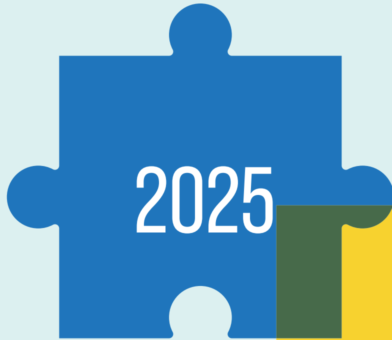
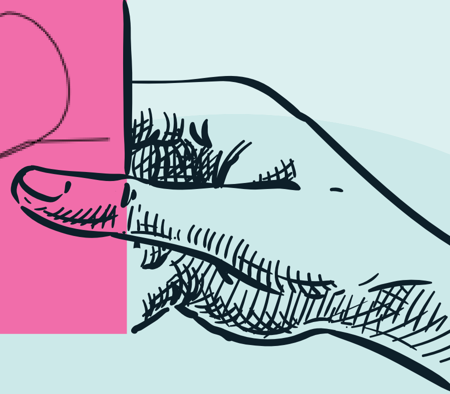
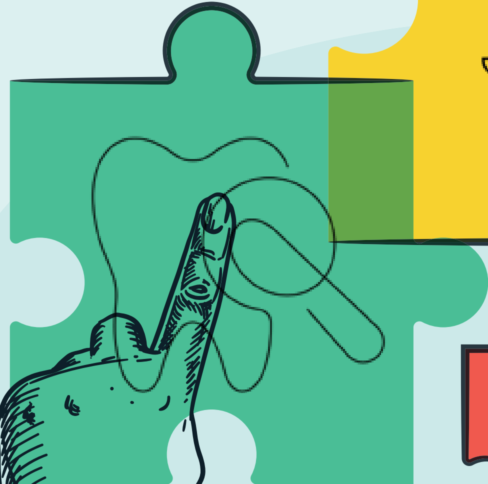
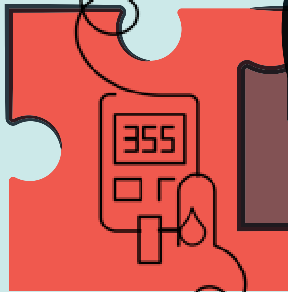
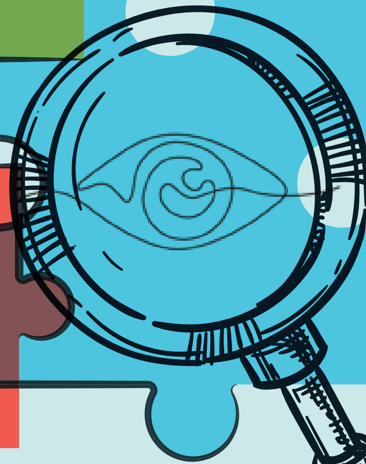


# Employee Benefits Guide

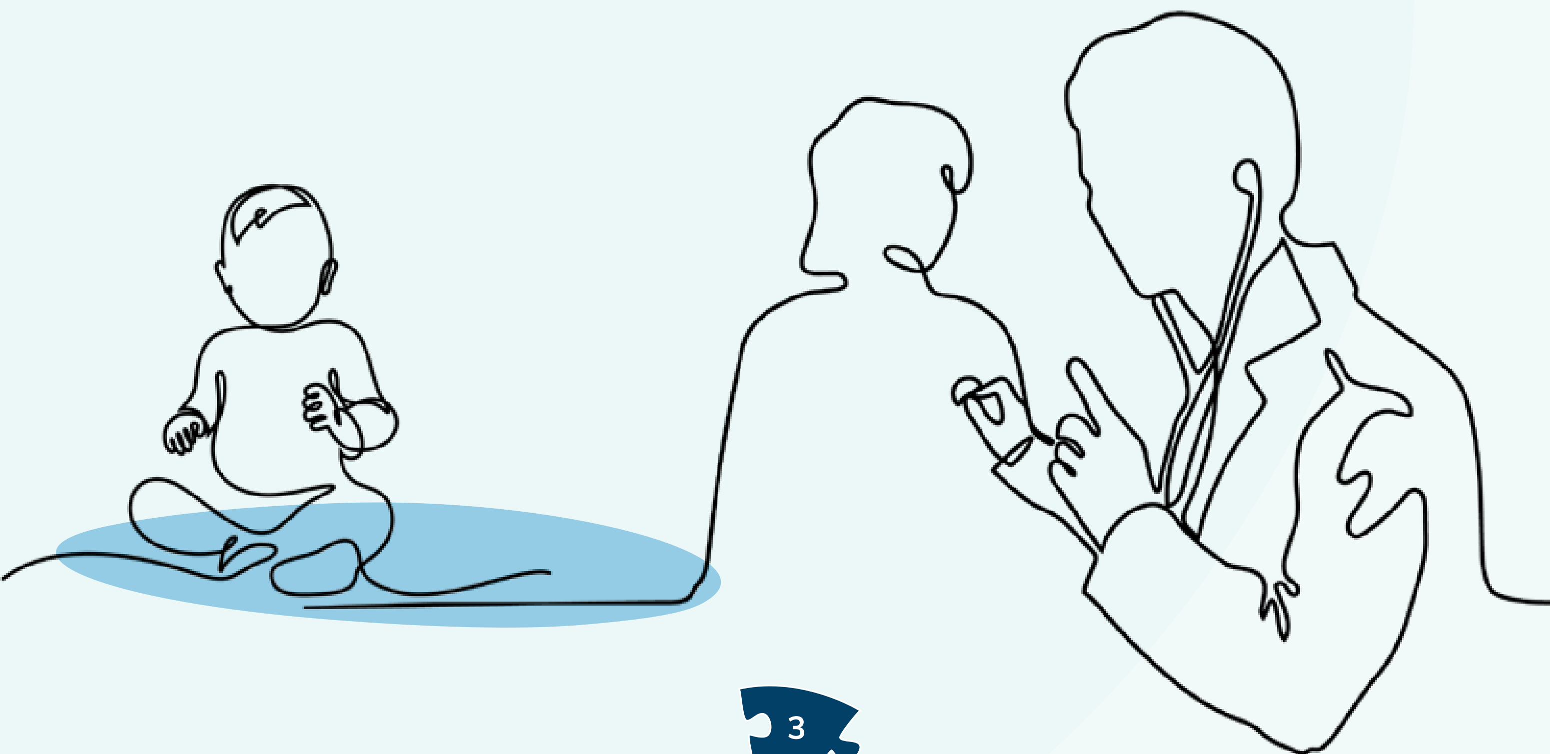
Putting it all together for you.

# Welcome

Our comprehensive employee benefits make it easy for you to piece together the perfect coverage for your specific needs. Read this guide first so you know what benefits are offered before making your selections. You may only enroll for or make changes to your benefits during New Hire onboarding and Open Enrollment or when you have a Qualifying Life Event.

# Benefits Worth Checking Out

Your New Benefits Begin: January 1, 2025



# Helpful Information

## Important Contacts

| Program | Carrier | Policy Number | Phone Number | Website / Email |
|---|---|---|---|---|
| **Medical** | Cigna | 3332620 | 800-244-6224 | www.mycigna.com |
| **Pharmacy** | Express Scripts | 9505 | 844-629-3700 | www.express-scripts.com |
| **Telemedicine** | MDLIVE for Cigna | 3332620 | 800-244-6224 | www.mycigna.com |
| **Health Savings Account (HSA)** | Cigna | 3332620 | 800-244-6224 | www.mycigna.com |
| **Employee Assistance Program (EAP)** | Voya/ComPsych | N/A | 800-697-0353 | guidanceresources.com; App: GuidanceNow; WebID: MY5848i |
| **Flexible Spending Accounts (FSA)** | Pinnacle Bank | C45508 | 888-282-2605 | www.pnfp.com/Hblogin info@health.pnfp.com |
| **Dental** | Cigna | 3332620 | 800-244-6224 | www.mycigna.com |
| **Vision** | Cigna | 3332620 | 888-353-2653 | www.mycigna.com |
| **Basic and Voluntary Life and AD&D** | Voya | 73487 | 800-955-7736 | www.voya.com |
| **Short Term Disability** | Catholic Diocese of Memphis | N/A | 901-373-1200 | www.cdom.org/human-resources |
| **Long Term Disability** | Voya | 73487 | 800-955-7736 | www.voya.com |
| **Retirement 403(b)** | Corebridge Financial | N/A | 800-448-2542 | www.corebridgefinancial.com/retire |
| **Accident Insurance** | Allstate | N/A | 800-521-3535 | www.allstate.com/mybenefits |
| **Cancer Insurance** | Allstate | N/A | 800-521-3535 | www.allstate.com/mybenefits |

## Availability of Summary Health Information

Your plan offers medical coverage options. To help you make an informed choice, review each plan's Summary of Benefits and Coverage (SBC) available from Human Resources.

# Table of Contents


6 Benefits Eligibility

6 How to Enroll

8 Medical Coverage

10 Telemedicine

11 Health Care Options

12 Cigna Resources

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18 List of Qualified HSA and FSA Expenses

19 Life and AD&D Insurance

20 Disability Insurance

21 Supplemental Benefits

22 Employee Assistance Program

23 Additional Benefits

24 Retirement Plan

25 Employee Monthly Contributions

26 Required Notices


If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see page 27 for more details.

# Benefits Eligibility

## Who is Eligible for Benefits

| Status | Eligibility | Enrollment | Coverage Begins |
|---|---|---|---|
| **New Hire** | • Regular, full-time and part-time employees working an average of 20+ hours per week | • Enroll by the deadline as shown in the Bswift enrollment window | • First of the month after completing 60 days of full-time employment |
| **Employee** | • Regular, full-time and part-time employees working an average of 20+ hours per week | • Enroll during Open Enrollment (OE) or when you have a Qualifying Life<br>• Event (QLE) | • OE: Start of the plan year<br>• QLE: Ask Human Resources |
| **Dependent(s)** | • Your legal spouse<br>• Child(ren) under age 26, regardless of student, dependency, or marital status<br>• Child(ren) over age 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return | • You must enroll the dependent(s) during OE or when you have a QLE<br>• When covering dependents, you must enroll for and be on the same plans | • Ask Human Resources, if needed |

## How to Enroll

Visit **www.paylocity.com** and log in to your self-service portal and click on the gray box in the upper left-hand corner that says ***HR/PAYROLL***. You will see a drop-down menu. Click on ***BSWIFT BENEFITS***. A welcome screen will appear with an orange button that says: ***START YOUR ENROLLMENT.***

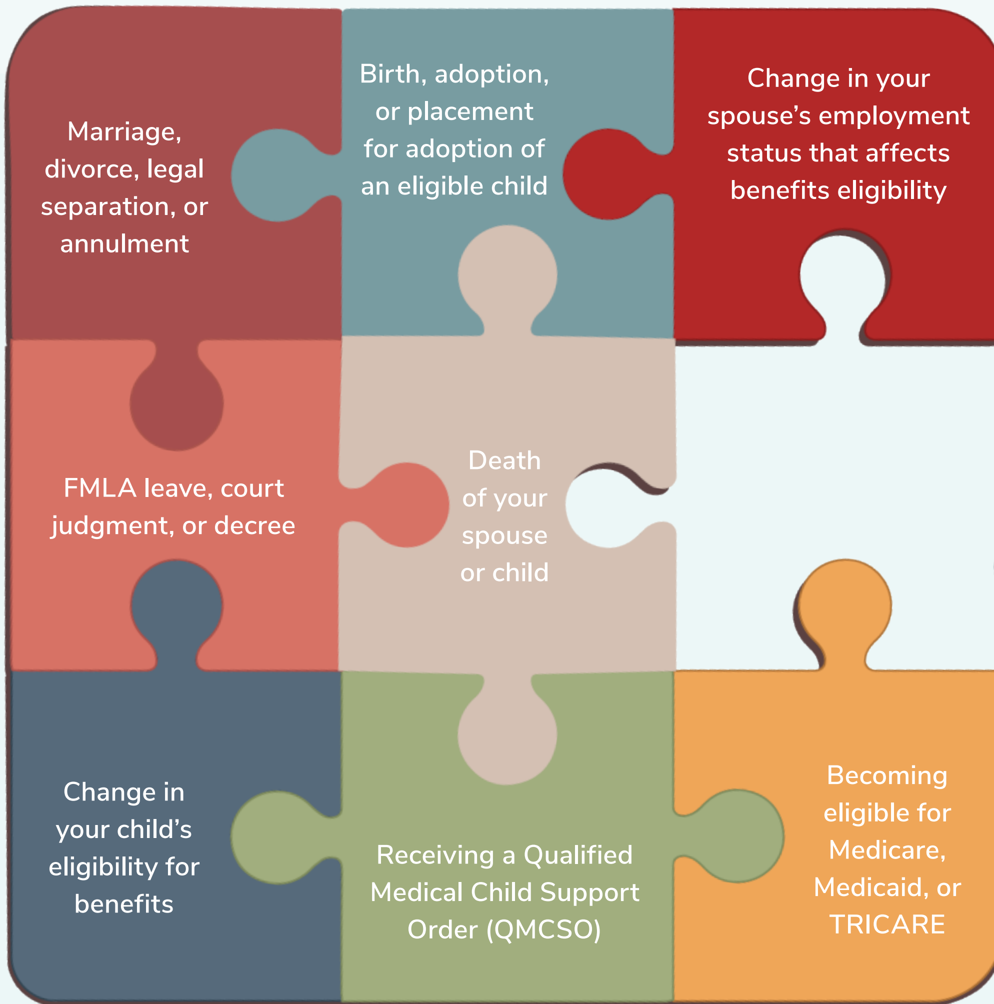
## Questions?

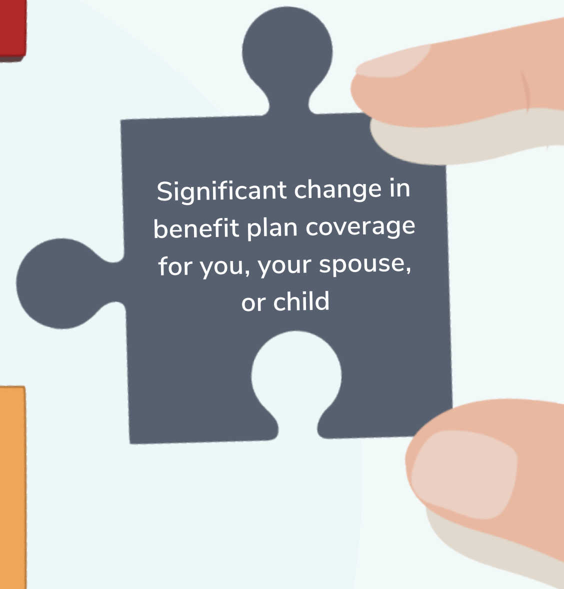
- Contact HR

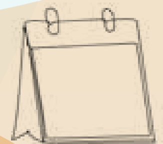
# Benefits Eligibility

## Qualifying Life Events

You may only change coverage during the plan year if you have a Qualifying Life Event, such as:



### 30 Days

Notify HR and complete your changes within 30 days of the event. You may need to provide documents to verify the change.

# Medical Coverage

The medical plan option through **Cigna** protects you and your family from major financial hardship in the event of illness or injury. You have a choice of two plans:

- **PPO Plan** – This PPO plan has a $2,000 Individual and a $6,000 Family in-network deductible.
- **HDHP Plan** – This HDHP plan has a $3,500 Individual and a $7,000 Family in-network deductible.

## Preferred Provider Organization (PPO)

A PPO allows you to see any provider when you need care. When you see providers in the **Open Access Plus** network for care, you will pay less and get the highest level of benefits. You will pay more for care if you use out-of-network providers. When you see in-network providers, your office visits, urgent care visits, and prescription drugs are covered with a copay, and most other network services are covered at the deductible and coinsurance level.

## High Deductible Health Plan (HDHP)

An HDHP allows you to see any provider when you need care, and you will pay less for care when you go to providers in the **Open Access Plus** network. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (see page 15).

### Find an In-Network Provider

- Visit **www.mycigna.com**
- Call **800-244-6224**

# Medical Coverage

## Medical Benefits Summary

| | PPO PLAN | | HDHP PLAN | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Calendar Year Deductible**<br>• Individual<br>• Family | $2,000<br>$6,000 | $6,000<br>$18,000 | $3,500<br>$7,000 | $10,500<br>$21,000 |
| **Out-of-Pocket Maximum**<br>Includes deductible<br>• Individual<br>• Family | $6,000<br>$12,000 | Unlimited<br>Unlimited | $5,000<br>$15,000 | Unlimited<br>Unlimited |
| | You Pay | | You Pay | |
| **Preventive Care** | $0 | 50%[1] | $0 | 40%[1] |
| **Telemedicine**<br>• MDLIVE Primary Care Services<br>• MDLIVE Specialty Services<br>• MDLIVE Urgent Care Services | $30 copay<br>$50 copay<br>$0 | Not covered | 20%[1]<br>20%[1]<br>20%[1] | Not covered |
| **Primary Care Physician** | $30 copay | 50%[1] | 20%[1] | 40%[1] |
| **Specialist** | $50 copay | 50%[1] | 20%[1] | 40%[1] |
| **Diagnostic Lab and X-ray** | $0 | 50%[1] | 20%[1] | 40%[1] |
| **Complex Imaging**<br>CT/PET scan, MRI | $0 | 50%[1] | 20%[1] | 40%[1] |
| **Urgent Care** | $20 copay | 50%[1] | $20 copay[1] | $20 copay[1] |
| **Emergency Room**<br>Copay waived if admitted | $250 copay | | $100 copay[1] | |
| **Inpatient Hospital Services** | 20%[1] | 50%[1] | 20%[1] | 40%[1] |
| **Outpatient Services** | 20%[1] | 50%[1] | 20%[1] | 40%[1] |
| **Prescription Drugs – Retail**<br>Up to 30-day supply<br>• Generic drugs<br>• Preferred brand name<br>• Non-preferred generic<br>• Specialty | **Express Scripts**<br><br>15% to $50 max<br>15% to $50 max<br>15% to $50 max<br>20% to $100 max | | **Express Scripts**<br><br>20% to $50 max[1]<br>20% to $50 max[1]<br>20% to $50 max[1]<br>20% to $100 max[1] | |
| **Prescription Drugs – Mail Order**<br>Up to 90-day supply<br>• Generic drugs<br>• Preferred brand name<br>• Non-preferred brand name<br>• Specialty | 15% to $100 max<br>15% to $100 max<br>15% to $100 max<br>20% to $100 max | | 20% to $100 max[1]<br>20% to $100 max[1]<br>20% to $100 max[1]<br>20% to $100 max[1] | |
| **Prescription Drugs Out-of-Pocket Maximum**<br>• Individual<br>• Family | $2,000<br>$6,000 | | $1,500<br>$4,500 | |

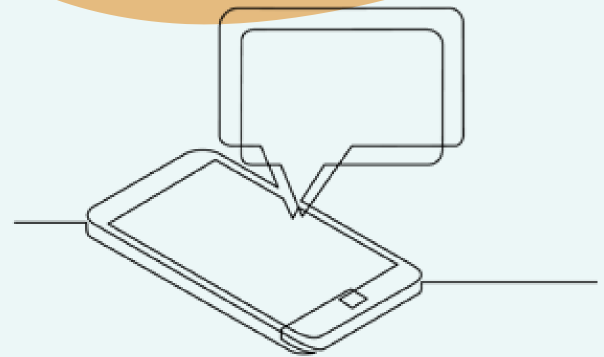
[1] The amount you pay after the deductible is met.

# Telemedicine

Your medical coverage offers telemedicine services through **MDLIVE** for **Cigna Healthcare**. Connect anytime day or night with a board-certified doctor via your mobile device or computer for free or for the same or less cost than a visit to your regular physician.

## Registration is Easy

- Log into **www.mycigna.com** and click on ***Talk to a doctor***.
- Call **888-726-3171**
- Download the **MDLIVE** app



While telemedicine does not replace your primary care physician, it is a convenient and cost-effective option when you need care and:

- Have a non-emergency issue and are considering an after hours health care clinic, urgent care clinic, or emergency room for treatment
- Are on a business trip, vacation, or away from home
- Are unable to see your primary care physician

## When to Use Telemedicine

Telemedicine providers can treat an assortment of conditions, including:

| Primary Care | Behavioral/Mental Health Care | Dermatology | Urgent Care |
|---|---|---|---|
| Preventive care | Addictions | Acne | Sore throat |
| Wellness screenings | Bipolar disorders | Eczema | Headache |
| Chronic conditions | Depression | Psoriasis | Earache |
| Lab work | Eating disorders | Rosacea | Fever |
| Diagnostic tests | Grief/Loss | Suspicious spots | Cold/Flu |
| | Panic disorders | | Bronchitis |
| | Parenting issues | | Allergies |
| | Postpartum depression | | Stomachache |
| | Stress | | Urinary tract infection |
| | Trauma/PTSD | | Pink eye |
| | | | Rashes |

**Do not use telemedicine for serious or life-threatening emergencies.**

# Health Care Options

Becoming familiar with your options for medical care can save you time and money.

| Health Care Provider | Symptoms | Average Cost | Average Wait |
|---|---|---|---|
| **Non-Emergency Care** | | | |
| Telemedicine<br>Access to care via phone, online video, or mobile app whether you are home, work or traveling; medications can be prescribed<br>**24 hours a day, 7 days a week** | • Allergies<br>• Cough/cold/flu<br>• Rash<br>• Stomachache | $ | **2-5 minutes** |
| Doctor's Office<br>Generally, the best place for routine preventive care; established relationship; able to treat based on medical history<br>**Office hours vary** | • Infections<br>• Sore and strep throat<br>• Vaccinations<br>• Minor/injuries/sprains and strains | $ | **15-20 minutes** |
| Retail Clinic<br>Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies<br>**Hours vary based on store hours** | • Common infections<br>• Minor injuries<br>• Pregnancy tests<br>• Vaccinations | $ | **15 minutes** |
| Urgent Care<br>When you need immediate attention; walk-in basis is usually accepted<br>**Generally includes evening, weekend and holiday hours** | • Sprains and strains<br>• Minor broken bones<br>• Small cuts that may require stitches<br>• Minor burns and infections | $$ | **15-30 minutes** |
| **Emergency Care** | | | |
| Hospital ER<br>Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility<br>**24 hours a day, 7 days a week** | • Chest pain<br>• Difficulty breathing<br>• Severe bleeding<br>• Blurred or sudden loss of vision<br>• Major broken bones | $$$$ | **4+ hours** |
| Freestanding ER<br>Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher<br>**24 hours a day, 7 days a week** | • Most major injuries except trauma<br>• Severe pain | $$$$$ | **Minimal** |

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

# Cigna Resources

## Member Website

myCigna.com serves as your one-stop shop for all Cigna health plan and benefits information. Key features include managing and tracking claims, accessing digital ID cards, finding in-network providers, accessing cost comparison tools, reviewing coverage details, and more. Visit www.mycigna.com to register.

- **One Guide** – Get help from a personal guide to navigate your Cigna benefits and resources. Call the number on the back of your Cigna ID card, use the click-to-chat function on www.mycigna.com, or call 866-494-2111.
- **Health Information Line** – Speak to a nurse anytime to get answers and recommendations based on your specific health situation. Call the number on the back of your Cigna ID card for 24/7 access.
- **Live, 24/7 Customer Service** – Contact a representative via phone, chat, or app.

## Mobile App

Download the **myCigna app** to access your Cigna health plan and benefits information while on the go. This app helps you organize and access important plan information on your smartphone or tablet. It is also available in Spanish.

## Cigna Digital ID Card

You have one ID card for both your pharmacy and medical needs. Cigna no longer issues and mails physical ID cards.

How to Access Your Digital ID Card

1. Log in at www.myCigna.com or the **myCigna app**.
2. Click or tap ID Cards.
3. View your card, as well as any dependents' card(s).
4. Email cards directly to doctors.
5. Save your digital ID cards in your Apple Wallet.

# Dental Coverage

Our dental plan helps you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work. Coverage is provided through **Cigna**.

## DPPO Plan

Two levels of benefits are available with the DPPO plan: in-network and out-of-network. You may see any dental provider for care, but you will pay less and get the highest level of benefits with in-network providers. You could pay more if you use an out-of-network provider.

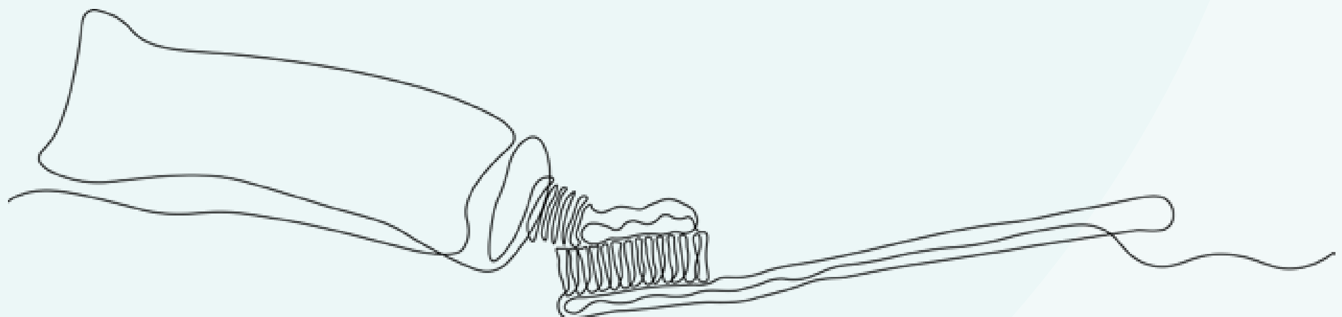
## Find an In-Network Provider

- Visit **www.mycigna.com**
- Call **800-244-6224**

## Dental Benefits Summary

| | Plan |
|---|---|
| | **In-Network and Out-of-Network[1]** |
| **Calendar Year Deductible**<br>• Individual<br>• Family | $50<br>$150 |
| **Calendar Year Benefit Maximum**<br>Per Individual | $1,500 |
| | **You Pay** |
| **Preventive Care**<br>Exams, cleanings, complete series X-rays | $0 (no deductible) |
| **Basic Care**<br>Fillings, extractions, periodontics, root canals, endodontics, oral surgery | $0 after deductible |
| **Major Restorative[2]**<br>Crowns, bridges, dentures, implants | 50% after deductible |

[1]Payment for covered services received from an out-of-network dentist is based on the 70th percentile of Usual, Customary and Reasonable (UCR) charges.
[2]A waiting period of 12 months applies to new hires only for major services. Refer to the Cigna Patient Charge schedule for details.



# Vision Coverage

Our vision plan offers quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems.

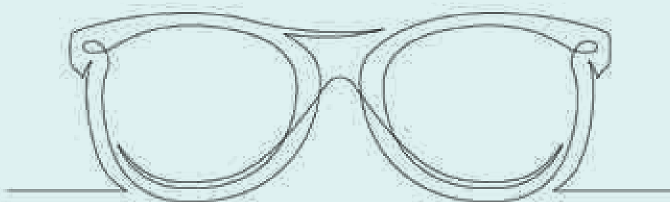
You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see in-network providers. Coverage is provided through **Cigna** using the **EyeMed** vision network.

### Find an In-Network Provider

- Visit **www.mycigna.com**
- Call **888-353-2653**

## Vision Benefits Summary

| | Vision Plan | |
|---|---|---|
| | **In-Network You Pay** | **Out-of-Network Reimbursement** |
| **Exam** | $60 allowance | Up to $60 allowance |
| **Lenses** | $250 allowance | Up to $250 allowance |
| **Frames** | $250 allowance | Up to $250 allowance |
| **Prescription Contact Lenses** | $250 allowance | Up to $250 allowance |
| **Benefit Frequency** | | |
| **Exam** | Once every 12 months | |
| **Lenses** | Once every 12 months | |
| **Frames** | Once every 12 months | |
| **Contacts** | Once every 12 months | |



# Health Savings Account

## A Health Savings Account (HSA) is a tax-exempt tool to supplement your retirement savings and to cover current and future health costs.

An HSA is a type of personal savings account that is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for current or future qualified medical expenses. There is no "use it or lose it" rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

## HSA Eligibility

You are eligible to open and contribute to an HSA if you are:

- Enrolled in the HSA-eligible HDHP
- Not covered by another plan that is not a qualified HDHP, such as your spouse's health plan
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else's tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits

## Contributions

If you enroll in the HDHP medical plan, the Catholic Diocese of Memphis will contribute $750 ($1,000 for family) to your HSA each year you first open your account.

| Maximum 2025 HSA Contributions | | | |
|---|---|---|---|
| | Employer | Employee | Total |
| **Individual** | $750 | $3,550 | **$4,300** |
| **Family** | $1,000 | $7,550 | **$8,550** |

You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are age 55 or older, you may make a yearly catch-up contribution of up to $1,000 to your HSA. If you turn 55 at anytime during the plan year, you are eligible to make the catch-up contribution for the entire plan year.

## Open an HSA

If you meet the eligibility requirements, you may open an HSA administered by **Cigna**. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA. To open an account, go to **www.mycigna.com**.

## Decide How To Use Your HSA Funds

**Use it Now**

- Make annual HSA contributions.
- Pay for eligible medical costs.
- Keep HSA funds in cash.

**Let it Grow**

- Make annual HSA contributions.
- Pay for medical costs with other funds.
- Invest HSA funds.

## Important HSA Information

- Always ask your network doctor to file claims with your medical, dental, or vision carrier so you will get the highest level of benefits. You can pay the doctor with your HSA debit card for any balance due.
- You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.
- You may open an HSA at the financial institution of your choice, but only accounts opened through **Cigna** are eligible for automatic payroll deduction and company contributions.

# Flexible Spending Account

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer two different FSAs: one for health care expenses and one for dependent care expenses. **Pinnacle Bank** administers our FSAs.

### How to Pay or Get Reimbursed for FSA Qualified Expenses

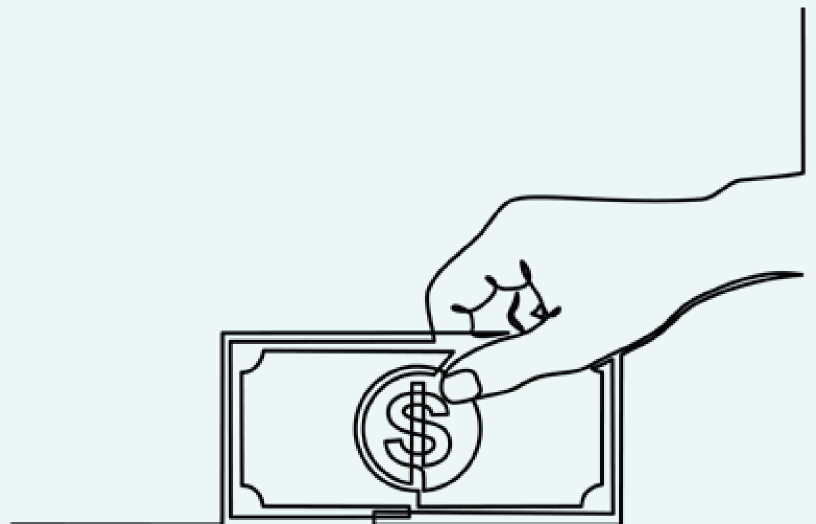
- Benefits Debit Card (Health FSA only)
  - Spend your Health Care FSA funds and file no claims.
  - Other than for copays, you must submit an itemized receipt.
- Pay out-of-pocket and submit receipts for reimbursement
  - Email – **info@health.pnfp.com**
  - Online – **www.pnfp.com/Hblogin**

## Health Care FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you or your eligible dependents. You may contribute up to **$3,300** annually to a Health Care FSA, and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision3
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA).



# Flexible Spending Account

## Dependent Care FSA

The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full-time. You can use the account to pay for daycare or babysitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.

### Dependent Care FSA Considerations

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns age 13 midyear, you may only be reimbursed for the time the child was under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

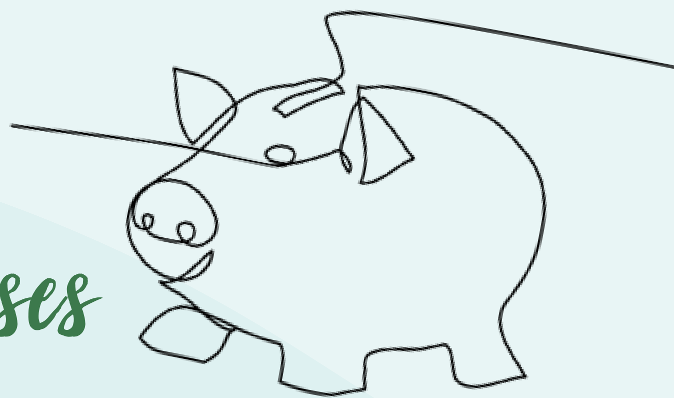
### Important FSA Rules

- The maximum per plan year you can contribute to a Health Care FSA is **$3,300**. The maximum per plan year you can contribute to a Dependent Care FSA is **$5,000** when filing jointly or head of household and **$2,500** when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- Your Health Care FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.
- You can continue to file claims incurred during the plan year for another 90 days (up until April 1, 2026).
- Your plan includes a grace period. You can continue to incur claims after the plan year ends for another two and a half months (up until March 15, 2026). You may file claims incurred during the grace period for another 90 days (up until June 13, 2026).

**Flexible Spending Accounts**

| Account Type | Eligible Expenses | Annual Contribution Limits | Benefit |
|---|---|---|---|
| **Health Care FSA** | Most medical, dental, and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses, and doctor-prescribed over-the-counter medications) | **$3,300** | Saves on eligible expenses not covered by insurance, reduces your taxable income |
| **Dependent Care FSA** | Dependent care expenses (such as daycare, after-school, or eldercare programs) so you and your spouse can work or attend school full-time | **$5,000** (filing jointly or head of household) **$2,500** (married and filing separate tax returns) | Reduces your taxable income |

# List Of Qualified HSA and FSA Expenses



The products and services listed below are examples of medical expenses eligible for payment under your Health Care Flexible Spending Account (FSA) or Health Savings Account (HSA). This list is not all-inclusive; additional expenses may qualify and the items listed may change in accordance with IRS regulations. Refer to IRS *Publication 502 Medical and Dental Expenses* at **www.irs.gov** for complete details.

Abdominal supports
Acupuncture
Alcoholism treatment
Ambulance
Anesthetist
Arch supports
Artificial limbs
Blood tests
Blood transfusions
Braces
Cardiographs
Chiropractor
Contact lenses
Convalescent home (for medical treatment only)
Crutches
Dental treatment
Dental X-rays
Dentures
Dermatologist
Drug addiction therapy
Drugs (prescription)
Elastic hosiery (prescription)
Eyeglasses
Guide dog
Gum treatment
Gynecologist
Healing services
Hearing aids and batteries
Hospital bills
Hydrotherapy
Insulin treatment
Lab tests
Lead paint removal
Legal fees
Lodging (away from home for outpatient care)
Metabolism tests
Neurologist
Nursing (including board and meals)
Obstetrician
Operating room costs
Ophthalmologist
Optician
Oral surgery
Organ transplant (including donor's expenses)
Orthopedic shoes
Osteopath
Oxygen and oxygen equipment
Pediatrician
Physician
Physiotherapist
Podiatrist
Postnatal treatments
Practical nurse for medical services
Prenatal care
Prescription medicines
Psychiatrist
Psychologist
Psychotherapy
Radium therapy
Registered nurse
Special school costs for the handicapped
Splints
Surgeon
Telephone or TV equipment to assist the hard-of-hearing
Therapy equipment
Transportation expenses (relative to health care)
Vaccines
Vitamins (if prescribed)
Wheelchair
X-rays

# Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance through **Voya** are important to your financial security, especially if others depend on you for support or vice versa.

With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies).

## Basic Life and AD&D

Basic Life and AD&D insurance are provided at no cost to you. **You are automatically covered at your annual earnings (up to $100,000) for each benefit**. Your benefit amount reduces to 65% at age 65, to 40% at age 70, and to 25% at age 75. Coverage terminates at retirement unless retiree coverage is provided.

## Voluntary Life and AD&D

If you need more coverage than Basic Life and AD&D, you may buy Voluntary Life and AD&D for yourself and your dependent(s). If you do not elect Voluntary Life and AD&D insurance when first eligible, or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before covering your spouse and/or child(ren).

Your benefit amount reduces to 60% of original coverage when you reach age 75; 35% at age 80; 27.5% at age 85; 20% at age 90; 7.5% at age 95, and 5% at age 100. Premium amounts are also reduced accordingly, and automatically adjusted for the new benefit amount.

## Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary, and you can change beneficiaries at anytime. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%).

| Voluntary Life and AD&D | |
|---|---|
| **Employee** | • Increments of $10,000 up to $500,000<br>• New Hire Guaranteed Issue $200,000<br>If member is already enrolled, they may increase at open enrollment by 2 increments ($20,000) with no Evidence of Insurability (EOI). If member has not previously enrolled, they may purchase 1 increment ($10,000) at open enrollment with no EOI. |
| **Spouse** | • Increments of $5,000 up to $250,000 not to exceed 50% of your election<br>• New Hire Guaranteed Issue $50,000 |
| **Child(ren)** | • Birth to age 26 - $2,500, $5,000, or $10,000<br>• New Hire Guaranteed Issue $10,000 |

| Employee and Spouse Coverage Monthly Rate per $1,000* | | | |
|---|---|---|---|
| Employee and Spouse | | | |
| Age | Rate | Age | Rate |
| **24-29** | $0.06 | **50-54** | $0.39 |
| **30-34** | $0.07 | **55-59** | $0.59 |
| **35-39** | $0.09 | **60-64** | $0.90 |
| **40-44** | $0.15 | **65-69** | $1.72 |
| **45-49** | $0.25 | **70+** | $2.54 |
| **Child Coverage** | | **$0.20** | |

| Monthly Rate per $1,000 | |
|---|---|
| **Employee** | $0.02 |
| **Spouse** | $0.02 |
| **Child(ren)** | $0.02 |

*Spouse coverage terminates at the earliest of: retirement (unless retiree coverage is provided), age 70, or when the spouse is no longer eligible.

## Conversion – Portability – Waiver of Premium

Upon termination of employment, you have the option to continue your company-paid Life and AD&D insurance and pay premiums directly to **Voya**. Your company-paid Life and AD&D insurance may be converted to an individual policy. Portability is available for Life coverage if you are enrolled in additional Life coverage. Portability is not available for AD&D. If you are disabled at the time your employment is terminated, you may be eligible for a Waiver of Premium while you are disabled. Contact Human Resources for a Conversion, Portability, or Waiver of Premium application.

# Disability Insurance

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We provide Short Term Disability (STD) and Long Term Disability (LTD) at **no cost to you**.

## Short Term Disability

STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, pregnancy, or non-work-related injury. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job related, it is considered Workers' Compensation, not STD.

Catholic Diocese of Memphis provides STD benefits through the Human Resources Department. The longer you are employed with us, the more time you will receive from this benefit when you have an illness or are injured.

| Short Term Disability Benefits | |
|---|---|
| **Length of Employment** | **Eligible Time Off at 75% Pay** |
| **6 months** | 1 month |
| **1-2 years** | 2 months |
| **2+ years** | 3 months |

## Long Term Disability

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 90 days. Benefits begin at the end of an elimination period and continue while you are disabled up to the maximum benefit period.

The Catholic Diocese of Memphis provides LTD benefits through **Voya**.

| Long Term Disability Benefits | |
|---|---|
| **Benefits Begin** | 91st day |
| **Percentage of Earnings You Receive** | 66.67% |
| **Maximum Monthly Benefit** | $5,000 |
| **Maximum Benefit Period** | SSNRA |
| **Pre-existing Condition Exclusion** | 3/12* |

*Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

# Supplemental Benefits

You and your eligible family members have the opportunity to enroll in additional coverage that complements our traditional health care programs through **Allstate**. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs such as deductibles, coinsurance, travel expenses, and non-medical expenses.

## Accident Insurance

Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plan helps offset the direct and indirect expenses resulting from an accident such as copayments, deductible, ambulance, physical therapy, childcare, rent, and other costs not covered by traditional health plans. See the plan document for full details.

| Allstate Voluntary Accident Plan | | |
|---|---|---|
| **Service** | **Benefit** | |
| | Plan 1 | Plan 2 |
| **Emergency Room** | $200 | $300 |
| **Ambulance – Ground/Air** | $200/$600 | $300/$900 |
| **Initial Hospitalization** | $1,000 | $1,500 |
| **Hospital Confinement** | $200 | $300 |
| **Intensive Care Unit** | $400 | $600 |
| **Specific Sum Injuries** Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc. | $60-$30,000 | $90-$45,000 |
| **Accidental Death & Dismemberment**[1] | $40,000 | $60,000 |
| **Employee Per Month Contributions** | | |
| **Employee** | $13.88 | $19.43 |
| **Employee & Spouse** | $23.99 | $33.58 |
| **Employee & Child(ren)** | $29.48 | $41.50 |
| **Employee & Family** | $38.70 | $53.87 |

[1] Percentage of benefit paid for dismemberment is dependent on type of loss.

## Cancer Insurance

Treatment for cancer is often lengthy and expensive. While your health insurance helps pay the medical expenses for cancer treatment, it does not cover the cost of non-medical expenses, such as out-of-town treatments, special diets, daily living, and household upkeep. In addition to these non-medical expenses, you are responsible for paying your health plan deductibles and/or coinsurance. Cancer insurance helps pay for these direct and indirect treatment costs so you can focus on your health.

| Allstate Voluntary Cancer Plan | |
|---|---|
| **Radiation and Chemotherapy Charges** Per 12-month period | $10,000 maximum |
| **Blood, Plasma, Platelets** Per 12-month period | $10,000 maximum |
| **Cancer Initial Diagnosis*** | $3,000 |
| **Surgery** | $3,000-$4,500 |
| **Hospital Confinement** Daily | $200 |
| **Bone Marrow or Stem Cell Transplant** | $1,000-$5,000 |
| **Employee Per Month Contributions** | |
| **Employee** | $21.26 |
| **Employee & Family** | $35.76 |

*Carcinoma in situ is not considered internal cancer

# Employee Assistance Program

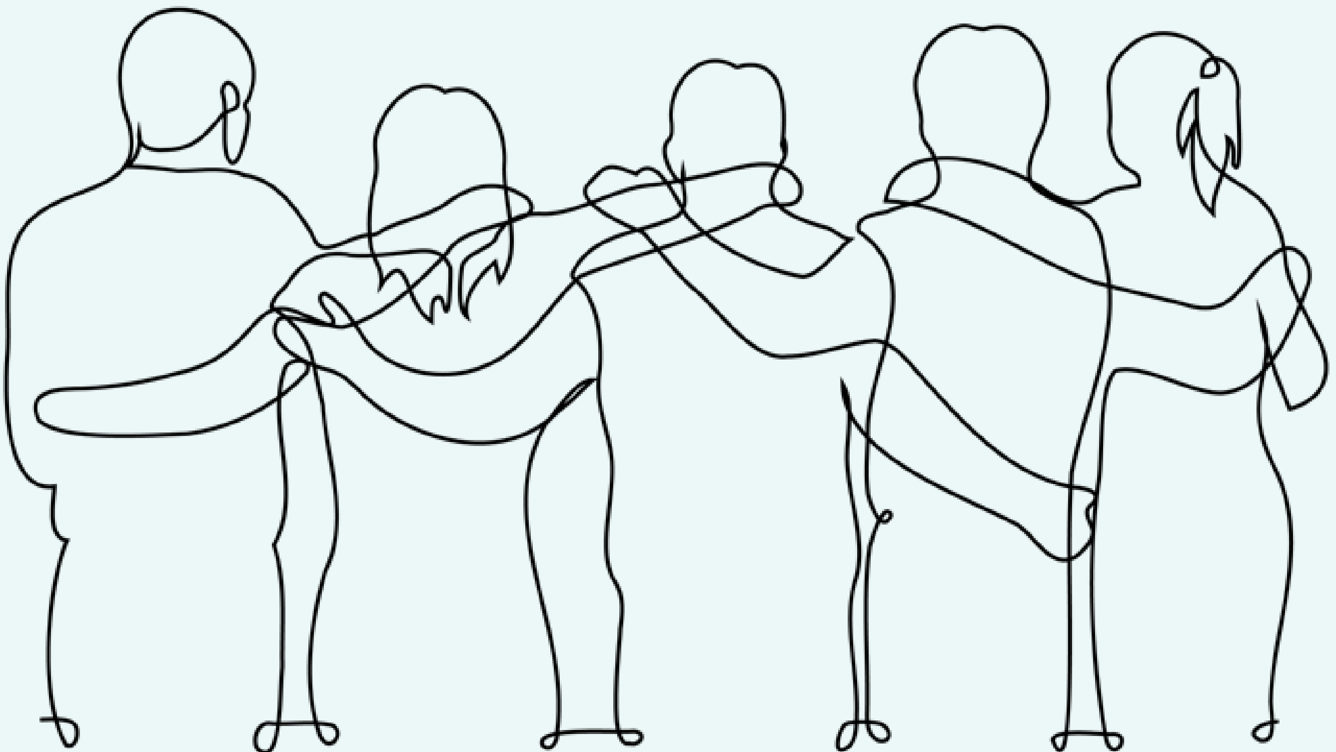
The Employee Assistance Program (EAP) from **Voya/ComPsych** helps you and family members cope with a variety of personal and work-related issues.

This program provides confidential counseling and support services at little or no cost to you to help with:

- Relationships
- Work/life balance
- Stress and anxiety
- Will preparation and estate resolution
- Grief and loss
- Childcare and eldercare resources
- Substance abuse

## For Support at Any Hour of the Day or Night

- Visit **www.guidanceresources.com**; use WebID: MY5848i
- Download the GuidanceNow app
- Call **800-697-0353**



# Additional Benefits

**Voya** offers the following benefits and services at no extra cost to you.

## Travel Assistance

If you are traveling more than 100 miles away from home, Voya Travel Assistance can help 24/7 with pre-trip planning, emergency medical needs, translation services, lost baggage or documents, legal referrals, and more.

- Call in the U.S., **800-859-2821**; everywhere else, **202-296-8355**
- Email: **ops@gga-usa.com**
- Online: **https://travelsecurity.garda.com**
- Contract Number: **17372020** (for registration)
- Group Number: **73487-0**

## Will Preparation

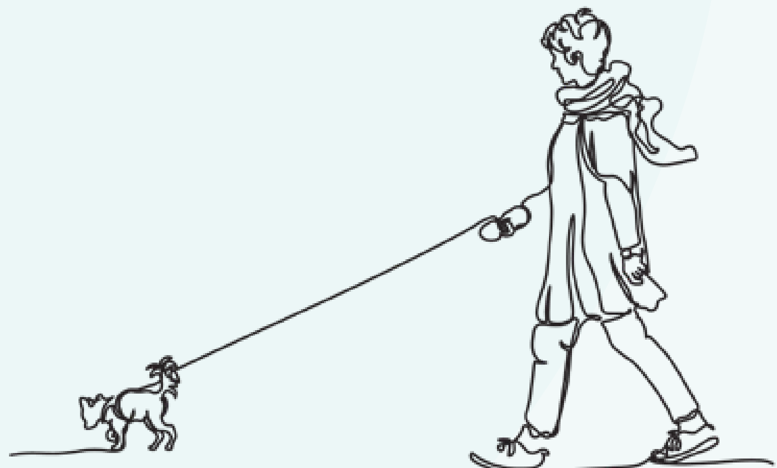
Creating a will is an important investment in your future. In just minutes, you can create a personalized will that keeps your information safe and secure. **Everest**'s online tool helps you create a basic will and other essential legal documents. The tool asks a series of questions and then creates the required clauses to create a downloadable document.

1. Go to **www.everestfuneral.com/voya**
2. Enter your email address and your employer's name
3. Create a password and complete your online profile
4. Access "Planning Tools"

## Funeral Planning and Concierge Services

Everest offers AV funeral concierge service with online tools and live support to help guide you through key decisions. It offers pre-planning, documentation of wishes, and cost comparisons for funeral-related expenses.

- Call **800-913-8318**
- Go to **www.everestfuneral.com/voya**.
- Use the group name **Catholic Diocese of Memphis** and group number **73487-0**.



# Retirement Plan

A 403(b) plan can be a powerful tool to help you be financially secure in retirement. Our 403(b) plan through **Corebridge Financial** can help you reach your investment goals.

## How the Retirement Plan Works

You are eligible to participate in the plan if you are 18 years of age. You may contribute up to the IRS limit.

You decide how much you want to contribute and can change your contribution amount anytime. All changes are effective as soon as administratively feasible and remain in effect until you update or stop your contributions. You also decide how to invest the assets in your account and may change your investment choices anytime. For more details, refer to your 403(b) Enrollment Guide or contact **Corebridge Financial** at **800-448-2542**.

## Enrollment

You are automatically enrolled at 2% of your earnings. If you want to change or cancel your contribution, you must contact **Corebridge Financial** at **www.corebridgefinancial.com/retire** or by calling **800-448-2542.**

## Company 403(b) Match

After you have been employed for one year with Catholic Diocese of Memphis, we will match 0.5% for each percentage you contribute up to a maximum match of 2%. In addition to the match, the Diocese will also contribute 5% to your account, whether or not you contribute anything.

## Vesting

You are always 100% vested in your own contributions. You are 100% vested in matching company contributions after three years of service.

## Investment Options

You may direct your contributions to any of the investments offered within the company 403(b) plan. Changes to your investments can be made by calling **800-448-2542**.

### 2025 IRS Contribution Limits

- $23,500
- $7,500 additional contribution if age 50 or older

# Employee Monthly Contributions

| | | | Your Contributions |
|---|---|---|---|
| **Medical – Full-time Employees 30-40 Hours per Week** | **PPO Plan** | **HDHP Plan** | |
| **Employee** | $150.00 | $55.00 | |
| **Employee + Spouse** | $550.00 | $370.00 | $ |
| **Employee + Family** | $800.00 | $590.00 | |
| **Medical – Part-time Employees 20-29 Hours per Week** | **PPO Plan** | **HDHP Plan** | |
| **Employee** | $565.00 | $470.00 | |
| **Employee + Spouse** | $965.00 | $785.00 | $ |
| **Employee + Family** | $1,215.00 | $1,005.00 | |
| **Dental** | | | |
| **Employee** | $38.09 | | |
| **Employee + Spouse** | $73.04 | | $ |
| **Employee + Family** | $104.79 | | |
| **Vision** | | | |
| **Employee** | | | |
| **Employee + Spouse** | Included with medical | | $ |
| **Employee + Family** | | | |
| **Life and AD&D** | | | |
| **Basic Life and AD&D** | Paid by Catholic Diocese of Memphis | | $ |
| **Voluntary Life and AD&D** | See page 19 for rates | | $ |
| **Disability** | | | |
| **Short Term Disability** | Paid by Catholic Diocese of Memphis | | $ |
| **Long Term Disability** | Paid by Catholic Diocese of Memphis | | $ |
| **Additional Benefits** | | | |
| **Accident** | See page 21 for rates | | $ |
| **Cancer** | See page 21 for rates | | $ |
| **Your Total Benefits Cost** | | | $ |

## Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

## Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

**Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)**

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later 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 enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

**Marriage, Birth or Adoption**

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

# Legal Notices

**For More Information or Assistance**

To request special enrollment or obtain more information, contact:

Catholic Diocese of Memphis
Colleen Goodspeed, Director Human Resources
5825 Shelby Oaks Drive
Memphis, TN 38134
**901-373-1200**

## 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 Catholic Diocese of Memphis and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers 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.
2. Catholic Diocese of Memphis has determined that the prescription drug coverage offered by the Catholic Diocese of Memphis medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. The HSA plan is not 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 a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Catholic Diocese of Memphis at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Catholic Diocese of Memphis prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

**For more information about this notice or your current prescription drug coverage:**

Contact the Human Resources Department at **901-373-1200**.

**NOTE:** You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also 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 in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **877-486-2048**.

# Legal Notices

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

**Remember:** Keep this Creditable Coverage notice. If 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 whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

January 1, 2025
Catholic Diocese of Memphis
Colleen Goodspeed, Director Human Resources
5825 Shelby Oaks Drive
Memphis, TN 38134
**901-373-1200**

## Notice of HIPAA 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.**

**Effective Date of Notice: September 23, 2013**

Catholic Diocese of Memphis Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

**Section 1 – Notice of PHI Uses and Disclosures**

**Required PHI Uses and Disclosures**

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

**Uses and disclosures to carry out treatment, payment and health care operations.**

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

**Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

**Payment** includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

**Health care operations** include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

**Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.**

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care.

# Legal Notices

Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

**Uses and disclosures for which your consent, authorization or opportunity to object is not required.**

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

**Uses and disclosures that require your written authorization.**

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

**Section 2 – Rights of Individuals**

**Right to Request Restrictions on Uses and Disclosures of PHI**

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

# Legal Notices

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

**Right to Request Confidential Communications**

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

**Right to Inspect and Copy PHI**

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

**Protected Health Information (PHI)**

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

**Designated Record Set**

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

**Right to Amend PHI**

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

**Right to Receive an Accounting of PHI Disclosures**

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

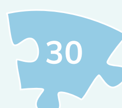
**Right to Receive a Paper Copy of This Notice Upon Request**

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

**A Note About Personal Representatives**

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).



# Legal Notices

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

**Section 3 – The Plan's Duties**

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

**Minimum Necessary Standard**

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

**De-Identified Information**

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

**Summary Health Information**

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

**Notification of Breach**

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

**Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary**

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

**Section 5 – Whom to Contact at the Plan for More Information**

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Catholic Diocese of Memphis
Colleen Goodspeed, Director Human Resources
5825 Shelby Oaks Drive
Memphis, TN 38134
**901-373-1200**

**Conclusion**

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

# Legal Notices

## 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 **1-877-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 **1-866-444-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 July 31, 2024. Contact your State for more information on eligibility.**

| Alabama – Medicaid |
|---|
| Website: http://www.myalhipp.com/<br>Phone: 1-855-692-5447 |

| Alaska – Medicaid |
|---|
| The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx |

| Arkansas – Medicaid |
|---|
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) |

| California– Medicaid |
|---|
| Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |

| Colorado – Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+) |
|---|
| Health First Colorado website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 |

| Florida – Medicaid |
|---|
| Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |

| Georgia – Medicaid |
|---|
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 |

| Indiana – Medicaid |
|---|
| Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |

| Iowa – Medicaid and CHIP (Hawki) |
|---|
| Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp<br>HIPP Phone: 1-888-346-9562 |

| Kansas – Medicaid |
|---|
| Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |

| Kentucky – Medicaid |
|---|
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms |

# Legal Notices

## Louisiana – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

## Maine – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

## Massachusetts – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

## Minnesota – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

## Missouri – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

## Montana – Medicaid

Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

## Nebraska – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

## Nevada – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

## New Hampshire – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

## New Jersey – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

## New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

## North Carolina – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

## North Dakota – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

## Oklahoma – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

## Oregon – Medicaid

Website: https://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

## Pennsylvania – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

## Rhode Island – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

## South Carolina – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

## South Dakota - Medicaid

Website: https://dss.sd.gov
Phone: 1-888-828-0059

## Texas – Medicaid

Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

## Utah – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

## Vermont– Medicaid

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

## Virginia – Medicaid and CHIP

Website: 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/CHIP Phone: 1-800-432-5924

## Washington – Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

| West Virginia – Medicaid and CHIP |
| --- |
| Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447) |

| Wisconsin – Medicaid and CHIP |
| --- |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 |

| Wyoming – Medicaid |
| --- |
| Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other States have added a premium assistance program since **July 31, 2024**, or for more information on special enrollment rights, you can contact either:

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

## 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 have not 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 a 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.

# Legal Notices

**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 cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced 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 cannot balance bill you 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 cannot balance bill you, unless you give written consent and give up your protections.

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

**When balance billing is not allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (like the 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 have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

This brochure highlights the main features of the Catholic Diocese of Memphis employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Catholic Diocese of Memphis reserves the right to change or discontinue its employee benefits plans at anytime.