Archdiocese of St. Louis

ARCHResources
SERVING THOSE WHO SERVE

Employee Benefits Plan
Administrative Manual

Archdiocese of St. Louis

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Archdiocese of St. Louis

As Catholics in the Archdiocese of St. Louis, in communion with the Bishop of Rome we are called by our Lord Jesus Christ to be His Church and live His Gospel. With joy, we strive to fulfill our Baptismal calling by prayer and worship, teaching and sharing our faith, serving others, and fostering unity in diversity, guided by the Holy Spirit. We commit ourselves to the responsible stewardship of all God's gifts.

Introduction

The Archdiocese of St. Louis provides a comprehensive employee benefit program for its employees. This Administrative Manual is designed to outline the important responsibilities of the Employer benefits administrator. The policies and procedures within this Administrative Manual should assist you in the day-to-day management of the employee benefit program. It is the primary responsibility of the Employer to properly administer the employee benefits for their employees. The Employer benefits administrator is the most important person in overseeing the smooth and proper working of the employees' benefits.

PLEASE NOTE: The Archdiocese strongly recommends that secure emails never be forwarded to and accessed on a mobile device. All parish/agency/school communications should be maintained on the parish/agency/school network/workstation.

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Benefit Program Outline

All Benefit Eligible Employees:

A. Must either be enrolled or waive coverage in the health plan due to Healthcare Reform requirements. Covered employees choose a medical plan from UnitedHealthcare (UHC):

UnitedHealthcare Standard Plan OR UnitedHealthcare Premier Plan

Included in the health insurance plan, covered employees automatically receive:

- Dental (Delta Dental of Missouri)
- Vision (Delta Vision)
- Prescription Drugs (UnitedHealthcare OptumRx)

Employees cannot select dental or vision benefits only.

B. Should be enrolled for Unum Long-Term Disability the first of the month following 90 days of active employment if scheduled to work 20 hours per week or 1,000 hours annually or more.

C. Should be enrolled to receive employer contributions in the Lay Retirement Plan through Empower following one year of active employment of 1,000 hours annually or more. All eligible Catholic Charities employees should be enrolled in their retirement plan(s).

D. Should be enrolled for Hartford 1x Salary Life Insurance and AD&D effective date of hire.

E. Should be given information on and may elect to purchase supplemental life insurance through the Hartford.

F. Should be given information on the Flexible Spending Account offered by TRISTAR Benefit Administrators.

G. Should be given information on the Employee Assistance Plan offered by Saint Louis Counseling.

H. May utilize the Adoption Assistance Program at no cost to the employee.

Note: Be sure to verify an employee's benefits eligibility on a regular basis, at least every 12 months but preferably quarterly. You have options if an employee is regularly working a minimum number of hours that meet each benefit plan's requirement:

1. Provide the employee the opportunity to enroll in any elected benefits and automatically enroll the employee in the employer paid benefit plan, or

2. Contact the employee's supervisor to decrease their regular scheduled hours, if you do not intend the employee to be offered benefits. If you have missed adding the employee to a benefit plan; please add them retroactively back to the benefit plan's eligibility date.

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The Archdiocese Health Insurance coverage includes the following four areas:

1. **Medical:** UnitedHealthcare (choice of Standard or Premier Plan).
2. **Prescription Drugs:** UnitedHealthcare/OptumRX.
3. **Dental:** Delta Dental of Missouri.
4. **Vision:** Delta Vision (utilizes EyeMed network).

*Note: Medical, Dental, and Vision coverage are bundled together in one premium. They can't be elected separately.

Annually there is an "Open Enrollment" (OE) period in which covered participants may make any changes they wish to their coverage. During the annual "OE" period, in the beginning of May, employees who had previously declined medical coverage for themselves and/or dependents may come into the plan as late enrollees without a special enrollment event. The effective date of changes for the "OE" period is July 1. The Archdiocese of St. Louis provides only a Pre-Tax Health Insurance Premium Plan for employees in which health insurance through payroll deductions are on a pre-tax basis.

UHC – UnitedHealthcare Choice Plus POS (Archdiocese Self-funded Medical Program)

A POS (Point of Service) Plan is a network of physicians and hospitals that has a contract with UHC to provide benefits. Members can choose any provider for care. However, if the member chooses an in-network provider (i.e. "goes in-network") they will receive a higher level of benefits.

Health Insurance Premiums and Major Provisions of the Health Insurance Plan can be found on the Benefits website:

- **Health Insurance Premiums – Full-Time and Part-Time Rates**
- **Major Provisions of the Health Insurance Plan**

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Rules of the Health Insurance Plan

Eligibility

Employees eligible to join the plan must be notified at date of hire of their right to enroll. All eligible employees must either enroll in a plan or waive coverage, due to healthcare reform requirements. Enrollment and waiver forms must be completed and submitted within 31 days of becoming eligible.

Who is Eligible?

- You must be considered an active employee working at least the equivalent of 1,000 hours annually. Teachers must have a half-time contract or more to be eligible.
- A religious employee on official assignment to the Archdiocese of St. Louis excluding Archdiocesan priests.
- A Permanent Deacon who is:
  - An employee working less than 1,000 hours annually for any Archdiocesan parish/organization employer;
  - A non-paid Permanent Deacon who is providing service to any Archdiocesan parish/organization;
  - The Permanent Deacon pays 100% of the premium for coverage under the plan.
- A Kenrick-Glennon Seminarian, studying for the Archdiocese of St. Louis priesthood.
- Former Employees eligible for the Early Retiree Plan or Continuation of Coverage Plan.
- Covered dependents of employees participating in this Plan. Eligible dependents are:
  - Spouse- the person to whom the Participant is married as recognized by the laws of the Catholic Church or the laws of the State of Missouri. It is always understood for his purpose that the spouse is of the opposite sex.
  - Child who is married or unmarried without respect to student or dependency status, until the end of the month of 26th birthday
  - Child above age 26 who is mentally or physically disabled and is principally dependent on you for support

When is an employee's health insurance effective?

- Coverage is generally effective first of the month, following date of hire. **Note:** The effective date for qualifying events is the event date, granted paperwork is submitted timely and completely.
- Educator under contract is effective September 1st.
- Principal effective August 1st.

Enrollment forms must be completed and submitted:

- Within 31 days of a Special Enrollment Period or date of hire.
- During the annual "open enrollment" period.

Enrollment

Employees enrolling in UnitedHealthcare Standard or Premier Plan

Coverage Tiers
Employee
Employee + One (Spouse or Dependent Child)
Employee + Family

1. Complete the Employee Health Insurance Form (see Appendix A for sample form)
   - Must be completed and submitted to employer's Business Manager within 31 days of event date.
   - If the employee is participating in Employee + 1 or Family coverage, review the dependents listed on the form to confirm for complete and accurate dependent information. Enrollment may be withheld until forms are accurately completed. Social security numbers are required.
   - Business Manager must retain a copy for your Employer records in the employee's file. The Employee Health Insurance Form is to be submitted to your HR Coordinator via scan email, or mail, or fax as soon as possible to:

Archdiocese of St. Louis
Office of Human Resources
20 Archbishop May Drive
St. Louis, MO 63119
Fax: 314.792.7548

Please Note: The Employer Benefits # is found on your payroll reports. If you are a parish, your parish # plus a number 7 placed in front of it, is your Employer Benefits #.

2. Enter appropriate information on **Employer Information** section on the health insurance form.
3. Provide employee:
   - Schedule of Benefits
   - UHC Summary Plan Description
   - Delta Dental Summary
   - Delta Vision Summary
   - Special Enrollment Notice

   or direct the employee to the Archdiocesan website at: **archstl.org/hrbenefits.**

   UHC will send a medical ID card, Delta Dental, and Delta Vision will send dental and vision ID cards to the employee's home address.

When Coverage Begins

- If an employee completes the enrollment form within 31 days of the date eligible:
  - For lay eligible new hires, the effective date is the 1st of the month following date of hire. For contracted educators, the effective date is September 1st. For Principal, the effective date is August 1st.
  - If an employee completes the enrollment form within 31 days of a qualifying event, coverage will be effective on the date of the qualifying event.
- Open Enrollment new enrollees are effective 7/1.

  If an employee is not actively working on the date coverage begins; coverage will become effective on the date he or she returns to active work.

- Coverage for dependents will begin as follows:
  - If an employee enrolls his/her eligible dependents (spouse and/or children) at the time he or she enrolls, coverage for those dependents will begin on the date the employee's coverage begins.
  - If an employee is not married or has no children at the time he or she became covered, the employee will become eligible for dependent benefits on the date the employee acquires an eligible dependent(s) through marriage, birth, adoption or otherwise as stated under "Eligibility." Coverage for each dependent will begin on the date eligible, provided the employee has enrolled and authorized contributions for dependent benefits on or before that date. An employee will have 31 days to enroll newly acquired dependents.

ID Card Note: Medical/Rx, dental, and vision ID cards are sent to the employee's home address within 7–10 business days after enrollment is received and uploaded into the carriers system. If an employee loses their medical, dental, or vision ID cards they can call the Office of Human Resources at 314.792.7546 or go to www.myuhc.com to print a temporary medical ID card and www.deltadentalmo.com to print a temporary dental card. To request a new vision ID card, the employee will need to call 844.549.2603.

IMPORTANT REQUIREMENTS

Non-Enrollment

If a new employee decides to waive health insurance, it is required that the employer does the following:

4. Complete the Employee Health Insurance Form, check the "waive" box on the top of the form and have the employee sign the form.
5. Keep and file the original "Waiver of Coverage" form with the employee's file and send a copy to the HR Office.

Late Enrollment

Insurance options are available to employees/dependents who did not sign up during their initial eligibility period and do not have a special enrollment event. These late enrollees may sign up for the plan during the annual open enrollment period in May each year. Coverage is effective on July 1 of that same year.

Termination

When coverage ceases for any reason.

- Coverage ends at the end of the month of the termination date. For educators under contract, coverage ends at the end of contract, July 31, and contracted Principals ends June 30.
- If coverage ceases due to a "special event," documentation relevant to the event may be required with termination forms.
- Proper completion of the health insurance termination form must be submitted on a timely basis, generally within 31 days, to terminate health insurance coverage for qualifying events (excluding termination of employment).
- Terminating participants may elect the Continuation of Coverage or Early Retiree provision at their cost, if they fulfill the eligibility requirements.

Changes to Enrollment

Covered employee who has a qualifying event (e.g. marriage, new child, legal separation, divorce). **Click here** for more details.

- New spouse/child must be enrolled within 31 days of the qualifying event or they will not be allowed to join the plan until the annual open enrollment period provided the employee enrolls at that time.
- Employee will need to complete the Employee Health Insurance Form. (include any required documentation) and submit to their Employer Business Manager within the 31 day time frame. **Qualifying Events Educational Video**

SPECIAL NOTES

Spousal Surcharge Policy

A spousal surcharge is an extra charge that an Archdiocesan benefit eligible employee will pay for electing to insure a spouse who has subsidized health insurance coverage available to them through his/her own employer. The spousal surcharge is an added charge of $200 per month to the usual employee contribution for health insurance. Please refer to page 33 for thorough information on the Spousal Surcharge administration and policy.

Members of Religious Orders and Medicare

Special rules apply to members of religious orders who have taken a vow of poverty and who are covered under a health plan. If such persons are age 65 or older and if their order has elected to be covered by Social Security, these individuals are entitled to Medicare at age 65. However, if the individual continues in employment after age 65 Medicare will be primary or secondary depending on to whom the individual provides services. If the services are provided to the order, then Medicare will be primary. If the services are provided to another employer who offers healthcare coverage, even if the compensation for the individual is paid directly to the order, then Medicare will be secondary. Please contact the Archdiocesan Benefits Office at **314.792.7546** if any of your participants fulfill any of the above criteria so that the Archdiocese can notify UHC that Medicare is primary and the Archdiocesan health plan is secondary.

Married couples who both work for the Archdiocese

Married couples eligible for the Archdiocesan Employee Benefit Plan may choose their plan coverage as one Employee + Family health plan, one Employee + One plan, or two Employee Only plans. If a married couple chooses the Employee + One or the Employee + Family plan, one spouse is responsible for paying the health insurance premium; there is no cost sharing between parishes.

New Employee Benefits Checklist

NEW HIRE BENEFITS ENROLLMENT CHECKLIST

New hire enrollment forms must be submitted within 31 days from contract date or first day of employment.

This checklist is designed to help you make your benefit enrollment elections. The following are required to be completed and submitted to your local benefits contact in order to finalize the benefits enrollment process:

Medical, Rx, Dental and Vision Benefits

- ***Health Insurance Enrollment Form*** – **Required** if you are enrolling in the medical, Rx, dental and vision plans. This is a packaged benefit offering and cannot be separated. Coverage is effective first of the month following date of hire.
- ***Notice of Privacy Practices (NPP)*** - **Required** for distribution/review at time of enrollment if you are enrolling in the medical, Rx, Dental and vision plans. (See NPP notice).

Waive Medical, Rx, Dental and Vision Benefits

- ***Health Insurance Waiver Form*** – **Required** if you are waiving medical, Rx, dental and vision coverage.

Health/Dependent Care Flexible Spending Account (FSA) Plan

- ***Employee Flexible Spending Plan Election Form*** – **Required** if you are enrolling in the health and/or dependent care flexible spending plan.
- You must re-enroll annually to continue participation in the FSA plan.

Life Insurance –Basic Life/AD&D

- You are automatically enrolled in the basic life/AD&D plan. There is no enrollment form to complete.
- ***Hartford Beneficiary Designation Form*** **– Required**. One beneficiary form may be completed if you are enrolled for both the Basic life/AD&D and Supplemental life plans.

Life Insurance – Supplemental Life

- ***Hartford Supplemental Life Insurance Form*** **– Required** if you are enrolling for supplemental life insurance.
- ***Hartford Beneficiary Designation Form*** **– Required** if you are enrolling for supplemental life insurance.
- *Evidence of Insurability (EOI) Form* – Required if you elect supplemental employee life insurance coverage in an amount greater than $100,000; and/or spouse coverage in an amount greater than $25,000.

Retirement Plan

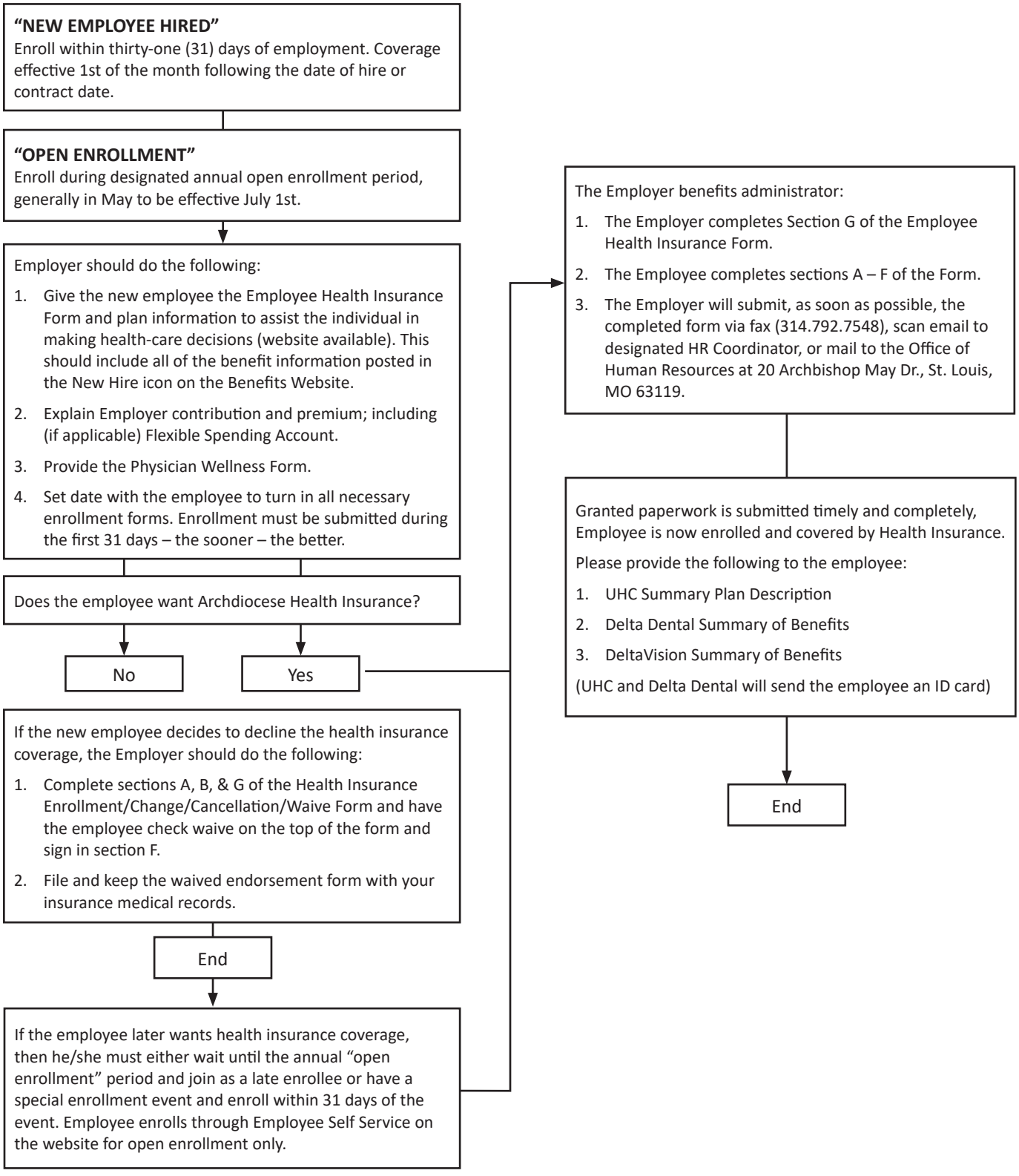
- Contact Empower – Enrollment allowed at any time. To enroll and to designate a beneficiary, call 866-467-7756 or establish on line at http://empowermyretirement.com; or contact your local Arthur J. Gallagher representatives: Mike Eagen (314) 792-7262 or Sharon Gogel (314) 792-7261.
- Cardinal Ritter Senior Services - Empower Retirement Plan: Contact your local Human Resources Representative/CRSS at 314-961-8000.
- Employer Contribution – **If you previously worked for the Archdiocese, and were receiving an employer contribution, notify your local benefits contact immediately to reinstate the contribution.**

Reminder: This benefit list is not comprehensive and is a guide to the forms that employees may need to submit for benefit enrollment processing. For additional information regarding all benefit plans and offerings please visit the following link: Employee Benefits and Forms | Human Resources | Archdiocese of St Louis (archstl.org) Rev 9 2022

Administration

Health Insurance Enrollment Administration Flow Chart

Enrollment: Each Employer benefit administrator is responsible for providing employees with appropriate health insurance information. For your convenience, the flow chart below reflects the enrollment process. Please direct your new hires to the Archdiocesan website at: **archstl.org/hrbenefits** for all plan information.



Special Enrollment Instructions For Qualifying Events

Included in the HIPAA (Health Insurance Portability and Accountability Act of 1996) is a provision for **Special Enrollment Periods**. It states that group health plans and insurers must offer special enrollment periods during which eligible persons are allowed on the plan without being considered late enrollees. If an employee experiences any of the qualifying events listed below, they may enroll, change or cancel their coverage within 31 days of the qualifying event date.

For some special enrollment periods, an employee may be able to switch between the Premier and Standard United Healthcare Plans. Examples of qualifying events are listed below:

- Legal separation
- Divorce
- Death
- Loss of coverage
- Reduction in work hours
- Employer contributions toward coverage have terminated
- Exhaustion of COBRA continuation or state continuation
- Marriage
- Birth of a child
- Adoption or placement for adoption of a child

Persons enrolling under these special enrollment conditions cannot be treated as late enrollees.

For persons losing other group coverage, special enrollments are effective the date the other coverage ends. Special enrollment is not available if the previous coverage loss resulted from fraudulent activity or because the person did not pay premiums. The Archdiocese Office of Human Resources must have documentation for marriages, divorces, legal separations, and adoptions, etc. See the next page for a list of qualified status changes and required documentation.

A group health plan must also provide a description of special enrollment rights to employees before or at the time they are eligible to enroll. The Enrollment Notice to Eligible Employees (Appendix F) should be used for this purpose. **This form should be photocopied and given to all employees at the time they are eligible to enroll.**

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The Archdiocese Office of Human Resources must have documentation for certain qualifying events. See the list below of qualifying events and any required documentation.

Event	Documents Required to Enroll in the Plan	Documents Required to Terminate from the Plan
Marriage	Marriage Certificate/License with Date of Marriage	Documentation Not Required
Divorce	Divorce Decree with Date of Divorce	Divorce Decree or signed Archdiocesan Forms (see **Appendix K and/or L**)
Legal Separation	Court's Legal Separation Agreement	Court's Legal Separation Agreement or signed Archdiocesan Form (see **Appendix K and/or L**)
Legal Annulment	Legal Annulment with Date of Annulment	Legal Annulment or signed Archdiocesan Form (see **Appendix K and/or L**)
Death	Documentation Not Required	Documentation Not Required
Birth	Documentation Not Required	Documentation Not Required
Adoption	Legal Adoption Papers	Documentation Not Required
Placement of Adoption	Letter of Placement	Documentation Not Required
Dependent Reaching 26 Years of Age*	Documentation Not Required	Documentation Not Required
Employee/Dependent Employment Status Change	Documentation Not Required	Documentation Not Required
Spouse/Dependent Enrollment in Health Insurance at New Job		
Employee/Spouse/Dependent Loss of Coverage or Current Enrollment in COBRA Plan	Letter from employer/previous employer or Archdiocese Special Enrollment Verification Form	Documentation Not Required
A Spouse, Dependent or Parent's (If Under 26 Years Old) Open Enrollment	Open Enrollment Document Information	Documentation Not Required
Marketplace Open Enrollment	Documentation Not Required	Documentation Not Required
Move In-/Out-of-Network Area	Documentation Not Required	Documentation Not Required
Court Order, Judgment, or Decree	Court Order	Documentation Not Required
Medicare or Medicaid Commences	Documentation Not Required	Documentation Not Required
Leave of Absence	Documentation Not Required	Documentation Not Required
Significant Coverage Decrease	Documentation Not Required	Documentation Not Required
Significant Cost Change 10%	Documentation Not Required	Documentation Not Required

*If coverage ceases for a dependent turning 26 years of age, his/her benefit coverage ends on the last day of the birthday month.
**If our employee is not currently enrolled in the Archdiocesan plan, then a qualifying event for our employee does not apply.

Open Enrollment Period

The "Open Enrollment Period" is when benefit eligible employees can enroll, terminate, or make any changes to their Archdiocesan-sponsored UnitedHealthcare Insurance Plan that they wish without having to experience a qualifying life event or be treated as a "late enrollee".

Eligible employees may also decide whether or not to participate in the Flexible Spending Accounts annually each year.

The Open Enrollment Period is typically the first two weeks of May each year (exact dates may vary year to year). Coverage will become effective on July 1 of that same year. You and employees may email the Office of Human Resources with questions or necessary information during Open Enrollment at: **openenrollment@archstl.org.**

Open Enrollment with the Employee Self-Service (ESS) Website

Employees can only use the Employee Self-Service for benefit changes during the "open enrollment" period. This website uses a secure method for transmitting information electronically, meaning the data sent between your computer and our system is encrypted before it is sent across the internet/network.

Employee Self-Service may become available for "special enrollments" and "new hire enrollments" in the future. We will inform you when it becomes available.

To use the Employee Self-Service portal, your employees will need the following:

1. The website address: **archstl.org/hrbenefits.** Click on Employee Self-Service tab shown next to the STAFF tab.
2. User Name (This is your Employee ID#, beginning with "ss")
3. Password
4. Internet access and a Windows PC are needed to use the Employee Self-Service website (no Mobile Devices). The employee should allow pop ups from this website, and "allow all content" if prompted. A Macintosh may be used if using the FireFox Internet Browser. If an employee does not have access to the Internet, you may want to assist them with Internet access at your office.

*Remind employees to keep login credentials in a safe and accessible place. If an employee is currently using ESS to review paychecks through the Archdiocese of St. Louis Finance Office, the employee already has a personal User Name and Password.

There is a **Password Assistance** tool for any employees that have forgotten their password.

If your employee has trouble logging in, your employee can call the Office of Human Resources at **314.792.7540** or email **humanresources@archstl.org**. There is also an ESS login help document and ESS Brainshark video available if needed, at **http://www.archstl.org/human-resources/employee-self-service**.

Pre-Tax Health Insurance Premium Plan

All employees of an Archdiocesan parish, agency or school currently participating in the Health Insurance Plan will have premiums paid automatically on a pre-tax basis. The goal of the Plan is to provide employees with the same medical insurance coverage at a lower cost.

FSA elections must be made annually online through ESS during Open Enrollment.

For additional information regarding the plan, please contact Stephanie Weider of the Archdiocese Office of Human Resources at **314.792.7546** or visit the website: **archstl.org/hrbenefits**.

Family and Medical Leave Act of 1993 (FMLA)

The Archdiocese of St. Louis provides FMLA which is up to 12 weeks of unpaid, job protected leave to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for at least one year, and for 1,250 hours over the previous 12 months.

Contact the Office of Human Resources for the necessary forms by calling **314.792.7540** or emailing **Humanresources@archstl.org**.

Reasons for Taking Leave:

Unpaid leave must be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage during the leave period just as though the employee had continued working.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

The FMLA time runs concurrent with any sick or vacation time of which cannot be used separately from the FMLA time.

Health Insurance Coverage and FMLA:

For up to three months on FMLA, the employer/employee pays the normal percentage amounts. If the employee continues to be off work due to a serious health condition after the FMLA period, your Employer may continue the coverage for three more months due to injury, sickness, or pregnancy at the premium percentage rate the employer determines. It is a total of 6 months. After the employee is out due to illness the above six months or after an approved one year leave (which is an additional 6 months), the employee would have to take the Continuation of Coverage provision or the Early Retiree Provision, depending on the employee's length of service and age.

Employees Health Insurance and Their Medicare Coordination

Please reference below regarding Medicare coordination with our UHC medical/prescription plan as an active employee/participant or terminating employee.

An active employee enrolled or eligible for the UHC Health Insurance Plan and Medicare:

- Employees may choose to continue participating in the UHC Standard or Premier Plan while also enrolled in Medicare A, B or D. Our UHC plan is primary and any Medicare coverage is secondary. There is coordination of benefits for Medicare A and B in the event of a covered claim. There is no coordination of benefits for the UHC prescription plan and Medicare D.
- Employees becoming eligible for Medicare due to their 65th birthday may opt to stay in our plan or opt to cancel our UHC coverage effective the first of the month of the eligible birth date. Medicare eligibility is a qualifying event to cancel the UHC plan.
- An employee's spouse who is covered in our UHC plan can continue as a dependent on the employee's UHC plan, even though eligible or covered by Medicare. Medicare is secondary for the dependent spouse too.
- If employees and/or spouses want to cancel their UHC plan midyear (outside of the Archdiocese Open Enrollment) because they want to solely participate in their Medicare, they can make the change during the Medicare Open Enrollment period. They cannot cancel their UHC plan just any time, unless there is a qualifying event.

An employee who is terminating employment and eligible or enrolled in Medicare:

- Effective January 1, 2023, the UnitedHealthcare® Group Medicare Advantage (PPO) plan will be an option for health care and prescription drug coverage for retired employees eligible for Medicare.
  - Retiring employees must be entitled to Medicare Part A and enrolled in Part B.
  - This plan is a custom Medicare Advantage (PPO) plan designed exclusively for retired employees of the Archdiocese of St. Louis.
  - Questions regarding coverage, eligibility and cost, should be directed to UnitedHealthcare Customer Service toll-free at **877.714.0178**, TTY 711, 8:00 a.m. – 8:00 p.m. daily.
  - Additional information is available at **www.archstl.org/hrbenefits** under the "Ending Employment" icon.

- The Archdiocese Health Insurance plan does not offer a supplemental Medicare plan for a terminating employee who is eligible for or enrolled in Medicare.
- Former employees need to contact Medicare for their Medicare enrollment. Often there is a Medicare form that is requested to be completed regarding previous health insurance coverage. You can assist the employees in completing their form and also provide them with the Medicare D Notice that is communicated each year. The Medicare D Notice is online at: **archstl.org/hrbenefits**, if they did not save the Medicare D Notice as instructed.
- It is not necessary to provide Continuation of Coverage Plan information to terminating employees who are 65 or older, since they are not eligible for the Continuation of Coverage or Early Retiree Plan, unless they have enrolled dependents who would be eligible to continue coverage.

Medicare and Medicare's Contact Information

The government's Medicare website for important information is **www.medicare.gov**. A very helpful handbook is accessible online at **http://www.medicare.gov/medicare-and-you/medicare-and-you.html**.

To contact Medicare the employee can call: **800.Medicare (633.4227)**.

UnitedHealthcare also has an excellent website, **http://www.medicaremadeclear.com** for employees who are seeking Medicare information.

When should an employee who is eligible for Medicare enroll?

When an employee is first eligible for Medicare, the employee has a seven-month Initial Enrollment Period to sign up for Part A and/or Part B. The effective date is determined by your 65th birthday, when you enroll and by Medicare at the time of enrollment.

Example

For example, if you're eligible when you turn 65, you can sign up during the seven-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

If an employee does not sign up for Part A and/or Part B when first eligible, and are not eligible for a Special Enrollment Period, then employees can sign up during the General Enrollment Period between January 1–March 31 each year.

Your coverage will start July 1. Late enrollment in Part A and/or Part B may result in higher premium.

Once the Initial Enrollment Period ends, you may have the chance to sign up for Medicare during a Special Enrollment Period.

There is an eight-month Special Enrollment Period to sign up for Part A and/or Part B that starts the month after the employment ends or the group health plan insurance based on current employment ends, whichever happens first.

Usually, a late enrollment penalty does not apply when signing up during a Special Enrollment Period.

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Employee Termination Benefits Checklist

Employee Name: _____ Termination Date: _____

_____ Give terminating employee a copy of the "Handout for Benefits Terminations".

_____ Remind employees that the health insurance ends on the last day of the month. If the employee is a contract teacher or principal, the plan coverage ends at the end of the contract period.

_____ Since the employee's health insurance is to be terminated as an active employee, complete and submit PAF terminating employment to:

Archdiocese of St. Louis
Office of Human Resources
20 Archbishop May Dr.
St. Louis, MO 63119
Fax: 314.792.7548

Or submit scan via email to your designated HR Coordinator.

_____ The Office of Human Resources will process for the Continuation of Coverage Provision, or the Early Retiree Plan, from the submitted termination PAF, if applicable.

_____ Remind employee to contact Gallagher Retirement Services at 314.792.7262 or 314.792.7261 regarding any questions on his/her retirement plan, if he/she was participating in the plan. See page 68 or contact Empower at 866.467.7756.

_____ Remind the employee that retirement distribution cannot be processed until after the final paycheck is issued and termination information is sent via electronic file feed.

_____ Employees moving into a 'substitution' position and/or continuing as part-time are not considered terminated for retirement account distribution purposes.

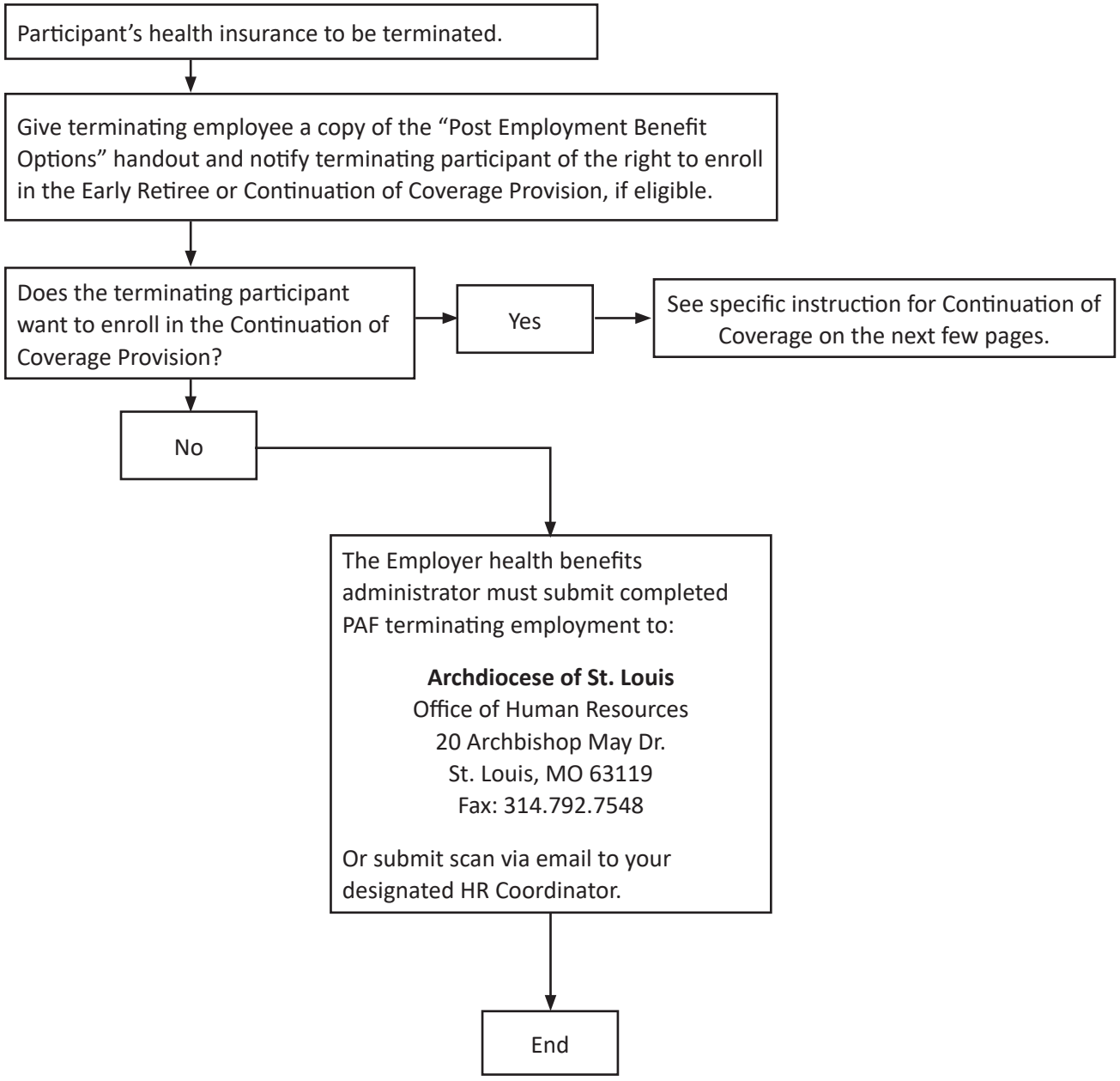
Dated: _____

Employer Representative: _____

Signature of person who completed this checklist.

FILE THIS FORM IN THE PERSONNEL FILE AT THE EMPLOYER.

Health Plan Termination Flow Chart



Termination

When coverage ends for health insurance:

1. If an employee terminates employment, the coverage will end on the last day of the month of the termination date.
2. If a teacher or Principal terminates employment, the coverage will end at the end of the contract.
3. If a teacher terminates midyear, the coverage will end on the last day of the month of the termination date. (The last paycheck does not determine the last date of employment.)
4. If an employee cancels coverage due to a qualifying event, coverage ends on the date of the qualifying event.
5. If an employee's dependent turns 26 years old, the coverage will end on the last day of the birthday month.

If an active participant in UHC is terminating employment, adhere to the following instructions:

1. Please make a copy of the Handout for Benefit Terminations and give it to the terminating employee.
2. To terminate your employee's participation in the health insurance plan, please follow these procedures:

   A. Complete and submit PAF terminating employment to:

Archdiocese of St. Louis
Office of Human Resources
20 Archbishop May Drive
St. Louis, MO 63119
Fax: 314.792.7548

Or submit scan via email to your designated HR Coordinator.

The Office of Human Resources will provide Continuation of Coverage and Early Retiree enrollment information to the terminated participant once the termination PAF is processed. The Continuation of Coverage and Early Retiree Provisions and costs are on the Archdiocesan HR/Benefits website link in the "Ending Employment" icon.

Note: COBRA, a law regarding temporary continuation of coverage for qualified employees/dependents, is not applicable to church plans. It has no bearing on this plan or the Archdiocese of St. Louis. In its place, however, please see the provisions for the Continuation of Coverage Plan detailed on pages 24-25.

Special Termination

1. **Divorce or Separation**
   The Archdiocese Employee Benefit Plan follows the Missouri Statute 452.317. The statute states the following:

   Missouri Statute 452, Section 452.317 states that Termination of Insurance prohibited, when...

   452.317. From the date of filing of the petition for dissolution of marriage or legal separation, no party shall terminate coverage during the pendency of the proceeding for any other party or any minor child of the marriage under any existing policy of health, dental or vision insurance.

   Special Note: The Archdiocese may allow a termination of insurance for a dependent spouse and or dependent children during the pendency of the proceedings, if the employee and/or spouse signs the ***Missouri Statute 452 Waiver Form*** to the Archdiocesan Employee Benefit Plan. **(See Appendix K or Appendix L.)**

   Special Note Regarding Step Children: If the employee is covering the spouse and step children, once the divorce is final, all coverage for the ex-spouse and step children is terminated on the date that the divorce is final.

2. **Death of Employee**
   The surviving spouse/dependent health insurance is offered in the event of an active employee's death for a maximum period of 12 months. The surviving spouse/dependent insurance is extended to those dependents currently covered as a health plan participant immediately prior to the death of the employee, regardless of their eligibility for Medicare. An employer, at their discretion, may contribute toward the cost of the surviving spouse/dependent health insurance premium. The employer will establish the terms of their contribution, if any, including the monthly dollar amount and duration of their contribution. If the employer chooses not to contribute, the surviving spouse/dependent will be responsible for 100% of the full premium cost. At the conclusion of the 12 month period, Continuation of Coverage or the Early Retiree health insurance may be offered, as outlined under the eligibility requirements. Noting, however, eligibility for Medicare is an exclusion for Continuation of Coverage or Early Retiree coverage.

In the Event of an Employee's Death

Review all current benefits for the employee at the time of death

1. Health Insurance
2. Supplemental Life Insurance and Basic Life Insurance
3. Any Employer Paid Life Insurance
4. Retirement Plan
5. Flexible Spending Accounts

Who to contact regarding the individual benefits?

- **Hartford Supplemental and Basic Life Insurance:** Linda Lenz at **314.682.0254** or **linda.lenz@thehartford.com**.
- **Arthur J. Gallagher & Co.:** Sharon Gogel at **314.792.7261** or Mike Eagen at **314.792.7262**.
- **Mass Mutual Retirement Plan:** The office of Human Resources for Cardinal Ritter Senior Services at **314.961.8000**.
- **FSA Medical or Dependent Care Accounts:** Tristar at **800.456.4584** or **flex@trstargroup.net**.
- If you need further assistance, contact the Office of Human Resources at **314.792.7546**.

Note: Cancel the appropriate benefits by the normal process of terminating coverage for any of your employee's effective date of the death.

POST-EMPLOYMENT BENEFIT OPTIONS

When your benefit coverage terminates through one of the Archdiocese of St. Louis plans, you may have options to continue coverage. Below is a summary of options that may be available for continuation.

COVERAGE	OPTIONS AFTER BENEFITS END
Health Insurance: • United Healthcare (UHC) – Medical/Rx: Standard or Premier Plan • Delta Dental - Dental • DeltaVision - Vision	If your health insurance is terminating, you may: • Elect to be covered by the Continuation of Coverage or Early Retiree provision, if eligible. (If you are eligible for Medicare, you are not eligible for this provision). • The Office of Human Resources will mail you Continuation of Coverage information and forms. • Monthly premiums are processed by automatic withdrawal on the 5th of each month. • Premiums may change annually 7/1. • Detailed information is available at www.archstl.org/hrbenefits under the "Ending Employment" icon. **UHC Medical/Rx Plans:** Effective 7/1/23 **Standard Plan**: *employee only*: $600; *employee + one*: $1,326; *employee + family*: $1,791 **Premier Plan**: *employee only*: $879; *employee + one*: $1,763; *employee + family*: $2,223
UnitedHealthcare Group Medicare Advantage (PPO) Plan	Effective January 1, 2023, the UnitedHealthcare® Group Medicare Advantage (PPO) plan will be an option for health care and prescription drug coverage. • **Retiring** employees must be entitled to Medicare Part A and enrolled in Part B. • This plan is a custom Medicare Advantage (PPO) plan designed exclusively for retired employees of the Archdiocese of St. Louis. • Questions regarding coverage, eligibility and cost, should be directed toUnitedHealthcare Customer Service toll-free at 1-877-714-0178, TTY 711, 8:00 a.m. – 8:00 p.m. daily. • Additional information is available at www.archstl.org/hrbenefits under the "Ending Employment" icon.
Hartford Basic Life and AD&D Insurance **Hartford Supplemental Life Insurance**	If your Basic Life insurance plan is terminating, or if you participated in the Supplemental Life insurance plan and coverage is reduced or ends for any reason except nonpayment of premiums, you may: • Convert your group Basic Life plan to an individual policy. • Convert or Port your Supplemental Life plan to an individual policy. • No medical certification is needed. • Application for Portability and/or Conversion and payment of the first premium is required within 31 days after your group coverage ends. • Family members may Port or Convert their coverage as well. • Certain benefits and limits may apply as outlined in the group policies and Notice of Conversion or Portability Form, available upon request or found at **www.archstl.org/hrbenefits** in the Life Insurance Plans icon. • Premiums will change at this time. • For additional information, contact Hartford's Conversion & Portability Administrator at 877-320-0484.
Empower 403(b) Lay Retirement Plans	If you participated in the lay employee 403(b) retirement plan, and have questions about your account and distribution options, contact: • Empower at 1.866.467.7756; or • A Gallagher representative at 314.792.7262 or 314.792.7261 • If you are transferring to another participating Employer/Agency, you are not eligible for a distribution. • Eligible distributions cannot be processed until the final paycheck has been issued.
Tristar Flexible Spending Accounts (FSA)	If you participated in one or both of the Flexible Spending Account Plans: • Your salary reductions will terminate. • You will be able to receive reimbursements for Medical Care and/or Dependent Care expenses incurred during the period of coverage prior to your date of termination. • You must file a claim within 30 days following the close of the Plan Year in which the expense arose. • Contact Tristar directly for additional information at 1.800.456.4584 (Option 4).

Unum Long Term Disability (LTD)	The Long Term Disability Benefit ends on the last day of employment. There is no conversion policy for the Long Term Disability Plan.
For further inquiries, contact the Office of Human Resources at the following E-mail: Benefits@archstl.org	

Revised 6/2023

Continuation of Coverage Provision

Who May Continue Coverage, When, and for How Long?

Any individual who has been covered under this Plan for three months or longer may elect to continue coverage. Anyone who is covered under another group healthcare plan at the time he or she becomes eligible for continuation or if covered by Medicare when he or she becomes eligible for continuation cannot participate in this Continuation of Coverage Plan. Anyone who is covered under a signed separation/severance agreement can participate in this Continuation of Coverage Plan for the limited time of the agreement. You may continue medical, prescription, dental and vision coverage under the Plan for yourself and your dependents for up to 18 months if your coverage terminates for any of the following reasons:

- If your employment terminates for any reason other than your gross misconduct or
- If your working hours are reduced and you are no longer considered eligible for coverage under the Plan.

Continuation of Coverage may extend from 18 months to 29 months for a participant and/or dependent who is disabled (as defined by the Social Security Administration) at the time of termination or reduction of hours, provided that such participant and/or dependent has given notice of the disability within 60 days of the Social Security determination and requested the extended continuation period before the end of the first 18 months.

Your dependents' coverage may be continued for up to 36 months if their coverage terminates for any of the following reasons:

- If you should die; or
- If you become divorced or legally separated from your spouse; or
- If your dependent child no longer meets the definition of an eligible dependent child under the Plan.

If the employee terminated after Medicare entitlement, the spouse/dependents are entitled to Continuation of Coverage for the longer of:

- 18 months from the date of the qualifying event (employee resignation/termination)
- 36 month from the date the employee became entitled to Medicare.

However, if the employee terminates employment just one month before Medicare entitlement, the spouse and dependents are entitled to Continuation of Coverage for up to 18 months.

When Continued Coverage Ends

The continued coverage will end for any person when:

- The cost of continued coverage is not paid on or before the date it is due; or
- That person becomes entitled to Medicare; or
- That person is covered or becomes covered under another group healthcare plan; or
- The Plan terminates for all employees; or
- That person has been in the continued coverage plan for applicable maximum time frame.
- That person submits a cancellation form indicating the termination date of coverage.

Coverage Change Due to a Qualifying Event

There are a limited number of qualifying events under the Continuation of Coverage Provision. You are eligible to change your coverage only when you experience one of the qualifying events listed below.

- Marriage
- Divorce/Legal Separation/Legal Annulment
- Death of Spouse/Dependent
- Dependent child reached 26 years of age
- Dependent begins a new job
- Birth of a Child
- Legal Adoption/Placement of Adoption
- Court Order, Judgment, or Decree
- Medicare commences
- Dependent loss of coverage

Notice Responsibilities

Within 60 days of termination or the qualifying event, it is your responsibility to notify the Archdiocesan Office of Human Resources at **benefits@archstl.org** or **314.792.7546** of whether or not you intend to enroll in the continued coverage provision plan. Regardless when enrollment paperwork is submitted. The Early Retiree/ Continuation of Coverage is effective the date after active employee coverage ends. Coverage and premiums are retroactive to that date. It is your responsibility or that of your spouse to notify the Archdiocesan Office of Human Resources, if you become divorced or legally separated. It is your responsibility or that of your covered child to notify the Office of Human Resources if your dependent child no longer qualifies as a covered dependent under the Plan. *If you, your spouse, or child, fail to properly notify the Office of Human Resources within the 60 day period, you, your spouse, or your dependent child will be unable to purchase continued coverage.*

Early Retiree Health Insurance Provision

An employee and/or his or her enrolled dependents in the Archdiocese of St. Louis Health Insurance Plan may continue full health/dental/vision coverage in the Early Retiree Plan if the following eligibility requirements are met by the employee at the time their employment ends:

- Age 55 or older.
- Not yet eligible for Medicare.
- Employee must either have been a half time or more teacher as defined by the Archdiocesan Policy or worked for 1,000 hours or more annually for ten of the prior twelve years to retirement.
- Employment must have been with a parish, school, or agency of the Archdiocese of St. Louis.

An employee who meets the above criteria is able to continue coverage in the Early Retiree Health Insurance Plan until he or she is eligible for Medicare health insurance coverage.

A covered spouse enrolled as a dependent is able to continue coverage as a dependent in the Early Retiree Plan for five years from the date the employee's employment ended or until they become eligible for Medicare, whichever comes first.

A covered child enrolled as a dependent is able to continue coverage as a dependent in the Early Retiree Plan for five years form the date the employee's employment ended or until they reach 26 years of age, whichever comes first.

Please note the following if an employee meets the aforementioned Early Retiree criteria but is eligible for Medicare at the time their employment ends:

- Their covered spouse is eligible to enroll in the Early Retiree Plan and continue coverage for five years or until their own Medicare eligibility date, whichever comes first.
- Their covered dependent child is eligible to enroll in the Early Retiree Plan and continue coverage for five years or until they reach 26 years of age, whichever comes first.

Should an Early Retiree participant obtain dependent(s) and wish to enroll the dependent(s), he or she would have thirty one (31) days from the date of the event (marriage/adoption/birth) to submit the request to add the new dependent(s).

The Early Retiree participant will be responsible for paying (100%) of the then current premium, plus any regular future premium increases, on a monthly basis. The participant will receive a monthly health insurance invoice via email and will pay the premium via automatic withdrawal from their designated bank account.

Archdiocese of St. Louis

If a participant of the Early Retiree Plan terminates coverage, he or she will not be eligible to enroll back into the Plan at a later date. If a retiree's former employer terminates participation with the Archdiocese Health Insurance Plan, coverage with the Archdiocese will also terminate. The eligibility requirements, availability, and the terms of the Early Retiree healthcare provisions are subject to change by the Archdiocese of St. Louis.

Effective 7/1/2023 – 6/30/2024, please see the table below for the monthly premium cost for Early Retiree health insurance coverage.

Health Plan	Participant Monthly Cost	Participant + 1 Dependent Monthly Cost	Participant + Family Monthly Cost
United Healthcare Standard Plan Total Monthly Premium	$600	$1,326	$1,791
United Healthcare Premier Plan Total Monthly Premium	$879	$1,763	$2,223

If you have any questions, please contact the Benefits Team at **314.792.7546** or by emailing **Benefits@archstl.org**.

Billing for Health Insurance Premiums

Health Insurance Benefit and Cost Reconciliation

Effective July 1, 2022: The Health Insurance Benefit and Cost Reconciliation process replaces monthly Health Insurance Invoices and payments. Health Insurance **costs and payments are included in each payroll run** and reflected in each PREEExpenseListing report. Agencies are responsible for verifying that health insurance benefits are processed correctly in payroll.
Cash flow planning: One-half (50%) of the monthly health insurance costs are included in each payroll run. This replaces the monthly payments that paid the invoices.

Reports needed:

1. BNEnrollment report: The report lists all employees currently enrolled to receive benefits. The amounts listed are annual amounts. Review the list after each payroll run and verify that all Personnel Action Forms (PAFs) were submitted and are processed correctly.
2. PREEExpenseListing: The report details the employees and their amounts owed for their premiums and applicable surcharge.

STEP 1: Reviewing the BNEnrollment report:

- Search this report for Medical / RX / Dental / Vision. Using Ctrl F and the word 'medical' automates the process.
- Verify that all additions, changes, and terminations appear on the report.
- Contact your HR Representative if errors and/or omissions exist.

Enrolled Benefits Report

Parish/Agency: 7510 - Holy Ghost

Benefits as of: 6/30/2022

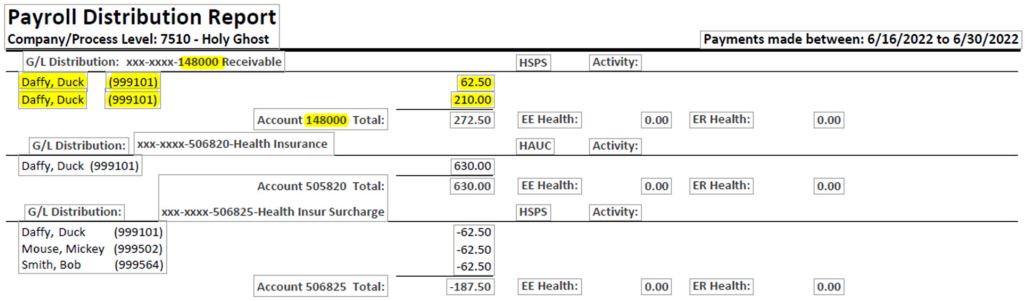
		EE Pre Cost	EE After Cost	Cover Amt	ER Cost
[redacted]					
Paid Retirmt Plan		0.00	0.00	0.00	5.00
Vol Retire Plan		10.00	0.00	0.00	0.00
Unum Long Term Disability		0.00	0.00	0.00	0.21
Decline Voluntary Spouse Life		0.00	0.00	0.00	0.00
Decline Voluntary Child Life		0.00	0.00	0.00	0.00
Hartford Basic Life Insurance		0.00	0.00	32,000.00	0.00
Hartford Voluntary Life		0.00	72.00	100,000.00	0.00
Employee Assistance Program		0.00	0.00	0.00	0.00
Spouse Surcharge Fee	Not Covering A S	0.00	0.00	0.00	0.00
Medical / Rx / Dental / Vision	Prem Emp Only	1,488.00	0.00	0.00	8,400.00
Waive FSA Dependent Care		0.00	0.00	0.00	0.00
Duck, Daffy (999101)					
Paid Retirmt Plan		0.00	0.00	0.00	5.00
Unum Long Term Disability		0.00	0.00	0.00	0.21
Decline Voluntary Child Life		0.00	0.00	0.00	0.00
Voluntary Spouse Life		0.00	72.60	25,000.00	0.00
Hartford Basic Life Insurance		0.00	0.00	39,000.00	0.00
Hartford Voluntary Life		0.00	145.20	50,000.00	0.00
Employee Assistance Program		0.00	0.00	0.00	0.00
Spouse Surcharge Fee	Spouse Surcharge	1,500.00	0.00	0.00	0.00
Medical / Rx / Dental / Vision	Stnd Family	5,040.00	0.00	0.00	15,120.00
Waive FSA Medical		0.00	0.00	0.00	0.00
Waive FSA Dependent Care		0.00	0.00	0.00	0.00
[redacted]					
Paid Retirmt Plan		0.00	0.00	0.00	5.00
Vol Retire Plan		26,400.00	0.00	0.00	0.00
Unum Long Term Disability		0.00	0.00	0.00	0.21
Voluntary Child Life		0.00	22.32	10,000.00	0.00
Hartford Basic Life Insurance		0.00	0.00	78,000.00	0.00
Hartford Voluntary Life		0.00	648.72	60,000.00	0.00
Employee Assistance Program		0.00	0.00	0.00	0.00
Medical / Rx / Dental / Vision	Prem Emp Only	1,488.00	0.00	0.00	8,400.00
Waive FSA Medical		0.00	0.00	0.00	0.00
Waive FSA Dependent Care		0.00	0.00	0.00	0.00
Mouse, Mickey (999502)					
Paid Retirmt Plan		0.00	0.00	0.00	5.00
Vol Retire Plan		10.00	0.00	0.00	0.00
Unum Long Term Disability		0.00	0.00	0.00	0.21
Decline Voluntary Child Life		0.00	0.00	0.00	0.00
Voluntary Spouse Life		0.00	72.60	25,000.00	0.00
Hartford Basic Life Insurance		0.00	0.00	56,000.00	0.00
Hartford Voluntary Life		0.00	290.40	100,000.00	0.00
Employee Assistance Program		0.00	0.00	0.00	0.00
Spouse Surcharge Fee	Spouse Surcharge	1,500.00	0.00	0.00	0.00
Medical / Rx / Dental / Vision	Prem Family	6,252.00	0.00	0.00	18,768.00
Waive FSA Dependent Care		0.00	0.00	0.00	0.00

6/20/2023 10:52 AM Agency Instructions

Page **2** of **3**

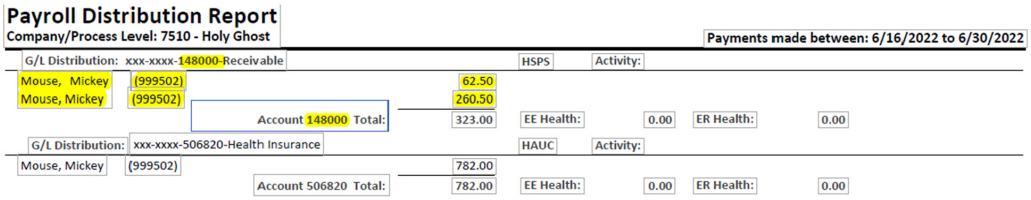
STEP 2: Reviewing the PREEExpenseListing report: Determining amounts owed to agency

- Search this report for 148000. Ctrl F and '148000' automates the process. This code indicates the employee was not paid and the agency has paid the employee's premium and spousal surcharge if applicable.
- Make a note or highlight name and amount of the health monies owed.



Payroll Distribution Report
Company/Process Level: 7510 - Holy Ghost
Payments made between: 6/16/2022 to 6/30/2022

G/L Distribution: xxx-xxxx-148000 Receivable				HSPS	Activity:			
Daffy, Duck	(999101)	62.50						
Daffy, Duck	(999101)	210.00						
Account 148000 Total:		272.50		EE Health:	0.00	ER Health:	0.00	
G/L Distribution: xxx-xxxx-506820-Health Insurance				HAUC	Activity:			
Daffy, Duck (999101)		630.00						
Account 505820 Total:		630.00		EE Health:	0.00	ER Health:	0.00	
G/L Distribution: xxx-xxxx-506825-Health Insur Surcharge				HSPS	Activity:			
Daffy, Duck	(999101)	-62.50						
Mouse, Mickey	(999502)	-62.50						
Smith, Bob	(999564)	-62.50						
Account 506825 Total:		-187.50		EE Health:	0.00	ER Health:	0.00	



Payroll Distribution Report
Company/Process Level: 7510 - Holy Ghost
Payments made between: 6/16/2022 to 6/30/2022

G/L Distribution: xxx-xxxx-148000-Receivable				HSPS	Activity:			
Mouse, Mickey	(999502)	62.50						
Mouse, Mickey	(999502)	260.50						
Account 148000 Total:		323.00		EE Health:	0.00	ER Health:	0.00	
G/L Distribution: xxx-xxxx-506820-Health Insurance				HAUC	Activity:			
Mouse, Mickey	(999502)	782.00						
Account 506820 Total:		782.00		EE Health:	0.00	ER Health:	0.00	

STEP 3: Clearing the 148000 Employees' Health Insurance account: This account reflects what is owed to the agency from employees.

- Notify the employee of the amount owed.
    - Deposit the employee's personal check to the agency demand account posting to the 148000 account.

If an employee is employed by more than one Archdiocese employer, the health insurance for that employee is expensed to the employer, according to the FTE for each location. Payroll would have to enter a PR23 allocation record but then the expense would go to the proper location. There is **no billing** any longer so there would be no reimbursement between two locations any longer.

Health Insurance Premium Billing Rules

New Enrollments: Employees/dependents enrolled with an effective date between or including the 1st and the 15th of the month are charged a full month's premium. Employees/dependents with an effective date after the 15th of the month through the 31st are not charged premiums for that month.

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Effective dates within the gray shaded calendar days indicate premium due for new enrollments.

Terminations: If an employee/dependent's health insurance terminates between or including the 1st and the 15th of the month, then no premiums are charged for that month. If an employee/dependent 's health insurance terminates between or including the 16th and 31st of the month, then the employer is charged a full month's premium for the employee. Retroactive termination adjustments will not be credited for more than two months.

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Effective dates within the gray shaded calendar days indicate premium due for terminated participants.

Changes: For any transferring employee or employee tier changes, the employee/employer will be charged the full premium amount if the employee is covered on or before the 15th of the month; the Archdiocese does not prorate for adds, terms, or changes for the monthly premium. **The employer who employs the transferring employee on the 15th of the month is billed for that month's premium. The coverage type/tier that an employee has on the 15th of the month is the coverage type/tier that will be billed for that month.** Health insurance changes are processed by automatic withdrawal by the Archdiocesan Finance Office, as part of each payroll run.

Catch-Up Employee Benefit Premium Payments

Employees who enroll in health insurance or other benefits who are within a time period of zero payroll remittance (ex: FMLA/medical leave, furlough, school year summer time off, or as a new hire without a first payroll deposit/deduction), please see the recommended process below for an employer to collect the employee's contribution for benefits.

*FMLA/medical leave, furlough, school year employees off in the summer – recommended option:

- The employer requests the employee pay the employee's contribution for health insurance by check at least monthly by the first of the month of coverage. The employer is recommended to terminate the employee's health insurance should the employee not pay the premiums timely.

The life insurance premium, if applicable, will be collected automatically through the payroll deduction arrears process, upon the employee's return to paid status.

Archdiocese of St. Louis

Health Insurance Premiums for Classification of Employees

	Full-Time	Part-Time	Non-Eligible
Teachers and Learning Consultants/Full-Time (Nine months out of the year)	X		
Teachers and Learning Consultants/Half-Time or more (yet less than full-time for nine months)		X	
Teachers and Learning Consultants (Nine months out of the year, less than half-time and works less than 2½ days a week)			X
School Year Employees who work nine months, five days a week for full school day (ex: School Secretaries, Maintenance, Teacher's Aide, Pre-School Teacher, Cafeteria, Cooks who are non-contract)	X		
School Year Employees who work more than 1,000 hours, but less than 1,820 hours annually and less than five full school days per week		X	
School Year Employees who work less than 1,000 hours annually and less than five full school days per week (ex: Bookkeeper, Maintenance, Clerical, Youth Minister)			X
Parish Employees who work more than 1,000 hours and less than 1,820 hours annually (yet not full-time)		X	
Parish Employees who work less than 1,000 hours			X

Health Insurance Premiums for Full-Time Employees and Educators

Effective July 1, 2023 through June 30, 2024	Employee Only	Employee + One Dependent*	Employee + Family*
Standard Plan – UnitedHealthcare			
Employee Contributions	$90.00 (15%)	$331.00 (25%)	$447.00 (25%)
Employer Contributions	$510.00 (85%)	$995.00 (75%)	$1,344.00 (75%)
Total Monthly Premium	$600.00	$1,326.00	$1,791.00
Premier Plan – UnitedHealthcare			
Employee Contributions	$131.00 (15%)	$440.00 (25%)	$555.00 (25%)
Employer Contributions	$748.00 (85%)	$1,323.00 (75%)	$1,668.00 (75%)
Total Monthly Premium	$879.00	$1,763.00	$2,223.00

Health Insurance Premiums for Part-Time Employees (1,000 hours or more per year) and Less than Full-Time Educators (work Half-Time or more and less than Full-Time)

Effective July 1, 2023 through June 30, 2024	Employee Only	Employee + One Dependent*	Employee + Family*
Standard Plan – UnitedHealthcare			
Employee Contributions	$240.00 (40%)	$663.00 (50%)	$895.00 (50%)
Employer Contributions	$360.00 (60%)	$663.00 (50%)	$896.00 (50%)
Total Monthly Premium	$600.00	$1,326.00	$1,791.00
Premier Plan – UnitedHealthcare			
Employee Contributions	$351.00 (40%)	$881.00 (50%)	$1,111.00 (50%)
Employer Contributions	$528.00 (60%)	$882.00 (50%)	$1,112.00 (50%)
Total Monthly Premium	$879.00	$1,763.00	$2,223.00

*A Spousal Surcharge of $200 a month may apply.

Archdiocese of St. Louis

Spousal Surcharge Policy and Administration

A spousal surcharge is an extra charge that an Archdiocesan benefit eligible employee will pay for electing to insure a spouse who has subsidized health insurance coverage available to them through his/her own employer. The spousal surcharge is an added charge of $200 per month to the usual employee contribution for health insurance.

Communication: It is very important to communicate the Spousal Surcharge Policy to your benefit eligible employees, especially those with a spouse. The best method of communication is to provide them the Spousal Surcharge Frequently Asked Questions and directions to the Archdiocesan website: **http://archstl.org/hrbenefits**. This website provides the most current information. The document, the Spousal Surcharge Frequently Asked Questions, is attached as **Appendix M** for you to read thoroughly for more in depth education.

Effective Dates: The employee seeking a spousal surcharge exemption will need to complete the Employee Health Insurance Form, as new hire, and/or for a qualifying event within 31 days of the event date.

If the employee is a new hire, not exempt from the surcharge, and the employee is covering the spouse in the Archdiocese Health Insurance plan, the effective date of the surcharge fee would be the same as the effective date of the employee's health insurance coverage.

For the employee's payroll deduction, the rule for the spousal surcharge would be the same as the rule for the employee contribution to the health insurance premium:

- If the effective date of the employee's health insurance enrollment is prior to the 16th of any given month, the employee owes the full health premium and the spousal surcharge fee for that month.
- If the effective date of the employee's health insurance enrollment is on or after the 16th of any given month, the employee does not owe any health insurance premium or spousal surcharge for that month.
- There is no prorating of the health insurance premium or the surcharge.
- The Archdiocese will not be retroactively reimbursing anyone for surcharge amounts already paid.

If you have a qualifying event for your Archdiocesan health insurance coverage, the effective date of the employee spousal surcharge would be the date of the qualifying event. A few of the more common qualified events include: marriage, divorce, birth of a baby, change in status such as part-time to full-time, etc. (For example, marriage is a qualifying event where the effective date of the surcharge is the date of the marriage.)

Exemption Status:

In general, the spousal surcharge will not be added if the Spousal Surcharge exemption is submitted within 31 days of the effective date and the enrolled spouse is one of the following:

- My spouse is not employed.
- My spouse is self-employed, does not provide themselves employer-subsidized health insurance coverage, and is not eligible for employer-subsidized health insurance.
- My spouse is employed with an Archdiocese of St. Louis parish, agency, or school.
- My spouse is employed and is not eligible for his/her employer's health insurance coverage.
- My spouse is employed and my spouse's employer does not offer health insurance coverage.
- My spouse is employed and is eligible for his/her health insurance coverage but the full premium cost is paid by the employee. There is NO employer contribution toward the cost of the health insurance.

In the event the spouse's exemption status changes, it is the employee's responsibility to complete an Employee Health Insurance Form marking the different exempt status.

Administration of Health Plan for Transfers and Rehires

Transferred and Rehired Health Plan Participant's Coverage and Effective Dates

Effective July 1, 2022, the administration of benefit elections for transferred and rehired health plan participants has been updated in order to comply with Affordable Care Act (ACA) requirements as summarized below:

Employee Transfers:

- Coverage is **effective immediately.**
- Plan elections transfer/remain the same.
- May not change plan coverage *(without another qualifying event).*
- NO HEALTH ENROLL FORM REQUIRED.

Rehire Employee (31 days or less):

- *Same rules as a transferred employee.*
- Coverage is **effective immediately.**
- Reinstatement of prior plan elections.
- May not change plan coverage (without another qualifying event).
- NO HEALTH ENROLL FORM REQUIRED.

Rehire Employee (on or between days 32 through 91):

- Coverage is **effective immediately.**
- May make **new plan elections** or **waive** coverage.
- REQUIRES COMPLETION OF A HEALTH ENROLL FORM OR WAIVER ELECTION.

Rehire Employee (92+ days):

- *Treat as a new hire enrollment.*
- Coverage is **effective the first of the month following the date of hire.**
- May **make new plan elections** or **waive** coverage.

Health Plan Premium Rules for Transferred Employees:

- The employer who employs the transferring employee on the 15th of the month is responsible for the employer portion of the monthly premium charged through payroll processing for the coverage type/tier for that month's premium. The transferring employee is responsible for the employee portion of the monthly premium, which is deducted from their paycheck.

Examples:

- Isaac is an hourly full-time employee at Parish A and his position is eliminated effective June 13th. He is offered to start a new part-time job at Parish B effective on June 14th, the next day.
- Existing benefits will be transferred from Parish A to Parish Band effective immediately for Isaac.
- Plan coverages may not be changed.
- Parish A **will not** be charged for the June monthly premium; and Parish B will assume premium charges commencing with the first payroll period of June.

Health Plan Premium Rules for Rehired Employees:

Example #1:

- Jacob is a part-time employee at school A and terminated employment on 7/1. He was rehired **(on day 59)** as a full-time Agency employee effective 8/29.
- Jacob's coverage through School A is effective through the end of the month of termination, until 7/31.
- Employee/School A are charged the full month's part-time premium rate for July; and Health insurance deductions will be taken from final paycheck.
- Upon rehire, coverage is effective immediately, on 8/29, at the Agency. Jacob may make new plan elections or waive coverage. The full-time premium rate will not be charged for August, (as the date of rehire was after the 15th of the month); and. Employee/Agency premium charges commence with the September pay cycle.

Example #2:

- Rachel is a school year employee at school A and terminated employment 5/31. She is rehired at school Bon 9/1 **(day 92).**
- Rachel's coverage at school A terminated on 5/31and all monthly premium deductions were withheld.
- Rachel's coverage at school B is effective on 10/1, the first of the month following rehire.
- She may make new plan elections or waive coverage.
- Monthly premium deductions will start on the first pay cycle of the month of 10/1.

Employees Designated as Leave No-Pay:

- The full health premium amount, inclusive of the employee and employer portion, will be billed to the employer.
- The employer will be responsible for collecting the employee portion of the premium payment due while on Leave No-Pay status.

Transferred employees (no break in employment) information for the 403b Retirement Plan, Flexible Spending Account Plan(s), and Hartford Supplemental Life Insurance Plans:

- All elections and contribution amounts for these benefits will remain the same. The HR Coordinators will update the transferred employee's process level to reflect their new employer in the HR database.
- NOTE- 403b Retirement Plan for transfers going from a Catholic Charities employer to Archdiocesan employer:
  - For employer contributions, the waiting period will be waived.
  - For employee voluntary contributions, the employee will need to take action and re-elect their 403b contribution percentage via their Empower online account with their new Archdiocesan employer.

When an address is updated in Human Resources database, the system automatically sends Empower an address update if the employee is enrolled in the Retirement Plan.

Address Changes

It is very important to communicate to all the benefit plans of your employee's address changes. That way explanation of Benefits (EOBs), Health Statements, and important letters will reach your employees on a timely basis, so please take the appropriate action below.

- Medical/Dental/Vision Insurance – Use Employee Health Insurance Form or Employee Self Service (benefits website)
- Retirement Plan – When address is updated in Human Resources database, the system automatically sends Empower an address update if the employee is enrolled in the Retirement Plan.
- Hartford Life Insurance – not necessary.
- Flexible Spending Account – When an address is updated in Human Resources database, the system automatically sends Tristar an address update if the employee is enrolled in the Flex Plan.

Claim Filing Procedures

- **Medical Claims (UnitedHealthcare Choice Plus)**

  All in-network providers are set up to bill UHC directly, however, as a Employer Benefits Administrator, you are responsible for keeping a supply of UHC claim forms on hand for employees for any out-of-network services. Out-of-Network providers often bill the employee. The UHC claim forms are available on the Archdiocese Benefits Website or on the UHC website at **www.myuhc.com**.

  Claims should be sent to:

  UnitedHealthcare
  PO Box 30555
  Salt Lake City, UT 84130-0555

  UHC will process the claim upon receipt.

- **Dental Claims (Delta Dental of Missouri)**

  Regardless of which medical plan an employee enrolls in, the dental coverage is always provided through Delta.

  Claims should be sent to:

  Delta Dental of Missouri
  12399 Gravois Road
  St. Louis, MO 63127-1702

- **Vision Claims (EyeMed)**

  Regardless of which medical plan an employee enrolls in, the vision coverage is always provided through DeltaVision (EyeMed).

  Claims should be sent to:

  EyeMed
  Attn: Claims Processing
  P.O. Box 967
  Rancho Cordova, CA 95741
  Fax: 916.852.2277

Employee Wellness Programs

The Archdiocese of St. Louis deeply cares about you and your employee's health and well-being. Annually the Employee Benefit Plan provides to all employees the flu vaccine program. It also provides benefit eligible employees an annual H&H Wellness Screening. For more wellness information, please access the Archdiocese website: http://archstl.org/wellness and click on the "Employee Wellness Programs" icon.

Employee Wellness Incentive Program

Benefit eligible employees, with at least one year of service and either working a minimum of 1,000 hours annually or a teacher with a half-time or more contract, may annually complete one of the following in order to receive an Archdiocesan paid, $125.00 contribution to their Archdiocese of St. Louis sponsored 403(b) retirement plan:

A. Receive an annual wellness exam with their physician of choice between May 1st and April 30th and submit the Employee Wellness Form (Appendix E) to H&H Health Associates. The deadline for H&H to receive this form is May 7th.

OR

B. Participate in the Archdiocesan paid, confidential H&H Health Associates health screening between May 1st and April 30th.

Important Notes:

- Participation in the health insurance plan is not a requirement to be eligible to receive the $125 retirement contribution.
- If your employees were hired on or before May 1st of the current wellness year, and have been working either a minimum of 1,000 hours annually or a teacher with a half-time or more contracts, they have fulfilled the one year of service requirement.
- If your employees participate in an H&H health screening, they do not need to submit this form.
- The $125 retirement plan contribution will be processed near the end of September, if the employees completed the above criteria. This is a discretionary contribution.

Employer Responsibilities:

- Review the Employee Wellness Incentive Retirement Contribution Frequently Asked Questions on pages 40-43 of this manual.
- Please keep your employees informed of this wellness incentive program. Although you are not responsible for their participation, communication and reminders are important.
- Direct them to the Archdiocesan Benefits website at **www.archstl.org/hrbenefits** and encourage them to review the information in the "Employee Wellness Programs" icon.

Frequently Asked Questions for the Archdiocesan Wellness Incentive Retirement Contribution (WIRC) & Employee Wellness Screening

Wellness Incentive Retirement Contribution (WIRC) & Investment Questions

Q. *What are the current wellness plan year dates?*
A. Runs from May 1 – April 30 each year

Q. *What is the Wellness Incentive Retirement Contribution (WIRC) for the current year?*
A. The amount is $125 for the current wellness plan year.

Q. *How do I know if I am currently an eligible employee for the Wellness Incentive Retirement Contribution?*
A. You are a benefit eligible employee, with at least one year of service, hired on or before May 1 and you are working at least 1,000 hours annually or a teacher with a half time or more contract.

Q. *If I am no longer actively employed with the Archdiocese, or no longer benefit eligible, and I previously completed the wellness program will I still receive the WIRC?*
A. The Wellness Incentive Retirement Contribution (WIRC) is for active benefit eligible employees. If you are no longer an active benefit eligible employee with the Archdiocese of St. Louis at the end of the Wellness Plan year, April 30th, you will not receive the WIRC.

Q. *If I am eligible and complete a wellness exam/screening how will I receive the Wellness Incentive Retirement Contribution (WIRC)?*
A. The funds will be processed in the fall each year and will be automatically deposited in your Archdiocese of St. Louis employer sponsored retirement account. The contribution is in addition to your normal monthly employer percentage contribution.

Q. *How will the Wellness Incentive Retirement Contribution (WIRC) be invested?*
A. If you have designated an investment allocation, then the contribution will be invested according to your designated investment election. If you do not have a designated investment allocation, then the contribution will be invested in the default fund. You can adjust your investment funds at any time.

Q. *If I participate in both the voluntary and employer retirement account, can I designate which account to deposit the Wellness Incentive Retirement Contribution (WIRC)?*
A. No. The WIRC will be deposited as an employer retirement account contribution.

Q. *Can I get the Wellness Incentive Retirement Contribution (WIRC) in cash instead of being deposited in the lay employer retirement account?*
A. No. The WIRC can only be received as a contribution to your lay employer 403(b) retirement account.

Q. *Can I opt out of receiving the Wellness Incentive Retirement contribution (WIRC)?*
A. No.

Q. *Once the Wellness Incentive Retirement Contribution (WIRC) is deposited in my employer retirement account, can I request a distribution of the amount?*
A. Yes, however, you must be eligible for a distributable event (Distribution/In-Service Withdrawal) as defined in the Plan Document.

Frequently Asked Questions for the Archdiocesan Wellness Incentive Retirement Contribution (WIRC) & Employee Wellness Screening

Q. Will a vesting schedule apply to the Wellness Incentive Retirement Contribution (WIRC)?

A. No, as with all Contributions to the 403(b) retirement plan, the contribution will be 100% vested immediately.

The Health Insurance Plan

Q. Can I get the employee wellness screening if I am benefit eligible but not enrolled in the UnitedHealthcare (UHC) Premier or Standard Plan?

A. Yes. The benefit of the exam/screening is to identify health risk factors early to be engaged in good health practices.

Q. Do I need to have the wellness exam/screening to be in the UHC Premier Plan?

A. No. There is no longer a wellness prerequisite for the UHC Premier Plan, whether or not you had a wellness exam/screening. You may participate in either the UHC Standard or Premier Plan.

Wellness Screening Questions

Q. If I am a benefit eligible employee and have less than one year of service (hired after May 1st) can I still receive the H&H Employee Wellness Screening?

A. Yes, a *benefit eligible* employee with less than one year of service can still receive the H&H Employee Wellness Screening.

Q. If I am an Archdiocesan priest, brother, or sister may I receive the H&H Employee Wellness Screening?

A. Religious priests, brothers, and sisters are eligible for an annual Archdiocesan paid H&H wellness screening, however, they are not eligible to receive the Wellness Incentive Retirement Contribution.

Q. Can I get the health screening any time during the wellness plan year or just in September and March?

A. For your convenience, you can get the screening anytime during the plan year between May 1st and April 30th. The screening must be scheduled through H&H Health Associates (314.845.8302) or online at wellness.hhhealthassociates.com. You will be directed to an H&H approved lab close to your home or work. The Archdiocese will sponsor onsite H&H Health screenings at multiple locations during the fall and spring each year, if feasible.

Q. Will the health results of my exam/screening be sent to the Archdiocese or my employer?

A. No. Individual health data will not be shared with your employer, the Archdiocese, our insurance provider, or any other entity. The alternative health screening is being conducted by H&H Health Associates or an H&H approved lab and will be managed in a completely confidential, HIPAA compliant manner.

Q. If I receive a serious diagnosis, will you terminate my health insurance plan?

A. No. Your health insurance continues and we have no knowledge of any diagnosis. We only want to encourage all participants to receive a wellness screening and to be engaged in good health practices.

Q. Does the physician who conducts my wellness exam have to be my primary care physician?

A. No. Any physician you choose, who meets the definition of a physician under the UHC health plan, can conduct your wellness exam.

Frequently Asked Questions for the Archdiocesan Wellness Incentive Retirement Contribution (WIRC) & Employee Wellness Screening

Q. Does the annual wellness exam require an employee copayment or coinsurance?

A. Maybe. The UHC plan generally covers preventive services, as specified in the health care reform law, at 100% without charging a copayment, coinsurance, or deductible, as long as they are received in the UHC health plan's network. UHC covers other routine services, which may require a copayment, coinsurance or deductible. Always refer to your plan documents for your specific coverage. Medical treatment for specific health issues or conditions, on-going care, laboratory tests or other health screenings necessary to manage or treat an already-identified medical issue or health condition are considered diagnostic care, not preventive care.

Q. If I do not complete the wellness screening for the current wellness plan year, to I need to do anything?

A. No.

Q. If I get the employee wellness screening during the current wellness plan year, do I need to complete the Physician Wellness form?

A. No. A Physician Wellness form is not required if you receive your employee wellness screening through H&H Health Associates.

Q. Can my spouse/child participate in the employer paid H&H wellness screening?

A. No. The H&H screening is a benefit provided to employees only. Your spouse/child may see the physician for a wellness exam, as the UHC plan typically covers preventive services.

Q. *If I fail to have a wellness exam/screening prior to April 30 can I ask for extra time?*

B. No. You have a full wellness plan year notice, from May 1st to April 30th to complete the wellness screening. Extra time allowances will not be granted due to administrative requirements.

Q. May I receive both an annual wellness exam from a physician and a health screening from H&H Health Associates?

A. Yes. The two covered preventive actions are not mutually exclusive.

Q. Should I get an H&H screening in lieu of an annual wellness exam by a physician?

A. While the H&H screening is a good wellness tool, it does not replace the importance of a comprehensive wellness exam and lab work by a physician on a regular and long term basis. We encourage you to develop a physician/patient relationship to enhance your quality of life.

Q. What is the H&H Comprehensive Wellness Screening scope of testing?

A. The comprehensive Wellness Screening panel from H&H Associates looks at a wide array of different diseases/illnesses, including diabetes, kidney function, nerve conduction & muscle contraction, heart rhythm, bone health , cellular repair, fluid balance, damage to bones/liver/heart, iron reserves & saturation, heart disease risk, thyroid function, immune system disorders, anemia, clotting Ability, infections, etc.

Archdiocese of St. Louis

Frequently Asked Questions for the Archdiocesan Wellness Incentive Retirement Contribution (WIRC) & Employee Wellness Screening

Q. What are the tests included in the H&H Employee Wellness Screening?

Triglycerides	Total Cholesterol	HDL Cholesterol	LDL Cholesterol
VLDL Cholesterol	Cholesterol Ratio	Total Iron	TIBC
Iron Saturation	Glucose	BUN	Creatinine
BUN/Creatinine Ratio	Sodium	Potassium	Chloride
Carbon Dioxide	Calcium	Protein	Albumin
Globulin	Albumin/Globulin Ratio	Bilirubin Total	Alkaline Phosphate
AST (SGOT)	ALT (SGPT)	White Blood Cell Count	Red Blood Cell Count
Hemoglobin	Hematocrit	MCV	MCH
MCHC	RDW	Platelet Count	Neutrophils
Lymphocytes	Monocytes	Eosinophils	Basophils
TSH	Hemoglobin A1C	Bilirubin Direct	UIBC
Neuts (Absolute)	Lymphs (Absolute)	Eos (Absolute)	Baso (Absolute)
Mono (Absolute)	PSA (if Male, 50+)		

Q. If I miss the spring or fall Archdiocesan Wellness Events, how can I get an H&H Employee Wellness Screening?

A. H&H Employee Wellness Screenings are available at over 1,600+ walk-in clinics nationally. Please contact H&H directly at 800.832.8302 or wellness.hhhealthassociates.com

On average, 25% of any population screened are considered "High Risk", meaning the individual is either completely unaware of a chronic illness/disease, or they are aware of a condition, but it is not under adequate control.

Important: This guide's Frequently Asked Questions and Description is intended to give you an overview of the Wellness Incentive Plan offered by the Archdiocese of St. Louis. Any of the benefit plans offered by the Archdiocese of St. Louis may be amended, revoked, suspended or terminated at the Archdiocese's sole discretion at any time.

Revised 5/2023

Archdiocese of St. Louis

Websites and Contact Information

Archdiocesan HR/Benefits

WEBSITE: **http://archstl.org/hrbenefits**
PHONE NUMBER: **314.792.7546**

The Office of Human Resources of the Archdiocese of St. Louis provides a comprehensive benefits website for obtaining and communicating benefit information for you and your employees. **http://archstl.org/hrbenefits**

This website includes information such as, the most current benefit forms, benefit booklets, helpful flyers, and benefit summaries. By clicking on the appropriate link, you can print out the desired material quickly and easily, when you need it.

UnitedHealthcare

WEBSITE: **www.myuhc.com**
CUSTOMER SERVICE NUMBER: **888.332.8885**

As a participant of UnitedHealthcare, members get online self-service access to their health information. They can:

- Request ID cards.
- Search for a doctor or hospital in their area.
- View their claims.
- Take an online Health Assessment to obtain immediate, confidential results about their overall health.
- Use the Personal Health Record to keep track of health conditions, medications, lab results, and appointments.
- Take advantage of Online Programs designed to help them achieve health and wellness goals.
- Improve their health by subscribing to a free Healthy Mind Healthy Body personalized e-newsletter, by choosing the topics that are of interest to them.
- Use the Quicken Health Expense Tracker to see a clear breakdown of their medical claims, access medical records back to 18 months, and pay bills in a safe secure environment.

Participants can register for immediate access:

- Go to **www.myuhc.com**
- Click on the “Register Now” button
- Enter your Personal information (found on your ID Card)
- The UHC plan is the UnitedHealthcare Choice Plus Plan, policy #0703597
- Choose your own User Name and Password
- Start using **myuhc.com**

Delta Dental of Missouri

WEBSITE: **https://deltadentalmo.com**
PHONE NUMBER: **314.656.3001**
TOLL FREE: **800.335.8266**
EMAIL: **service@deltadentalmo.com**

Employees or you can go online and order and print temporary Delta Dental ID cards.

1. Select "Members" and Sign In.
2. Select "My Benefits"
3. Select Benefits/24 "View general benefits"
4. Enter SSN, last name and DOB then "Login"
5. Select "Request an ID Card"
6. Mailing address will be displayed, select "Submit Request"
7. Participants should receive card within 15 calendar days.

DeltaVision through EyeMed Network

WEBSITE: **DeltaDentalMO.com/Vision**
PHONE NUMBER: **877.226.1412**

To find out more, or to search for an in-network vision provider, visit **DeltaDentalMO.com/Vision**.

Although an ID Card is not required for an appointment, if an ID Card needs to be replaced, employees or you can contact customer service.

Tristar Administrators Flexible Spending Account (FSA)

WEBSITE: **http://www.myrsc.com**
PHONE NUMBER: **800.456.4584**
EMAIL: **flex@tristargroup.net**

If employees have any funds remaining in their account, they can file a claim online directly to Tristar for reimbursement of medical claims by going to **https://www.myrsc.com**. If they do not remember their Tristar username and password, they can contact Tristar at **800.456.4584** or **flex@tristargroup.net**.

Once they are logged in, click on the "Online Claims Entry" tab at the bottom left side of the screen. Click again on "Start New Claim Form." Follow the steps to enter the claims. They can upload saved receipts or copy their receipts and then fax or mail receipts to Tristar Group. Employees can also file for reimbursement of medical claims via mail or fax.

Employee Assistance Program (EAP)

Saint Louis Counseling
PHONE NUMBER: **888.629.3835** | FAX: **314.792.7059**

Archdiocese of St. Louis

This section of your administrative manual outlines the information necessary to assist you in the management of the Hartford Basic and Supplemental Life Insurance Plans. The benefit plans should be given to employees at the same time they are given information for the group health insurance. Benefit Summaries and Hartford Forms to distribute to employees are available on the Archdiocesan website at **archstl.org/hrbenefits.**

Archdiocese of St. Louis

Employer-Paid Basic Life and AD&D Insurance – Hartford Policy #677885

Employers of the Archdiocese of St. Louis will provide eligible employees an employer paid Basic Life and Accidental Death & Dismemberment (AD&D) benefit plan, administered by Hartford Life.

Billing Information for the Life and AD&D Insurance:

The Hartford Life Insurance cost will be invoiced through Archdiocesan consolidated billing, along with the Flexible Spending Account (FSA) and the Employee Assistance Programs (EAP) billing. If a benefit eligible employee works at two or more Archdiocesan locations, the employer who has the employee working the greatest number of hours, pays the full $83.00 cost. There is no prorating between employers. There are no payroll deductions, since it is an employer paid benefit.

Who is eligible for the life and AD&D insurance?

All benefit eligible active lay and deacon employees working a minimum of 1,000 hours annually or a teacher with a half-time or more contract are eligible for the Hartford Basic Life Insurance and AD&D benefit. The Basic Life and AD&D benefit is one times the employee's basic annual earnings.

When is the employee enrolled for the life and AD&D insurance?

New hires will receive this benefit the first day of active employment.

What do you need to do?

1. Provide your employee the Hartford Life Insurance and AD&D Summary of Benefits and a Hartford Life Beneficiary Designation Form (Appendix C). Your employees are instructed to complete and submit the form to you via in person or fax.
2. Make a copy of the completed beneficiary form and save in the employee's file.
3. Please send a copy of the employee's completed beneficiary designation form to the Office of Human Resources via:

   Scan Email: Benefits@archstl.org
   Fax: 314-792-7548
   Mail: Archdiocese of St. Louis
   Office of Human Resources
   20 Archbishop May Drive
   St. Louis, MO 63119

Beneficiary Information:

If your employee currently participates in the Hartford Supplemental Life Insurance plan, the employee's beneficiary designation will apply to both the Hartford Supplemental Life and Basic Life plans.

In the event of your employee's death and if there is no beneficiary designation, the life insurance benefit proceeds may, at Hartford's option, be paid to a surviving spouse, child(ren), parents or the estate, as written in the Benefit Fact Summary document.

Imputed Income Reporting:

Employee participants who make an annual salary of $50,000 or above are subject to an imputed income tax, per the Internal Revenue Code Section 79. Generally speaking, imputed income can be defined as the perceived cash value of a benefit and an employee pays tax on that amount. It is not a dollar for dollar straight income tax.

The imputed cost of coverage in excess of $50,000 must be included in income and are subject to social security and Medicare taxes. The IRS code provides an exclusion for the first $50,000 of group-term life insurance coverage provided under a policy carried by an employer. There are no tax consequences to participating employees who do not exceed the annual salary of $50,000.

If the employee exceeds an annual salary of $50,000, the imputed income will be reported as wages in boxes 1, 3, and 5 of the employee's Form W-2. Also, it is reported in box 12 with code "C" of the W-2 for informational purposes.

Claims:

In the event of an employee's death, please contact the Office of Human Resources at **314.792.7546** to assist you in completing the Hartford Life Claim Form (Appendix G). To access a Hartford Life Claim Form, go to the Archdiocesan website at: **http://archstl.org/hrbenefits**.

Questions:

If you have any questions, please contact the Archdiocese Office of Human Resources at **Benefits@archstl.org** or call **314.792.7546**.

Disclaimer:

The Hartford Summary of Benefits is a brief description of the Life Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the Insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your Insurance coverage. In the event of any difference between the Benefit Announcement Sheet and the Insurance policy, the terms of the Insurance Policy apply.

Summary of Benefits 2023: Archdiocese of St. Louis Policy #677885

Hartford Basic Life Insurance and AD&D Benefits

The Plan	Archdiocese of St. Louis benefit eligible employees are provided a Hartford basic life and accidental death & dismemberment benefits (AD&D). These benefits are provided by the employer at no cost to the employees.
Eligibility	Archdiocese parish, school, and office benefit eligible active lay and deacon employees working a minimum of 1,000 hours a year or more, a teacher with a half-time contract or more, a married priest, or a Catholic Charities* benefit eligible active lay employee working a minimum of 35 hours a week or more.
Benefit Amount	The life and AD&D benefit is one times the employee's basic annual earnings, rounded to the next higher $1,000, if not already a multiple thereof, to a maximum of $250,000.
When can I enroll?	Eligible employees are automatically covered by the Hartford basic life and AD&D insurance; they do not have to enroll.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. New hires would be covered the first day of work. There is no waiting period. The employee must be actively at work with his/her employer on the day the coverage takes effect.
Is this a taxable benefit?	The Life Insurance is a tax-free benefit in amounts up to $50,000. As employer paid life insurance, coverage above $50,000 will generate a taxable income event for the employee.
Will Benefits Reduce?	Life and AD&D benefits will reduce by 50% rounded to the next higher $500, if not already a multiple of $500, on July 1 following the date the employee attains age 70. All coverage cancels at termination.
How do I assign a Beneficiary?	The beneficiary is the person (or persons) or legal entity (entitles) who receives a benefit payment if the employee dies while covered by the policy. The assigned beneficiary designation is legally binding. The employee should assign a beneficiary and may change the beneficiary at any time. To access the Beneficiary Designation Form, go the Archdiocesan website at: http://archstl.org/hrbenefits.
When does the life and AD&D insurance end?	Coverage will end on the earlier of a) the last day of the month following the date employment terminates or are no longer eligible or b) the last day of the month following the date the employee is no longer actively at work unless continued in accordance with the Continuation Provisions noted in the policy booklet.
Can I keep my life coverage if I leave my employer?	Subject to the contract, the covered employee has the option to convert the group life coverage to your own individual policy. To access a Notice of Conversion/Portability Form, go to the Archdiocesan website at: http://archstl.org/hrbenefits. The employee should submit the completed form within 31 days of canceling the group life coverage. If the employee has questions about this information, eligibility, or status of a request, the employee contacts a Hartford representative at 1.877.320.0484.
AD&D	AD&D insurance does not cover losses caused by or contributed by: • sickness; disease; or any treatment for either; • any infection, except certain ones caused by an accidental cut or wound; • intentionally self-inflicted injury, suicide or suicide attempt; • war or act of war, whether declared or not; • injury sustained while in the armed forces of any country or international authority; • taking prescription or illegal drugs unless prescribed for or administered by a licensed physician; • injury sustained while committing or attempting to commit a felony; • injury sustained while intoxicated
Questions	Questions regarding the life insurance coverage can be directed to: • Your parish, office, agency administrator. • The Archdiocese Office of Human Resources: 314.792.7546, Benefits@archstl.org. • A Hartford representative: 1.800.523.2233.

*Catholic Charities administration, St. Patrick Center, Child Center Marygrove, St. Louis Counseling, LAMP, Queen of Peace Center, Good Shepherd Children & Family Services, and St. Martha's Hall.

Archdiocese of St. Louis

Supplemental Life – Hartford

Policy #677885

Employers of the Archdiocese of St. Louis will provide eligible employees with the opportunity to enroll in Supplemental Life coverage. You play an important role in the administration of this benefit. Your responsibilities include:

- Ensuring that all eligible employees apply appropriately and timely for coverage or sign waivers declining coverage. (Appendix B)
- Keeping accurate records on plan enrollment, census information, and coverage levels to aid in the preparation of your billing statements.
- Maintaining employee Hartford Information Forms and other important plan records in your office.
- Determining when an applicant needs to submit a Personal Health Application and completing the Employer's section of the application.
- Notifying employees of their Conversion, Portability and Waiver of Premium rights in a timely manner, if applicable.

Plan Design

Eligibility	All active employees working 1,000 or more hours per year are eligible for coverage on their date of hire. Spouse coverage is available only if the employee has elected coverage and is subject to 50% of the employee amount. Child coverage is available for child from the age of 14 days to 26th birthday regardless of student status, provided the employee is enrolled and approved for coverage.
Enrollment Period	All employees should complete an enrollment form electing or declining coverage within 31 days of their date of hire. Employee enrolling after the 31 day period will be required to provide evidence of insurability for any amount of coverage.
Effective Date	Coverage will be effective on the later of: • The employee's date of hire, provided they enrolled within 31 days of their date of hire • The date the employee signs their enrollment form provided they enrolled within 31 days of their date of hire • The date Hartford approves their Personal Health Application

Benefit Amount	Benefit amounts are as follows: **Employee coverage** – Increments of $10,000 to a maximum of $300,000 **Spouse coverage** – Increments of $5,000 to a maximum of $150,000, subject to 50% of the employee's approved amount of coverage. **Child coverage** – Increments of $5,000 to a maximum of $15,000
Reductions Due to Age	Employee and Spouse benefits will reduce to 65% at age 70, to 45% at age 75 and to 30% at age 80 based on the employee's age. These reductions will automatically appear on your bill.
Guaranteed Issue Amount	**Employee** – $100,000 **Spouse** – $25,000 **Child** – $15,000 Employees enrolling within 31 days of their date of hire are guaranteed up to the Guaranteed Issue Amount. Amounts over the Guaranteed Issue Amount require the employee and/or spouse to complete a Personal Health Application and be approved for coverage.
	Monthly rates are based on the employee's age as of their effective date of coverage and will increase on July 1 of each year following the date the employee moves to the next age band. Spouse coverage is based on employee's age. Child cost is based on a unit cost and not per child. The employee's cost for child coverage is the same regardless of the number of children they have enrolled. Premium is required the first of the following month. **Employee and Spouse Monthly Rates per $1,000 of Benefit**

Age	Hartford
<25	0.060
25-29	0.060
30-34	0.068
35-39	0.073
40-44	0.101
45-49	0.142
50-54	0.242
55-59	0.417
60-64	0.641
65-69	0.901
70-74	1.271
75+	1.986
Child	0.930 per $5,000

Termination of Coverage	Employee Coverage will end on the earlier of 1) the date the employee is no longer eligible or 2) the end of the month that the employee terminates coverage. 3) employee cancels the plan. Dependent coverage will end on the date the dependent is no longer eligible for coverage. Important note, employees must complete and submit a Hartford Supplemental Life Form to their employer's business manager to drop a dependent child's supplemental life insurance upon attainment of age 26, as this is not an automatic process (refunds will only go back 2 years, if at all). Premium is required to the end of the month following termination. Any overpayments will be credited on your next monthly bill. Coverage may be continued by the employee and/or dependent, provided they enroll for Conversion or Portability. Coverage may also continue under one of the following continuation provisions, provided premium is paid during this time. Military Leave – 12 weeks Sickness or Injury – 12 months Family Medical Leave – 12 weeks
Waiver of Premium	Employees who are totally disabled and not working may continue their life insurance past the 12-month period if they are approved for waiver of premium. To be eligible, they need to be under the age of 60 at the time of the disability and be disabled for at least 6 months. Employees will need to complete the Waiver of Premium form and be approved for coverage prior to the end of the 12-month period in order to continue their life insurance past the 12-month period.
Conversion and Portability	Conversion – Employees and Dependents may convert the supplemental life insurance to an individual policy if they enroll for conversion with 31 days of the date their coverage ends. Premiums are based on their age at the time of conversion. Portability – Employees may elect Portability if their coverage is terminating prior to their Social Security Normal Retirement Age. This option allows you to continue all or a portion of your and your dependent's Supplemental Life Insurance coverage under a separate Portability term policy. To elect Portability, you must apply and pay the premium within 31 days of the termination of your Supplemental Life Insurance. Evidence of Insurability will not be required. Portability is not available to dependent children who have reached the limiting age of 26. Employees can contact Hartford's Conversion and Portability Department for policy or rate information at **877.320.0484**.
Accelerated Death Benefit	If an employee or dependent is diagnosed as terminally ill with a life expectancy of 12 months or less, they may be eligible to receive payment of a portion of their life insurance. The remaining amount of the life insurance would be paid to their beneficiary upon death. They will need to complete the Accelerated Death Benefit form.

Steps Involved in Administration and Billing for Supplemental Life Insurance

1. **New Hire:** When a benefits eligible employee is first hired, give the employee the Hartford Supplemental Life Insurance Enrollment/Change Form, Hartford Beneficiary Designation Form, and benefits booklet.

2. Inform the employee that he or she has 31 days to complete the Hartford Supplemental Life Insurance Enrollment/Change Form to elect or waive this coverage. After 31 days, Evidence of Insurability (EOI) will be required for benefits. Insert the Location Code # (Parish number) on the form. Send the completed form via scan email or fax (314-792-7548) to your designated HR Coordinator.

3. Ask that the employee complete, sign and date the Hartford Beneficiary Designation Form and name a beneficiary for their Basic Life and AD&D Insurance and Employee Supplemental Life Insurance (if elected and approved). Make sure to keep a copy of the completed Beneficiary Designation Form in the employee's file and send a copy via scan email to the Benefits Specialist in the Archdiocese Benefits/HR Office for record keeping purposes.

4. **Late Enrollees:** Employees requesting coverage after their 31 day enrollment period will need to complete an Evidence of Insurability (EOI) Form and be approved by Hartford. Keep a copy of the EOI Form with the enrollment form. Business Managers/local benefits contacts will need to complete any Employer Sections of the EOI Form and provide to the employee. Employee and spouse (if applicable) will need to complete the remaining information, sign and date, and mail to the address on the last page of the form. Hartford will notify the employee and the Archdiocese Benefits/HR Office of their approval or denial. Approved amount will appear on the next invoice following the approval date.

5. **Cancellation of Coverage:** An employee can cancel their employee, spouse, and/or child supplemental life coverage at any time. If the employee decides to cancel his/her coverage, the employee must complete and sign a new Hartford Supplemental Life Insurance Enrollment/Change Form requesting to cancel coverage. Business Manager/local benefits contacts will submit the cancellation form to their designated HR Coordinator via scan email and/or fax (314-792-7548) for processing in the HR/Benefits database.

   - If cancellation is due to termination, provide the employee with Hartford Conversion and Portability information included in the Post-Employment Benefit Options handout on page 22-23 of this manual. Premium is required to the end of the month following termination.

6. **In the Event of a Death Claim:** Contact Stephanie Weider, Benefits Specialist, via email at **stephanieweider@archstl.org** or call **314.792.7544**. Please use same contact for an employee with a terminal illness or a disability lasting six months or longer.

Important Billing Notes: ***Hartford bills for full months only and does not do partial month billing. The payroll deduction amount will apply to the Guaranteed Issue amount only. Once the employee has been approved for amounts over the Guaranteed Issue amount, the payroll deduction will be increased to the total amount approved by Hartford. For new enrollments, the premium is due the first of the following month. For terminations, the premium is required to the end of the following month. For any supplemental life overpayments, please contact your designated HR Coordinator and the Archdiocese Benefits Specialist.***

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Hartford Life Contact Information

As an employee benefits contact, your active participation in the claim administration process will help employees get the most from their Benefit Plan. Please feel free to contact anyone below should you have a service need or a question to be answered.

Primary Contact:	Hartford Life Customer Service	**Phone:** 866.294.7987 **Email:** gbdcustomerservice@thehartford.com
Secondary Contact:	Linda Lenz Account Manager Hartford Life Insurance Co. 12312 Olive Street, Suite 350 St. Louis, MO 63141	**Phone:** 314.682.0254 **Fax:** 860.392.5985 Linda.lenz@thehartford.com
Conversions and Portability:	Hartford Administration Conversion & Portability Unit P.O. Box 248108 Cleveland, OH 44124-8108	**Phone:** 877.320.0484 **Fax:** 440.646.9339
Medical Underwriting:	Hartford Life Insurance Co. Medical Underwriting Unit P.O. Box 2999 Hartford, CT 06104-2999	**Phone:** 800.331.7234 **Fax:** 860.843.3221 **Email:** medical.uw@thehartford.com
Enrollment Changes:	Hartford Employer view website, email or fax number	**Website:** www.employerview.com **Email:** list.bill@thehartford.com **Fax:** 888.701.8234 **For Email or Fax, be sure to include your policy number, billing ID, effective date of change**
Billing and Premiums:	The Hartford Group Benefits P.O. Box 783690 Philadelphia, PA 19178-3690 **Overnight or 2nd Day Air Only Address:** Lockbox Services (Box #3690) The Hartford MAC Y1372-045 401 Market Street Philadelphia, PA 19106	**Phone:** 866.294.7987 **Fax:** 888.701.8234

Archdiocese of St. Louis

Long-Term Disability – Unum

Policy #374488

This section of your administrative manual outlines the information necessary to assist you in the management of the Unum Long-Term Disability program. This program is available to eligible employees of the Archdiocese following 90 days of active continuous employment. The benefit summary explaining the Long-Term Disability plan should be given to each employee at the time they become eligible for these benefits.

Eligibility	All full-time active lay employees and those part-time lay employees who regularly work an average of at least 20 hours per week and religious community employees (sisters, brothers, priests excluding Archdiocesan Priests) working in a position who regularly work an average of at least 20 hours per week. Also for employees who regularly work in teaching or school administration positions, such employees (teachers, administrators, administrative assistants, maintenance workers, custodians, cooks and others) will be deemed to be working 20 hours per week for eligibility purposes during periods of school vacation or seasonal breaks. *Be sure to audit an employee's eligibility on a regular basis. Once an employee who is regularly working a minimum of 20 hours per week and has satisfied the 90 day new hire waiting period, add them to the LTD plan. If you have missed adding the employee, please add them retroactively and remit the back payment to Unum on the next billing invoice.
Waiting Period	Coverage begins on the first of the month following 90 days of active, continuous employment.
Amount of Insurance	60% of basic monthly earnings not to exceed the maximum monthly benefit, less other income benefits.
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	The greater of: (1) $100; or (2) 15% of the monthly benefit before deductions for other income benefits.
Elimination Period	180 Days of continuous disability for which no benefit is payable.
Contributions	The cost of the Long-Term Disability is paid entirely by the employer.
Note:	For all teachers (paid on a 10 month or 12 month cycle) – "basic monthly earnings" means 1/12th of the teachers annual contract salary in effect prior to the date disability begins.

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The Long-Term Disability plan is administered as follows:

Claims

In the event of a claim, the LTD Claim Form must be completed and submitted for review online through **www.Unum.com/claims** or via the Unum Customer App. The employee and employer (Business Manager/ local Benefits contact) will both need to register for an online account with Unum to electronically submit the completed Employee Statement and Employer Statement. The employee's physician completes the Attending Physician Statement and provides to the employee so that they can upload that portion of the LTD Claim Form Online. For more information regarding online claim submission, please review the flyers linked below.

- **How to File Disability Employer Statement Online Flyer**
- **How to File Disability Claim Online Employee Flyer**

Archdiocese of St. Louis

Employee Assistance Plan (EAP) – Saint Louis Counseling

Plan Description	The Archdiocese of St. Louis Employee Assistance Program (EAP) is an internal employee assistance program offering short-term mental health counseling and work/life management. An eligible employee or their household family members can access this service to help with problems.
Eligibility Criteria	All employees, who are an active full-time employee or work at least 1,000 hours per year, and their household members.
Waiting Period	None
Effective Date	Date of hire.
Employer Cost	$25.68 per employee per year.
Billing	Consolidated billing with Archdiocesan Finance Office.
Phone	**314.544.3800**

All EAP counselors are master's level (or above) mental health professionals who have extensive training in problem assessment, treatment and referral.

By simply making a call to the Archdiocese of St. Louis EAP, **314.544.3800**, an eligible employee or household family member (with or without employee's participation) can access the following services:

- **EAP Counseling Benefits**
  - One through ten (1-10) visits per issue in a calendar year, through the EAP is at no charge.
- **What kind of problems can the EAP help with and who can use the program?**
  - EAP counselors can help employees and their families deal with a wide range of personal problems. Some of the most common problem areas are:
    - Family Problems
    - Parenting Issues
    - Marital/Relationship Conflicts
    - Emotional Concerns (Stress, anxiety, depression)
    - Work/Management Issues

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- **Is this service confidential?**

  Confidentiality is totally assured for the employee and their family members. The staff of EAP adheres to all federal and state guidelines regarding confidentiality. As the employer, you will not be informed of their participation. Information only will be released with the employee's written permission or in a life threatening situation, or child abuse.

- **Where are EAP offices located?**

  Offices shall be within a reasonable distance of the employee's place of employment. See below for office locations. There are also affiliate providers throughout the Archdiocese of St. Louis.

For the convenience of its clients, Saint Louis Counseling maintains offices throughout the community.

- **South County Office/Administration**
  5 Premier Drive, Suite 200
  Fenton, MO 63026
  P. 314.544.3800
- **O'Fallon, MO Office**
  311 South Main, Suite 100
  O'Fallon, MO 63366
  P. 636.281.1990
- **Union Office**
  Franklin County Family Resource Center
  500 Clark Avenue
  Union, MO 63084
  P. 636.583.1800
- **Florissant Virtual Office**
  P. 314.831.1533
- **Bellefontaine Neighbors Office**
  10235 Ashbrook Drive
  St. Louis, MO 63137
  P. 314.831.1533
- **Troy, MO Office**
  #140 Professional Pkwy
  Troy, MO 63379
  P. 636.528.5911
- **Herculaneum Office**
  1349 McNutt Street
  Herculaneum, MO 63048
  P. 636.638.2203

Archdiocese of St. Louis

Lay Employees Retirement Plan #768150, the Priest Plan #768170

IMPORTANT: *This retirement plan is only available to eligible employees of employers of The Archdiocese of St. Louis which have signed an "adoption agreement" pertaining to the retirement plan document.*

This is a 403(b) tax-sheltered annuity retirement plan. Each participant in the Plan has an Individual Account which includes employee salary deferrals, employer nonmatching contributions and the earnings on these amounts.

Plan Administrator:

Archdiocesan Benefits Committee – represented by:
Gigi Henson, Director of Benefits and Compensation
20 Archbishop May Drive
St. Louis, MO 63119

Fund Manager:

The fund manager is Empower Retirement Solutions. The Archdiocese Empower Client Service Manager is Amber Pearson at **303.737.6763** or at **Amber.Pearson@empower.com**. Empower Online Service Center at **866.467.7756**.

Employer Contributions

- **Staff and hourly employees:** Those who have worked 1,000 hours during a consecutive 12-month period commencing on an Employee's employment commencement date in a Plan year.

  Teachers: Those with (at least) ½ time through full-time contracts (includes contracts at multiple locations).

- Any employee who has satisfied their eligibility period requirement and becomes a participant in the plan shall continue to be a participant even if he or she falls below the 1,000 hour or ½ time or full-time status (this includes teachers who fall below this threshold and substitute teach).
- A terminated employee who was previously eligible for the 5% contribution who becomes re-employed within the Archdiocese is eligible for immediate participation in the plan with 5% employer contributions and immediately eligible for employee pre-tax deferrals.

Employee Contributions:

Any employee, beginning with the employee's first pay period and whether or not he or she is, or ever will be eligible for employer contributions, may elect to contribute a percentage of their pay (within Federal limits) to their individual account. Each employee who wants to voluntarily contribute to their Individual Account must go online to Empower's website at **http://empowermyretirement.com** and complete the following steps:

1. Login to your participant portal on Empower's website.
2. Click *Account*.
3. Click *Contributions*.
4. Click *Edit* and go through the prompts to elect your per pay check employee contribution percentage(s).

Employees will receive a communication from Empower regarding enrolling as well. Contributions can only be made through payroll deductions and can be elected as pre-tax, post-tax (Roth option), or both. For more information, **click here** and review the link titled *Pre-tax vs. Roth (Post-tax) Contributions Presentation*.

Employer Contributions:

- Staff and hourly employees: Those who have worked 1,000 hours during a consecutive 12-month period commencing on an Employee's employment commencement date in a Plan Year.
- Teachers: Those with (at least) 1/2 time through full-time contracts (includes contracts at multiple locations).
- Any employee who has satisfied their eligibility period requirement and becomes a participant in the plan shall continue to be a participant even if he or she falls below the 1,000 hour or 1/2 time or full-time status (this includes teachers who fall below this threshold and substitute teach).
- A terminated employee who was previously eligible for the 5% contribution who becomes re-employed within the Archdiocese is eligible for immediate participation in the plan with 5% employer contributions and immediately eligible for employee pre-tax deferrals.
- Employer contributions commence on the first pay period of the month following the 365-day service "eligibility" period.
- Employees in Lawson with a status of AF or AP, will be automatically enrolled for the purpose of receiving employer non-elective contributions. Employer Administrators will need to monitor the hours of their Employees with a status of AN in Lawson; and notify HR if 1,000 hours has been achieved during a 12-month period from the employee's date of hire and/or their subsequent anniversary date.
- Each pay period thereafter, employer contributions will constitute a percentage of pay to the employee's individual account.
- Employer contributions do not require employees to make salary deferral contributions to receive them.
- Employees will be immediately vested (own) in employer contributions upon deposit to their individual account.

Important Note:

It is very important that employees who have met the eligibility requirements receive their Lay Retirement Plan 5% employer contribution or the appropriate Catholic Charities employer contribution rate.

Please see the possible different examples for determination of eligibility.

- Ex: A teacher ends her Archdiocesan school contract yet becomes a substitute teacher. The substitute teacher still meets the Retirement Plan Eligibility and therefore would receive 5% contribution at any time she/he was paid to sub.
- Ex: A part time music teacher works at a parish elementary school and also works a few hours at two other Archdiocesan parishes by playing the piano at their Sunday mass. The employee's total hours between the three Archdiocesan employers has met the 1,000 hour requirement and would receive the 5% contribution independently from each of the three parishes per the employee's gross salary earned at those employers.
- Ex: A rehire who previously worked for the Archdiocese and who had previously met his/her eligibility requirement for the 5% contribution, would receive the 5% contribution immediately.
- Ex: An employee previously worked at an Archdiocesan High School and transferred to work with a Catholic Charities agency. The Charities employee would receive the appropriate employer contribution immediately according to the agencies retirement plan.

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It is very important to ask employees, substitute teachers, or seasonal employees if they work or worked at another employer in the Archdiocese of St. Louis in order to determine their eligibility for the employer retirement contributions. If you have any concerns or questions on eligibility please, contact Mike Eagen or Sharon Gogel, Gallagher Benefit Services, for clarification.

Enrollment Procedures:

Each employer is responsible for informing new employees of the retirement plan and their ability to defer salary upon hire, including employees who would not meet eligibility requirements to receive the employer contribution. **Please contact your Gallagher plan consultants (Mike Eagen at 314.792.7362 and Sharon Gogel at 314.792.7261) for details regarding the plan.**

Gallagher will coordinate with employees/employers to initiate the enrollment process.

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Archdiocese Retirement Plan – Employer Responsibilities

Empower Retirement is the Archdiocese's Retirement Plan record keeper. All Archdiocesan Lawson employee data is transmitted monthly to Empower through a secure census file generated and maintained by the Archdiocese Office of Human Resources.

The Empower Plan Service Center website is **www.empowermyretirement.com**. This is where participants can enroll in/change salary deferral contributions, submit funds, designate a beneficiary, view retirement account information and more. If you have questions about the Empower Plan Service Center website or your account, please contact:

Empower Customer Service: **866.467.7756**

Gallagher Retirement Consultants:

Sharon Gogel: **314.792.7261** or **Sharon_Gogel@ajg.com**

Mike Eagen: **314.792.7262** or **Michael_Eagen@ajg.com**

New Hires and Retirement Plan information:

- Provide the new hire the 2023 Plan Highlights found in the **403b Retirement Plan.**
- Confirm with the new hire if he/she has had any previous employment with the Archdiocese or is currently working for another Archdiocese of St. Louis employer to determine early and/or immediate eligibility for the employer paid 5% retirement contribution.
- Make sure the new employee's HR data (name, address, status, salary, gender, and marital status) is entered in Lawson by submitting a PAF form.
- The HR Office electronically sends the census file to upload on Empower's website.
- Inform the new hire that he/she should go online to register their account at **www.empowermyretirement.com** or via phone at **866.467.7756**, after their second pay deposit. Then the employee can elect salary deferrals and assign beneficiary(s).
- Notify Gallagher Benefits of eligible employees by scheduling a meeting date for your employees to discuss their options.
- **The employer contribution must commence once the employee meets his/her eligibility requirement.**
- Track the new hire for one year of service anniversary or eligibility in order to enroll him or her in the 5% employer sponsored 403b plan. Lawson parish employees with a status of AF or AP are tracked automatically within the employee's Lawson eligibility; however, parishes need to track the one year of service manually for those employees with the status of AN.

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Ongoing Employees and Possible Changes:

- Process employees' payroll for their voluntary **salary deferrals,** as alerted in the Empower Plan Sponsor website.
  - Lawson employers utilize the HR Office to process alerts and changes for the employee salary deferrals.
- To enroll the employee after one year of service for the Employer Paid Retirement plan's 5% contribution:
  - With Lawson, the Office of HR processes the 5% enrollment automatically if the employee status is AF or AP, starting the first of the month following one year of service, and then the Payroll Office submits the funds via ACH. If the employee status is AN, and the employee satisfies the eligibility requirements, contact the Office of HR, as manual enrollment may be required.
- For any employee information changes such as marital status change, employment status change, and mailing address change, the information must be entered:
  - In Lawson, via a Personal Action Form (PAF) form sent to the Archdiocese of St. Louis HR office. The Archdiocese will gather the information and securely transmit it to Empower.

NOTE: Within 2 payroll periods, regardless of the method of payroll processing, Empower should receive the indicative data from the Archdiocese's secure data transmission to Empower.

Terminating Employees:

- Please inform the employee who is terminating employment with the Archdiocese of St. Louis to contact either Mike Eagen at **314.792.7262/michael_eagen@ajg.com** or Sharon Gogel at **314.792.7261/sharon_gogel@ajg.com**.
- Submit the proper termination date on a PAF form to Human Resources, the Archdiocese then transmits the termination date to Empower.

Archdiocese of St. Louis

Retirement Plan (403b) Support by Gallagher Benefit Services, Inc.

Gallagher provides the following services to the Archdiocese of St. Louis and its employees:

- Explain the 403(b) and Roth plan option funds. Explain the Empower employee website.
- Periodically visit each site for one-on-one reviews and/or group educational seminars.
- Assist the bookkeepers with remittances questions, employer/employee contributions etc. Also train new bookkeepers on all retirement plan procedures.
- Provide up-to-date information on tax laws relating to retirement plans as well as IRS limits for employee contributions.
- Provide explanations to enhance the employee's understanding of quarterly statements, summary plan document, prospectus and any other information that they receive regarding their retirement plan.
- Explain how to use the technologies (website and telephone system) provided by Empower Retirement Solutions for the employee to access individual account information.

For further information or assistance on the Retirement Plan, please contact:
Mike Eagen at **314.792.7262** / **michael_eagen@ajg.com** or
Sharon Gogel at **314.792.7261** / **sharon_gogel@ajg.com**

Their address is as follows:
Gallagher Benefit Services, Inc.
Cardinal Rigali Center
20 Archbishop May Drive
St. Louis, MO 63119

THE ARCHDIOCESE OF ST. LOUIS LAY EMPLOYEES RETIREMENT PLANS PRIOR TO EMPOWER RETIREMENT SOLUTIONS AND ARTHUR J. GALLAGHER & CO. RETIREMENT SERVICES

As the Employer Benefits Administrator, you may periodically receive an inquiry from a former employee or an active employee with multiple retirement plans. Please feel free to give the following customer service telephone numbers to anyone inquiring about the specific retirement plans below:

Equitable 403(b)	800.628.6673
Equitable Pension	800.628.7789
Principal	800.944.8631
Aetna	800.872.3862
Prudential	877.778.2100

403(b) Plan Corrections Guide for Common Contribution Errors

Employee Plans Compliance Resolution System

Description EPCRS:

If a Plan Sponsor makes a mistake(s) with respect to the administration of the qualified retirement plan, then the Internal Revenue Service ("IRS") has established the Employee Plans Compliance Resolution System ("EPCRS") as a means to remedy the mistake(s) and avoid the consequences of disqualification. A correction for a mistake(s) should be reasonable and appropriate. Additionally, the correction method should resemble one already provided for in the Internal Revenue Code and Plan Sponsors should consider all facts and circumstances. Revenue Procedure 2016-51 is the guidance governing the EPCRS program.

On December 31, 2012, the IRS issued its updated EPCRS, which expanded and updated existing compliance corrections programs available to retirement plans generally and also provides 403(b) plan sponsors with expanded opportunities to correct a wide range of retirement plan defects. These new EPCRS provisions were available to 403(b) plan sponsors on a voluntary basis prior to April 1, 2013, but they are mandatory effective April 1, 2013. Plan sponsors should correct plan errors following the guidance outlined in Revenue Procedure 2016-51. The main concept of the EPCRS process it to get participant accounts back to where they would have been if the error did not occur.

The Archdiocese of St. Louis has established the following correction procedures for common errors in the administration of the Archdiocese of St. Louis 403(b) Plan. The Archdiocese of St. Louis deems these correction procedures to be reasonable and appropriate.

Late Remittance of Contributions

Description of Error:

It is expected that all Employer(s) will remit all contributions to the 403(b) plan on the pay date. If contributions are not remitted to the 403(b) Plan on the pay date, then the Archdiocese will consider these contributions delinquent and may require lost earnings to be calculated.

Determination of Delinquent Contributions:

Internally, the Archdiocese will not consider to have Empower calculation lost earnings unless the contributions are more than seven (7) business days delinquent.

Description of Correction Process:

- The Archdiocese may track the remittance of contributions from Employer(s) and will communicate to the Employer(s) if contributions are deposited after the pay date.
- If the Archdiocese considers a contribution remittance delinquent, then a correction request will be submitted to Empower to calculate lost earnings. Empower charges a processing fee for this calculation of $75/hr.
- The Employer(s) will need to pay the Empower $75/hr processing fee.

Earnings Calculation:

- If the correction period is within the time that Empower has provided recordkeeping service (10/2/2017), then earnings will be calculated based on the participants actual rate of return.
- If the correction period extends beyond the time that Empower has provided recordkeeping services (i.e. prior to 10/02/2017), then for the period prior to 10/02/2017 earnings will be calculated based on best performing fund and the actual rate of return for the time that Empower has been recordkeeping the plan.

Missed Contributions

Description of Error:

There are instances in which contributions for a participant are not paid by a Employer(s) on time. Below are the two (2) main reasons for missed contribution errors.

1. A newly eligible employee's pre-tax salary deferral election is not processed by the Employer(s). The Employer(s) fails to provide the 5% employer contribution for an eligible employee
2. These missed contributions should be deposited into the plan plus earnings to make the participant(s) whole.

Description of Correction Process:

- The Employer(s) needs to determine the amount of the missed contributions for each pay period. Missed employee salary deferrals and missed 5% employer contributions need to be accounted for separately on the correction template spreadsheet. The spreadsheet needs to reflect the pay date of the missed contributions as this will be the start date of the correction period used to calculate missed earnings.
- To remain in line with historical practice and limit the number of $75/hr Empower processing fees, please administer the following process for determining whether or not Empower will calculate lost earnings for missed contribution corrections.
  - Step 1 – Gallagher is notified by Employer(s) that a missed contribution error has been discovered and provides Gallagher with a spreadsheet with the missed contributions.
  - Step 2 – The Archdiocese of St. Louis has established a procedure where lost earnings that is less than $10.00 will not be funded, therefore the contribution will be deposited without requesting Empower to calculate lost earnings.
  - Step 3 – Gallagher will use the Department of Labor earnings calculator to determine if the lost earnings on the missed contributions is in excess of $10.00.
  - Step 4 – If the Department of Labor earnings calculator determines that the amount of the lost earnings exceeds $10.00, then Gallagher will communicate the missed contribution error to the Office of Human Resources for approval of earnings calculations to be submitted to Empower for processing. Empower may apply a $75/hr. processing fee which will need to be paid by the Employer(s) which missed the contribution.

Earnings Calculation:

- If the correction period is within the time that Empower has provided recordkeeping service (10/2/2017), then earnings will be calculated based on the participants actual rate of return.
- If the correction period extends beyond the time that Empower has provided recordkeeping services (i.e., prior to 10/2/2017), then for the period prior to 10/2/2017 earnings will be calculated based on best performing fund and the actual rate of return for the time that Empower has been recordkeeping the plan.

Contribution Overpayments (Individual)

Description of Error:

Due to delays in reporting termination dates, sometimes employees get paid for another pay cycle after termination when they should not have received any pay. This overpayment generally results in overpayment of salary deferral contributions and/or 5% employer contributions. These overpayments are ineligible contributions to the Plan and should be removed plus applicable earnings.

Description of Correction Process:

- Step 1: Gallagher to verify participant did not liquidate his/her account prior to Step 2:
  - Account liquidated – No further action
  - Account balance – move to Step 2
- Step 2: Employer(s) provides correction template spreadsheet to Sharon Gogel of Gallagher.
- Step 3: Sharon will submit to Empower to recover the overpayment.
- Step 3: Empower will calculate earnings on the overpayment using the actual rate of return.
- Step 4: Empower will withdrawal the excess employer contribution plus applicable earnings from the participant's account.
- Step 5: Empower will deposit the proceeds from the withdrawal into a forfeiture account the can be used to offset future employer contributions.
- Empower may charge $75/hr to process the correction which will be due from the Employer(s).

Excess Payroll Contributions (Over **Two Pay Periods)**

Description of Error:

Occasionally there have been errors where Employer(s) erroneously submit a contribution file twice for the same pay period resulting in excess contributions being deposited into participant accounts. Typically this error affects multiple employees. These excess contributions plus earnings need to be removed from the affected participant accounts.

Description of Correction Process:

- The Employer(s) needs to provide a completed correction template spreadsheet identifying the excess contributions for each affected participant to Sharon Gogel. Excess salary deferrals and excess 5% employer contributions need to be accounted for separately on the spreadsheet. The spreadsheet needs to reflect the pay date of the missed contributions as this will be the start date of the correction period used to calculate missed earnings.
- The correction template spreadsheet is sent to Sharon for review and submission to Empower.
- Empower will process the correction and calculate earnings.
- Empower may charge $75/hr fee to process the correction which will be due from the Employer(s).

Earnings Calculation:

- If the correction period is within the time that Empower has provided recordkeeping service (10/2/2017), then earnings will be calculated based on the participants actual rate of return.
- If the correction period extends beyond the time that Empower has provided recordkeeping services (i.e., prior to 10/2/2017), then for the period prior to 10/2/2017 earnings will be calculated based on best performing fund and the actual rate of return for the time that Empower has been recordkeeping the plan.

Excess Payroll Contributions (Within Two Pay Periods)

Description of Error:

Occasionally there have been errors where Employer(s) erroneously submit a contribution file twice for the same pay period resulting in excess contributions being deposited into participant accounts. Typically this error affects multiple employees. In order to minimize correction costs, a common industry practice is to correct these “near term” excess contributions by making adjustments to the contributions on the next contribution remittance file.

Description of Correction Process:

- The Employer(s) will make adjustments on the next contribution remittance file sent to Empower to reduce the excess salary deferral and/or 5% employer contribution.
- Example: Participant A has $100 deducted for salary deferral contributions and $75 contributed for the 5% employer contribution for Pay Period X. The Employer(s) mistakenly submits Pay Period X contribution file twice. The error is discovered quickly and the Employer(s) will make adjustments on the following Pay Period Y. Participant A has $110 in salary deferral contributions and the 5% employer contribution is $80 for Pay Period Y. The Employer(s) will adjust the contribution file for Pay Period Y to reflect a $10.00 ($110 minus $100) salary deferral contribution and $5 ($80 minus $75) for the 5% employer contribution.
- An earnings calculation will not be required.

Archdiocese of St. Louis

Adoption Assistance Program

The Archdiocese of St. Louis has established an Adoption Assistance Program to provide benefits to eligible employees who seek to adopt an eligible child. The purpose of the program is to provide financial reimbursement towards the cost of certain qualified adoption expenses, as well as provide Paid Leave to the employee.

Eligible Employees:

At the time of finalization of the adoption, an employee is eligible if he or she:

1. Has completed one continuous year of employment with one or more Archdiocesan entities; and
2. Is a full-time employee who has worked at least 1,820 hours in the 12 months prior to the finalization of the adoption or is a full-time educator, or is a part-time employee who has worked at least 1,000 hours in the previous 12 months, or is a less-than-full-time educator who works at least half-time; and
3. Has conducted the adoption through Good Shepherd Children and Family Services' criteria; and
4. Is otherwise an employee in good standing, as determined by the Employer in its sole discretion; and
5. Has been married for more than one year to a spouse of the opposite sex.

Eligible Child:

An eligible child is any individual who, at the time the adoption expenses are paid or incurred, is under the age of 18, or who is physically or mentally incapable of caring for him or herself. Adoptions of children who are related to the employee through marriage or family are not eligible for Reimbursement of Expenses or Paid Leave for Adoption through the Adoption Assistance Program.

Reimbursement Expenses:

Full-Rime Employee – Up to $4,000 per adoption

Part-Time Employee – Up to $2,000 per adoption

Reimbursement Exclusions:

- Expenses that have been or will be reimbursed by another source (e.g., another employer's plan, or any federal, state or local program) will not be reimbursed by this program.
- The claimant must be an active employee and completed the claim notification/request form to receive reimbursement for qualified adoption expenses. If a claimant terminates employment before the adoption is legally final, no expenses are eligible for reimbursement.

Claim Process:

Upon placement of the adopted child/children, complete and submit an Adoption Reimbursement Request Form to the Archdiocesan Office of Human Resources Director of Benefits. The completed form must be accompanied by a certified and notarized copy of the record of placement or final court order, and itemized receipts. See sample form in **Appendix J**.

Claim Period:

Receipts may be submitted up to six months after the placement of the child/children in the employee's home. No reimbursement will be made for receipts submitted after the six-month period.

Funding Reimbursement:

Reimbursement is administered and funded by the Archdiocese. As such, the Archdiocese Employee Benefit Plan shall instruct the Employer as to the appropriate reimbursement amount, and shall be responsible for providing reimbursement to the Employer, who shall subsequently issue payment, less required payroll tax deductions, to the employee.

Paid Leave:

In addition to reimbursement of expenses, the Plan provides each eligible employee up to twenty (20) days of paid leave from work. Paid Leave for Adoption under the Plan means paid time off the job in order to secure or to care for a newly adopted child. In consultation with the Plan Administrator, the respective Employer shall compensate the qualified employee for Paid Leave for Adoption through its ordinary payroll process, subject to the amounts and limits as provided herein. Paid Leave for Adoption is in addition to, and may not be used in conjunction with, other paid time off for which the employee may be eligible (e.g., vacation/personal/sick days), and shall be counted toward any entitlement the employee may have under the Family and Medical Leave Act (FMLA).

*Refer to the policy at **archstl.org/hrbenefits** for a detailed and accurate description of the benefits.

Archdiocese of St. Louis

References

The following references are provided for the convenience of the Employer benefits administrators and are not for general distribution. Most employee questions that you cannot answer can be found in the employee booklet or can be directed to the telephone numbers on the employee's health I.D. cards.

1. **Archdiocese of St. Louis Benefit Policy** (procedures and billing inquiries)
   Office of Human Resources
   20 Archbishop May Drive
   St. Louis, MO 63119
   Phone: 314.792.7546
   Fax: 314.792.7548
   Website: **http://archstl.org/hrbenefits**
   Contacts – Gigi Henson, Director of Benefits and Compensation, 314.792.7543
   Stephanie Weider, Benefits Specialist, 314.792.7544
   Sally Malinee, Benefits Coordinator, 314.792.7545

2. **Gallagher Benefit Services, Inc.** (Assistance in administrative problems)
   12444 Powerscourt Drive, Suite 500
   St. Louis, MO 63131
   Contacts – Rani Heck, Account Executive (Direct: 314.800.2171)
   Emily Ganninger, Account Manager (Direct: 314.800.2167)

3. **UnitedHealthcare (UHC) Plan**
   Member Services: 888.332.8885
   Website: **www.myuhc.com**

4. **UHC Inpatient Pre-Hospital Admission certification (Pre-Certification)**
   Phone Number (must be contacted before entering hospital): 800.627.0687

5. **Delta Dental Plan**
   Phone: 800.335.8266
   Website: **https://deltadentalmo.com**

6. **DeltaVision Plan**
   Phone: 844.549.2603
   Website: **www.DeltaDentalMO.com/Vision**

7. **Hartford Basic Life/AD&D and Supplemental Life Insurance Program**
   Website: **www.employerview.com**
   Linda Lenz, Account Manager
   Hartford Life
   800.523.2233

8. **Unum Long-Term Insurance Program:**
   Website: **www.unum.com**
   - LTD Claims –800.633.7479; Fax: 800.447.2498
   - Unum Chattanooga Customer Care Center
     PO Box 12030
     Chattanooga, TN 37401-3030

9. **Employee Assistance Program (EAP):**
   Saint Louis Counseling
   Phone: 314.544.3800
   Fax: 314.792.7059

10. **TRISTAR Benefit Administrators Flexible Spending Account**
    Website: **https://www.myrsc.com**:
    Eligibility: 800.456.4584
    Claim Analysts: 800.456.4584
    Marketing: 800.456.4584
    Email: flex@tristargroup.net

11. **Adoption Assistance Program**
    Good Shepherd Children and Family Services
    Phone: 314.854.5700

12. **Empower Retirement**
    Phone: 866.467.7756
    Website: **www.empowermyretirement.com**
    Gallagher Retirement Consultants:
    - Sharon Gogel: 314.792.7261 or Sharon_Gogel@ajg.com
    - Mike Eagen: 314.792.7262 or Michael_Eagen@ajg.com

Archdiocese of St. Louis

Appendix

The samples in this Administrative Manual are for your reference only. Please do not utilize a copy of a sample in the administration of your program. Forms may be obtained online at **archstl.org/hrbenefits.**

Archdiocese of St. Louis Health Insurance
Enrollment/Change/Cancellation/Waive Form

*This form automatically enrolls/changes/cancels/waives you and your dependent(s) for Medical and Prescription coverage provided by UnitedHealthcare, Dental coverage provided by Delta Dental of Missouri, and Vision coverage provided by Delta Vision.

Please check one box:
☐ Open Enrollment ☐ Enroll ☐ Change ☐ Cancel ☐ Waive

Effective Date of Action: **(Required)**
*Please note that coverage ends on the last day of the month of termination.

A. QUALIFYING EVENT

Date of Qualifying Life Event

*Supporting documentation required for the qualified life events marked with an asterisk.

☐ New Hire
☐ Transfer from/to:
☐ Loss of Other Coverage*
☐ Spouse/Dependent: Begins New Job
☐ Marriage, Divorce, or Legal Separation*
☐ Birth of Child, Adoption, or Placement in Employee's Home*
☐ Dependent Reaching Maximum Dependent Age
☐ Death of Spouse/Dependent
☐ Court Order/Judgment/Decree*
☐ Spousal Surcharge Status
☐ Other (Describe):

B. EMPLOYEE INFORMATION

☐ Check box if providing a new name and/or new address.

Last Name	First Name	MI	SSN (last 4 digits) or Employee Number
			XXX-XX-

Address	Apt #	City	State	Zip Code

Phone Number	Email Address	Date of Hire

Date of Birth

Gender ☐ M ☐ F

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widower/Widow ☐ Religious

C. COVERAGE SELECTIONS – Select Plan option

TOTAL MONTHLY PREMIUM	UnitedHealthcare			
		Standard Plan FT/PT		Premier Plan FT/PT
Employee Only	☐	$90.00/$240.00	☐	$131.00/$351.00
Employee + One (Complete Section D)	☐	$331.00/$663.00	☐	$440.00/$881.00
Family (Complete Section D)	☐	$447.00/$895.00	☐	$555.00/$1,111.00
Waive	☐ I do not wish to enroll in coverage at this time.			

Notice of Enrollment Rights: I acknowledge that I have been offered the opportunity to enroll in health insurance coverage through my employer. I understand that if I choose to waive coverage for myself and/or any eligible dependent(s) that enrolling for coverage at a later date would be subject to treatment as a late enrollee and that I may only enroll during an annual open enrollment period or during a Special Enrollment Period, provided that I request enrollment within 31 days after such event.

D. SPOUSE AND DEPENDENT INFORMATION

Check Appropriate Box	Last Name	First Name	Social Security Number	Gender	Relationship	Date of Birth	Other Insurance
☐ Enroll ☐ Cancel				☐ M ☐ F	Spouse		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N
☐ Enroll ☐ Cancel				☐ M ☐ F	Dependent		☐ Y ☐ N

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Appendix A

E. SPOUSAL SURCHARGE

Employee Attestation: A spousal surcharge is an extra charge to an employee for insuring a spouse who has coverage available through his/her own employer. For further questions, go to **http://archstl.org/spousalsurcharge**.

By completing the Spousal Surcharge section of this enrollment form, I attest that the provided information is true and complete to the best of my knowledge. I also understand that if my spouse's group health insurance status changes, it is my responsibility to notify my employer's benefits administrator within 31 days of such change. It is also my responsibility to ensure on a timely basis that my paycheck withholding correctly reflects my surcharge exemption. Any false statements, as it relates to my spousal health insurance information, shall be considered grounds for disciplinary action up to and including termination. I permit the Archdiocese to verify that my attestation is correct.

If you are not eligible for an exemption, please check the box below:

☐ I acknowledge that a Spousal Surcharge fee of $200 per month will be applied.

If you are exempt from the spousal surcharge, please check the box next to one of the following:

☐ My spouse is not employed.
☐ My spouse is self-employed, does not provide themselves employer-subsidized health insurance coverage, and is not eligible for employer-subsidized health insurance.
☐ My spouse is employed with an Archdiocese of St. Louis parish, agency, or school.
☐ My spouse is employed and is not eligible for his/her employer's health insurance coverage.
☐ My spouse is employed and my spouse's employer does not offer health insurance coverage.
☐ My spouse is employed and is eligible for his/her employer's health insurance coverage but the full premium cost is paid by the employee. There is NO employer contribution toward the cost of the health insurance.

If you are not covering a spouse/spouse canceled from health insurance, please check the following box: ☐

F. EMPLOYEE SIGNATURE (PLEASE RETURN COMPLETED FORM TO YOUR LOCAL EMPLOYER REPRESENTATIVE.)

HIPAA electronic consent language: The Health plan provides medical, dental, vision, and flexible spending account benefits. Under federal law, we are required to provide you with a Notice of Privacy Practices (the 'Notice') of how medical information obtained through the Health plan may be used and disclosed and how you can get access to that information. I understand that the Notice is provided here within this form, but will be provided to me electronically in the future, and that I may also request a paper copy of the Notice at any time by contacting the Archdiocese of St. Louis Human Resources – Benefits Specialist at **Humanresources@archstl.org** or **314.792.7540**. The Notice is also available online at **https://www.archstl.org/human-resources**. I also understand that if I choose not to receive the Notice electronically, or if my email address needs updated, then I must notify the Archdiocese of St. Louis Human Resources – Benefits Specialist at **Humanresources@archstl.org** or **314.792.7540**.

Authorization/Release of Information: On behalf of myself and anyone enrolled on, or added to this form, I authorize my employer to deduct my contributions toward the cost of this coverage from my salary. I further authorize release of information pertaining to medical history or services rendered, or for any analytical or research purposes, from any physician, medical practitioner, hospital, and clinic, other medical or medically related facility, insurance or reinsurance company, employer or third party administrator. I understand that information used under this authorization may be used to determine eligibility for coverage and benefits for my dependents and me and that such information may be released to persons or organizations performing business or services in connection with the processing of any claims submitted under this plan.

Notice of Termination Rights: I understand that if my health insurance premium is deducted on a pre-tax basis, then I am limited as to when I may drop coverage under this plan: during open enrollment or upon a qualifying life event.

Dependent Attestation: I certify that the documentation provided is true and correct and meets the Definition of Eligible Dependents eligibility requirements. I understand that the falsification of documents or covering of ineligible dependents may result in termination of coverage.

Employee Confirmation: I confirm that the information I have provided on this form is complete and accurate.

Employee Signature _____ **Date** _____

G. EMPLOYER SECTION: FOR ADMINISTRATION TO COMPLETE

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of this application, 1) Please review all sections and confirm the employee completed the appropriate information, 2) Complete the information in this section and 3) Provide your signature and date of signature. Retain the original in your employee's medical file whether the employee is waiving or electing coverage. Within 31 calendar days of the hire date, qualifying event, or termination: **Please fax the completed form to 314.792.7548, mail to the Office of Human Resources at 20 Archbishop May Dr., St. Louis, MO 63119, or submit via email to your designated HR coordinator..**

Employment Status: (Check one) ☐ Full-Time ☐ Part-Time

Employer **Process Level**

EMPLOYER Signature **Date:**

Position/Title **Phone Number:** **EMPLOYER Email Address:**

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Appendix A (continued)

NOTICE OF PRIVACY PRACTICES

Archdiocese of St. Louis Group Health Plan

Effective Date: April 14, 2003
Last Revision Date: April 14, 2022

This Notice Describes How Your Protected Health Information May Be Used and Disclosed and How You Can Get Access To This Information.

Please Review It Carefully.

Who Will Follow This Notice

This notice describes the medical information practices of the Archdiocese of St. Louis' Group Health Plan (the "Plan") and that of any third party that assists in the administration of Plan claims. This Notice describes the Privacy Practices of the health programs on Exhibit A offered under the Plan, which may be updated from time to time.

Our Pledge Regarding Protected Health Information

The Plan understands that your protected health information and your health is personal. The Plan is committed to protecting your protected health information. This notice applies to all of the medical records the Plan maintains. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your protected health information created in the doctor's office or clinic.

This notice will tell you about the ways in which the Plan may use and disclose your protected health information. It also describes obligations and your rights regarding the use and disclosure of protected health information.

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to you protected health information
- give you this notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the notice that is currently in effect.

The Plan reserves the right to change the terms of this Notice and to make new provisions about your protected health information that it maintains, as allowed or required by law. The Plan will provide you with a copy of revised Notices of Privacy Practices if any material changes are made by making it available to you upon request and by posting it on its website.

How We May Use and Disclose Your Protected Health Information

The following categories describe different ways that the Plan uses and discloses protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. The Plan may use or disclose your protected health information to facilitate medical treatment or services by providers. The Plan may disclose protected health information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, disclosure of information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment. The Plan may use and disclose your protected health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Pan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. Also medical information may be shared with a utilization review or precertification service provider. Likewise, medical information may be shared with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. The Plan may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the use of medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage, submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs: business planning and development such as cost management; and business management and general Plan administrative activities.

As Required By Law. The Plan will disclose your protected health information when required to do so by federal, state or local law. For example, disclosure of medical information when required by a court order, in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, disclosure of your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, your protected health information may be disclosed to certain employees of the Employer. Those employees will **only** use or disclose that information as necessary to perform plan administration functions or as otherwise required or permitted by HIPAA. Your protected health information may not be used for employment purposes without your express authorization.

Special Situations

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan (as described by HIPAA) for purposes of facilitating claims payments under that plan.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release protected health information as required by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths,
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose your protected health information in response to a court or administrative order. The Plan may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena. warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if. under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the hospital, and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Appendix A (continued)

Coroners, Medical Examiners and Funeral Directors. The Plan may release your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release protected health information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, your protected health information may be released to the correctional institution or law enforcement official. This release would be necessary:

(a) for the institution to provide you with health care:
(b) to protect your health and safety or the health and safety of others, or
(c) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information used or disclosed about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information disclosed about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to. In your request, you must tell us:

(a) what information you want to limit;
(b) whether you want to limit our use, disclosure or both; and
(c) to whom you want the limits to apply, for example, disclosures to your spouse.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child. The Plan retains discretion to deny access to your PHI to 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. This also applies to personal representatives of minors.

Right to Accounting of Electronic Health Records. If a "covered entity" maintains an "electronic health record" about you, you have the right to (1) obtain a copy of the information in electronic format and (2) tell the covered entity to send the copy to a third party. The covered entity may charge you a reasonable fee for labor costs for sending the electronic copy of your health information.

Right to be Notified of a Breach. You have the right to be notified in the event that the Plan (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website:
https://www.archstl.org/human-resources/employee-benefits-and-forms/administration

Changes to This Notice

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for medical information already available about you as well as any information received in the future. A copy of the current notice will be posted on the Plan website. The notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS
The Plan welcomes an opportunity to address any concerns that you may have regarding the privacy of your health information. If you believe that the privacy of your health information has been violated, you may file a complaint with the Contact Person listed below. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint. **You will not be penalized or retaliated against for filing a Complaint.**

CONTACT PERSON
Archdiocese of St. Louis Human Resources/Benefits - HIPAA
Address: 20 Archbishop May Drive
St Louis, Missouri 63119
Email Address: Humanresources@archstl.org
Telephone Number: 314-792.7540

Appendix A (continued)

Exhibit A

Health Plans Included in this Notice:

UnitedHealthcare
Delta Dental
Flex Spending Program
Employee Assistance Program
Wellness Program

PRINT

DCN23FM2ASL

Appendix A (continued)

ARCHDIOCESE OF ST. LOUIS

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford Customer Service 1.800.523.2233
Policy # 677885

Supplemental Life Insurance Form

Name: _____
Date of Birth: _____
Date of Hire: _____

For Employer Use Only:
Location Code #: _
Employer Name: _

Social Security#: _____
Occupation: _____
Gender: _____
Marital Status: _____

Salary: Not required, default to $1- annual

Select One of the Following: ☐ Enroll ☐ Change ☐ Cancel Effective Date: _____

Supplemental Life Insurance - Employee

You have the opportunity to enroll in Archdiocese of St. Louis's Supplemental Life Insurance plan. You may elect coverage in **$10,000** increments up to a maximum of $300,000. **If you are a new hire and enrolling within 31 days of your date of hire, you are guaranteed coverage up to $100,000. If you elect coverage greater than $100,000, you are required to complete *Evidence of Insurability (EOI)* and be approved for the extra coverage. If you are enrolling after your 31 day enrollment period, you are considered a late enrollee and will need to complete *Evidence of Insurability (EOI*) and be approved for any amount of coverage.**

Please refer to the Premium Worksheet at the end of this form to determine your monthly cost for this coverage.

☐ I elect to **enroll in or change** the Supplemental Life plan at the monthly cost indicated on the Premium Worksheet for the coverage amount below.

Elected Benefit Amount in $10,000 Increments: _____

☐ I elect to **decline/cancel** the Supplemental Life plan.

Note: Benefits will automatically reduce to 65% of your elected amount on July 1 following the date you turn age 70, to 45% at age 75 and to 30% at age 80.

Supplemental Life Insurance – Spouse

If you elect the Supplemental Life Insurance for yourself, you may elect Supplemental Life Insurance for your Spouse. Your election may be made in increments of **$5,000** to a maximum of $150,000 but may not exceed 50% of your approved election. If you are a timely applicant, your spouse is guaranteed coverage up to $25,000. If electing coverage as a late enrollee or over $25,000, *Evidence of Insurability (EOI)* will need to be completed and approved before coverage is effective.

Please refer to the Premium Worksheet at the end of this form to determine your monthly cost for this coverage.
Note: supplemental spouse premiums are based on the employee's age not the spouse's age.

☐ I elect to **enroll in or change** my Spousal Supplemental Life plan at the monthly cost indicated on the Premium Worksheet for the coverage amount below.

Elected Benefit Amount in $5,000 Increments: _____

☐ I elect to **decline/cancel** the Supplemental Life plan for my Spouse.

Spouse First Name	Spouse Last Name	Gender	Marriage Date	Birth Date	Social Security #

Appendix B

Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life Insurance for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren). Your election may be made in increments of $5,000 to a maximum of $15,000. Children are covered from age 14 days to their 26th birthday regardless of student status. **Employees must complete and submit a *Hartford Supplemental Life Insurance Form* to their employer's business manager to drop a dependent child's supplemental insurance coverage upon attainment of age 26, as this is not an automatic process.**

Please refer to the Premium Worksheet at the end of this form to determine your monthly cost for this coverage. One premium will insure all your eligible children, regardless of the number of children you have.

☐ I elect to **enroll in or change** my dependent child(ren) Supplemental Life plan at the monthly cost indicated on the Premium Worksheet for the coverage amount below.

Elected Benefit Amount: $5,000_____ $10,000_____ $15,000_____

☐ I elect to **decline/cancel** the Supplemental Life plan for my dependent child(ren).

Child First Name	Child Last Name	Gender	Birth Date	Social Security#

Employee Confirmation

I have been given the opportunity to enroll in Archdiocese of St. Louis's Group Supplemental Life Insurance plan. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

Signature: _____ **Date:** _

Email: _____

Instructions: 1. Please fax or give the completed form to your Benefits Administrator at your parish/office/agency/school.
2. Keep a copy for your records.

Appendix B (continued)

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

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Appendix C

Clear Form

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: XXX XX ☐☐☐☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: ( ) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)

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Appendix C (continued)

Archdiocese of St. Louis

Long Term Disability Insurance

can replace part of your income if a disability keeps you out of work for a long period of time.

How does it work?

This employer-paid coverage pays a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

Your employer is paying the cost of this coverage. You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of 19 hours per week. **Coverage amounts** Cover 60% of your monthly income, up to a maximum payment of $5,000. *See the Legal Disclosures for more information.

The monthly benefit may be reduced or offset by other sources of income. The IRS may require you to pay taxes on certain benefit payments. See your tax advisor for details.

Archdiocese of St. Louis is paying the cost of this coverage. Coverage is guaranteed so you don't have to answer medical questions.

Elimination period (EP)

Your elimination period is 180 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits.

Benefit duration (BD)

This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits to age 65.

What's covered?

This insurance may cover a variety of conditions and injuries. Here are Unum's top reasons for long term disability claims:[1]

- Cancer
- Back disorders
- Injuries
- Cardiovascular
- Joint disorders

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

What else is included?

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

Survivor benefit

If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Waiver of premium

If you're disabled and receiving benefit payments, Unum waives your cost until you return to work.

1 Unum internal data, 2018. Note: Causes are listed in ranked order.

EN-2044 (1-20) FOR EMPLOYEES 374488

Appendix D

Exclusions and limitations

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by Archdiocese of St. Louis for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Benefit Duration (BD)

The duration of your benefit payments is based on your age when your disability occurs. Your Long Term Disability benefits are payable while you continue to meet the definition of disability. Please refer to your plan document for the duration of benefits under this policy.

Definition of disability

You are considered disabled when Unum determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to sickness or injury; and
- You have a 20% or more loss of indexed monthly earnings due to the same sickness or injury

After 24 months, you are considered disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability."Substantial and material acts" means the important tasks, functions and operations that are generally required by employers from those engaged in your usual occupation and that cannot be reasonably omitted or modified.

Pre-existing conditions

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services including diagnostic measures for the condition, or took prescribed drugs or medicines for it in the 3 months just prior to your effective date of coverage; and
- The disability begins in the first 12 months after your effective date of coverage.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive or are entitled to receive:

- Workers' compensation or similar occupational benefit laws, including a temporary disability benefit under a workers' compensation laws
- Automobile liability insurance policy
- Other group insurance plans
- A group plan sponsored by your employer
- Governmental retirement system
- Salary continuation or sick leave plans - if included
- Retirement payments
- Social Security or similar governmental programs

Exclusions and limitations

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- Intentionally self-inflicted injuries;
- Active participation in a riot;
- War, declared or undeclared or any act of war;
- Commission of a crime for which you have been convicted;
- Loss of professional license, occupational license or certification; or
- Pre-existing conditions (See the disclosure section to learn more).

The loss of a professional or occupational license does not, in itself, constitute disability.

Unum will not pay a benefit for any period of disability during which you are incarcerated.

The lifetime cumulative maximum benefit for all disabilities due to mental illness is 24 months. Disabilities based primarily on self-reported symptoms are limited to 24 months. Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities are not continuous and/or are not related. Payments can continue beyond 24 months only if you are confined to a hospital or institution as a result of the disability.

Termination of coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim that occurs while you are covered under the policy or plan.

Social Security advocacy services are provided by GENEX Services, Inc. or The Advocator Group, LLC. Referral to one of our advocacy partners is determined by Unum.

Worldwide emergency travel assistance services, provided by Assist America, Inc., are available with select Unum insurance offerings. Terms and availability of service are subject to change and prior notification requirements. Services are not valid after coverage terminates. Please contact your Unum representative for details.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al. or contact your Unum representative.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

Appendix D (continued)

Archdiocese of St. Louis

Physician Wellness Form

Benefit eligible employees, with at least one year of service and either working a minimum of 1,000 hours annually or a teacher with a half-time or more contract, may annually complete one of the following in order to receive an Archdiocesan paid, $125 Wellness Incentive Retirement Contribution (WIRC) to their Archdiocese of St. Louis sponsored retirement plan:

A. Receive an annual wellness exam with your physician of choice between May 1, 2023 and April 30, 2024

The deadline for H&H to receive this form is no later than May 7, 2024.

OR

B. Participate in the Archdiocesan paid, confidential H&H Health Associates health screening between May 1, 2023 and April 30, 2024.

IMPORTANT NOTES:

- Participation in the health insurance plan is not a requirement to be eligible to receive the $125 WIRC.
- Religious sisters, brothers, and priests are not eligible to receive the $125 WIRC; however, they are eligible to receive an annual Archdiocesan paid H&H health screening.
- If you were hired on or before May 1, 2023, and have been working either a minimum of 1,000 hours annually or a teacher with a half-time or more contract, you have fulfilled the one year of servicerequirement.
- If you receive an H&H health screening, you do not need to submit this form.
- The $125 WIRC will be processed in the fall of 2024 if you have completed the above criteria *and* are benefit eligible *and* actively employed with the Archdiocese of St. Louis at the end of the Wellness Plan year; April 30th.

Employee Instructions: Please fill out all requested information. (please print)

Employee Last Name: First Name: MI: Date of Birth: (mm/dd/yy) Last 4 Digits of SSN:

_____

Home Street Address: Phone #

_____

City: State: Zip Code:

_____

Name of Parish, School, or Agency Employer: Your Email Address (optional):

_____

CERTIFICATION: I certify that I received an annual wellness exam with my physician on the date noted below. I understand that if I provide false information, it may lead to disciplinary action.

Your Physician's Name: (Physician is not instructed to sign this form) Date of Physician Exam:(mm/dd/yy)

_____

Employee Signature: Date: (mm/dd/yy)

Questions? Please contact the Archdiocesan Office of Human Resources at: benefits@archstl.org or refer to the Archdiocesan website at archstl.org/hrbenefits | Employee Wellness Programs.

Employee Instructions: This completed and signed Employee Wellness Form should be sent to H&H Health Associates. Email is the recommended method of delivery so that you have proof of sending the form.

Mail: H&H Health Associates 3660 South Geyer Road Suite 100, Laumeier III St. Louis, MO 63127 Attn: Archdiocese Wellness	**Fax:** To H&H Health Associates at 314.845.8087 To verify receipt of fax you can call 314.845.8302 Regarding: Archdiocese Wellness	**Email:** To H&H Health Associates at nurses@hhhealthassociates.com Subject: Archdiocese Wellness

(Wellness Plan year 5/1/2023 – 4/30/2024)

Appendix E

Notice to Eligible Employees. Special Enrollment Rights

If you refuse enrollment for yourself and your dependents, you may later enroll within 31 days of a change in family status or loss of other health coverage. Loss of health coverage includes separation, divorce, death; termination of employment, reduction in work hours, exhaustion of continuation, or if employer contributions toward your coverage have terminated.

Change in family status includes marriage, birth, adoption, or placement for adoption of a child. If you or your dependent spouse is not enrolled for this coverage, you can also enroll during the special enrollment period when a change in family status occurs.

You are required by the plan to sign a waiver of coverage if you are refusing enrollment in the Archdiocesan plan at this time, be sure to sign and date the waiver and indicate the reason for waiving coverage.

Examples of qualifying events are listed below:

- Legal separation
- Divorce
- Death
- Loss of coverage
- Reduction in work hours
- Employer contributions toward coverage have terminated
- Exhaustion of COBRA continuation have terminated
- Marriage
- Birth of a child
- Adoption or placement for adoption of a child

Appendix F

Group Life and Accidental Death Claim Forms for Employee or Dependent

THE HARTFORD

To the Employer
The loss of a valued employee, or their loved one, can be difficult and we want to assist you in filing the claim as quickly as possible. Please read all instructions below regarding completion of these forms.

- All claims must be submitted, along with the beneficiary designation form(s) on file with the Employer/Plan, if any. If none on file, the Policyholder/Employer shall certify to that fact on the claim form.

Submit claim by mail to: The Hartford
Group Life Claims
P.O. Box 14299
Lexington, KY 40512-4299

By Fax to: 1-866-954-2621
By E-Mail to: gbclaimcslife@thehartford.com

PART I - EMPLOYER'S STATEMENT - TO BE COMPLETED IN FULL FOR ALL CLAIMS (1 of 2)
(Please verify if the employee qualifies for any other group benefits through The Hartford and submit the claim accordingly)

Policy Number(s): Life/AD&D: 677885 AD&D: _____ Business Travel Accident: _____

Group Policyholder/Employer Name: Archdiocese Of St. Louis

Name of Insured/Employee:	Social Security Number:	
Employee's Full Address:	Date of Birth:	Date of Death:

If you already have a copy of the death certificate, please submit it with the claim application.

Insured/Employee's Marital Status (if known): ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partnered ☐ Unknown

Date of Hire:	Effective date of employee's Insurance:	☐ Salaried ☐ Hourly	Branch/Location:	Occupation:

Classification: Class (if known): _____ ☐ Full-time ☐ Part-time ☐ Union

Employee's actual date last physically at work: _____

Provide reason employee did not return to work on their next scheduled workday: _____

☐ Illness ☐ FMLA (provide approval form) ☐ Retirement - Date: _____ ☐ Other (please explain): _____

Premiums paid to date for Insured/Employee?: ☐ Yes ☐ No If No, date insurance was discontinued or not in force: _____

Indicate if any of the following apply to this Employee:

☐ Has been approved for LBO/Accelerated Death Benefits ☐ Has been Approved for Waiver of Premium
☐ Has been Approved for Long Term Disability ☐ Applied for Conversion ☐ Applied for Portability

AMOUNT OF INSURANCE BEING CLAIMED FOR EMPLOYEE OR AMOUNT IN FORCE FOR EMPLOYEE IF DEPENDENT CLAIM

- **Form is to be completed in its entirety and signed by the Official Representative of the Policyholder/Employer on page 2.**
- **Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of** paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment.
- **AD&D Amount(s) should only be included if death was due to an accident.**

Basic Life: $	Supplemental Life: $
AD&D Basic: $	AD&D Supplemental: $

Earnings, if used to calculate Benefit Amount (reported earnings should be as defined in your policy. Attach W-2 if applicable)

Employee's Rate of Earnings used to calculate benefit Amount: $_____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually ☐ W-2

Regular number of hours scheduled to work (if applicable):	Effective date of above reported earnings:	Do earnings include commissions or bonuses?: ☐ Yes ☐ No

If Supplemental Life coverage is in force, was this elected during Annual Enrollment?: ☐ Yes ☐ No Date elected:	Did employee complete Evidence of Insurability (EOI)? ☐ Yes ☐ No Date EOI approved:

Does the coverage claimed above reflect age reductions?: ☐ Yes ☐ No

Please continue on next page

Appendix G

Group Life and Accidental Death Claim Forms for Employee or Dependent

THE HARTFORD

PART I - EMPLOYER'S STATEMENT (2 OF 2)
BENEFICIARY / CONTACT INFORMATION - TO BE COMPLETED BY EMPLOYER/TPA FOR ALL CLAIMS

Do you have beneficiary designations on file? ☐ Yes ☐ No If Yes, please include all designations with your claim submission

- **Please provide beneficiary contact information below, if available. Otherwise, provide known contact information for next of kin or insured's emergency contact**

Has the beneficiary completed a Funeral Home Assignment, and provided it to you? ☐ Yes ☐ No

- **If Yes, please include the Funeral Assignment with your claimsubmission**
- **If No, please provide any Funeral Home information available to you:** _____

Name of Insured/Employee:		Social Security No.:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:
Beneficiary Name:	Date of Birth:	Relationship:
Full Mailing address:		
Telephone Number: ( )	Cell Number: ( )	E-mail Address:

DEPENDENT INFORMATION - ONLY COMPLETE FOR DEPENDENT CLAIM

- If dependent claim is for a child, provide necessary paperwork to support the dependent was a full-time student OR support the dependent child was incapacitated, as applicable. Our claim team can help you if you're unsure what paperwork is necessary.

Full name of Deceased Dependent	Deceased Social Security Number	Date of Birth	Date of Death	Relationship to Employee
Last Residence (number, street, City, State, Zip Code)	Is Employee Actively at Work? ☐ Yes ☐ No If No, complete date last worked and reason on page 1		Have premiums been paid to date for this dependent? ☐ Yes ☐ No	
Was the dependent child over the Policy's limiting age? ☐ Yes ☐ No	Was the dependent child a full-time student? ☐ Yes ☐ No If Yes, and required by the Policy, include school enrollment verification		Was dependent child incapacitated? ☐ Yes ☐ No	

AMOUNT OF INSURANCE BEING CLAIMED FOR DEPENDENT

- **Submission of claims on any voluntary or contributory Life plans, including Dependent coverage, must include copies of paper enrollment forms and/or online enrollment screen prints of current and two prior plan years for history of benefit elections and timely enrollment**
- **Include AD&D amount(s) only if death was due to an accident**

Basic Life: $	Supplemental Life: $	AD&D Basic: $	AD&D Supplemental: $
If Supplemental Dependent Life coverage is in force, was this elected during Annual Enrollment?: ☐ Yes ☐ No Date elected:		Did employee complete Evidence of Insurability (EOI) for Dependent?: ☐ Yes ☐ No Date EOI Completed	
Dependent benefit is a: ☐ Flat Amount ☐ Percentage of Employee's amount If a percentage, please complete amount of employee insurance above		Does Coverage claimed reflect age reduction(s)? ☐ Yes ☐ No	

Indicate if any of the following apply to this Employee:

☐ Has been approved for LBO/Accelerated Death Benefits ☐ Has been Approved for Waiver of Premium
☐ Has been Approved for Long Term Disability ☐ Applied for Conversion ☐ Applied for Portability

TRAVEL INFORMATION – ONLY COMPLETE FOR BUSINESS TRAVEL ACCIDENT CLAIMS

- **If available, please include any travel itineraries, incident reports or police reports**

Trip Begin Date: _____ Scheduled Trip End Date: _____ Injury sustained during: ☐ Work Activity ☐ Pleasure Activity
Amount of BTA Insurance claimed: $_____ Date of Accident: _____ Time of Accident (hr, min) ____ : ____ ☐ AM ☐ PM
Place of Accident: _____ Fully describe the circumstances of the Accident and nature of injuries. If known: (Include incident/police reports as available; attach separate sheet, if necessary) _____

EMPLOYER CERTIFICATION

I hereby certify that the information provided on the Employer Statement is true and complete, according to the records of the Employer. I agree that this information is subject to audit by The Hartford and/or its representative.

Archdiocese Of St. Louis
Employer _____ Address _____

Signature _____ Date _____ Their Authorized Representative (Please print) _____

( ) _____ E-mail Address _____ ( ) _____
Telephone Number Facsimile Number

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Appendix G (continued)

Group Life and Accidental Death Claim Forms for EMPLOYEE or Dependent

THE HARTFORD

PART II - BENEFICIARY'S STATEMENT (1 of 2)

Release of claim forms is not an admission of coverage under a policy for an employer, group or organization

We know this is a difficult time, and we want to assist you in filing your claim as quickly as possible. Please read all instructions below regarding completion of these forms. Also, please read the "Important Notice" on page 6.

- This form is to be completed in its entirety indicating your current address, date of birth and Social Security Number.
- All beneficiaries must elect a Payment Option on the next page. Please refer to the Safe Haven Interest Rate Notice and the Safe Haven Program Terms & Conditions pages of this form.
- **If the claim proceeds are payable to an Estate**, the beneficiary section below must be completed by the Executor or Administrator of the Estate. An official certificate of such person's legal appointment and qualification must be attached to this form. Please include the Estate Tax Identification Number. If none available, please explain.
- **If the claim proceeds are payable to a Trust**, the beneficiary section below must be completed by the Trustee and/or Successor Trustee(s) of the Trust. Applicable Trust pages indicating the name and date of the Trust; name of Trustee and Successor Trustee; and signature pages, must be attached to this form. Please include the Trust Tax Identification Number. If none available, please explain.
- **If any designated beneficiary is a minor**, the beneficiary section below must be completed by a custodian or guardian. Include the minor's Social Security Number and copy of the minor's birth certificate. Letters of Guardianship/Conservatorship and the supporting Court Order appointing the guardian/conservator for the minor's **estate or property** must also be included, if applicable.
- **If the claim is for a dependent child enrolled in an accredited school of higher learning**, submitted documents should include a student enrollment form executed by the school, applicable if required under the Policy.
- **If the claim submitted is for a Foreign Death**, Include both the Official Death Certificate and the Death of American Citizen abroad form. Please note that additional documents may be required upon claim review.

The Company reserves the right to require or to obtain further proof of information should it be deemed necessary.

Name of Deceased:	Date of Death:	Claim Number (If known):

Deceased's Permanent Address:

Deceased's Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partnered

If the death certificate has been made available to you, please mark the manner of death:

☐ Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending/Undetermined/Unknown Cause (If known): _____

Please provide a copy of the death certificate with your submission. If not available, please submit as soon as possible.
If the death was due to an accident, please note there is an additional questionnaire to complete on page 5.

Please provide the Funeral Home information:

Name:	Contact Person:	Telephone Number:
		( )

Please continue on next page to elect a payment option

Appendix G (continued)

Group Life and Accidental Death Claim Forms for EMPLOYEE or Dependent

THE HARTFORD

PART II - BENEFICIARY'S STATEMENT (2 of 2)

GROUP POLICYHOLDER/EMPLOYER NAME: Archdiocese Of St. Louis		
Name of Insured/Employee:	Date of Birth:	Social Security Number:

Substitute W-9 Statement

Under penalties of perjury, I certify that:

(1) the number shown on this form is my correct taxpayer identification; and

(2) I am not subject to a back-up withholding, because, (a) I am exempt from back-up withholding; or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest and dividends; or (c) the IRS has notified me that I am no longer subject to back-up withholding; and

(3) I am a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item (2) above, if you have been notified by the IRS that you are currently subject to back-up withholding, because, you have failed to report all interest and dividends on your tax return.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signature:	*Date:*

DEATH BENEFIT PAYMENT OPTION

The Hartford offers payment options. Please know if you do not make an election below, we will pay your benefits by the Safe Haven Program, except in AK, MN, NY, FL, CT or NC. The Safe Haven program option is not available for benefits less than $10,000 (less than $15,000 for MN residents) or when payable under the Voluntary Accidental Death plan, Accidental Dismemberment plan, or the Business Travel Accident plan. Further, the Safe Haven Program is not an option for minor beneficiaries, estates or trusts.

Please review the Safe Haven Program Terms & Conditions and the disclosure on the interest rate earned.

☐ I would like the full amount of the insurance proceeds payable to me in a single distribution, into the Safe Haven Program. I have reviewed and understand the Safe Haven Program Terms & Conditions that have been provided to me.

☐ I would like the full amount of the insurance proceeds payable to me by check.

Beneficiary Name: (print)	Date of Birth:	Relationship:
Citizenship: ☐ U.S. citizen ☐ U.S. resident ☐ Non-resident alien (Request a W-8BEN)		
Complete Mailing Address: (Number & Street)	Beneficiary's Social Security Number or Estate /Trust Tax ID:	
(City, State & Zip Code)	Telephone Number: Day: ( ) Evening: ( )	

Personal Cell Telephone Number: ( ) May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by e-mail? ☐ Yes ☐ No Please initial here: _____ to confirm your election

By signing below:

(1) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 6 of this claim form package.

(2) **I Understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

(3) **I Hereby Certify** that the information provided on this Beneficiary Statement is true and complete, to the best of my knowledge.

(4) **I Understand and Agree that if I receive claim proceeds which are not due to me, I will reimburse The Hartford.**

Signature: X	Date:	E-mail address:

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Appendix G (continued)

Group Life and/or Accidental Death Claim Form
for EMPLOYEE or DEPENDENT

THE HARTFORD

Claimant's Statement of Accidental Death (complete only if death was due to an accident)

- If death was due to an accident, death certificate must be submitted at time of claim
- If you do not know or have a response to a question, please indicate "N/A"
- You must complete and sign the Authorization to Obtain and Disclose Information found on pages 7 and 8

Group Policyholder/Employer Name: Archdiocese Of St. Louis

Group Policy Number(s): Life/AD&D: 677885 AD&D: Business Travel Accident:

Name of Insured/Employee: **Social Security Number:**

Name of Deceased: (if different from above) Age: Relationship to Employee: ☐ Spouse ☐ Child

Has a Workers' Compensation claim been filed? ☐ Yes ☐ No If "Yes," what is the status of the claim?

On what date did the accident happen? Where did the accident happen? City: State:

Please describe injuries received:

Did accident result in death? ☐ Yes ☐ No If "Yes," on what date?

If injury was sustained while traveling on policyholder/employer business, please complete the following:
Trip Begin Date: Scheduled Trip End Date:
Injury was sustained during: ☐ Work Activity ☐ Pleasure Activity

For all accident claims, please complete the following:

Describe in detail how the accident happened:

Name and address of law enforcement agency involved: *(Please submit copy of Police Accident Report and/or Case Number)*

List name/address/phone number of all physicians consulted for the injury/death:

List name/address/phone number of all hospitals consulted:

Did the deceased have any chronic disease or physical defect or deformity? ☐ Yes ☐ No If "Yes", describe in detail:

Was an autopsy performed? ☐ Yes ☐ No If "Yes," provide name/address/telephone number of coroner, if known:

Was an inquest held? ☐ Yes ☐ No If "Yes", verdict:

Please complete and sign the Authorization to Obtain and Disclose Information, pages 7 and 8

Appendix G (continued)

Important Notice - Please read the statement that applies to your state of residence and sign the bottom of the page.

For residents of all states EXCEPT Arizona, Alabama, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of Ohio: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

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Appendix G (continued)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THE HARTFORD

I allow all doctors, hospitals, other health care providers, pharmacy, pharmacy benefit managers, government agencies (including, but not limited to, Federal, State or Local, and the Social Security Administration and Veterans Administration), insurers, employers, financial institutions, educational institutions, health plans, health insurance carriers, policyholders, contract holders, vendors, health and benefit insurers and administrators or their successors ("Records Holders") to give to and discuss with The Hartford and its representatives, the following personal, private, or privileged information, records, or documents related to:

Insured's Name (Please Print)	Date of Birth	Employer/Policyholder's Name:
		Archdiocese Of St. Louis

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or substance abuse, and behavioral or mental health (but excluding psychotherapy notes); work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security or other government benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and /or leave request(s) and/or request(s) for accommodation. Such information shall be referred to herein collectively as "My Information."

I understand that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. Without limiting the foregoing, I authorize The Hartford to use or disclose My Information (i) to my employer for: a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation, adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits, leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, grievance, alternative dispute resolution, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim, other audits or benefit program reviews; (ii) to administrators or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan/program or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance, reinsurance or analytical purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes ; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others or myself; (ix) as may be reasonably necessary to respond to regulatory or similar complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud. I understand that My Information disclosed to The Hartford and re-disclosed to others could include information regarding alcohol and substance abuse, HIV/AIDS, other communicable diseases, and behavioral and mental health records.

(Continue to next page)

Appendix G (continued)

I understand that once my Information is given out as allowed in this form, federal privacy laws may not protect it and it may be re-disclosed by The Hartford. I also understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. The Authorizations set forth herein expire two years from the date listed below, or upon my written revocation, if earlier, except as may be reasonably necessary to prevent or detect perpetration of a fraud, adjudicate a benefits claim, respond to regulatory or similar complaints, or protect the personal safety of others or myself. I understand that if The Hartford is the administrator of my employer's self-insured disability program or leave program that my employer is entitled to receive my records without this Authorization. I understand that a revocation of this Authorization is not effective to the extent that any of my Record Holders or The Hartford has relied on this Authorization or to the extent that the Hartford has a legal right to contest a claim for benefits or to contest the policy. If I do not sign this Authorization, The Hartford may not be able to review my claim and determine whether I am eligible for benefits. This may result in a delay or denial of my request for benefits.

The Information released under this Authorization can be submitted to The Hartford electronically, by phone or fax, or by mail. I agree that a copy of this Authorization may be treated as a signed original. I understand that I am entitled to receive a copy of this Authorization upon request. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

NOTICE TO INFORMATION PROVIDERS:
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family members genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.

_____ _____
Signature of Claimant or Legal Representative **Date**

_____
Name and Relationship to Claimant *(if signed by Legal Representative)*

Form must be signed and dated.

Appendix G (continued)

INTEREST RATE NOTICE

The Safe Haven® Program

Effective 11/01/18, the rate of interest credited on assets in the Safe Haven Program is **0.65%***

Safe Haven is intended to provide our customers with a convenient means for paying for their immediate needs and to allow them time to decide how to use the remaining balance of their insurance or annuity proceeds. Interest is paid from the date your claim is settled to the date you withdraw your funds.

Interest is compounded daily and credited to your account on the last day of each month. Interest will be available for withdrawal the day it has been credited.

If you elect to participate in The Hartford's Safe Haven program, your insurance or annuity proceeds ("Safe Haven assets") will be held in The Hartford's general account.

The Hartford will earn investment income on Safe Haven assets. The difference between the investment income earned on the Safe Haven assets and the interest rate credited to our customers participating in the Safe Haven program will provide The Hartford with a profit and cover the expenses we incur.

*The Hartford, in its sole discretion, determines the credited interest rate and can change the rate at any time. The current rate of interest will be displayed on your Program statement or you can call Customer Service at 1-800-918-2335. In determining the interest rate, we also factor in the impact of The Hartford's profitability, general economic trends, competitive factors and administrative expenses.

The interest rate is effective 11/01/18; all other information and representations herein are as of 10/15/11.

Appendix G (continued)

Terms and Conditions

This constitutes a supplemental contract.

The Safe Haven Program

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Fire Insurance Company, Hartford Life Insurance Company, Hartford Life and Annuity Insurance Company, Hartford Life and Accident Insurance Company, and Hartford Life Group Insurance Company. Hartford Life Insurance Company and Hartford Life and Annuity Insurance Company are acting as the administrator of the Safe Haven program for Time Insurance Company, Union Security Life Insurance Company of New York and Union Security Insurance Company. Refer to the original policy for the appropriate insurer.

A. Your Proceeds

The full amount of the insurance proceeds payable to you has been distributed, in a single distribution into the Safe Haven Program. This is a draft account, not a checking account. Checks are drafts drawn on banks. Under the Safe Haven Program, your money is not held in a bank. It is held in The Hartford's general account. As a result, your drafts are drawn on The Hartford and are only payable through the Bank of New York Mellon, 500 Ross St, Room 1380, Pittsburgh, PA 15262.

The draft kit mailed to you provides access, at any time, to part or all of these funds by writing one or multiple drafts, which you can use like personal checks. Please note that certain merchants as part of their business protocol, may screen a customer's check or draft payment for acceptance using a variety of factors (e.g. customer's check writing history) and/or utilize third party check verification services. A merchant may consider the nature of a draft account as one factor in their screening process.

You understand that after the distribution into The Safe Haven Program, which constitutes full payment of the insurance proceeds, any claim that you may pursue against The Hartford will relate to the undertaking between you and The Hartford as to The Safe Haven Program, not the insurance policy. Original claim settlement options are not preserved.

B. Interest Earned

The Hartford credits interest on your money compounded daily and credited to you on the last day of each month. Interest is earned on the funds in Safe Haven from the date your claim under the insurance policy is settled and the full amount payable to you has been distributed, in a single distribution, through the Safe Haven Program. Interest will be available for withdrawal on the day it has been credited.

The Hartford in its sole discretion, determines the credited interest rate. The interest rate is based, in part, upon the analysis of interest rates credited on similar short-term products. In determining the interest rate, we also factor in the impact of The Hartford's profitability, general economic trends, competitive factors and administrative expenses.

Your money in the Safe Haven Program is held in The Hartford's general account. The Hartford will earn investment income on Safe Haven assets. The difference between the investment income earned on the Safe Haven assets and the interest rate credited to our customers participating in the Safe Haven program will provide The Hartford with a profit and cover the expenses we incur.

C. Tax Reporting and Considerations

The interest earned on your account is considered taxable income. The Hartford is required by law to report the interest amount annually to you and the Internal Revenue Service (IRS). If the interest earned in Safe Haven during the year is $10.00 or more and you are a U.S. Person, a form 1099-INT will be mailed to you at the end of the year.

Appendix G (continued)

If you are a Foreign Person, the interest amount is subject to different reporting requirements.

Choosing and keeping a retained asset account may have tax implications. Please consult with a tax advisor with any tax questions related to your account.

D. Not FDIC Insured

Your money in the Safe Haven Program is not held in a bank account and is not insured by the Federal Deposit Insurance Corporation; nor is it backed or guaranteed by any federal or state government agency. Your money is held in the general account of the applicable issuing company of The Hartford and your ability to withdraw your money is based on the claims paying ability of the issuing company as listed above.

In the event of insurer insolvency, your state's Insurance Guaranty Association provides some coverage of assets in the Safe Haven Program. Since coverage varies by state, we advise you to contact your state's guaranty association for information about coverage and limitations. You can find the link to their website at www.nolhga.com - the National Organization of Life and Health Insurance Guaranty Associations (phone: 703-481-5206).

E. Minimum Balance Requirement

If the balance of your proceeds drops below $750, we will mail you a check for the balance of your funds, the accrued interest, and a closeout statement on the last day of the month. Certain accounts that are scheduled to receive future deposits are exempt from this requirement; please contact customer service with any questions.

F. Statements

Each quarter you will be mailed a statement showing withdrawals, interest credited, cleared drafts, current interest rate, and any other activity.

Interim monthly statements will only be provided upon request or when there are new transactions posted or credited to your proceeds other than earned interest.

G. Fraud Prevention & Your Responsibilities

You should exercise reasonable care and promptness in examining your statement and notify customer service immediately if you question a particular transaction. Failure to report any questionable transactions in a timely manner may result in loss of funds.

You should keep your Safe Haven draft book in a safe and secure location. In the event you lose possession of your Safe Haven draft book, you must notify customer service. Failure to report a lost or stolen draft book in a timely manner may result in loss of funds.

You are responsible to provide a valid W-9 form for name, signature and tax identification number verification. Failure to do so may impact transaction processing, security authentication and our mutual efforts to prevent fraud.

In the event of reasonably suspected or known fraud, The Hartford reserves the right to freeze funds in the account pending timely receipt of required documents, investigation and resolution. To the extent required by applicable state law, The Hartford is responsible for any unauthorized use of the Safe Haven account and will make you whole in the event of an unauthorized use, including among other events, payment made on a forged instrument.

H. Cleared Drafts

Cleared drafts will be retained by the Bank of New York Mellon and will not be returned to you. A copy of cleared drafts will be printed on your statement.

You may also obtain a copy of a cleared draft by contacting Customer Service.

I. Fees and Withdrawal Restrictions

The Safe Haven Program does not charge any fees against your account.

There are no restrictions for withdrawal frequency or minimum withdrawal amounts.

J. Deposits

You may not make deposits into Safe Haven. Only interest earned and insurance proceeds distributed to you may be deposited.

K. Ending Participation in Safe Haven

You can choose from any of the three following options to terminate your participation with Safe Haven:

- Write a draft for the entire balance;
- Call Customer Service and request that your participation be terminated;

Appendix G (continued)

- Write a letter asking that your participation be terminated and mail it to:

  The Hartford
  Safe Haven Program
  P.O. Box 5005
  Hartford, CT 06102

Please include your name, account number, address, signature, and a phone number on all correspondences.

L. Account Inactivity

We may be obligated to transfer (escheat) your money in the Safe Haven Program to your state if no activity occurs in the account within the time period specified by your state's unclaimed property laws. Safe Haven understands the importance of customer communication and will make reasonable and customary attempts to research and contact you seeking your response prior to any such transfer. It is important that you keep your name, address and contact information current.

Examples of account activity that indicate your desire to continue participation may include:

- Contacting customer service to update or confirm your contact information
- Viewing account activity and other information online at http://www.thehartford.com
- Calling our automated phone system 24/7 at 1-866-414-8181 for basic information
- Writing a draft to pay bills, make purchases, get cash, invest, et cetera.

As always, if you need assistance with any of these options then call customer service. We are here to serve you.

M. Changes in Terms and Conditions; Acceptance

The Hartford reserves the right to change the terms and conditions of this Safe Haven program. You will be informed in your quarterly statement that changes have been made. Your continued usage of the services provided through Safe Haven constitutes acceptance of these terms and conditions.

In addition, The Hartford reserves the right to terminate your participation at any time.

N. Address Change

Please notify us of any change of address. Failure to provide new address information could cause a delay in your receipt of quarterly statements and year-end tax forms.

O. Assignments

Your Safe Haven is not transferable.

P. Beneficiary Designation

You can specify primary and contingent beneficiaries for your Safe Haven proceeds who will receive any remaining funds in the event of your death. We request that you provide us with beneficiary information prior to establishing your account. For each named beneficiary, we request their address, social security number, date of birth, phone number and percent distribution. You may easily obtain a beneficiary designation form at any time by contacting Customer Service. Your beneficiary designation will be effective only if you execute a beneficiary designation form and receive our letter of confirmation.

If you do not designate a beneficiary, The Hartford, upon notification of your death and receipt of a valid death certificate and required documents, will close your account and pay any remaining funds to your estate.

Q. Authorized Persons

You, the accountholder, are the only contact authorized to act on this account unless the appropriate legal authorization is established (e.g. power of attorney, guardianship, or conservatorship paperwork) and the required program documents are completed and returned. Program documents will be supplied upon your request and will require that you provide the proper identification information for any party being granted financial authorization, including their name, address, phone number, social security number, date of birth and signature. Upon receipt of legal and program documents, a review will be performed to determine authorization and you will be provided a confirmation of processing.

Appendix G (continued)

R. Payment Interruption

In the event of insolvency of the issuing company, a lengthy delay is possible before you can get your money.

S. Customer Service

For additional information and answers to any questions, you can reach our Customer Care Center toll free at 1-800-918-2335. Or write us, including your name, account number, address, signature, and phone number, at:

The Hartford
Safe Haven Program
P.O. Box 5005
Hartford, CT 06102

For Private Express Mail Carriers:

The Hartford
Safe Haven Program
1 Griffin Road North
Windsor, CT 06095-1512

Automated services provide basic transactions 24 hours a day, 7 days a week by calling 1-866-414-8181. This toll free number is also located on your quarterly statement.

FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.

Appendix G (continued)

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Language Assistance Services

We[1] provide free language services to help communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call **1-866-633-2446** or the toll-free member phone number listed on your health plan ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: **한국어(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الأتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

Appendix H

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាមានផ្តល់ជូន ឥតគិតថ្លៃ សម្រាប់អ្នក។ សូមទូរស័ព្ទ ទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' 1-866-633-2446 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

ΠΡΟΣΟΧΗ : Αν μιλάτε **Ελληνικά (Greek)**, υπάρχει δωρεάν βοήθεια στη γλώσσα σας. Παρακαλείστε να καλέσετε 1-866-633-2446.

ધ્યાન આપો: જો તમે **ગુજરાતી (Gujarati)** બોલતા હો તો આપને ભાષાકીય મદદરૂપ સેવા વિના મૂલ્યે પ્રાપ્ય છે.
કૃપા કરી 1-866-633-2446 પર કોલ કરો.

Notice of Non-Discrimination

We[1] do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UTAH 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call **1-866-633-2446** or the toll-free member phone number listed on your health plan ID card (TTY/RTT 711). We are available Monday through Friday, 8 a.m. to 8 p.m. E.T.
You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free **1-800-368-1019, 1-800-537-7697 (TDD)**
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

[1]For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "We" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Medical Information Privacy Notice

Effective January 1, 2023

We[2] are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as **www.myuhc.com**. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Collect, Use, and Disclose Information

We collect, use, and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to collect, use, and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may collect, use, and disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation (when permitted by applicable law) or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may collect, use, and disclose health information to aid in your treatment or the coordination of your care. For example, we may collect information from, or disclose information to, your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may collect, use, and disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also deidentify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may collect, use, and disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may collect, use, and disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.
- **For Communications to You.** We may communicate, electronically or via telephone, these treatment, payment or health care operation messages using telephone numbers or email addresses you provide to us.

We may collect, use, and disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may collect, use, and disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents**. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may collect, use, and disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to federal law, to protect the privacy of your information and are not allowed to collect, use, and disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information:
    1. Alcohol and Substance Abuse
    2. Biometric Information
    3. Child or Adult Abuse or Neglect, including Sexual Assault
    4. Communicable Diseases
    5. Genetic Information
    6. HIV/AIDS
    7. Mental Health
    8. Minors' Information
    9. Prescriptions
    10. Reproductive Health
    11. Sexually Transmitted Diseases

Appendix H (continued)

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests in accordance with applicable state and federal law. In certain circumstances, we will accept your verbal request to receive confidential communications; however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. If we maintain a website, we will post a copy of the revised notice on our website. You may also obtain a copy of this notice on your plan website, such as **www.myuhc.com**.
- **You have the right to make a written request that we correct or amend** your personal information. Depending on your state of domicile, you may have the right to request deletion of your personal information. If we are unable to honor your request, we will notify you of our decision. If we deny your request, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the disputed information and what you consider to be the correct information. We will make your statement accessible to parties reviewing the information in dispute.

Appendix H (continued)

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, **please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-633-2446 (TTY/RTT 711).**
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address:

  UnitedHealthcare
  Customer Service - Privacy Unit
  PO Box 740815
  Atlanta, GA 30374-0815

- **Timing.** We will respond to your telephonic or written request within 30 business days of receipt.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

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[2]This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Enterprise Life Insurance Company; Freedom Life Insurance Company of America; Golden Rule Insurance Company; Healthplex Dental Services, Inc.; Healthplex Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; March Vision Care, Inc.; MCNA Insurance Company; MD – Individual Practice Association, Inc.; Medica Health Plans of Florida, Inc.; Medica Healthcare Plans, Inc.; National Foundation Life Insurance Company; National Pacific Dental, Inc.; National Foundation Life Insurance Company; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; New Orleans Regional Physician Hospital Organization, L.L.C.; Solstice Health Insurance Company; Solstice Healthplans of Arizona, Inc.; Solstice Healthplans of Colorado, Inc.; Solstice Healthplans of New Jersey, Inc.; Solstice Healthplans of Ohio, Inc.; Solstice Healthplans of Texas, Inc.; Solstice Healthplans, Inc.; Solstice of Illinois, Inc.; Solstice of New York, Inc.; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Peoples Health, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Sierra Health and Life Insurance Company, Inc. (DBA UnitedHealthcare Insurance Company USA applicable to Arkansas and Maryland only); Solstice Benefits, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of California, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Freedom Insurance Company; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of America; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Integrated Services, Inc.; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United Healthcare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of the Rockies, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Appendix H (continued)

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2023

We[3] are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About This Notice

If you have any questions about this notice, please **call the toll-free member phone number on your health plan ID card or contact the UnitedHealth Group Customer Call Center at 1-866-633-2446 (TTY/RTT 711).**

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[3]For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the sixth page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group of California, Inc.; AmeriChoice Corporation; Benefitter Insurance Solutions, Inc.; Claims Management Systems, Inc.; Dental Benefit Providers, Inc.; Ear Professional International Corporation; Excelsior Insurance Brokerage, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; Golden Rule Insurance Company; HealthMarkets Insurance Agency; Healthplex of CT, Inc.; Healthplex of ME, Inc.; Healthplex of NC, Inc.; Healthplex, Inc.; HealthSCOPE Benefits, Inc.; International Healthcare Services, Inc.; Level2 Health IPA, LLC; Level2 Health Management, LLC; Life Print Health, Inc.; Managed Physical Network, Inc.; Optum Care Networks, Inc; Optum Global Solutions (India) Private Limited; OptumHealth Care Solutions, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; Physician Alliance of the Rockies, LLC; POMCO Network, Inc.; POMCO, Inc.; Real Appeal, LLC; Solstice Administrators of Alabama, Inc.; Solstice Administrators of Arizona, Inc.; Solstice Administrators of Missouri, Inc.; Solstice Administrators of North Carolina, Inc.; Solstice Administrators of Texas, Inc.; Solstice Administrators, Inc.; Solstice Benefit Services, Inc.; Solstice of Minnesota, Inc.; Solstice of New York, Inc.; Spectera, Inc.; Three Rivers Holding, Inc.; UHIC Holdings, Inc.; UMR, Inc.; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; UnitedHealthcare, Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; Urgent Care MSO, LLC; USHEALTH Administrators, LLC; USHEALTH Group, Inc.; and Vivify Health, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products. This list of health plans is complete as of the effective date of this notice. For a current list of health plans subject to this notice go to www.uhc.com/privacy/entities-fn-v1.

Appendix H (continued)

The Archdiocese of St. Louis Lay Employees Retirement Plan features and highlights

Read these highlights to learn more about your plan. If there are any discrepancies between this document and the Plan Document, the Plan Document will govern.

About the 403(b) plan

A 403(b) plan is a retirement savings plan designed for employees of tax-exempt organizations. A 403(b) plan allows eligible employees to save and invest through voluntary salary contributions.

Eligibility requirements

Employee contributions
After age 21, employees may contribute as soon as their information is received by Empower. You will receive a communication from Empower regarding enrolling (typically after your first paycheck after you have become eligible). Employees may contribute up to 85% of compensation or the IRS limit, whichever is less. In 2022, the contribution limit is $20,500 for employees under 50 and $27,000 for employees turning age 50 or older.

Contributions can be either pretax or Roth:

Pretax contributions are made with pretax dollars. In other words, with the pretax option, you've haven't yet paid income taxes on the money you contribute. You will pay income taxes on the entire amount withdrawn when you take a distribution.

Roth contributions are made with after-tax dollars. In other words, with the Roth option, you've already paid income taxes on the money you contribute. You will not pay income taxes on the money you contributed when you take a distribution. Continue reading below for more details on the taxation of any earnings on your Roth contributions.

If you withdraw your Roth contributions and any earnings after you've reached age 59½ or severed employment due to death or disability — and after you've satisfied the five-year holding period requirement — the distribution is income tax and penalty free.

If you take a distribution from your Roth 403(b) account before age 59½, death or disability — or before you have satisfied the five-year holding period requirement — you will pay income taxes plus a 10% penalty, if applicable, on any earnings that are distributed.

No income tax or penalty is due on Roth contributions distributed from the plan since such contributions were made with after-tax dollars.

Before taking a distribution, contact your Gallagher representatives: Mike Eagen (314-792-7262) or Sharon Gogel (314-792-7261) with any questions.

Archdiocese contributions
Currently, the Archdiocese of St. Louis makes a 5% discretionary contribution for eligible employees over the age of 21 starting with the first pay period of the month following the completion of one year of service.

This benefit is contributed to the plan for all eligible employees. You do not have to make your own contributions to receive this employer contribution.

Eligible employees are staff personnel working 1,000 or more hours during the 365-day period or teachers with at least a half-time contract (single or combined between parishes). See the Summary Plan Description for additional details. Hours worked at multiple employers (e.g., Charities, Marygrove, Good Shepherd and parishes) are consolidated to calculate the year-of-service (1,000 hours) eligibility requirement.

Vesting schedule

All employer contributions are immediately 100% vested.

Investment options[1]

A wide array of core investment options is available through your plan. Each option is explained in further detail in your plan's fund sheets. Once you have enrolled, investment option information is also available through the website at **empowermyretirement.com** or at **866-467-7756**. The website and the voice response system are available to you 24 hours a day, seven days a week.

In addition to the core investment options, a self-directed brokerage account (SDBA) is available. The SDBA allows you to select from numerous investment options for additional fees. The SDBA is intended for knowledgeable investors who acknowledge and understand the risks associated with the investments contained in the SDBA.

Call Empower at **866-467-7756** for more information.

Transfers and allocation changes[2]

You can move all or a portion of your existing balances between investment options and change how your payroll contributions are invested.

Rollovers[3]

Only plan administrator-approved balances from an eligible 457(b), 401(k), 403(b) or 401(a) plan or an IRA may be rolled over to the plan.

Consider all your options and their features and fees before moving money between accounts.

Appendix I

Withdrawals

Qualifying distribution events are as follows:

- Retirement
- Permanent disability
- Financial hardship (as defined by the Internal Revenue Code and your plan's provisions) (one per year)
- Severance of employment (as defined by Internal Revenue Code provisions)
- Attainment of age 59½
- Death (your beneficiary receives your benefits)

Ordinary income tax will apply to each distribution. Distributions received prior to age 59½ may also be assessed a 10% early withdrawal federal tax penalty. Refer to your Summary Plan Description for more information about distributions.

Loans

Your plan allows you to borrow the lesser of $50,000 or 50% of your eligible total vested account balance. The minimum loan amount is $1,000, and you have up to 60 months to repay your general-purpose loan.

There is also a $50 origination fee for each loan, which is deducted from loan proceeds, plus an ongoing annual $50 fee.

Plan fees

Recordkeeping or administrative fees
An annual asset fee of 0.185% will be deducted from your account quarterly.

A charge of $300 per occurrence will be deducted for qualified domestic relations order (QDRO) processing services, which include QDRO reviews, calculations and distributions.

Distribution fees

The fee for a one-time lump-sum distribution is $15.

Fees for installment payments are:

- $15 per installment distribution setup
- $15 annual maintenance fee each year after the first year

Investment option fees

Each investment option has an investment management fee that varies by investment option. These fees are deducted by each investment option's management company before the daily price or performance is calculated. Fees pay for trading individual securities in the underlying investment options and other management expenses. Funds may also impose redemption fees on certain transfers, redemptions or exchanges.

There may be a recordkeeping or administrative fee for investing in certain investment options. Please contact your Empower representative for more information about any potential investment option fees.

Asset allocation funds are generally subject to a fund operating expense at the fund level as well as prorated fund operating expenses for each underlying fund in which they invest. For more information, see the fund prospectus and/or disclosure document.

There is an additional annual fee of $50 for the SDBA option, deducted from your account at $12.50 quarterly, and the possibility of transaction fees to participate in the SDBA option.

How do I get more information?

For questions about enrolling, salary deferral changes, retirement options, retirement plan details, assistance with your asset allocation and other plan-related issues, contact your Gallagher representatives: Mike Eagen (314-792-7262) or Sharon Gogel (314-792-7261).

You can also visit the plan website at **empowermyretirement.com** or call **866-467-7756** for more information. The website provides details regarding your plan as well as financial education information, financial calculators and other tools to help you manage your account.

1 Prospectuses, disclosure documents and investment-related options/services information are only available in English. Please have them translated as needed prior to investing.

2 Transaction requests received in good order after the close of the New York Stock Exchange will be processed the next business day.

3 Governmental 457 plan funds rolled into another type of plan or account may become subject to the 10% early withdrawal penalty if taken before age 59½.

Appendix I (continued)

ARCHDIOCESE OF ST. LOUIS
ADOPTION ASSISTANCE PROGRAM
REIMBURSEMENT REQUEST FORM

INSTRUCTIONS: Please contact the Archdiocesan Office of Human Resources at 314.792.7540 if you have any questions about this form or the *Adoption Assistance Program*. Once you have completed and signed this form, please attach the verifying documents and original proof of expenses, and forward it to the Office of Human Resources – Director of Benefits.

EMPLOYEE INFORMATION:

Social Security Number: _____

Last Name: _____ First Name: _____

Address: _____
Street City State Zip

Employed by (parish/school):_____

Home Phone: _____ Work Phone: _____

CHILD(REN) INFORMATION:
I confirm the following:

- Child(ren)'s name(s): _____
- Child(ren)'s date(s) of birth *(mm/dd/yyyy)*: _____
- Date child(ren) placed in my home for purposes of adoption:_____
- Date, or anticipated date, of finalization of child(ren)'s adoption: _____

REQUEST FOR REIMBURSEMENT

I am applying for reimbursement of the following adoption expenses:

Date of expense *(mm/dd/yyyy)*	Description (Include name of person or entity to which expense was paid. Attach original bills, receipts, or cancelled checks.)	Amount
		$
		$
		$
		$
		$
		$
	TOTAL REQUESTED REIMBURSEMENT:	$

Appendix J

EMPLOYEE STATEMENT OF UNDERSTANDING

I certify that the receipts or cancelled checks I am submitting are qualified adoption expenses under the Archdiocese's *Adoption Assistance Program*. Qualified adoption expenses include reasonable and necessary adoption fees, court costs, attorney fees, travel expenses (including amounts expended for meals and lodging, and other expenses) that are: (i) directly related to, and the principal purpose of which is for, the legal adoption of an eligible child by the eligible employee, (ii) not incurred in violation of State or Federal law, or in carrying out any surrogate parenting arrangement, (iii) not for the adoption of the child of the employee's spouse or other relative, and (iv) not reimbursed by another source (*e.g.*, grants, another employer).

I certify that these expenses are not incurred in violation of State or Federal law or in carrying out any surrogate parenting agreement, nor are these expenses incurred in connection with my adoption of the child of my spouse or other relative. Furthermore, these expenses have not been nor will they be reimbursed under an employer plan other than this *Adoption Assistance Program*, nor have they been previously reimbursed by the Archdiocese's *Adoption Assistance Program*, nor by any other source.

I further acknowledge that to the extent that any income tax exclusion or credit may be available to me, I will first claim that exclusion or credit before claiming the expense under this Program. I also acknowledge that I cannot claim the exclusion and the credit for the same expense.

I understand that the Archdiocese of St. Louis does not make any commitment or guarantee that amounts paid to me under this *Adoption Assistance Program* will be excludable from my gross income for Federal, State or Local income tax purposes, or that any other Federal tax treatment will apply to or be available to me. I understand that it is my obligation to determine whether any payment made under the *Adoption Assistance Program* is excludable from my gross income for income tax purposes.

I hereby certify that the information I have furnished in support of this claim for reimbursement under the *Adoption Assistance Program* is true and correct.

Employee Signature _____ Date _____

Employee Name (please print) _____

Submit the completed form with a certified and notarized copy of the record of placement or final court order. Also include original bills, itemized receipts, and/or cancelled checks. Expenses may be submitted up to six months after placement of the child in the employee's home. No reimbursement will be made for expenses submitted after that time. Send the form and enclosures to:

Office of Human Resources
Attn: Director of Benefits
Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, MO 63119

Appendix J (continued)

Archdiocese of St. Louis
Cardinal Rigali Center
20 Archbishop May Drive
St. Louis, Missouri 63119

Office of Human Resources
p) 314.792.7546
f) 314.792.7548

EMPLOYEE MISSOURI STATUTE 452 WAIVER FORM

The Archdiocesan Employee Benefit Plan follows the Missouri Statute 452.317. The statute states the following:

> "From the date of filing of the petition for dissolution of marriage or legal separation, no party shall Terminate coverage during the pendency of the proceeding for any other party or any minor child of The marriage under any existing policy of health, dental or vision insurance".

The Archdiocese may allow a termination of insurance for a dependent spouse and or dependent children during the pendency of the proceedings, if you sign the following waiver statements to the Archdiocesan Employee Benefit Plan.

I understand that I have a right to require that coverage be continued under Missouri Law.
I hereby waive my (or my children's, if applicable) right to continued health coverage under the plan and request that the coverage be terminated as of _____, 20_____.

I release the Archdiocese Employee Benefit Plan and the Archdiocese of St. Louis from any liability in connection with the termination of coverage.

I waive my (or my children's, if applicable) right to the Archdiocese Cobra-like plan, the Continuation of Coverage plan.

I understand that foregoing is irrevocable and that once coverage is terminated, it will not be reinstated (unless the individual again becomes eligible under the terms of the plan. For example, if I and my spouse reconcile and I want to add the spouse and children back on the health plan during Open Enrollment).

If I am terminating dependent children from the health insurance plan, I and my spouse have complete legal authority to act on behalf of the minor children.

Employee Name (printed):	
Employee Signature:	
Date of Signature:	
Employee Email Address:	
Employee Telephone #:	

Please fax (314-792-7548) or scan/email the completed form to the Office of Human Resources at Benefits@archstl.org. For questions, please contact the Archdiocese of St. Louis Office of Human Resources at 314.792.7546 or Benefits@archstl.org.

Appendix K

Archdiocese of St. Louis
Cardinal Rigali Center
20 Archbishop May Drive
St. Louis, Missouri 63119

Office of Human Resources
p) 314.792.7546
f) 314.792.7548

MISSOURI STATUTE 452 SPOUSAL WAIVER FORM

The Archdiocesan Employee Benefit Plan follows the Missouri Statute 452.317. The statute states the following:

> "From the date of filing of the petition for dissolution of marriage or legal separation, no party shall Terminate coverage during the pendency of the proceeding for any other party or any minor child of The marriage under any existing policy of health, dental or vision insurance".

The Archdiocese may allow a termination of insurance for a dependent spouse and or dependent children during the pendency of the proceedings, if you sign the following waiver statements to the Archdiocesan Employee Benefit Plan.

I understand that I have a right to require that coverage be continued under Missouri Law.
I hereby waive my (or my children's, if applicable) right to continued health coverage under the plan and request that the coverage be terminated as of _____, 20____.

I release the Archdiocese Employee Benefit Plan and the Archdiocese of St. Louis from any liability in connection with the termination of coverage.

I waive my (or my children's, if applicable) right to the Archdiocese Cobra-like plan, the Continuation of Coverage plan.

I understand that foregoing is irrevocable and that once coverage is terminated, it will not be reinstated (unless the individual again becomes eligible under the terms of the plan. For example, if I and my spouse reconcile and I want to add the spouse and children back on the health plan during Open Enrollment).

If I am terminating dependent children from the health insurance plan, I and my spouse have complete legal authority to act on behalf of the minor children.

Employee's Name (printed):	
Employee's Spouse Name (printed):	
Employee's Spousal Signature:	
Date of Signature:	
Spouse's Email Address:	
Spouse's Telephone #:	

Please fax (314-792-7548) or scan/email the completed form to the Office of Human Resources at Benefits@archstl.org. For questions, please contact the Archdiocese of St. Louis Office of Human Resources at 314.792.7546 or Benefits@archstl.org.

Appendix L

ARCHDIOCESE OF ST. LOUIS

Employee Receiving A Benefits Premium Advance

As a result of your non-payment of your benefits premium, we will be advancing you a sum of $_____ to cover that expense.

You agree to the following payroll deductions. The amount you owe is $_____. In order to minimize the impact upon you, we will permit you to pay back the amount in ___ installments. This converts to $ _____ each pay period and will start with your next check. We request that you sign this Promissory Note so that the amount can be repaid. Should you leave before repayment is complete, the balance will be deducted from your final check.

Employer Signature: _____

Date: _____

Employee Signature: _____

Printed Name: _____

Telephone Number: _____

Email Address: _____

Please give this signed form to your benefits or payroll administrator.

Appendix M

SPOUSAL SURCHARGE **FREQUENTLY ASKED QUESTIONS**

Spousal Surcharge Basics

1. **What is a Spousal Surcharge?**

   - A spousal surcharge is an extra charge that an Archdiocesan employee pays for electing to insure a spouse who has subsidized health insurance coverage available to them through their own employer.
   - The Archdiocesan spousal surcharge is an added charge of $200 **per month** to the usual employee contribution for health insurance.
   - For a list of the current Archdiocesan health insurance premium rates please visit www.archstl.org/hrbenefits

2. **Why did the Archdiocese of St. Louis implement a Spousal Surcharge policy?**

   The spousal surcharge encourages those who have medical coverage available through their employer to take advantage of that coverage. The Archdiocese Employee Benefit Plan is self-insured and helps pay the cost of each member's healthcare coverage and actual claims. If the employee's spouse moves to their employer's plan and uses that benefit instead, it saves the Archdiocese the cost of the claims and will help keep our medical plans more affordable. The Archdiocese establishes its premiums on the basis of the cost of the actual claims which ultimately makes the plan more affordable to the employee.

3. **What is a Spousal Surcharge Employee Attestation?**

   An employee's attestation is the employee's acknowledgement that any information provided regarding their spouse's employment status is true and complete to the best of their knowledge. The attestation also recognizes that if the spouse's group health insurance status changes, it is the employee's responsibility to notify their employer's business manager/local benefits contact **within *31 days of such change***. It is also the employee's responsibility to ensure on a timely basis that their paycheck withholding correctly reflects any surcharge exemption. Any false statements, as it relates to their spousal health insurance, shall be considered grounds for disciplinary action up to and including termination. The attestation also permits the Archdiocese to verify that the information provided is correct.
   Throughout the year, if your spouse experiences a qualified event change in insurance eligibility at their employment, you will be able to change your exemption status.

4. **How do I submit a new or changed Spousal Surcharge Attestation?**

   - By completing the ***Spousal Surcharge*** section on the Employee Health Insurance Form and submitting this paperwork to your employer's business manager/local benefit contact regarding any new benefit enrollments or changes within 31 days of the status change.
   - During Open Enrollment*, changes and attestations are elected online through Employee Self Service (ESS) at www.archstl.org/human-resources/employee-self-service.

   **See the Spousal Surcharge Open Enrollment Online Action section in this document for additional Open Enrollment instructions.*

1

Appendix N

5. **What are the exemptions to the Spousal Surcharge?**

   The spousal surcharge fee will *not* be added if the Spousal Surcharge Exemption is submitted *on time* and *the enrolled spouse is designated as one of the following*:

   - My spouse is not employed.
   - My spouse is self-employed, without employer-subsidized health insurance coverage, and is not eligible for employer subsidized health insurance
   - My spouse is employed with an Archdiocese of St. Louis parish, agency, or school.
   - My spouse is employed and is not eligible for his/her employer's health insurance coverage.
   - My spouse is employed and my spouse's employer does not offer health insurance coverage.
   - My spouse is employed and is eligible for his/her health insurance coverage but the full premium cost is paid by the employee. There is NO employer contribution toward the cost of the health insurance.

Effective Dates & Billing Rules of the Spousal Surcharge

6. **When does the Spousal Surcharge go into effect?**

   If you are not exempt from the surcharge and you and your spouse enroll in the Archdiocese Health Insurance Plan, the effective date of the surcharge fee would be the same as the effective date of enrollment with health insurance coverage.
   - If you are a new hire, the effective date of your health insurance and spousal surcharge fee is the 1st of the following month.
   - If enrolling due to a qualifying event and the effective date of your health insurance enrollment is on or between the 1st and the 15th of any given month, you owe the full health premium and spousal surcharge for that month.
   - If enrolling due to a qualifying event and the effective date of your health insurance enrollment is on or after the 16th of any given month, you do not owe any health insurance premium or spousal surcharge for that month.
   - This amount is deducted on a pre-tax basis just as your health insurance employee contribution is deducted on a pre-tax basis. There is no after-tax option.
   - There is no prorating of the health insurance premium or the surcharge.
   - The Archdiocese will not be retroactively reimbursing anyone for surcharge amounts already paid.

7. **What happens if I am paying the Spousal Surcharge Fee and fail to change my employee attestation to a Spousal Surcharge Exemption?**

   The Archdiocese will **not** be retroactively reimbursing for surcharge amounts already paid. You will be exempt from the surcharge **after** receipt of the Employee Health Insurance Form marking the spousal surcharge exemption **and** according to the aforementioned payroll deduction rules.

Spousal Surcharge Open Enrollment Online Action

8. **When is the Archdiocese of St. Louis Annual Open Enrollment period?**

   Typically the first two weeks in May.

   - ✓ If you elect to cover your spouse, you will need to review your spouse's surcharge eligibility every Open Enrollment period.
   - ✓ If you need to make a spousal surcharge fee or exemption change, you will need to go online through Employee Self Service during Open Enrollment to make a change.

- ✓ Changes during the annual Open Enrollment period are effective July 1.

9. **If you already have your Spousal Surcharge Employee Attestation of a fee or exemption in place prior to July 1, will I need to do anything at Open Enrollment each year?**

   - First, please review your spouse's employment status and eligibility for coverage at this time.
   - If your appropriate spousal surcharge fee or exemption is not changing, no action is required.
   - If you need to make a spousal surcharge change, go online to Employee Self Service | Human Resources | Archdiocese of St Louis (archstl.org) to change your election.

10. **If I am cancelling my spouse's coverage on the Archdiocese health insurance plan during Open Enrollment, do I need to do anything in regards to canceling the Spousal Surcharge?**

    If you are removing your spouse from your health insurance plan effective July 1, you would continue through the online Open Enrollment screens and click on *"Not Covering a Spouse"* in the spousal surcharge screen.

11. **What happens if I fail to go online during Open Enrollment and elect the Spousal Surcharge Exemption?**

    - Your payroll deduction will continue to automatically include the $200 monthly spousal surcharge for your spouse's Archdiocesan health care plan.
    - Outside of Open Enrollment, you may complete the Spousal Surcharge Fee section on the Employee Health Insurance Form and submit this paperwork to your employer's business manager/local benefit contact for any new benefit enrollments or changes.
    - Additionally, in the event employees do not complete the Employee Self Service Spousal Surcharge election accurately, they may be subject to their coverage under the plan being terminated or they may be subject to other disciplinary actions up to and including termination.

Spouse's Employment and Medical Coverage Eligibility Status

12. **My spouse is currently between jobs. Can I enroll my spouse while they are job searching?**

    Yes, you can enroll your spouse in the Archdiocesan health plan without a spousal surcharge while they are unemployed. However, if at any time your spouse becomes eligible for coverage through a new employer, you must notify the Office of Human Resources at 314.792.7546 or via an email to benefits@archstl.org **within 31 days** of their eligibility on their new employer's plan.

13. **What happens if my spouse finds a new job and I forget to notify the Office of Human Resources and they remain enrolled in the Archdiocese Plan with the Spousal Surcharge Exemption?**

    You owe your employer the cost of the spousal surcharge for however many months your spouse was enrolled while they were eligible for insurance through their own employer. It is the responsibility of each employer to resolve issues such as these.

14. **What if my spouse is going to school and is eligible for a student health plan from the school?**

    The spousal surcharge only applies to spouses who are actively employed and eligible for group medical coverage through their employer. If your spouse is eligible for coverage as a student, they would be eligible for the Archdiocesan health care plan and you are eligible for an exemption. If you previously elected an exemption, no action is required of you. If your spouse's student status has changed and now you want to apply for an exemption or need to pay the fee, please go online to Employee Self Service.

15. **What if my spouse and I are both Archdiocesan employees?**
    If you are married to a benefit eligible Archdiocesan employee, you are eligible for an exemption.

SPOUSAL SURCHARGE **FREQUENTLY ASKED QUESTIONS**

16. **What if my spouse has to pay 100% of his insurance where they work?**

    You are eligible for an exemption. You will only have to pay the $200 monthly spousal surcharge if your spouse has access to employer-subsidized coverage, where the employer is paying part or all of the insurance plan costs. To find out if your spouse's employer is paying part of the plan cost, your spouse should ask their HR/benefits representative.

17. **Is my spouse required to enroll other family members into his/her employer sponsored group medical coverage?**

    No. Dependent children up to the age of 26 years old are still eligible to enroll in the Archdiocesan health insurance plan without the additional surcharge.

18. **Whose health insurance plan will cover my children, the Archdiocesan plan or my spouse's employer's plan?**

    If your spouse's employer provides coverage for children and your children meet the eligibility requirements for both plans, you and your spouse will need to decide as to which plan(s) to enroll in. We recommend comparing the key features of both plans, to help with your decision.

19. **My spouse's employer holds open enrollment at a different time of the year. What should we do?**

    The Archdiocese of St. Louis Open Enrollment may be a qualifying life event for your spouse to enroll in their employer's health insurance plan. Your spouse should ask their employer's HR/Benefits representative if they can enroll due to the Archdiocesan Open Enrollment or due to this significant cost change, effective July 1. You may contact the Archdiocese Office of Human Resources by calling 314.792.7546 or emailing benefits@archstl.org for additional information and assistance.

20. **What happens if my working spouse's group medical coverage is terminated because they lose their job? Does my spouse have to elect and exhaust COBRA/Continuation of Coverage before being eligible for enrollment in the Archdiocesan health plan?**

    A spouse is not required to elect COBRA/Continuation of Coverage. If a spouse loses other coverage due to losing their job, this qualifies as a life event, and the spouse can then be enrolled in the Archdiocesan plan. To enroll and be exempt from the surcharge, the employee must complete the Employee Health Insurance Enrollment/Change Form, mark the Spousal Surcharge Exemption, and submit with any required documentation to their employer benefits administrator **within 31 days** of the spouse losing coverage.

21. **Does my spouse's Medicare coverage have any bearing on the Spousal Surcharge?**

    No, Medicare eligibility or coverage is neither a reason for a spousal surcharge exemption nor a cause for the surcharge fee. Medicare has no bearing on the Spousal Surcharge Policy.

22. **If I am in the Archdiocesan Early Retiree Plan or the Continuation of Coverage Plan, am I subject to the Spousal Surcharge?**

    You are exempt from the spousal surcharge since you pay the full premium.

Questions?

Please email any Benefits or Employee Self-Service questions to benefits@archstl.org
or call the Office of Human Resources at 314-792-7546 and we will be happy to assist you.

Revised 5/2023

Appendix N (continued)

ARCHDIOCESE OF ST. LOUIS

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) allows you to save 25%-28% on qualified medical, dental, vision, and dependent care expenses on a pre-tax basis. This untaxed money is used to reimburse you for expenses that you would normally pay with after tax income.

PLAN YEAR:

- July 1, 2023 through June 30, 2024

ELIGIBLE PARTICIPANTS:

- Parish/School/Agency employees who work 1,000 or more hours per year.
- Teachers with a half time contract or more.

ELIGIBLE EXPENSES:

- Eligible Health Care Expenses not covered by a group health insurance plan.
- Dependent Care Expenses so you and your spouse can work.

COST:

- There is no cost to you!

ENROLLMENT PROCEDURES:

- Complete your online Employee Self Service benefits enrollment between May 1st and May 16th.

GRACE PERIOD

- **Health Care Account:** $3,050 maximum per plan year

  You have until September 15, 2024, to incur Health Care claims for the 7/1/2023 to 06/30/2024 plan year. All Health Care claims will need to be submitted to TRISTAR by December 15, 2024. Plan carefully as any unused Health Care contributions are forfeited at the end of the plan year.

- **Dependent Care Account:** $5,000 maximum per calendar year
  - If Married filing jointly, Head of Household, or Single

  $2,500 maximum per calendar year
  - If Married filing separately

  You have until September 15, 2024, to incur Dependent Care claims for the 7/1/2023 to 06/30/2024 plan year. All Dependent Care claims will need to be submitted to TRISTAR by December 15, 2024. Plan carefully as any unused Dependent Care contributions at the end of the plan year are forfeited.

REIMBURSEMENT PROCEDURES:

- Submit a claim on the mobile App – Mobile Summit or
- Submit a claim on TRISTAR's website, tristar.summitfor.me or
- Complete a FSA Reimbursement Claim Form.
- Contact TRISTAR for your Username and Password

INFORMATION & INQUIRIES:

- Contact Office of Human Resources at 314-792-7546 or benefits@archstl.org for Employee Self-Service online enrollment questions.
- Contact TRISTAR Benefit Administrators at 800-456-4584 Option 4 with any benefit or claim questions.

Appendix O

Archdiocese of St. Louis Health Insurance
Employee Flexible Spending Plan Election Form

COMPLETED BY EMPLOYER: Please check one of the following:

❒ Open Enrollment Election **(July 1, 2023 through June 30, 2024)**
❒ New Hire Employee **(Plan Year July 1, 2023 through June 30, 2024)**
❒ Qualifying Event: Change of Contribution Payroll Deduction or Termination of Plan

Effective Date **Qualifying Event for Change**

Date of first paycheck affected

Parish / School / Agency Employer Name

Parish / School / Agency Address

1. EMPLOYEE INFORMATION

Last Name **First Name** **MI**	**Date of Birth**	**Gender** ❒ Male ❒ Female
Home Mailing Address	**Social Security Number** xxx-xx-	
City **ST** **Zip Code**	**Marital Status** ❒ Married ❒ Unmarried	
Home Telephone Number	**Date Employed**	

2. I elect to allocate the following: MEDICAL REIMBURSEMENT PLAN

Medical Reimbursement Plan (Do not include employee health insurance premium contributions) Maximum Allowable Account Amount is $3,050 per Plan Year

Annual Amount ☐

Total $ amount for the FSA plan year **total will be divided among remaining pay periods in the FSA plan year*

3. I elect to allocate the following: DEPENDENT CARE REIMBURSEMENT PLAN

Dependent Care Reimbursement Plan

Maximum Allowable Account if Single, Head of Household or Married, Filing Joint Return is $5,000 per Plan Year

Maximum Allowable Account amount if Married, Filing Separate Return is $2,500 per Plan Year.

Annual Amount ☐

Total $ amount for FSA plan year **total will be divided among remaining pay periods in the FSA plan year*

4. DESIGNATE YOUR BENEFICIARY

I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible spending account should be made payable to the undersigned.

Primary Beneficiary Name **Relationship**

Contingent Beneficiary Name **Relationship**

5. READ AND SIGN

My signature on this form certifies that I have received and read the printed material explaining my employer's flexible spending program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (i.e., marriage, divorce, birth or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above.

Signature of Applicant _____ **Date** _____

Please submit your completed and signed FSA Election Form via fax to 314.792.7548

PRINT

20FM3a_FSAay

Appendix P

ARCHDIOCESE OF ST. LOUIS FLEXIBLE SPENDING ACCOUNT
REIMBURSEMENT HEALTH CARE CLAIM FORM

1. Employee Information: Complete all sections.				
Employer Information	Parish/Agency Employer Name			
Employee Information ☐ Check box if new address.	Employee's Last Name	First Name	Initial	Employees Social Security No. - -
	Home Address			
	City	State	Zip	Daytime Phone Number

2. Health Care: An itemized statement is required including date of service, type of service, and total charge. Certain procedures and prescription medication is not reimbursable under the Archdiocese of St. Louis Health Reimbursement plan.

ALL PRESCRIPTION DRUG CLAIMS MUST INCLUDE DOCUMENTATION FROM THE PHARMACY THAT CLEARLY IDENTIFIES THE NAME OF THE MEDICATION IN ORDER TO RECEIVE REIMBURSEMENT FROM THE ARCHDIOCESE OF ST. LOUIS HEALTH REIMBURSEMENT PLAN.

Please check one of the following boxes:

☐ Charges attached are partially covered benefits under my health and/or dental insurance coverage. Enclosed is an Explanation of Benefits from my insurance. An Explanation of Benefits is required even if charges are applied to your deductible or out-of-pocket liability.

☐ Charges are **not** a covered benefit by any insurance plan for which the patient is enrolled.

☐ Charges attached are for reimbursement of my office visit or prescription drug co-pay due at the time of service. My insurance company does not provide an Explanation of Benefits for these services. Enclosed is an itemized receipt provided by the provider of service.

Date (s) Incurred	Name of Person Receiving Care	Description of Expense	Provider Name (i.e., clinic, doctor, hospital)	Total Expense	Amt. Paid by Insurance	Amount Remaining
			TOTAL AMOUNT OF MEDICAL EXPENSE	$	$	$

3. Employee Certification: Employee signature required.

I certify that the above information is correct. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical expenses, which will not be paid or reimbursed under any other plan. I certify that these expenses qualify for reimbursement under the Internal Revenue Code AND the Archdiocese of St. Louis Health Reimbursement Plan as outlined on the reverse side of this form and the Plan Document.

I certify that I have not submitted any claims related to abortion, contraceptives, sterilization or artificial fertilization procedures.

Employee's Signature:	Date
_____	/ / Mo. Day Year

Please mail or fax the completed claim form and appropriate statements to:

TRISTAR Benefit Administrators

5820 S Eastern Ave Ste 250 Las Vegas, NV 89119
(800) 456-4584 Option 4
Fax (702) 216-1623
Email: flex@tristargroup.net

Shaded area completed by TRISTAR Benefit Administrators

Reference Number:_____ Date:_____

Appendix Q

ARCHDIOCESE OF ST. LOUIS FLEXIBLE BENEFIT REIMBURSEMENT DEPENDENT CARE CLAIM FORM

PLEASE READ THE GUIDELINES FOR ELIGIBLE REIMBURSEMENTS ON THE REVERSE SIDE

1. Employee Information: Complete all sections.				
Employer Information	Parish/Agency Employer Name			
Employee Information	Employee's Last Name	First Name	Initial	Employees Social Security No. / /
	Home Address			
Check box if new address. ☐	City	State	Zip	Daytime Phone Number

2. Dependent Care: A receipt is required from your daycare provider that includes dates of care and total charge. If you do not have a receipt, the daycare provider must sign verification section.

Dependent Receiving Care Name	Relationship	Age	Date(s) of Care	Daycare Provider (Name and Soc. Sec. No./Federal Tax ID)	Amount

DAYCARE PROVIDER VERIFICATION: I certify that the expenses shown are valid.

Daycare Provider Signature _____ Social Security Number / Federal Tax ID _____ Date _____

3. Employee Certification: Employee signature required.

I certify that the above information is correct. I understand that any amounts submitted for dependent care and for which I receive reimbursement cannot also be claimed under the dependent care income tax credit. I understand any medical reimbursements I receive may not be included on my income tax return.
I certify that I am requesting reimbursement of medical and/or dependent care expenses, which will not be paid or reimbursed under any other plan.
I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and as outlined on the reverse side of this form.

Employee's Signature: _____ Date: _____

Please send the completed claim form and appropriate statements to:

TRISTAR Benefit Administrators
5820 S Eastern Ave Ste 250
Las Vegas, NV 89119
1-800-456-4584 Option 4
Fax: 702-216-1623
Email: flex@tristargroup.net

Appendix R

GUIDELINES FOR ELIGIBLE REIMBURSEMENTS

If you apply for reimbursement of expense that IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply, according to the Internal Revenue Code. Similar treatment will be applied to overpayment of reimbursed expenses or reimbursement for expenses that have already been reimbursed from some other source.

In general, Section 125 of the Internal Revenue Code governs the tax status of Flexible (or Cafeteria) Benefit Plans, of which Employee Reimbursement Accounts are a part. Eligibility for pre-tax reimbursement is covered specifically in Code Sections 105 and 106 (Accident/health Plans) and Section 129 (Dependent Care).

DEPENDENT CARE REIMBURSEMENT

Expenses to provide care for your dependents may qualify for reimbursement. Eligible dependents include children under age 13, a disabled child, a disabled spouse, or a disabled parent.
To be eligible, you must be working while your dependents receive care, or if you are married, your spouse must be:

1. A wage earner,
2. A full-time student for at least 5 months during the year, or
3. A disabled and unable to provide for his or her own care.

Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:

1. Licensed nursery schools and licensed day care centers.
2. Individuals (other than your dependents) who provide care for your children in or outside your home or for your disabled spouse or dependent parent in your home.

IRS Regulations limit the amount of reimbursement expense for dependent care to the lower of the annual earned Income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns $200 per month (1 dependent) or $400 per month (two or more dependents).

An additional IRS Regulation limits the amount you can contribute to the dependent care account to $5,000 for a single parent with children, $5,000 for a married parent filing jointly, and $2,500 for a married parent filing separately. This amount may change with IRS regulations.

Under IRS Regulations, qualified individuals can receive tax credit for dependent care costs. This credit is claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Reimbursement Account. The maximum amount that can be used for the tax credit is reduced by any amount you use from the Dependent Care Reimbursement Account.

Revised 3/2021

Appendix R (continued)

FLEXIBLE SAVINGS ACCOUNT

ADMINISTRATIVE SERVICES MANUAL

THE ARCHDIOCESE OF ST. LOUIS

TRISTAR BENEFITS ADMINISTRATORS
PO Box 65887
West Des Moines, IA 50265
800-456-4584

Appendix S

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Revised for 7/1/2016 Renewal

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INTRODUCTION

TRISTAR Benefits Administrators is pleased to be your Flexible Benefits Plan Administrator. We are committed to provide your employees and your organization with quality, effective, and friendly administrative services.

This Administrative Services Manual has been prepared to assist you in managing your Flexible Spending Account program. We encourage you to use this manual as a reference tool.

It contains the basic instructions necessary to properly administer your program with a minimum amount of time and effort. While this manual contains general rules and procedures to follow, it is not a contract and should not be viewed as such. The benefits and extent of coverage provided are governed at all times by the terms of your plan document and insurance/reinsurance contracts. Always refer to your plan document for benefit amounts and plan provisions. Questions or problems regarding your Flexible Spending Account should be referred to:

1. You, as the Parish/Office/Agency bookkeeper/payroll administrator, for determining eligibility, plus initial enrollment and enrollment changes, or

2. TRISTAR Benefits Administrators for benefit/claim, billing, banking, reporting, etc., questions.

PARISH/OFFICE/AGENCY / AGENCY GROUP NUMBERS

Each Parish/Office/Agency will be assigned its own Group Number, which will be:

A03XXX (The last 3 numbers will be your 3-digit Parish number or an assigned number)

Please use this Group Number with all correspondence. The enrollment form has been designed so that you only need to specify your 3-digit Parish/Office/Agency to identify the Parish/Office/Agency where each employee is enrolled. If you do not know your group number, please call Anne Hager at the Office of Human Resources of the Archdiocese of St. Louis at 314-792-7544. She can provide you with the 3-digit group number.

Appendix S (continued)

Archdiocese of St. Louis

TRISTAR Benefit Administrators Service Team
800-456-4584

Employer Web Access: tristar.summitwith.us

Claim Analyst and Eligibility Processing

- Tania Gonzalez — Extension: 2772
  Tania.gonzalez@tristargroup.net

Administrative Invoicing

TBAeligibility@tristargroup.net

Account Management

- Lynette Buchwald, Account Manager — Extension: 7324
  Lynette.buchwald@tristargroup.net

Accounting and Claim Funding

- Rose Anderson — 888-558-7478 x1012
  Rose.anderson@tristargroup.net

Flex Claims Submission:

Mail:	5820 S Eastern Ave Suite 250, Las Vegas, NV 89119
Fax:	(702) 216-1623
Email:	flex@tristargroup.net
Online:	tristar.summitfor.me

Appendix S (continued)

MONTHLY ADMINISTRATION FEE BILLING PROCEDURES

Effective July 1, 2008, the Archdiocese of St. Louis became responsible for the cost of this plan for all member churches and schools. There is no monthly invoice mailed to each member organization. The monthly administrative fee invoice is paid by the Archdiocese of St. Louis. Annually, in July, TRISTAR invoices the Archdiocese of St. Louis for a per eligible employee fee. The Archdiocese of St. Louis collects the FSA per eligible employee fee payments from each employer through the Consolidated Billing process to pay TRISTAR's annual invoice.

Please see page 8 of this manual for instructions on submitting flexible benefits plan contributions that are withheld from each plan participant's pay. The employee contribution amounts, if changed from the prior month, must be submitted to TRISTAR Benefits Administrators BEFORE the change takes place by the payroll department of the church or school.

Appendix S (continued)

ENROLLMENT / ELIGIBILITY ADMINISTRATION

TRISTAR Benefit Administrator's Enrollment Department services include the maintenance of eligibility records. This department also provides customer service, including providing information for continuation of coverage. Provided below is a brief description of each of these services.

Employee Election Form Processing

All employees wishing to participate must enroll on-line via the Archdiocese of St. Louis Benefit Enrollment System or fully complete an ***Archdiocese of St. Louis Employee Flexible Benefits Plan Election form***. The Parish/Office/Agency administrator should obtain the election forms, and then should forward them to TRISTAR Benefits Administrators in West Des Moines. Mail all completed forms to the address below:

TRISTAR Benefits Administrators
Enrollment Department
PO Box 65887
West Des Moines IA 50265

An ***Employee Flexible Benefits Plan Election Form*** must be fully completed for all new employees whether or not they wish to participate in the Flexible Benefits Plan.

There is an open enrollment period for each Plan Year (July 1 - June 30). **All employees wishing to participate must enroll online or complete a new election form each new plan year. The Archdiocese Human Resource Office will inform you of deadlines for the open enrollment period.**

Eligibility Processing

Your TRISTAR Benefits Administrators Enrollment Specialist is responsible for adding and terminating employees from the Flexible Spending Plan during the Plan Year upon receiving notification from you. The Enrollment Specialist will also change coverage options for enrolled employees which results from such events as the following:

1. Updating an employee's home address; and

2. Updating an employee's benefit plan election(s)

The **Enrollment Update Form**, (a copy of which is included in the back of this booklet), will assist you in reporting new employees, qualified employees changing their original contribution, and employees terminating from your plan. **PLEASE NOTE:** each new person must enroll online or complete an *Employee Flexible Savings Account Election Form.*

The middle section of the Enrollment Update Form is for you to list any qualified employees wishing to make a change to their original contribution amount or a change to the employee's address. Please refer to the Flexible Spending Account Plan Document for the IRS guidelines for changing a contribution. Please note: **an *Employee Flexible Savings Account Election Form* must be fully completed for those employees listed in this section of the Enrollment Update Form.** If your employee is a transfer from another Archdiocesan Parish/Office/Agency, it is necessary to confirm with the employee whether or not they participate in the

Appendix S (continued)

Flexible Spending Plan and what their payroll deduction is for the current Plan Year. See Transferring Employees section below.

The bottom section of the Enrollment Update Form should list those individuals terminating coverage. Please fill out all columns of this section. An updated election form is not needed.

Transferring Employees

If your new employee is transferring from a previous Archdiocese Parish/Office/Agency, please confirm with the employee whether or not they participate in the Flexible Spending Plan and what their payroll deduction is for the current Plan Year. Please note that:

1. The transferring employee's plan participation and annual election would remain unchanged;

2. Confirm the total amount of medical spending account and/or dependent care spending account contributions that the previous Parish/Office/Agency actually withheld from the employee's pay during the current Plan Year;

3. Upon the employee's transfer, the balance of the annual medical spending account and/or dependent care contribution elections not yet deducted from the employee's pay by the former Parish/Office/Agency would be withheld evenly over the remaining paydays in the Plan Year with the new Parish/Office/Agency; and

4. Do not have your transferring employee complete another election form.

5. Please notify the Archdiocese Office of Human Resources by email benefits@archstl.org or by fax at 314.792.7548.

Employee Terminations

An employee who terminates employment will also terminate participation in the FSA plan. **Please notify TRISTAR Benefits Administrators immediately.** Please send an email to Lynette.Buchwald@tristargroup.net or by faxing the form to 515-224-7367 Attention Lynette Buchwald. The employee may file claims for eligible expenses incurred only up to their termination date.

Also, please notify the Archdiocese Office of Human Resources by email benefits@archstl.org or by fax at 314.792.7548.

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CLAIM ADMINISTRATION

Contribution Processing

Contributions are the funds deducted from a participant's income and reimbursed to the participant following the submission of an eligible claim. Changes to the contribution amount for any individual should be reported on or before the date of the change. This assures accurate and timely adjustments are made to the participant's account prior to check issuance. The pledge amount is divided by the number of payroll periods to determine the contribution for a calendar year. These contributions are then applied to the participant's account on each of the payroll dates specified by the employer.

Claim Processing

Flexible spending account requests for reimbursement (i.e., claims) will be processed on a bi-weekly reimbursement processing. Expenses that qualify as an eligible benefit under a medical insurance plan must first be processed under such applicable insurance plan(s) prior to Flexible Spending Account consideration. The expense will not be considered a Flexible Spending Account claim until the participant has been mailed the final determination of the medical insurance benefits or has signed a claim form indicating the expense is not covered by any other plan.

Expenses that qualify for dependent care reimbursement must be verified by the day care provider or by a payment receipt.

Customer Service

TRISTAR Benefit Administrator’s goal is to provide the level of service that our customers could label as "legendary service."

Telephone calls and letters are handled promptly and courteously. Reports are provided as outlined. Funds are accounted for accurately, and claims and inquiries are processed promptly. Guidance is offered, problems are anticipated, and solutions are provided.

Every employee or covered person is considered a valued customer who is entitled to prompt, personal, and courteous service. This is reflected in the professional manner each piece of correspondence, telephone call, and personal contact is handled.

We provide toll-free WATS line service and a designated client claim representative so all claim inquiries are answered by the same individual who processes your employees' claims. Our responsive online system and highly trained staff are ready to serve your employees with the person-to-person service they deserve.

ERISA And IRS Requirements

Church plans are exempt from ERISA, COBRA, and many other Federal regulations. However, most FSA rules apply to church plans.

PLAN CONTRIBUTION FUNDING

Each Parish/Office/Agency will submit to TRISTAR Benefits Administrators *each month* plan contributions withheld from employees' pay for deposit into a bank account for each Parish/Office/Agency. **Amounts withheld during a calendar month must be remitted to TRISTAR Benefits Administrators no later than the 5th working day of the following month.** (For example, employee contributions withheld during the month of July 2021 must be remitted to TRISTAR Benefits Administrators no later than 8/8/2021.)

Each Parish/Office/Agency will receive monthly reports (as listed and described on the next page).

Please note: It is possible for a Parish/Office/Agency to have a surplus or a deficit account balance as of any date, including as of the end of a Plan Year. This could occur when:

1. Year-to-date reimbursement payments exceed year-to-date employee contributions (deficit);

2. Year-to-date contributions exceed year-to-date reimbursement payments (surplus);

3. An employee terminates, and reimbursements made to that employee exceed that employee's contributions as of the termination date (deficit); and/or

4. Amounts are forfeited by employees per the "use it or lose it" rule because employee contributions exceed total reimbursements requested as of the end of the Plan Year (surplus).

Reimbursement requests for Dependent Care Expense Plan claims incurred during a Plan Year can be submitted up to 90 days after the end of the Plan Year (e.g., eligible expenses incurred during the 7/1/2021 to 6/30/2022 Plan Year, can be submitted to TRISTAR Benefits Administrators until 9/30/2021 for reimbursement). Reimbursement requests for Medical Care Expense Plan claims incurred during a Plan Year can be submitted up to 90 days after the end of the Plan Year and Grace Period (e.g., eligible expenses incurred during the 7/1/2021 to 6/30/2022 Plan Year, and 07/01/2021 to 09/15/2022 Grace Period can be submitted to TRISTAR Benefits Administrators until 12/15/2022 for reimbursement).At that time, a final accounting of any surpluses or deficits for the prior Plan Year can be determined. Any net surplus belongs to the Archdiocese of St. Louis and net deficit must be funded by the Parish/Office/Agency.

Once all claims for a Plan Year have been processed, each Parish/Office/Agency can then determine if a deficit or surplus was incurred for that Plan Year. Determine any surplus or deficit as follows:

1. Determine all reimbursements made by TRISTAR Benefits Administrators per the final monthly reports provided only for the Plan Year that has ended (e.g., only consider reimbursements made for expenses incurred during that Plan Year), as reported on the final "Account Balance Report" for the Plan Year;

2. Subtract total Flexible Benefits Plan bank account deposits made to TRISTAR Benefits Administrators during the plan year (include only deposits made for pay dates during that 7/1 through 6/30 plan year); and

3. If total reimbursements made to employees are more than deposits you made to TRISTAR Benefits Administrators, submit an additional deposit to TRISTAR Benefits Administrators for the difference. Effective July 1, 2008, if deposits are more than reimbursements, this amount is retained by the Archdiocese of St. Louis and these funds to offset the administrative fees for this plan.

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The bank account deposit options are:

1. Your Parish/Office/Agency initiating an ACH transfer of funds to TRISTAR Benefit Administrator's bank account; or

2. Issuing funds by check.

Either of the two methods is acceptable. The monthly Fund Account Statements will confirm bank account deposits processed by TRISTAR Benefits Administrators.

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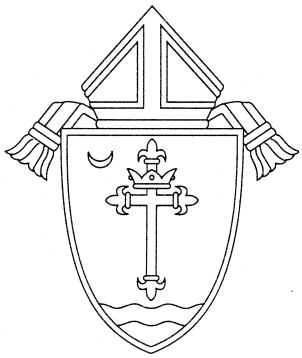
ARCHDIOCESE OF ST. LOUIS



FLEXIBLE BENEFITS PLAN

SUMMARY PLAN DESCRIPTION

Group Numbers: A03100-A03999

Premium Payment Plan

Medical Reimbursement Plan

Dependent Care Assistance Program Reimbursement Plan

JULY 1, 2003
REVISED: JULY 1, 2023

Appendix T

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INTRODUCTION

Archdiocese of St. Louis has chosen TRISTAR Benefit Administrators as the Administrative Services firm for the Archdiocese of St. Louis Flexible Benefits Plan (the Plan).

If the employee and/or covered dependents have any questions about this Archdiocese of St. Louis Flexible Benefits Plan, they should contact TRISTAR Benefit Administrators. The staff of TRISTAR Benefit Administrators is there to serve.

The TRISTAR Benefit Administrators telephone number is:

800-456-4584

All claims and correspondence should be submitted to the following:

TRISTAR Benefit Administrators
5820 S. Eastern Avenue, Suite 250
Las Vegas, NV 89119

flex@tristargroup.net

tristar.summitfor.me

This plan will comply with any current and/or future emergency legislation enacted, including, but not limited to, claim processing procedures, enrollment and/or eligibility guidelines, and COBRA and/or continuation of coverage guidelines. Such legislation may include, but is not limited to, responses to a pandemic, such as the FFCRA or the CARES Act.

Appendix T (continued)

FLEXIBLE BENEFITS PLAN QUESTIONS AND ANSWERS

Q-1. What is the purpose of the Plan?

This Plan is designed to permit an Eligible Employee to pay on a pre-tax basis for his share of premiums under the Insurance Plan, and to contribute to an account for pre-tax reimbursement of certain Medical Care Expenses and Dependent Care Expenses.

Q-2. What benefits are provided by the Plan?

The plan includes the following three component benefit plans:

a. **Premium Payment Component** - Under the Premium Payment Component of the Plan an Eligible Employee's share of the premiums under the Insurance Plan(s) will be paid for with pre-tax Salary Reduction dollars.

b. **Medical Care Reimbursement Component** - Permits an Employee to pay for the Employee's and any eligible dependent's qualifying Medical Care Expenses (defined in Q-21) that are not otherwise reimbursed by insurance with pre-tax dollars, subject to the current IRS Allowable Maximum, which is $3,050 for 2023; and

c. **Dependent Care Assistance Program (DCAP)** - Under the DCAP Component of this Plan, Participant may elect to receive benefits in the form of reimbursements for Eligible Employment-Related Expenses and to pay the premium for such benefits via Salary Reductions.

Q-3. Who can participate in the Plan?

An Eligible Employee will first become eligible to make an election to receive benefits on the later of his Employment Commencement Date or the date he becomes an Eligible Employee. An Eligible Employee who does not elect to receive benefits when first eligible may not enroll until the next Open Enrollment Period.

An "Eligible Employee" means:

1. Employees working at least 1,000 hours annually;

2. Teachers with one-half-time or more contracts;

3. Religious Employees on assignment with the Archdiocese;

4. Kenrick-Glennon Seminarians who are eligible for coverage under the Archdiocese of St. Louis Health Care Plan; and

5. Permanent Deacons who are eligible to participate in the Archdiocese of St. Louis Health Care Plan.

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"Eligible Employee" does not include any individuals classified by the Employer as contract workers, independent contractors, casual employees, any leased employees as defined in Code Section 414(n), or any individuals who perform services for an Employer but who are paid by a temporary or other employment or staffing agency.

Those employees who actually participate in the Plan are called "Participants." A Participant will cease to be a Participant in this Plan upon the earliest of:

1. The expiration of the Plan Year for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);

2. The termination of this Plan;

3. The date on which the Participant ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee; or

4. The date the Participant revokes his election to receive benefits under a circumstance when such change is permitted under the terms of this Plan.

If no beneficiary is named or if no beneficiary survives the employee, the Plan, at their option, may pay eligible medical or dependent care account balances to 1) the executors or administrators of the employee's estate; or 2) all to the surviving Spouse; or 3) if the Spouse does not survive the employee, in equal share to the surviving children; or 4) if no child survives the employee, in equal share to the surviving parents.

Q-4. How do I become a participant?

1. *Election When First Eligible.* The election will be made by submitting an Enrollment Form (paper or online) to the Administrator.

2. *Elections During Open Enrollment Period.* During each Open Enrollment Period with respect to a Plan Year, the Administrator will provide an Enrollment Form to each Employee who is eligible to receive benefits in this Plan. The Enrollment Form will enable the Employee to elect to receive benefits in the various components of this Plan for the next Plan Year, and to authorize the necessary Salary Reduction to pay for the benefits elected. The Enrollment Form must be returned to the Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to receive benefits during an Open Enrollment Period, he will become eligible to receive benefits on the first day of the next Plan Year. The Enrollment Form can be completed on paper, or via an online document.

3. *Eligible Employee Who Fails to File an Enrollment Form.* If an Eligible Employee fails to file (or fails to timely file) an Enrollment Form within the time frames described above, then the Employee may not elect to receive benefits in the Plan until the next Open Enrollment Period or until a change in status event would justify an earlier mid-year election change. If an Eligible Employee who fails to file an election is eligible for

Appendix T (continued)

Insurance Plan benefits, his share of the premiums for such benefits may be paid with after-tax dollars outside of this Plan until such time as the Employee files, during a subsequent Open Enrollment Period, a timely Enrollment Form to participate in the Premium Payment Component of this Plan.

Q-5. What tax advantages would I experience as a result of participating in the Plan?

You may save both federal income tax and FICA (Social Security) taxes by participating in the Flexible Benefits Plan. Here is an example of the possible tax savings of paying for your share of the contributions for Premium Payment Component under the Flexible Benefits Plan. Suppose that you are married and have one child and that your share of the required contributions for Premium Payment Component for family coverage is an annual total of $6,400. Suppose also that your gross pay is $75,000 and your spouse (a student) earns no income and that you file a joint tax return.

As illustrated in detail by the Table below, if you elect to salary-reduce $6,400 to pay for the Medical Insurance contributions, then your annual take-home pay would be $56,627. If instead you elect to pay the contributions on an after-tax basis, then your annual take-home pay would be only $55,177. This is because by participating in the Flexible Benefits Plan for Medical Insurance contributions, you will be considered for tax purposes to have received $68,600 in gross pay, so you save $1,450 per year. How much an employee actually saves will depend on what family members are covered and the contributions for the coverage, the total family income, and the tax deductions and exemptions claimed. There may be state tax savings, too. And salary reductions also lower earned income, which can impact the earned income credit for eligible taxpayers.

Caution: The amount of the contributions used in this example is not meant to reflect your actual Contributions - the actual contribution amounts will be described in a document provided separately to you by Archdiocese of St. Louis.

	With Cafeteria Plan *		**No Cafeteria Plan**
1. Adjusted Gross Income	$75,000		$75,000
2. Salary Reductions for Premiums	($6,400)		$0
3. W-2 Gross Wages	$68,600		$75,000
4. Standard Deduction	($9,700)		($9,700)
5. Exemptions	($9,300)		($9,300)
6. Taxable Income (line 3 minus lines 4 & 5)	$49,600		$56,000
7. W-2 Gross Wages	$68,600		$75,000
8. Federal Income Tax (line 6 @ tax schedule)	($6,725)		($7,685)
9. FICA Tax (7.65% of line 3)	($5,248)		($5,738)

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10. After-Tax Premium Payments	$0		($6,400)
11. Pay after Taxes and Premium Payments (line 7 minus lines 8, 9, & 10)	$56,627		$55,177

Q-6. Can I change my election during the Plan Year?

Except as described below in this section a Participant's election under the Plan is irrevocable for the duration of the Plan Year to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Plan Year regarding:

1. Participation in this Plan;

2. Salary Reduction amounts; or

3. Election of particular component plan benefits.

The exceptions to the irrevocability requirement which would permit the Participant to make a mid-year election change in benefits and/or Salary Reduction amounts for the Premium Payment Component, the DCAP, and the Medical Reimbursement Component are as set forth below.

1. **Leaves of Absence.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits, and DCAP Benefits). You may change an election under the Plan upon FMLA and non-FMLA leave only as described in Q-14.

2. **Change in Status.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits as limited below, and DCAP Benefits as limited below). If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which Archdiocese of St. Louis determines are permitted under subsequent IRS regulations:

    a. a change in your legal marital status (such as marriage, legal separation, annulment, divorce, or death of your Spouse);

    "Spouse" means the person to whom the Participant is married, as recognized by the laws of the Catholic Church or the laws of the State of Missouri. It is always understood for this purpose that the Spouse is of the opposite sex. Notwithstanding the above, for purposes of the Dependent Care Assistance Program Component, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate, principal residence from the Participant during the last six months of the taxable year, and does not furnish

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more than half of the cost of maintaining the principal place of abode of the Participant.

b. a change in the number of your tax Dependents (such as the birth of a child, adoption, or placement for adoption of a Dependent, or death of a Dependent);

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code § 152; except that: (a), for purposes of accident or health coverage, any child to whom Code § 152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the year) is treated as a dependent of both parents; or (b) for purposes of accident or health coverage, any child under the age of 27; and (c) for purposes of the Dependent Care Assistance Program Component, a dependent means a qualifying individual as defined in Code § 21(b)(1) with respect to the Participant and in the case of divorced parents, the child shall, as provided in Code § 21 (e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code § 152(e)(1)) and shall not be treated as a qualifying individual with respect to the non-custodial parent. Notwithstanding the foregoing, the Health FSA Plan of this Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, as defined in ERISA § 609(a), even if the child does not meet the definition of Dependent.

c. any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility under a cafeteria plan (including this Plan) or other employee benefit plan of yours, your Spouse, or your Dependents. Such events include any of the following changes in employment status:

i. termination or commencement of employment;

ii. a strike or lockout;

iii. a commencement of or return from an unpaid leave of absence;

iv. a change in worksite;

v. switching from salaried to hourly - paid (or visa-versa);

vi. switching from union to non-union (or visa-versa);

vii. switching from part-time to full-time (or visa-versa);

viii. incurring a reduction or increase in hours of employment; or

ix. any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

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d. an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age or similar circumstances); or

e. a change in your, your Spouse's or your Dependent's place of residence.

If a Change in Status occurs, you must inform Archdiocese of St. Louis and complete a new election for Pre-Tax Premiums within 31 days of the occurrence.

3. **Change in Status - Other Requirements.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits as limited below, and DCAP Benefits as limited below). If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator (in its sole discretion) will determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility (for DCAP Expense reimbursement, the event may also affect eligibility for the dependent care exclusion). In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   a. Loss of Spouse or Dependent Eligibility; Special Continuation Rules. For accident and health benefits (e.g., health, dental and vision coverage, accidental death and dismemberment coverage and Health Care Expense Reimbursement benefits), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent ceasing to satisfy the eligibility requirements for coverage, you may only elect to cancel accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status;

      Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee-plus-one-dependent coverage, or family coverage. Before the Plan Year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the Plan Year; Sharon loses eligibility for coverage under the plan, while the child is still eligible for coverage under the plan. Mike now wishes to cancel his previous election and elect no health coverage. The divorce between Mike and Sharon constitutes a Change in Status. An election to cancel coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

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However, if you, your Spouse, or a Dependent elect continuation coverage under Archdiocese of St. Louis's plan, you may be able to increase your contribution to pay for such coverage;

b. Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which you, your Spouse, or your Dependent gain eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan;

c. Dependent Care Assistance Program (DCAP) Benefits. With respect to the DCAP Expense Reimbursement benefit, you may change or terminate your election only if:

i. such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under the Plan; or

ii. your election change is on account of and conforms with a Change in Status that affects the eligibility of dependent care expenses for the available tax exclusion.

Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a DCAP as part of its cafeteria plan. Mike elects to reduce his salary by $2,000 during a Plan Year to fund dependent care coverage for his daughter. In the middle of the Plan Year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care program. This event constitutes a Change in Status. Mike's election to cancel coverage under the dependent care program would be consistent with this Change in Status.

4. **Special Enrollment Rights.** (Applies to Premium Payment Benefits that are Group Health Plans, but not to Medical Care Reimbursement Benefits or DCAP Benefits). If you, your Spouse and/or a Dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e. due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of a continuation period), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents, provided that you request enrollment within 31 days of the marriage, birth, adoption, or

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placement for adoption. Please refer to the group health plan description for an explanation of special enrollment rights;

5. **Certain Judgments, Decrees, and Orders.** (Applies to Premium Payment Benefits that Provide Accident or Health Coverage, and to Medical Care Reimbursement Benefits, but not to DCAP Benefit). If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your Dependent child (including a foster child who is your tax Dependent) to be covered under this Plan you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former spouse) cover the Dependent child, you may change your election to revoke coverage for the child;

6. **Entitlement to Medicare or Medicaid.** (Applies to Premium Payment Benefits, Medical Care Reimbursement Benefits as limited below, but not to DCAP Benefits). If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's accident or health coverage. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such, you may, subject to the terms of the underlying plan, elect to begin or increase that person's accident or health coverage;

7. **Change in Cost.** (Applies to Premium Payment Benefits, to DCAP Benefits as limited below, but not to Medical Care Reimbursement Benefits). For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individual (e.g. family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage:

    a. Increase or Decrease For Insignificant Cost Changes. You are required to increase your elective contributions (by increasing Salary Reductions) to reflect insignificant increases in your required contribution for their Plan, and to decrease your elective contributions to reflect insignificant decreases in their required contribution. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. Archdiocese of St. Louis, on a reasonable and consistent basis, will automatically effectuate this increase in affected employees' elective contributions on a prospective basis;

    b. Significant Cost Increases. If Archdiocese of St. Louis determines that the cost charged to you for your Plan significantly increases during a Period of Coverage, you may (a) make a corresponding prospective increase in your elective contributions (by increasing Salary Reductions); (b) revoke your election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Plan offered by Archdiocese of St. Louis that provides similar coverage, or (c) drop coverage prospectively if there is no other Plan option available that provides similar coverage. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidelines;

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c. Significant Cost Decreases. If Archdiocese of St. Louis determines that the cost charged to you for your Plan significantly decreases during a Period of Coverage, Archdiocese of St. Louis may permit the following election changes: (a) Participants who are enrolled the Plan option other than the Plan option that has decreased in cost may change their election on a prospective basis to elect the Plan option that has decreased in cost; and (b) Employees who are otherwise eligible under Q-3 may elect the Plan option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Plan option. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidelines; and

d. Limitations on Change in Cost Provisions for DCAP Benefits. The above "Change in Cost" provisions apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§152(a)(1) through 152(a)(8), incorporating the rules of Code §§152(b)(1) and 152(b)(2).

Example: Employee Mike is covered under an indemnity option of his employer's accident and health insurance coverage. If the cost of this option significantly increases during a period of coverage, then Mike may make a corresponding increase in his payments or may instead revoke his election and elect coverage under an HMO option.

8. **Change in Coverage.** (Applies to Premium Payment Benefits, and DCAP Benefits, but not to Medical Care Reimbursement Benefits). For purposes of this section, "similar coverage" means coverage for the same category of benefits for the same individual (e.g. family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage:

a. Significant Curtailment. If coverage is "significantly curtailed" (as defined in subsection (i) below, you may elect coverage under another plan that provides similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (iii) below), you may drop coverage if no similar coverage is offered by Archdiocese of St. Louis. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment is "significant," and whether a Loss of Coverage has occurred:

i. Significant Curtailment Without Loss of Coverage. If Archdiocese of St. Louis determines that your coverage under this Plan (or your Spouse's or Dependent's coverage under the employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan) during a Period of Coverage, you may revoke your election for the affected coverage, and in lieu of thereof, prospectively elect coverage under

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another Plan option that provides similar coverage. Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally;

ii. Significant Curtailment With a Loss of Coverage. If Archdiocese of St. Louis determines that your coverage under this Plan (or your Spouse's or Dependent's coverage under this employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, you may revoke his election for the affected coverage, and may either elect coverage under another Plan that provides similar coverage, or drop coverage if no other Plan option providing similar coverage is offered by Archdiocese of St. Louis; or

iii. Definition of Loss of Coverage. For the purposes of this section, a "Loss of Coverage" means complete loss of coverage (including the elimination of a Plan, the PPO ceasing to be available where you or his Spouse or Dependent resides, or you or your Spouse of Dependent losing all coverage under a Plan by reason of an overall lifetime or annual limitation). In addition, Archdiocese of St. Louis in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Plan (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in a preferred provider network);

- a reduction in benefits for a specified type of medical condition or treatment with respect to which you or your Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

b. Addition or Significant Improvement of a Plan. If, during a Period of Coverage, the Plan adds a new benefit option or significantly improves an existing benefit option, Archdiocese of St. Louis may permit the following election changes:

i. Participants who are enrolled in a Plan option other than the newly-added or significantly improved benefit option may change their elections on a prospective basis to elect the newly-added or significantly improved benefit option; and

ii. Employees who are otherwise eligible under Q-3 may elect the newly-added or significantly improved benefit option on a prospective basis, subject to the terms and limitations of the Plan. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will

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decide whether there has been an addition of, or a significant-improvement in a Plan option in accordance with prevailing IRS guidelines;

c. Loss of Coverage Under Other Group Health Coverage. You may prospectively change your election to add group health coverage for yourself or your Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(400)), the Indian Health Service, or tribal organization; a state health benefits risk pool, or a foreign government group health plan, subject to the terms and limitations of the applicable Plan(s);

d. Change in Coverage Under Another Employer Plan. You may make a prospective election change that is on account of and corresponds with a change under an employer plan (including a plan of the employer or a plan of your Spouse's or Dependent's employer), so long as: (a) the other cafeteria plan or qualified benefits plan permits it's participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election of a Period of Coverage that is different from the Plan Year under the cafeteria plan or qualified benefit plan. For example, if an election is made by your Spouse during your employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. Archdiocese of St. Louis, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidelines; or

e. DCAP Coverage Changes. You may make a prospective election change that is on account and corresponds with a change by yourself in the dependent care service provider. For example: (a) if you terminate one dependent care provider and hire a new dependent care service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage;

If you are entitled to change an election as described in this section must do so in accordance with the procedures described in this section; or

9. **Prevent Discrimination.** Additionally, the Plan's Administrator may modify your election(s) downward during the Plan Year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

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Q-7. How are my Premium Payments Made?

If an Employee elects to pay his Insurance Plan premiums under the Premium Payment Component, then the Employee's share (as determined by the Employer) of the premium for the Insurance Plan(s) benefit(s) elected by the Participant will be financed by Salary Reductions. The Salary Reduction for each pay period for a Participant is an amount equal to the annual premium divided by the number of pay periods in the Plan Year, or an amount otherwise agreed upon. Salary Reductions are applied by the Employer to pay for the premium for the Participant's benefits and, for the purposes of this Plan, are considered Employer contributions. The Employer will pay under this Plan its share of the premiums for Participants who elect to participate in the pre-tax feature of this Plan. For those who elect the after-tax option, both the Employee and Employer portions of the premiums will be paid outside of this Plan.

Q-8. What if I terminate my employment during the Plan Year or I lose eligibility for other reasons?

If your employment with Archdiocese of St. Louis is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. See the insurance booklets for information on your right to continued or converted coverage after termination of your employment. If you are rehired within the same Plan Year and are eligible for the Plan, you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less, your prior elections will remain in effect for the remainder of the Plan Year.

If you cease to be an eligible Employee for reasons other than termination, such as a reduction in hours, you must complete the waiting period described in Q-3 before again becoming eligible to participate in the plan.

Q-9. Will I pay any administrative costs under the Plan?

Archdiocese of St. Louis is currently bearing the entire cost of administering the Plan.

Q-10. How long will the Plan remain in effect?

Although Archdiocese of St. Louis expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time. It is also possible that future changes in state or federal tax laws may require that the Plan be amended accordingly.

Q-11. What happens if a claim for benefits is denied?

Insurance Plan Coverage Claims. If your claim is for a benefit under one of the component Benefit Plans or Policies, you will generally proceed under the claims procedure applicable under the component Benefit Plan or Policy.

Claims Under the Plan. If a claim for reimbursement under the Medical Reimbursement Component or the DCAP is wholly or partially denied, or if the Participant is denied a benefit under this Plan (such as the ability to pay for premiums on a pre-tax basis) due to an issue germane to the Participant's coverage under this Plan (such as a determination of a Change in

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Status, a "significant" change in premiums charged, or eligibility and participation matters under the Flexible Benefits Plan document), then the claims procedure described below will apply.

The payment of any benefit set forth herein is subject to the provision that the Participant furnish such proof and releases as the Administrator may reasonably require before approving the payment of any such benefit.

If the Administrator determines that a claim should be denied in whole or in part, written notice will be given to the Participant within a reasonable period of time after receipt of the claim. The written notice will list:

1. The reasons for denial;

2. The plan provisions on which denial is based;

3. A description of additional information which may be necessary;

4. An explanation of how the claim may be reviewed.

Q-12. What effect will Plan participation have on Social Security and other benefits?

Plan participation will reduce the amount of your taxable compensation. Accordingly, there could be a slight decrease in Social Security benefits and/or other benefits (e.g., pension, disability, and life insurance) which are based on taxable compensation.

Q-13. What is the Family and Medical Leave Act?

If your Administrator is subject to the Family and Medical Leave Act (FMLA) (generally, employers with at least 50 employees are subject to such) and if you are on eligible leave under FMLA, then you may continue to pay for your Health Insurance coverages on an after-tax basis, or other arrangements may be available (such as prepaying on a pre-tax basis via extra salary reductions before you go on leave). If your Administrator pays a portion of your Health Insurance premiums, then it must continue those payments. However, if you do not return from FMLA, you may be required to repay Archdiocese of St. Louis-paid portion of the Health Insurance premiums. If your Administrator is subject to FMLA, then you should be provided with a complete explanation of your FMLA rights and responsibilities.

Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

If the Participant's Employer is subject to the Family and Medical Leave Act (FMLA) (generally, employers with at least 50 employees are subject to such) and if the Participant is on eligible leave under FMLA, then the Participant may continue to pay for his Insurance Plan and Medical Reimbursement Component coverage on an after-tax basis, or other arrangements may be available (such as prepaying on a pre-tax basis via extra Salary Reductions before the leave commences). If the Participant's Employer pays a portion of the Participant's Insurance Plan premiums, then it must continue those payments. However, if the Participant does not return from FMLA, the Participant may be required to repay Employer-paid portion of the Insurance

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Plan premiums. If the Participant's Employer is subject to FMLA, then the Participant should be provided with a complete explanation of his FMLA rights and responsibilities.

FMLA Leaves of Absence. If the Participant goes on a qualifying leave under the FMLA, to the extent required by the FMLA, the Participant's Employer will continue to maintain the Participant's Insurance Plan benefits and Medical Care Reimbursement Benefits on the same terms and conditions as if the Participant were still active (that is, his Employer will continue to pay its share of the premium to the extent the Participant opts to continue coverage). The Employer may elect to continue all Insurance Plan benefits and Medical Care Reimbursement Benefits for Participants while they are on paid leave (as long as Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant will pay his share of the premiums by the method normally used during any paid leave (for example, on a pre-tax Salary Reduction basis if that is what was used before the FMLA leave began).

If the Participant is going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and the Participant opts to continue his Insurance Plan benefits and Medical Care Reimbursement Benefits, then the Participant may pay his share of the premium in one of three ways:

1. With after-tax dollars while on leave;

2. With pre-tax dollars to the extent the Participant receives Compensation during the leave, or by pre-paying all or a portion of the Participant's share of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of the Participant's pre-leave Compensation, including unused sick days and vacation days. To pre-pay, the Participant must make a special election before such Compensation would normally be available to the Participant (but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or

3. By other arrangements agreed upon between the Participant and the Administrator (for example, the Administrator may pay for coverage during the leave and withhold amounts from the Participant's Compensation upon his return from leave).

If the Employer requires all Participants to continue Insurance Plan benefits and Medical Care Reimbursement Benefits during the unpaid leave, the Participant may discontinue paying his share of the required premium until the Participant returns. Upon returning from leave, the Participant must pay his share of any required premiums that the Participant did not pay during the leave. Payment for the Participant's share will be withheld from his Compensation on either a pre-tax basis or an after-tax basis, as the Participant and the Administrator may agree.

If the Participant's Insurance Plan benefits or Medical Care Reimbursement Benefits cease while on FMLA leave (e.g. for non-payment of required contributions), the Participant will be entitled to resume such Insurance Plan benefits and Medical Care Reimbursement Benefits, as applicable, upon return from such leave on the same basis as he was participating in the Plan before the leave, or otherwise required by the FMLA. The Participant is entitled to have coverage for such Insurance Plan benefits and Medical Care Reimbursement Benefits automatically reinstated so long as coverage for Employees on non-FMLA leave is automatically reinstated upon returning from leave. But, despite the preceding sentence, with regard to

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Medical Care Reimbursement Benefits, if the Participant's coverage ceased, he will be entitled to elect whether to be reinstated in the Medical Care Reimbursement Benefits at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining Period of Coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay premiums. If the Participant elects the pro-rata coverage, the amount withheld from his Compensation on a payroll-to-payroll basis for the purpose of paying for reinstated Medical Care Reimbursement Benefits will equal the amount withheld before FMLA leave.

Non-FMLA Leaves of Absence. If the Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, after-tax contributions while on leave, or catch-up contributions after the leave ends, as may be determined by the Administrator.

Q-15. What are Medical Care Expense Reimbursement Benefits?

Under the Medical Care Reimbursement component, you purchase a specific level of Medical Care Reimbursement benefits, paying for coverage through a Salary Reduction Agreement with Archdiocese of St. Louis, in lieu of a corresponding amount of current pay, which means that the premiums you pay will be with pre-tax funds. In return, you may be reimbursed from the plan for certain eligible Medical Expenses. This arrangement helps you because the level of coverage you elect is non-taxable; thereby saving you social security and income taxes on the amount of the premiums you pay.

Q-16. What is my "Medical Care Expense Reimbursement Account"?

If you elect benefits under this portion of the Plan, a Medical Care Reimbursement Account will be set up in your name to keep a record of the reimbursements you are entitled to, as well as the premiums you have paid for such benefits during the Plan Year. Your Medical Care Reimbursement Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the employer).

Q-17. What annual benefits are available under the Medical Reimbursement component, and how much will they cost?

The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Plan Year will be the current IRS Allowable Maximum, which is $3,050 for 2023. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Plan Year shall be $1. Amounts received that are attributable to reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be attributed to the Participant. For subsequent Plan Years, the maximum and minimum annual benefit amount may be changed by the Administrator and shall be communicated to Employees via the Enrollment Form, via another document, or via the Online Enrollment Form. If a Participant enters the Plan mid-year, then the annual maximum amount of benefit may be prorated for the first partial year of participation.

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Q-18. How is my Medical Care Expense Reimbursement benefit paid?

The annual premium for a Participant's benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $3,050 annual benefit amount is elected, then the annual premium amount is also $3,050). The Salary Reduction for each pay period for a Participant is an amount equal to the annual premium divided by the number of pay periods in the Plan Year, or an amount otherwise mutually agreed upon. Salary Reductions are applied by the Employer to pay for the premium for the Participant's benefits and, for the purposes of this Plan, are considered Employer contributions.

Q-19. What amounts will be available for Medical Care Expense Reimbursement Plan at any particular time during the Plan Year?

Provided that you have continued to contribute the periodic amounts for this benefit, the full, annual amount of coverage you have elected will be available at any time during the Plan Year, although reduced by the amount of prior reimbursements received during the year.

Q-20. How do I receive reimbursement under the Plan?

Expenses That May Be Reimbursed. Under the Medical Reimbursement Component, a Participant may receive reimbursement for Medical Care Expenses incurred while he is a Participant during the Plan Year for which an election is in force. A medical expense is incurred at the time the medical care or service giving rise to the expense is furnished.

Maximum Reimbursement Available. Reimbursement for Medical Care Expenses of the maximum dollar amount elected by the Participant for a Plan Year (reduced by prior reimbursements during the Plan Year) shall be available at all times during the Plan Year, regardless of the actual amounts credited to the Participant's Medical Reimbursement Account. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after coverage under this Plan has terminated, unless the Participant has elected continuation coverage.

Timing of Reimbursement. As soon as is practical after the Participant submits a reimbursement claim to the Administrator, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approved the claim), or the Administrator will notify the Participant that his claim has been denied.

Use-It-or-Lose-It Rule. If a Participant does not submit enough expenses to receive reimbursements for the full amount of coverage elected for a Plan Year, then the excess amount will be forfeited and applied by the Employer.

Applying for Reimbursements. A Participant can submit a paper claim, including the receipt, to TRISTAR Benefit Administrators for reimbursement. You must include written statement(s)/bill(s) from an independent third party(ies) stating that the medical expense(s) have been incurred, and the amount of such expense(s) along with a TRISTAR Benefit Administrators claim form.

1. Complete the Flexible Benefits Plan Reimbursement claim form. This form is available

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from your employer or from TRISTAR Benefit Administrators; and

2. Submit documentation of the expense by mailing, faxing, or emailing it to TRISTAR Benefit Administrators.

Mailing Address:	TRISTAR Benefit Administrators 5820 S. Eastern Avenue, Suite 250 Las Vegas, NV 89119
Fax Number:	702-216-1623
Email Address:	flex@tristargroup.net

Account balance information is available online at tristar.summitfor.me . You may also file a claim online through this website.

You will have until December 15th following the end of the Plan Year and Grace Period in which to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year and Grace Period. You will be notified in writing if any claim for benefits is denied.

Q-21. What are "Medical Care Expenses" that may be reimbursed from the Medical Care Reimbursement?

Under the Medical Care Reimbursement component, you purchase a specific level of Medical Care Reimbursement benefits, paying for coverage through a Salary Reduction Agreement with Archdiocese of St. Louis in lieu of a corresponding amount of current pay, which means that the premiums you pay will be with pre-tax funds. In return, you may be reimbursed from the plan for certain eligible Medical Expenses. This arrangement helps you because the level of coverage you elect is non-taxable; thereby saving you social security and income taxes on the amount of the premiums you pay.

For purposes of the Medical Care Reimbursement Coverage Option, "Medical Care Expense" means expenses incurred by you, your Spouse, or your Dependents for "medical care" as defined in Code § 213(d).

The following expenses are eligible for reimbursement under the Medical Reimbursement Coverage:

Acupuncture.

Ambulance.

Chiropractic related services.

Deductible, coinsurance, and co-payments.

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Dental fees - exams, fillings, x-rays, dentures, orthodontic fees, etc. For orthodontic services, payment can only be considered for services actually performed during the Plan Year, including the initial placement fee, and monthly adjustment fees, and not the total orthodontia fee

Hearing aids and batteries.

Laser surgery for vision improvement.

Learning disability - Tutoring by licensed school or therapist as recommended by a physician.

Massage Therapy (if prescribed by a Physician and if a letter of medical necessity is provided).

Medical fees such as x-ray and laboratory services.

Menstrual care products such as liners, pads, tampons, and cups.

Over-the-counter items such as allergy and sinus treatment, pain relief items, cold and flu medicine, Covid tests, denture adhesive and cleaners, diaper rash ointments and creams, gastrointestinal medication, adult incontinence supplies, laxatives, nasal spray, nasal strips, toothache and teething pain relievers and wart removal treatments.

Personal Protective Equipment (PPE) such as face masks and hand sanitizer.

Physical Therapy or Occupational Therapy by a licensed therapist.

Physician fees.

Psychotherapy and psychoanalysis provided the expenses are for medical care.

Special schools to relieve a handicapped condition.

Vaccinations and immunizations.

Transportation expenses, if the expenses are primarily for and essential to medical care.

Vision care - Eye Exams, Eyeglasses, Contact lenses, and contact lens solution.

Weight loss programs and/or drugs prescribed to induce weight loss, provided the program is prescribed by a doctor to treat an existing disease (e.g. obesity, heart disease, or diabetes), and is not simply to improve general health.

Wheelchairs-includes rental or purchase.

The following expenses are NOT eligible for reimbursement under a Medical Care Expense Reimbursement Plan:

Abortion related services.

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Any item that does not constitute “medical care” as defined under Code § 213.

Any item that is not reimbursable under Code § 213 due to the rules in Prop. Treas. Reg. § 1.125-2, Q-7(b)(4) or other applicable regulations.

Automobile insurance premiums.

Bottled water.

Contraceptives, including, but not limited to oral contraceptives, contraceptive devices (i.e. diaphragms, IUD’s), contraceptive injectionables (e.g. Depo-Provera), or contraceptive implants (i.e. Norplant).

Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease. "Cosmetic surgery" means any procedure or drug which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

Cosmetics, toiletries, toothpaste, etc.

Costs for sending a problem child to a special school for benefits the child may receive from the course of study and disciplinary methods.

Custodial care.

Diaper service or diapers.

Foods associated with a weight loss program.

Funeral and burial expenses.

Health club dues, or fitness programs.

Health insurance premiums.

Home or automobile improvements.

Household and domestic help (even though recommended by a qualified physician due to an Employee's or Dependent's inability to perform physical housework).

In vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, or other artificial fertilization procedures.
Long-term care services.

Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.

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Social activities, such as dance lessons, even if recommended by a qualified physician for general health improvement.

Maternity clothes.

Salary expense of a nurse to care for a healthy newborn at home.

Sterilization, tubal ligation, or vasectomy.

Uniforms or special clothing.

For more information about what items are - and are not - Medical Care Expenses, consult IRS Publication 502 ("Medical and Dental Expenses") under the headings "What Medical Expenses Are Deductible?" and "What Expenses Are Not Deductible?" But use the Publication with caution, because it was meant only to help taxpayers figure out what medical expenses can be deducted on the Form 1040 Schedule A (i.e., to figure out their tax deductions), not what is reimbursable under a Medical Care Reimbursement. In fact, some of the statements in the Publication are not correct when determining whether that same expense is reimbursable from your Medical Care Reimbursement. This is because there are several fundamental differences between what is deductible as medical care (under Code §§ 213(a) and 213(b)) and what is reimbursable as medical care under a Medical Care Reimbursement (under Code § 213(d)). Not all expenses that are deductible are reimbursable under a Medical Care Reimbursement. (For example, health insurance premiums, founders' fees, lifetime care, long-term contracts, and long-term care services are listed as deductible expenses in Publication 502, but generally, they cannot be reimbursed from your Medical Care Reimbursement.) Not all expenses that are reimbursable under a Medical Care Reimbursement are deductible. (For example, Medical Care Reimbursements may reimburse OTC drugs if they qualify as medical care under Code § 213(d), but they are still not deductible under Code §§ 213(a) and 213(b).)

Ask the Plan Administrator if you need further information about which expenses are - and are not - likely to be reimbursable but remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

Q-22. When must the expenses be incurred?

Medical Expenses must be incurred during the 14 1/2 month period that starts at the beginning of the Plan Year and ends on the 15th of the third month after the end of the Plan Year (e.g. if the Plan Year is July 1 to June 30, claims must be incurred no later than September 15. The period from July 1 to September 15 is called the "Grace Period") A medical expense is incurred when the service that gives rise to the expense is provided; when the expense is paid is irrelevant. You may not be reimbursed for any expenses arising before the Plan became effective, before your Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except for Continuation Coverage).
You will have until December 15th following the end of the Plan Year and Grace Period to submit a claim for reimbursement for Eligible Expenses incurred during the previous Plan Year and the Grace Period. You will be notified in writing if any claim for benefits is denied.

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Q-23. What if the Medical Expenses I incur during the Plan Year and Grace Period are less than the annual amount I have elected for Medical Care Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual medical expenses you have incurred and the annual coverage level you have elected and paid for. Any amount allocated to an Account will be forfeited by the Participant and be used as provided in the Plan, if it has not been applied to the elected benefit for any Plan Year by December 15th following the end of the Plan Year and Grace Period, for which the election was effective. Amounts forfeited will be used to offset administrative expenses and future costs.

Q-24. Forfeiture of Unclaimed Reimbursement Account Benefits

Any Medical Care Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year and Grace Period following the Plan Year and Grace Period in which the expense was incurred will be forfeited.

Q-25. What are Dependent Care Expense Reimbursement (DCAP) Benefits?

Under the Dependent Care Assistance Program (DCAP) component, you provide a source of pre-tax funds to reimburse yourself for your Eligible DCAP Expenses by entering into a Salary Reduction Agreement with your Administrator under which you agree to a salary reduction to fund DCAP Expenses in lieu of a corresponding amount of your regular pay. This arrangement helps you because the coverage you elect is non-taxable, thereby saving you social security and income taxes on the amount of your salary conversion.

Q-26. What is my "DCAP Expense Reimbursement Account"

Under the DCAP Component of this Plan, Participant may elect to receive benefits in the form of reimbursements for Eligible Employment-Related Expenses and to pay the premium for such benefits via Salary Reductions.

Q-27. What is the maximum DCAP benefit I may elect?

The maximum annual benefit amount that you may elect to receive under this Plan in the form of reimbursements for Eligible Employment-Related Expenses incurred in any Plan Year and Grace Period is $5,000. Because the Plan year and Calendar year are different, it is important to make sure you do not incur more than $5,000 in any Calendar year. The minimum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Eligible Employment-Related Expenses incurred in any Plan Year shall be $1. For subsequent Plan Years, the maximum and minimum annual benefit amount may be changed by the Administrator and shall be communicated to Employees via the Enrollment Form, via another document, or via the Online Enrollment Form. If a Participant enters the Plan mid-year, then the annual maximum amount of benefit will be prorated for the first partial year of participation.

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Q-28. How is my DCAP Expense benefit funded?

When you complete the Salary Reduction Agreement, you specify the amount of DCAP benefits for which you wish to pay with your salary reduction. Thereafter, your DCAP Reimbursement Account will be credited with the portion of your gross income that you have elected to forgo through salary reduction. These portions will be credited as of each pay period. The amount that is available for reimbursements at any particular time will be whatever has been credited to your DCAP Reimbursement Account, less any reimbursements already paid.

For example, suppose you have elected to be reimbursed for $2,600 per year for DCAP Expenses, and you have chosen no other benefit under the Employer's Cafeteria Plan. Your DCAP Reimbursement Account would be credited (and funded) with a total of $2,600 during the Plan Year. Thus, if you are paid bi-weekly, you would have a total of $100 credited to your DCAP Reimbursement Account each payday to pay reimbursements under this Plan.

Q-29. What is an "Eligible DCAP Expense" for which I can claim a reimbursement?

You may be reimbursed for work-related dependent care expenses incurred on behalf of any individual in your family who is under age 13, and whom you could claim as a Dependent on your federal income tax return; any other Dependent who is mentally or physically incapable of caring for himself or herself, or your Spouse, if the Spouse is likewise physically or mentally incapacitated.

Generally, these expenses must meet *all* of the following conditions for them to be Eligible DCAP Expenses:

1. The expenses are incurred for services rendered after the date of your election to receive DCAP Expense Reimbursement, and during the calendar year to which it applies;

2. Each individual for whom you incur the expense is:

    a. a Dependent under age 13 whom you are entitled to a personal tax exemption as a dependent, or

    b. a Spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself;

3. The expenses are incurred for the care of a Dependent (as described above) or, for related household services, and are incurred to enable you to be gainfully employed;

4. If the expenses are incurred for services outside your household and such expenses are incurred for the care of a Dependent who is under age 13, such Dependent regularly spends at least 8 hours per day in your home;

5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provides for more than 6 individuals not residing at the facility), the center complies with all applicable state and local laws and regulations;

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6. The expenses are not paid or payable *to* a child of yours who is under age 19 at the end of the year in which the expenses are incurred or an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent;

7. This reimbursement (when aggregated with all other DCAP Reimbursements during the same year) may not exceed the least of the following limits:

    a. $5,000;

    b. $2,500 if you are married, but you and your Spouse files separate tax returns;

    c. your taxable compensation (after your salary reduction under the Flexible Benefits Plan); or

    d. if you are married, your Spouse's actual or deemed Earned Income;

For this purpose, expenses are incurred when the services giving rise to the expenses have been rendered; when you pay for the expense is irrelevant. For purposes of (D) above, your spouse will be deemed to have Earned Income of $250 ($500 if you have two or more dependents described in paragraph 2 above), for each month in which your spouse is:

1. Physically or mentally incapable of self-care, or

2. A full-time student.

You are encouraged to consult your personal tax advisor or IRS Publication 17 "Your Federal Income Tax" for further guidance as to what is or is not an Eligible Expense if you have any doubts.

Q-30. What amounts will be available for DCAP Expense Reimbursement at any particular time during the Plan Year?

The amount of coverage that is available for reimbursement of DCAP Expenses at any particular time during the Plan Year and Grace Period will be equal to the amount credited to your DCAP Expense Reimbursement Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year and Grace Period.

Q-31. How do I receive a DCAP Expense Reimbursement under the Plan?

Timing of Reimbursement. As soon as practical after the Administrator receives a reimbursement claim from the Participant, the Employer will reimburse the Participant for the Participant's Eligible Employment-Related Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his claim has been denied.

Use-It-or-Lose-It Rule. If a Participant does not submit enough expenses to receive reimbursements for the full amount of coverage elected for a Plan Year and Grace Period, then the excess amount will be forfeited and applied by the Employer.

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Applying for Reimbursements. The Participant must submit a claim to TRISTAR Benefit Administrators on a Claim Form that will be supplied. If there is enough money in your Dependent Care Expenses Reimbursement Account, you will be reimbursed for the eligible expenses during the next scheduled reimbursement period.

If a claim is for an amount that is more than your current Dependent Care Reimbursement Account balance, then the excess part of the claim will be carried over into the next reimbursement period, to be paid out as the balance becomes adequate. You will not be reimbursed for any expenses that arise before the Salary Reduction Agreement becomes effective, or for any expense incurred after the close of the Plan Year and Grace Period.

To have your claims processed as soon as possible, you should read the claims instructions. It is not necessary for you to have actually paid an amount due for Dependent Care Reimbursement Account Expenses-only for you to have *incurred* the expense, and that it is not being paid for or reimbursed from any other source. Note that if you have paid for the expense but if the services have not yet been rendered, the expense has not been incurred for this purpose. For example, if you pay for your child's day care on the first day of the month for care given during that month, the expense has not been incurred until the end of that month.

In addition, you will have until December 15th , following the Plan Year and Grace Period in which to submit a claim for reimbursement for Dependent Care Reimbursement Account Expenses incurred during the previous Plan Year and Grace Period. You will be notified in writing if any claim for benefits is denied.

For this purpose, Eligible Employment-Related Expenses have been incurred when the services giving rise to the expenses have been rendered.

Q-32. What if the Eligible Employment Related DCAP Expenses I incur during the Plan Year and Grace Period are less than the annual amount of coverage I have elected for DCAP Expense Reimbursement?

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Employment Related DCAP Expenses you have incurred, on the one hand, and the annual coverage you have elected and paid for, on the other. Any amount allocated to an Account will be forfeited by the Participant and restored to Archdiocese of St. Louis if it has not been applied to provide the elected reimbursement for any Plan Year by December 15th following the end of the Plan Year and Grace Period for which the election was effective. Amounts so forfeited will be used to offset reasonable administrative expenses and future costs.

Q-33. Will I be taxed on the DCAP benefits I receive?

You will not normally be taxed on your DCAP benefits, up to the limits set out in Q-30 of this summary. However, to qualify for tax-free treatment, you will be required to file IRS Form 12441 or a similar form listing the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

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Q-34. If I participate in the DCAP, will I still be able to claim the household and dependent care credit on my federal income tax return?

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the *balance* of your Dependent Care Expenses may be eligible for the dependent care credit under Code § 21 (Dependent Care Credit) (e.g., if you elect $3,000 of coverage under the DCAP and are reimbursed $3,000, but you had Dependent Care Expenses totaling $5.000, you could count the excess $2,000 when calculating the Dependent Care Credit if you have two or more dependents). Note: the amount of any Dependent Care Credit you may have available will be offset by any DCAP Benefits received under the plan.

Q-35. What is the Dependent Care Credit?

The Dependent Care Credit is an allowance for a percentage of your annual Dependent Care Expenses as a credit against your federal income tax liability under the Code. In determining what the tax credit would be for the current year, you may take into account $3,000 of such expenses for one dependent, or $6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35% of your qualifying expenses (to a maximum credit amount of $1,050 for one dependent or $2,100 (for two or more dependents), to a minimum of 20% of such expenses (producing a maximum credit of $600 for one dependent or $1,200 for two or more dependents). The maximum 35% rate must be reduced by 1% (but not below 20%) for each $2,000 portion (or any fraction of $2,000) of your adjusted gross incomes over $15,000.

Illustration: Assume that in the current year, you have one dependent for which you have incurred dependent care expenses of $3,600, and that your adjusted gross income is $20.000. Since only one dependent is involved, the credit will be calculated by applying the appropriate percentage to the first $3,000 of the expenses. The percentage is 32%. Thus, your tax credit would be $3,000 x 32% = $960. If you had incurred the same expenses for two or more dependents, your credit would have been $3,600 x 32% = $1,152, because the entire expense would have been taken into account, not just the first $2,400.

For more information about how the Dependent Care Credit works, see IRS Publication Number 503 (“Child and Dependent Care Expenses”). You may also wish to consult a tax advisor.

Q-36. When would I be better off to include the reimbursements in my income and claim the credit, rather than to treat the reimbursements as tax-free?

Generally, if you are in one of the lower income tax brackets, you might come out ahead by not participating in the DCAP and by claiming the Dependent Care Credit instead. On the other hand, generally the more income taxes you are required to pay, the better it would be tax-wise to participate in the DCAP. Because the actual determination of the preferable method for treating benefit payments depends on a number of factors such as one's tax filing status (e.g., married, single, head of household), number of dependents, etc., each Participant will have to determine his or her tax position individually in order to make the decision between taxable and tax-free benefits. Use IRS Form 2441 (Child and Dependent Care Expenses) to help you. You may also wish to consult a tax advisor.

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Q-37. Forfeiture of Unclaimed DCAP Expense Reimbursement Account Benefits

Any Reimbursement Account benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year and Grace Period in which the DCAP Expense was incurred will be forfeited.

Q-38. Reimbursements after Termination.

When a Participant ceases to be a Participant as defined under Q-3, the Participant's Salary Reductions will terminate, as will his election to receive reimbursements. However, the Participant will be able to receive reimbursements for Eligible Employment-Related Expenses incurred during the Plan Year before his participation terminates, as long as the claims for reimbursement are submitted within 167 days following the end of the Plan Year in which the expense arose.

Q-39. What is the Privacy Policy?

Commitment to Protecting Health Information

This Flexible Benefits Plan ("Plan") will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the plan participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The plan participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;

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2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the *Plan Sponsor* may receive and use *PHI* for *plan administration* purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose *PHI* other than as permitted or required by the *Plan Document*s or as required by law (as defined in the *privacy standards*);
- Ensure that any agents, including a subcontractor, to whom the *Plan Sponsor* provides *PHI* received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such *PHI*;
- Not use or disclose *PHI* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor,* except pursuant to an authorization which meets the requirements of the *privacy standards;*
- Notify *participants* of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Notify the Federal Trade Commission of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
- Report to the *Plan* any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- Make available *PHI* for amendment and incorporate any amendments to *PHI* in accordance with section 164.526 of the *privacy standards* (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services *("HHS"),* or any other officer or employee of *HHS* to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);
- Obtain authorization prior to the sale of any *PHI*;
- If feasible, return or destroy all *PHI* received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such *PHI* when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the *PHI* infeasible; and

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- Ensure that adequate separation between the *Plan* and the *Plan Sponsor,* as required in section 164.504(f)(2)(iii) of the *privacy standards* (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - Only employees, or classes of employees, or other persons under control of the *Plan S*ponsor designated as such by *Plan Sponsor* and listed below at the end of this Section*,* shall be given access to the *PHI* to be disclosed.
  - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.
  - In the event any of the individuals described in above do not comply with the provisions of the *Plan Document*s relating to use and disclosure of *PHI,* the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the *Plan* or solicit bids from prospective issuers. *"Plan administration"* functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan Document*s have been amended to incorporate the above provisions; and
- The *Plan Sponsor* agrees to comply with such provisions.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids from health plans for providing health insurance coverage under this Plan; or modifying, amending, or terminating the Plan.

The *Plan* is prohibited from using or disclosing genetic information for underwriting purposes, such as determining eligibility or determination of benefits, computation of premium or contribution amounts, and other activities related to the creation, replacement, or renewal of a contract of health insurance or health benefits.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan,* but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

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Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the *privacy standards* (45 CFR 164.504(f)(1)(iii)), the *Plan* may disclose to the *Plan Sponsor* information on whether an individual is participating in the *Plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan* to the *Plan Sponsor.*

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *third party administrator*, to disclose *PHI* to stop-loss carriers, excess loss carriers or managing general underwriters *("MGUs")* for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures shall be made in accordance with the *privacy standards*.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment, and Health Care Operations: The Plan has the right to use and disclose a plan participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the plan participant's information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    a. a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

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b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
c. locate and notify persons of recalls of products they may be using; and
d. a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the plan participant's agreement, if the Plan reasonably believes him/her to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a 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.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative, or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the plan participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the plan participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director, or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

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9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance 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 threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a plan participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the plan participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the plan participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the plan participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends, or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a

Appendix T (continued)

certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the plan participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the plan participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions, or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

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GENERAL INFORMATION ABOUT THE PLAN

Plan Name:	Archdiocese of St. Louis Flexible Benefit Plan
Plan Number:	501
Effective Date:	July 1, 2003
Plan Year:	July 1 through June 30

Employer Name and Address

Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, MO 63119-5004

Employer Federal Tax Identification Number

43-0653244

Plan Administrator Name, Address, and Telephone Number

Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, MO 63119-5004
314-792-7540

Archdiocese of St. Louis appoints a Committee that keeps the records for the Plan and is responsible for the administration of the Plan. The Committee will also answer any questions you may have about your Plan. You may contact the Committee at the above address for any further information about the Plan.

Service of Legal Process

Archdiocese of St. Louis
20 Archbishop May Drive
St. Louis, MO 63119-5004
Attention: Flexible Benefits Plan Committee

Claims Administrator

TRISTAR Benefit Administrators
5820 S. Eastern Avenue, Suite 250
Las Vegas, NV 89119
800-456-4584

Appendix T (continued)

ARCHDIOCESE OF ST. LOUIS FLEXIBLE BENEFITS PLAN CLAIM FORM

PLEASE READ THE GUIDELINES FOR ELIGIBLE REIMBURSEMENTS ON THE REVERSE SIDE

1. Employee Information: Complete all sections.				
Employer Information	Parish/Agency Employer Name			
Employee Information ☐ Check box if new address.	Employee's Last Name	First Name	Initial	Employees Social Security No. - -
	Home Address			
	City	State	Zip	Daytime Phone Number

2. Health Care: An itemized statement is required including date of service, type of service, and total charge.

Please check one of the following boxes:

☐ Charges attached are partially covered benefits under my health and/or dental insurance coverage. Enclosed is an Explanation of Benefits from my insurance. An Explanation of Benefits is required even if charges are applied to your deductible or out-of-pocket liability.

☐ Charges are **not** a covered benefit by any insurance plan for which the patient is enrolled.

☐ Charges attached are for reimbursement of my office visit or prescription drug co-pay due at the time of service. My insurance company does not provide an Explanation of Benefits for these services. Enclosed is an itemized receipt provided by the provider of service.

Date (s) Incurred	Name of Person Receiving Care	Description of Expense	Provider Name (i.e., clinic, doctor, hospital)	Total Expense	Amt. Paid by Insurance	Amount Remaining
			TOTAL AMOUNT OF MEDICAL EXPENSE	$	$	$

3. Dependent Care: A receipt is required from your daycare provider that includes dates of care and total charge. If you do not have a receipt, the daycare provider must sign verification section.

Dependent Receiving Care Name	Relationship	Age	Date(s) of Care	Care Provider (Name and Soc. Sec. No./Federal Tax ID)	Amount

DAYCARE PROVIDER VERIFICATION: I certify that the expenses shown are valid.

Signature _____ Soc. Sec. No. / Federal Tax ID _____ Date _____

4. Employee Certification: Employee signature required.

I certify that the above information is correct. I understand that any amounts submitted for dependent care and for which I receive reimbursement cannot also be claimed under the dependent care income tax credit. I understand any medical reimbursements I receive may not be included on my income tax return. I certify that I am requesting reimbursement of medical and/or dependent care expenses, which will not be paid or reimbursed under any other plan. I understand that these expenses must qualify for reimbursement under the Internal Revenue Code and as outlined on the reverse side of this form. I certify that none of the medical reimbursements are for items (including contraceptives, sterilization, and abortion) contrary to the Doctrine of the Catholic Church.

Employee's Signature	Date / / Mo. Day Year

Please send the completed claim form and appropriate statements to:

TRISTAR BENEFIT ADMINISTRATORS
5820 S. Eastern Avenue, Suite 250
Las Vegas, NV 89119
(800) 456-4584
Email: Flex@tristargroup.net Fax#: 702-216-1623

Appendix T (continued)

GUIDELINES FOR ELIGIBLE REIMBURSEMENTS

PLEASE MAKE A COPY OF ALL ENCLOSURES FOR YOUR PERSONAL REFERENCE/INCOME TAX RECORDS.

If you have not submitted the medical and/or dental expense to your insurance plan(s), please do so prior to submission on this Flexible Spending Account Reimbursement form.

If you apply for reimbursement of expense that IRS later determines to be ineligible, those reimbursements may be taxed as ordinary income and certain penalties may apply, according to the Internal Revenue Code. Similar treatment will be applied to overpayment of reimbursed expenses or reimbursement for expenses that have already been reimbursed from some other source.

In general, Section 125 of the Internal Revenue Code governs the tax status of Flexible (or Cafeteria) Benefit Plans, of which Employee Reimbursement Accounts are a part. Eligibility for pre-tax reimbursement is covered specifically in Code Sections 105 and 106 (Accident/Health Plans) and Section 129 (Dependent Care).

MEDICAL REIMBURSEMENT

Generally, any expense that is allowed under IRS Code § 213 is eligible except as shown in the SPD. Please refer to your Flexible Benefit Plan SPD for details

Acupuncture.
Ambulance.
Chiropractic related services.
Deductible, coinsurance, and co-payments.
Dental fees - exams, fillings, x-rays, dentures, orthodontic fees, etc. For orthodontic services, payment can only be considered for services actually performed during the plan year, including the initial placement fee, and monthly adjustment fees, and not the total orthodontia fee
Items used by individuals with respect to menstruation including tampons, pads, liners, cups, sponges, or other similar products.
Hearing aids and batteries.
Laser surgery for vision improvement.
Learning disability - Tutoring by licensed school or therapist as recommended by a physician.
Massage Therapy (if prescribed by a Physician and if a letter of medical necessity is provided).
Medical fees such as x-ray and laboratory services.
Menstrual care products such as liners, pads, tampons, and cups.
Over-the-counter items such as allergy and sinus treatment, pain relief items, cold and flu medicine, Covid tests, denture adhesive and cleaners, diaper rash ointments and creams, gastrointestinal medication, adult incontinence supplies, laxatives, nasal spray, nasal strips, toothache and teething pain relievers and wart removal treatments.
Personal Protective Equipment (PPE) such as face masks and hand sanitizer.
Physical Therapy or Occupational Therapy by a licensed therapist.
Physician fees.
Psychotherapy and psychoanalysis provided the expenses are for medical care.
Special schools to relieve a handicapped condition.
Vaccinations and immunizations.
Transportation expenses, if the expenses are primarily for and essential to medical care.
Vision care - Eye Exams, Eyeglasses, Contact lenses, and contact lens solution.
Weight loss programs and/or drugs prescribed to induce weight loss, provided the program is prescribed by a doctor to treat an existing disease (e.g. obesity, heart disease, or diabetes), and is not simply to improve general health.
Wheelchairs – includes rental or purchase.

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DEPENDENT CARE REIMBURSEMENT

Expenses to provide care for your dependents may qualify for reimbursement. Eligible dependents include children under age 13, a disabled child, a disabled spouse, or a disabled parent.

To be eligible, you must be working while your dependents receive care, or if you are married, your spouse must be:

1. A wage earner,
2. A full-time student for at least 5 months during the year, or
3. A disabled and unable to provide for his or her own care.

Expenses eligible for reimbursement are those incurred to enable you to be gainfully employed, and include covered charges by:

1. Licensed nursery schools and licensed day care centers.
2. Individuals - other than your dependents - who provide care for your children in or outside your home or for your disabled spouse or dependent parent in your home.
3. Housekeepers, maids, or cooks in your home, to include their food and lodging in your home, as long as their services are performed for the benefit of your eligible dependent(s).

IRS Regulations limit the amount of reimbursement expense for dependent care to the lower of the annual earned Income of you or your spouse. If your spouse is disabled or a full-time student, this limitation assumes that your spouse earns $200 per month (one dependent) or $400 per month (two or more dependents).

An additional IRS Regulation limits the amount you can contribute to the dependent care account to $5,000 for a single parent with children, $5,000 for a married parent filing jointly, and $2,500 for a married parent filing separately. This amount may change with IRS regulations.

Under IRS Regulations, qualified individuals can receive tax credit for dependent care costs. This credit is claimed on your personal tax return. You cannot claim the tax credit for any dependent care costs reimbursed from the Dependent Care Reimbursement Account. The maximum amount that can be used for the tax credit is reduced by any amount you use from the Dependent Care Reimbursement Account.

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Appendix T (continued)