50,000 Core Life paid for by the location where you work, you have the option to apply for and (if approved by the Standard Underwriters) purchase Supplemental Life Insurance for yourself, your spouse and your child(ren).

	Employee	Spouse	Child(ren)
Increments	$10,000	$10,000	$2,500, $5,000, $7,500, or $10,000
Maximum Benefit Amount	$500,000	Not to exceed the employee's benefit amount	

Eligible children may be covered from birth to age 26.

If an employee or spouse elects or increases coverage during annual enrollment, an Evidence of Insurability (EOI)* form must be completed, submitted by June 1, 2024 to the Standard, and approved by The Standard. This form is available within the MyEnroll system during the Open Enrollment process.

The basic core life and supplemental life insurance benefits are subject to the following age reduction schedule: reduction by 35% at age 65, 58% at age 70 and 70% at age 75.

Premium per $10,000 increments:

Monthly			
Age	Rate	Age	Rate
Under age 20	$0.63	**50–54**	$4.63
20–24	$0.75	**55–59**	$8.00
25–29	$0.88	**60–64**	$11.00
30–34	$1.13	**65–69**	$20.75
35–39	$1.50	**70–74**	$33.50
40–44	$2.00	**75–79**	$54.25
45–49	$2.88	**80+**	$87.88

Your rates are based on your age at your last birthday.

Your spouse's rates are based on their age at their last birthday. They will change on the plan anniversary date coinciding with or next following your last birthday as you advance to a higher age bracket.

Monthly	
Dependent Child Benefit Amount Selected	Rate (Regardless of # of children)
$2,500	$0.125
$5,000	$0.250
$7,500	$0.375
$10,000	$0.500

Considering Retirement

Medicare and Group Health Plan Coverage

When you retire and are Medicare-eligible, you have a number of important decisions to make prior to your Archdiocesan health benefits ending. These may include whether to enroll in Medicare Part B, join a Medicare Prescription Drug Plan, or buy a Medigap policy.

Understanding your choices

To help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's best for you, you can visit www.medicare.gov and select "Compare Medicare Prescription Drug Plans" and "Compare Health Plans and Medigap Policies in Your Area." You can also call your State Health Insurance Assistance Program. To get the telephone number for your state's program, call 1.800. MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

Medicare Part D (prescriptions)

Those eligible for Medicare are provided a letter of creditable coverage. The letter states that the prescription drug program currently provided by the Archdiocese Healthcare Plan exceeds Medicare Part D. Medicare participants and individuals over age 65 are advised that they could select the Archdiocese of Cincinnati Healthcare Plan instead of Medicare Part D if they are still actively employed by the AOC and benefit eligible. The letter permits Medicare eligible persons to join Medicare Part D at a later date, if they choose, without paying a late entrant "penalty." This letter will be provided annually prior to Medicare open enrollment.

RetireMed is an additional source of information. They are an independent health plan advisory service that offers guidance to individuals in need of insurance options upon retirement. Their goal is to give retirees information and guidance to choose the insurance plan that best meets their retirement budget, needs and lifestyle - at no cost to the retiree. RetireMed can be reached at 1.877.268.2863 or www.retiremed.com.

401(k) Plan

Empower Retirement

The Archdiocese of Cincinnati 401(k) Plan became effective January 1, 2011. This Plan is an important benefit intended to help employees in their retirement years as a supplement to their personal retirement savings, Social Security benefits, the frozen Archdiocese of Cincinnati Pension Plan for Lay Employees and the terminated Archdiocese of Cincinnati 403(b) Plan.

Eligible participants can: (1) make their 401(k) elective contributions; (2) receive Archdiocese base contributions; and (3) receive favorable tax advantages through either Pre-Tax or Roth 401(k) elections.

Specific 401(k) account details, investment options, and additional retirement readiness tools are attainable through the Empower Retirement participant website – empowermyretirement.com.

Contact Information

If you would like to further research your benefit options, find a provider, or ask detailed questions about your benefit coverages, you may contact the insurance companies/service providers directly. Listed below are toll-free phone numbers and websites for those that provide benefits and services to AOC employees.

Benefit	Administrator	Phone	Website/Email
Medical	Anthem	1.844.995.1752	www.anthem.com
Prescription	OptumRx	1.800.797.9791	www.optumrx.com
Life & AD&D/LTD/ Voluntary Life	The Standard	Life 1.800.628.8600 LTD: 1.800.368.1135	www.standard.com
Voluntary Dental	Delta Dental	1.800.524.0149	www.memberportal.com
Voluntary Vision	VSP	1.800.877.7195	www.vsp.com
Flexible Spending Account (FSA)	BAS	1.866.694.6423	AOCBenefits@basusa.com
Benefits Customer Service (MyEnroll)	BAS	1.866.694.6423	AOCBenefits@basusa.com
401(k)	Empower Retirement	1.866.467-7756	www.empowermyretirement.com
The Christ Hospital Center of Excellence	The Christ Hospital	513.557.4882	www.thechristhospital.com
Lay Employee Pension Plan	UMR	1.888.640.1700	N/A

AOC Benefits Website

Find a wealth of information about your benefits and explore helpful decision-making tools. At home or on the road, you can go to: https://resources.catholicaoc.org/employee-benefits

Here's just a small sampling of what you'll find:

» Benefit plan information

» Links to providers such as Anthem, OptumRx, Delta Dental, VSP Vision.

» Helpful decision-making tools

» Health news

» Find specific information and summaries of the benefits offered by the Archdiocese of Cincinnati

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice.

This document is an outline of the coverage and services provided by the carrier(s) or vendor(s). It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details and are available for your reference through Archdiocese of Cincinnati or upon request

Legal Notices

Grandfathered Plan Disclosure

This group health plan is maintained as a "grandfathered health plan" under the Patient Protection and Affordable 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. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Women's Health & Cancer Rights Act

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

» All stages of reconstruction of the breast on which the mastectomy was performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance;

» Prostheses; and

» Treatment of physical complications of the mastectomy, including lymphedema.

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

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742

OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

HIPAA Special Enrollment Rights

Archdiocese of Cincinnati Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Archdiocese of Cincinnati Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a** standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Archdiocese of Cincinnati has d**etermined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Archdiocese of Cincinnati coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Archdiocese of Cincinnati coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

» Visit www.medicare.gov.

» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

» Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

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

Name of Entity/Sender:	Archdiocese of Cincinnati
Contact:	Bill Maly
Address:	100 East Eighth Street, Cincinnati OH 45202
Phone Number:	(513) 421.3131

Marketplace 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 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Benefits Office.

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

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

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 Archdiocese of Cincinnati		**4. Employer Identification Number (EIN)** (EIN) 31-0538501
5. Employer address 100 E 8th Street		**6. Employer phone number** 513.421.3131
7. City Cincinnati	**8. State** Ohio	**9. ZIP code** 45202
10. Who can we contact about employee health coverage at this job? **Benefits Office**		
11. Phone number (if different from above)	**12. Email address** finance@catholicaoc.org	

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

» As your employer, we offer a health plan to:

☑ All employees. Eligible employees are:
Full-time employees who work 30+ hours per week or teach 15+ classroom hours per week (certificated teacher in charge of the classroom).
Variable-hour employees who have worked an average of 30+ hours per week or have taught an average of 15+ classroom hours per week during the prior 12-month measurement period (certificated teacher in charge of the classroom).
Teachers who are employed by Athenaeum of Ohio and teach 14+ semester hours per year (or have taught an average of 14+ semester hours per year during the prior 12-month measurement period for variable hour teachers).

☐ Some employees. Eligible employees are:

» With respect to dependents:

☑ We do offer coverage. Eligible dependents are: The plan allows coverage for your legal opposite-sex spouse and/or your child(ren) (biological, adopted, step or foster) from birth to the end of the month that your child attains age 26.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

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

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

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

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

    ☐ **No**

14. Does the employer offer a health plan that meets the minimum value standard*?

    ☐ Yes (Go to question 15)

    ☐ No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard[2] offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

    a. How much would the employee have to pay in premiums for this plan?

    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year?

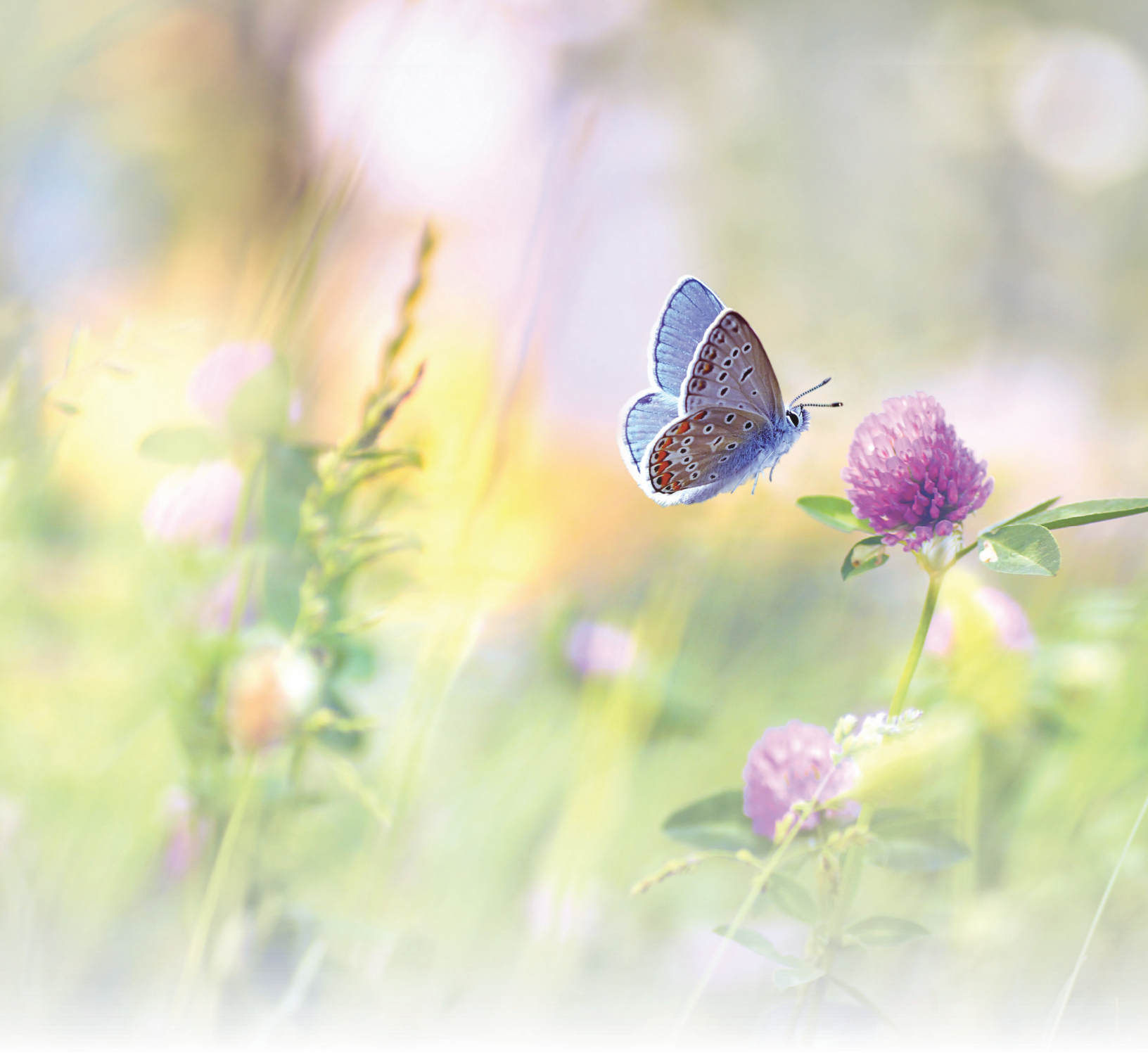
Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan?

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

2 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).



This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting

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