JULY 1, 2015 – JUNE 30, 2016
BENEFITS SUMMARY

ARCHDIOCESE OF CHICAGO

The Human Resources Department wishes to thank the parishes and schools for providing the images used in this guide. All images within these pages are from parishes and schools within the Archdiocese of Chicago.

This guide is intended to give you an overview of the benefit plans offered by the Archdiocese of Chicago. All specific plan provisions are described in the legal documents governing the plans. If there are any discrepancies between this guide and the plans' legal documents, the legal documents will govern. Any of the benefit plans offered by the Archdiocese of Chicago may be amended, revoked, suspended or terminated at the Archdiocese's sole discretion at any time. In addition, neither this description nor your participation in the Archdiocese's benefit plans creates a contract or guarantee of employment.

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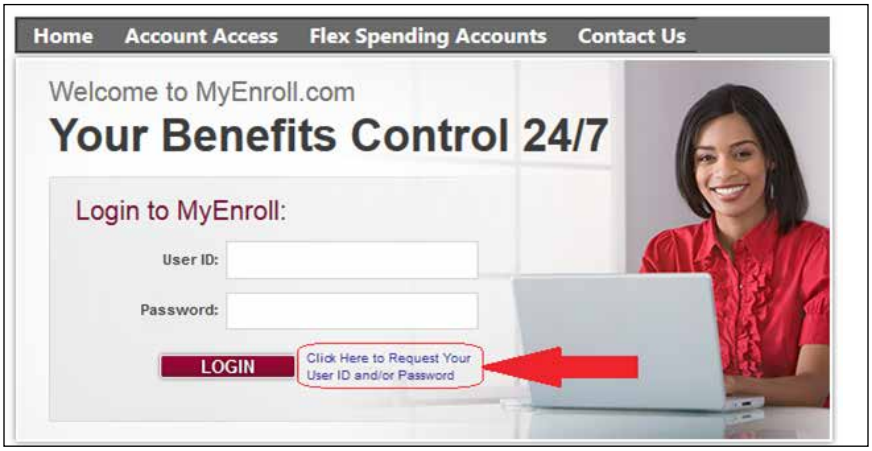

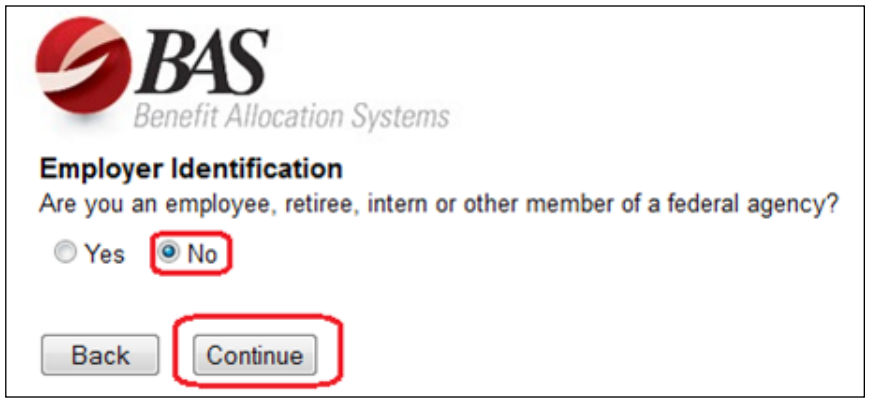

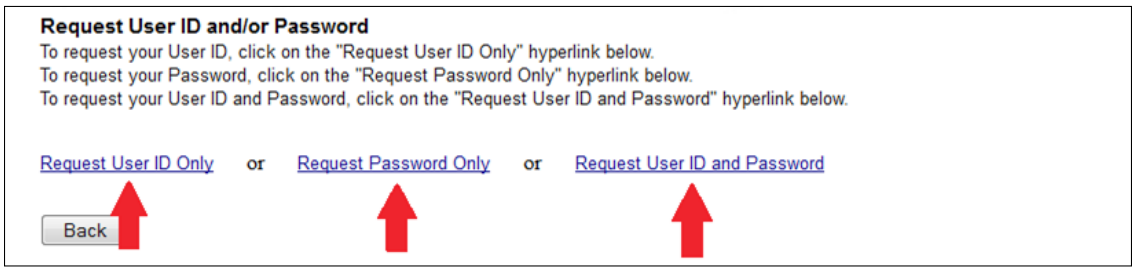

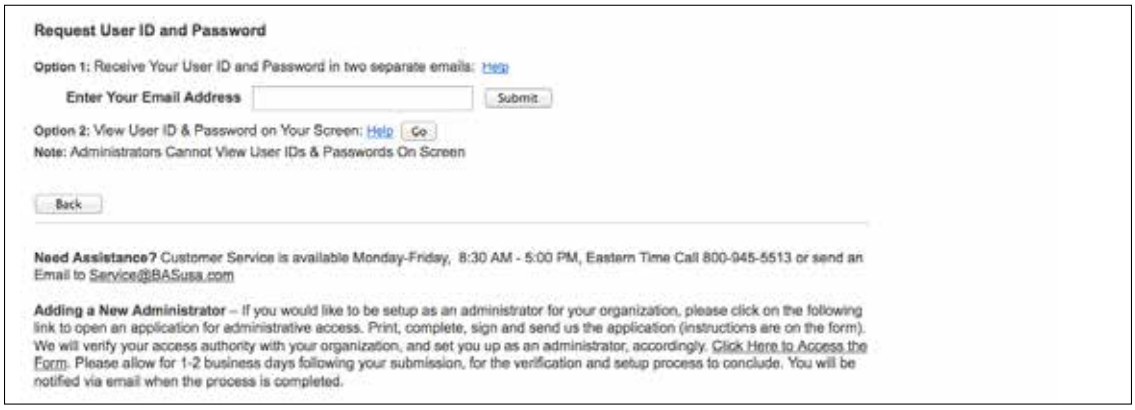

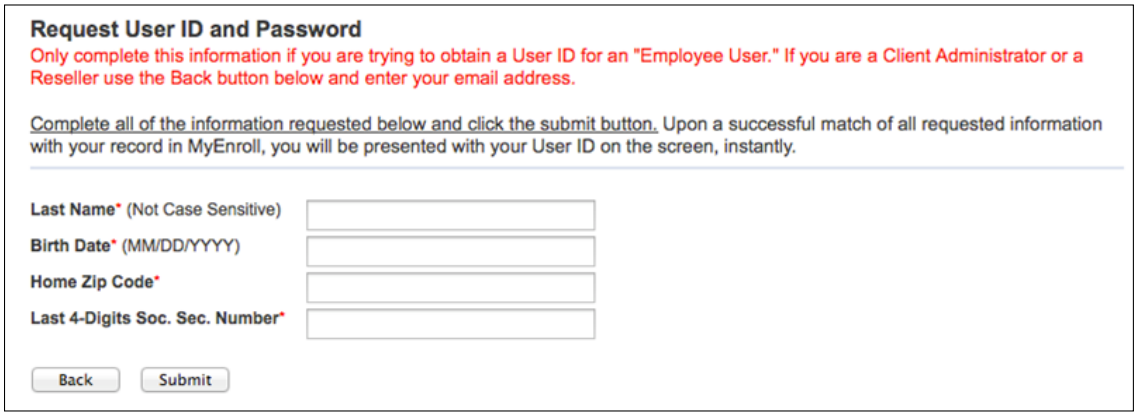

Online Benefits Enrollment

The Archdiocese of Chicago has partnered with **Benefit Allocation Systems, Inc. (BAS)** to enable our staff to take advantage of online benefit enrollment using **MyEnroll.com.** MyEnroll is an enterprise system for insurance enrollment and administration that provides a secure online benefit web portal. ***All benefit eligible staff are required to make benefit elections at new hire and enrollment changes during Open Enrollment via the MyEnroll site.***

MyEnroll also houses benefit related forms and plan documents along with other benefit information.

Please utilize the screen shots to your left to logon to www.myenroll.com:

Why the Archdiocese Cares about Benefits

The Archdiocese of Chicago provides comprehensive benefit options for a couple of reasons:

- We want you to be healthy.
- We want you to stay protected from the financial burden of catastrophic medical expenses.

Why? Because we're all in this together. Benefits are best managed through a partnership — for the Archdiocese that means we work hard to design, price and administer quality and affordable benefits. As part of that commitment, we provide access to quality insurance programs and pay the majority of your health care premiums.

We ask you to share in this partnership by taking the time to learn about your benefits, choosing your coverage carefully, and using your benefits wisely. We believe it's important to offer benefits that have a positive impact on your health, your wealth and your life.

The Archdiocese Employee Benefits Mission Statement

The Archdiocese of Chicago is a diverse community of men and women dedicated to caring for and serving others, while following the teachings of the Catholic Church. To support and reward your contribution to that service, we are committed to providing you and your family with high-quality benefits at a competitive cost.

Enrollment Guidelines

Your Eligibility

You are eligible to participate in the Archdiocese of Chicago's benefits if you are an employee regularly scheduled to work at least 26 hours each week for eight months of the year or more. The number of hours you work, if holding part-time positions at more than one parish or school, are added together to determine your eligibility.

New Employee Eligibility

New employees are eligible for benefits the first of the month following one full calendar month of service in either a full-time or benefits-eligible part-time position.

Former Employee Eligibility

Former employees who return to work in a benefits-eligible position within six months of termination are eligible for benefits on the first of the month following rehire.

Dependent Eligibility

If you are eligible and enrolling in benefits you may also enroll your eligible dependents, who are:

- Your husband or wife.
- Your unmarried children up to age 26, regardless of student status.
- Your children of any age who are mentally or physically handicapped and dependent on you for support if they were covered prior to reaching age 26.

Starting with the 2015 plan year, employees will be required to substantiate and document the relationship with their dependents for coverage purposes.

How to Enroll

If you're a current employee, annual open enrollment offers you the opportunity to enroll in or make changes to your benefit selections (new employees must enroll within 30 days of their benefit-entry date). Read below for detailed enrollment instructions:

1. Your July 2015 open enrollment period is **May 18 – June 2, 2015**.
2. Review your current benefit elections in the MyEnroll system and determine your benefit needs for next year.
3. During this year's annual enrollment, **you will be required to log on to the MyEnroll system at www.myenroll.com, and go through the enrollment process to verify your elections and/or make any desired changes.** This must be completed by **June 2, 2015.**
4. If you wish to enroll in the FSA Plan, you may do so online through the MyEnroll system. No forms needed.

Benefit Coverage Period

The choices you make during annual enrollment remain in effect from **July 1, 2015** through **June 30, 2016**.

Benefit coverage will stop on the last day of the month following the date you are no longer employed by the Archdiocese or you no longer meet the eligibility requirements (coverage for your dependents will also end on the date your coverage ends). However, extended health coverage may be available for up to 18 months at your own expense. See the Extended Health Coverage section of the Human Resources website.

All Health and Dental premium deductions will be taken on a pre-tax basis unless you specify otherwise through the MyEnroll system.

If you have questions, please contact your local benefits administrator. You can also call **312.534.5360** or email **hr@archchicago.org**.

Qualified Life Events

The Archdiocese of Chicago's benefit plans are qualified under and governed by tax codes. As a result, you can enroll, cancel or change your level of coverage only during the annual open enrollment period or if you experience a qualified life event.

You must submit a new enrollment form along with supporting documentation for the change within **30 days** of a qualified event. If you are eligible to make coverage changes, your changes must be consistent with the qualified event.

Qualified events include but not limited to:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss of coverage for your spouse or dependent(s)

This includes changing your enrollment from FAMILY to SINGLE coverage, and dropping coverage. You must show proof of a qualified change in family status to add or drop coverage in all cases other than open enrollment.

It is your responsibility to submit a new enrollment form within 30 days of a a qualifying event. Otherwise, you'll need to wait until the next open enrollment period to make any changes.

If you cancel coverage at any time other than annual open enrollment due to a qualifying change, you **must** provide documentation showing evidence of the change and proof of other coverage.

Your Medical Plan Benefits

The Archdiocese of Chicago's medical plans provide important protection against potentially burdensome health care expenses. Since both you and the Archdiocese share in the cost of coverage, and your contributions may be made on a before-tax basis, you save money when you choose one of our medical plans.

The Archdiocese offers three medical plans, all administered by Blue Cross Blue Shield of Illinois (BCBSIL), to help you meet your medical needs and the needs of your family. Your choices include the:

- PPO Plan*
- HMO Illinois
- Blue Advantage HMO

All medical plans include the same prescription drug benefits with Express Scripts.

** The PPO Plan is self-insured, which means the Archdiocese pays the cost of claims, not the insurance company. BCBSIL administers the plan for the Archdiocese and the cost of the plan is directly related to the amount of claims paid.*

Spouses Both Working for the Archdiocese

Where an employee and spouse both work in a benefits-eligible capacity for the Archdiocese, our policy allows for one spouse to enroll in Family Medical coverage while being charged the Single coverage rate. The parish, school or agency that employs the spouse who is enrolled in Family coverage will be charged the full cost, including the appropriate employee contribution and the employer cost. The employee pays the appropriate Single coverage contribution, and the remaining cost should be shared between the two parishes, schools or agencies.

How the PPO Plan Works

To help bring you the best coverage at the most affordable cost, BCBSIL negotiates with doctors, hospitals and other providers who agree to become "preferred providers" in the BCBSIL network and charge lower rates. This helps control costs for both you and the Archdiocese, as we share in the cost of your medical benefits.

Under the PPO medical plan, you can visit any licensed provider of your choice. When you choose a provider that is part of the BCBSIL network, you'll receive higher, in-network benefits for most services. However, if you go to an out-of-network provider, your benefits will be paid at a lower level and it's likely that:

- The cost of the service will be higher, and
- You'll be responsible for paying the full cost of service up front and filing a claim form for reimbursement.

To determine if your current doctor participates in the BCBSIL network, or to find a new network doctor or hospital, visit **www.bcbsil.com**.

How the HMO Plans Work

Under the HMO medical plans, you have in-network benefits only. You must select a primary care physician (PCP) who will coordinate all of your medical care.

To determine if your current doctor participates in either HMO network, or to find a new network doctor or hospital, visit **www.bcbsil.com**. Keep in mind that the HMO Illinois medical plan offers a more extensive provider network than the Blue Advantage plan. Blue Advantage is a subset of HMO Illinois. Although Blue Advantage offers a smaller network of primary care physicians and hospitals, participants enjoy the same high quality health care at a considerably lower cost than HMO Illinois participants.

YOUR COST FOR COVERAGE

	Blue Cross Blue Shield Monthly Employee Contribution Amounts July 1, 2015 – June 30, 2016	
	Individual	**Family**
PPO	$93.00	$523.00
HMO Illinois	$89.00	$440.00
Blue Advantage	$50.00	$386.00

HMOI participants: Consider the Blue Advantage Plan for significant cost-saving opportunity!

While the Blue Advantage doctor network is not as extensive as the HMOI network, many doctors in the HMOI plan also participate in the Blue Advantage HMO plan. HMO Illinois participants whose primary care physicians are also in the Blue Advantage HMO plan can continue to see the same doctor with lower out-of-pocket expense by switching to the Blue Advantage plan during this year's open enrollment.

- Primary care physician office visits under Blue Advantage have a **$15 copay** compared to **$25** under HMO IL.
- Specialist office visits under Blue Advantage have a **$25 copay** compared to **$35** under HMO IL.
- Employee payroll deductions for single and dependent coverage are considerably lower under Blue Advantage than for HMO IL.

Check with your physician's business office or log on to **www.bcbsil.com** to see if your current doctor is in the Blue Advantage HMO plan.

MEDICAL PLAN COMPARISON *(July 1, 2015 – June 30, 2016)*

	PPO Plan		HMO Illinois Plan	Blue Advantage HMO Plan
	In-network	**Out-of-network**	**In-network only**	**In-network only**
Annual deductible — maximum of two deductibles a family each plan year	$500		$0	$0
Annual out-of-pocket maximum — maximum amount you'll pay each plan year out of your own pocket****				
Single	$2,500	$4,000	Not applicable	Not applicable
Family	$4,500	$7,500		
Coinsurance — what the plan pays	85% after deductible	75% after deductible	100% (no deductible)	100% (no deductible)
Adult and children immunizations and inoculations, well child and well adult care	100% not subject to deductible	75% after deductible	$0 copay	$0 copay
Routine physical	100% not subject to deductible	75% after deductible to $500 calendar year maximum	$0	$0
Smoking cessation	Counseling services covered at 100%	75% after deductible	Counseling services covered at 100%	Counseling services covered at 100%
Regular office visit*	85% after deductible	75% after deductible	$25 copay	$15 copay
Specialist office visit*	85% after deductible	75% after deductible	$35 copay	$25 copay
Accident expenses/emergency room services**	100% (no deductible)		$100 copay (waived if admitted)	$100 copay (waived if admitted)
Hospital stay — inpatient and outpatient	85% after deductible †	75% after deductible	100% after $100 copay (no deductible)	100% after $100 copay (no deductible)
Second surgical opinion	100% (no deductible)	75% (no deductible)	100%	100%
Organ transplant***	85% after deductible	75% after deductible	100%	100%
Inpatient mental health and substance abuse services	85% after deductible	75% after deductible	100% (no deductible)	100% (no deductible)
Outpatient mental health and substance abuse services	85% after deductible	75% after deductible	$35 copay	$25 copay

* *Excludes prescription drug copays, mental health/substance abuse copays and the deductible.*

** *If you're enrolled in the PPO Plan and use emergency room services for non-emergencies, you'll be charged $100 each visit. True emergencies must be reported within 72 hours for 100% coverage under the PPO Plan.*

*** *Covers cornea, kidney, bone marrow, heart valve, musculoskeletal or parathyroid human organ/tissues. Heart, heart/lung, liver, pancreas and pancreas/kidney will be covered when performed in an approved facility with medical director approval.*

† *Hospital inpatient admissions must be reported within 72 hours. Failure to do so results in reduction of coverage to 50% under the PPO Plan.*

**** *Deductible is now part of the out of pocket maximum.*

ARCHDIOCESE OF CHICAGO
NOTICE OF PRIVACY PRACTICES

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

Certain employer-sponsored health plans are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (**"**HIPAA**"**) to maintain the privacy of your health information that the plan creates, requests, or is created on the Plan's behalf, called Protected Health Information (**"**PHI**"**) and to provide you, as a participant, covered dependent, or qualified beneficiary, with notice of the plan's legal duties and privacy practices concerning Protected Health Information.

The terms of this Notice of Privacy Practices (**"**Notice**"**) apply to the **following plans (collective and individually reference in this Notice as the "Plan"):**

Archdiocese of Chicago PPO Health benefit Plan

Archdiocese of Chicago HMO Illinois Benefit Plan

Archdiocese of Chicago Blue Advantage HMO Benefit Plan

Archdiocese of Chicago Wellness Program

Archdiocese of Chicago Health Care Flexible Spending Account Plan

This Notice describes how the Plan may use and disclose your PHI to carry out payment and health care operations, and for other purposes that are permitted or required by law.

The Plan is required to abide by the terms of this Notice so long as the Plan remains in effect. The Plan reserves the right to change the terms of this Notice as necessary and to make the new Notice effective for all PHI maintained by the Plan. Copies of revised Notices in which there has been a material change will be mailed to all participants then covered by the Plan. Copies of our current Notice may be obtained by calling the Privacy Office at the telephone number or address below.

DEFINITIONS

Plan Sponsor means The Archdiocese of Chicago and any other employer that maintains the Plan for the benefit of its associates.

Protected Health Information ("PHI") means individually identifiable health information, which is defined under the law as information that is a subset of health information, including demographic information, that is created or received by the Plan and that relates to your past, present, or future physical or mental health or condition; the health care services you receive; or the past, present, or future payment for the health care services you receive; and that identifies you, or for which there is a reasonable basis to believe the information can be used to identify you.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that the Plan may use and disclose your PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below or otherwise permitted by law, the Plan will not use or disclose your PHI unless you have signed a form authorizing the Plan to use or disclose specific PHI for an explicit purpose to a specific person or group of persons. [*Include if the plan will record or maintain psychotherapy notes:* Most uses and disclosures of psychotherapy notes will be made only with your authorization.] Uses and disclosures of your PHI for marketing purposes and/or the sale of your PHI require your authorization. You have the right to revoke any authorization in writing except to the extent that the Plan has taken action in reliance upon the authorization.

Uses and Disclosures for Payment –The Plan may use and disclose your PHI as necessary for benefit payment purposes without obtaining an authorization from you. The persons to whom the Plan may disclose your PHI for payment purposes include your health care providers that are billing for or requesting a prior authorization for their services and treatments of you, other health plans providing benefits to you, and your approved family member or guardian who is responsible for amounts, such as deductibles and co-insurance, not covered by the Plan.

For example, the Plan may use or disclose your PHI, including information about any medical procedures and treatments you have received, are receiving, or will receive, to your doctor, your spouse's or other health plan under which you are covered, and your spouse or other family members, unless you object, in order to process your benefits under the Plan. Examples of other payment activities include determinations of your eligibility or coverage under the Plan, annual premium calculations based on health status and demographic characteristics of persons covered under the Plan, billing, claims management, reinsurance claims, review of health care services with respect to medical necessity, utilization review activities, and disclosures to consumer reporting agencies.

Uses and Disclosures for Health Care Operations – The Plan may use and disclose your PHI as necessary for health care operations without obtaining an authorization from you. Health care operations are those functions of the Plan it needs to operate on a day-to-day basis and those activities that help it to evaluate its performance. Examples of health care operations include underwriting, premium rating or other activities relating to the creation, amendment or termination of the Plan, and obtaining reinsurance coverage. Other functions considered to be health care operations include business planning and development; conducting or arranging for quality assessment and improvement activities, medical review, and legal services and auditing functions; and performing business management and general administrative duties of the Plan, including the provision of customer services to you and your covered dependents.

[Family and Friends Involved in Your Care – If you are available and do not object, the Plan may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and the Plan determines that a limited disclosure is in your best interest, the Plan may share limited PHI with such individuals. For example, the Plan may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish us to share PHI with your spouse or others, you may exercise your right to request a restriction on our disclosures of your PHI (see below), including having correspondence the Plan sends to you mailed to an alternative address. The Plan is also required to abide by certain state laws that are more stringent than the HIPAA Privacy Standards, for example, some states give a minor child the right to consent to his or her own treatment and, under HIPAA, to direct who may know about the care he or she receives. There may be an instance when your minor child would request for you not to be informed of his or her treatment and the Plan would be required to honor that request.

Business Associates – Certain aspects and components of the Plan's services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our third party administrator, reinsurance carrier, agents, attorneys, accountants, banks, and consultants. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations. However, if the Plan does provide your PHI to any or all of these outside persons or organizations, they will be required, through contract or by law, to follow the same policies and procedures with your PHI as detailed in this Notice.

Plan Sponsor -- The Plan may disclose a subset of your PHI, called summary health information, to the Plan Sponsor in certain situations. Summary health information summarizes claims history, claims expenses, and types of claims experienced by individuals under the Plan, but all information that could effectively identify whose claims history has been summarized has been removed. Summary health information may be given to the Plan Sponsor

when requested for the purposes of obtaining premium bids, for providing coverage under the Plan, or for modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor whether you are enrolled in or have disenrolled from the Plan.

Other Products and Services – The Plan may contact you to provide information about other health-related products and services that may be of interest to you without obtaining your authorization. For example, the Plan may use and disclose your PHI for the purpose of communicating to you about health benefit products or services that could enhance or substitute for existing coverage under the Plan, such as long term health benefits or flexible spending accounts. The Plan may also contact you about health-related products and services, like disease management programs that may add value to you, as a covered person under the Plan. However, the Plan must obtain your authorization before the Plan sends you information regarding non-health related products or services, such as information concerning movie passes, life insurance products, or other discounts or services offered to the general public at large.

Other Uses and Disclosures – Unless otherwise prohibited by law, the Plan may make certain other uses and disclosures of your PHI without your authorization, including the following:

- The Plan may use or disclose your PHI to the extent that the use or disclosure is required by law.
- The Plan may disclose your PHI to the proper authorities if the Plan suspects child abuse or neglect; the Plan may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- The Plan may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- The Plan may disclose your PHI in response to a court order specifically authorizing the disclosure, or in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request), provided written and documented efforts by the requesting party have been made to (1) notify you of the disclosure and the purpose of the litigation, or (2) obtain a qualified protective order prohibiting the use or disclosure of your PHI for any other purpose than the litigation or proceeding for which it was requested.
- The Plan may disclose your PHI to the proper authorities for law enforcement purposes, including the disclosure of certain identifying information requested by police officers for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; the disclosure of your PHI if you are suspected to be a victim of a crime and you are incapacitated; or if you are suspected of committing a crime on the Plan (e.g., fraud).
- The Plan may use or disclose PHI to avert a serious threat to health or safety.
- The Plan may use or disclose your PHI if you are a member of the military, as required by armed forces services, and the Plan may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- The Plan may disclose your PHI to state or federal workers' compensation agencies for your workers' compensation benefit determination.
- The Plan may, as required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of the HIPAA Privacy Rules.

Verification Requirements -- Before the Plan discloses your PHI to anyone requesting it, the Plan is required to verify the identity of the requester and the requester's authority to access your PHI. The Plan may rely on reasonable evidence of authority such as a badge, official credentials, written statements on appropriate government letterhead, written or oral statements of legal authority, warrants, subpoenas, or court orders.

RIGHTS THAT YOU HAVE

To request to inspect, copy, amend, or get an accounting of PHI pertaining to your PHI in the Plan, you may contact the Privacy Officer at the Archdiocese of Chicago, 385 N. Rush Street, Chicago, Illinois 60611, 312-534-5386.

Right to Inspect and Copy Your PHI – You have the right to request a copy of and/or inspect your PHI that the Plan maintains, unless the PHI was compiled in reasonable anticipation of litigation or contains psychotherapy notes. In certain limited circumstances, the Plan may deny your request to copy and/ or inspect your PHI. In most of those limited circumstances, a licensed health care provider must determine that the release of the PHI to you or a person authorized by you, as your **"**personal representative,**"** may cause you or someone else identified in the PHI harm. If your request is denied, you may have the right to have the denial reviewed by a designated licensed health care professional that did not participate in the original decision. Requests for access to your PHI must be in writing and signed by you or your personal representative. You may ask for a *Participant PHI Inspection Form* from the Plan through the Privacy Office at the address below. If you request that the Plan copy or mail your PHI to you, the Plan may charge you a fee for the cost of copying your PHI and the postage for mailing your PHI to you. If you ask the Plan to prepare a summary of the PHI, and the Plan agrees to provide that explanation, the Plan may also charge you for the cost associated with the preparation of the summary.

Right to Request Amendments to Your PHI – You have the right to request that PHI the Plan maintains about you be amended or corrected. The Plan is not obligated to make requested amendments to PHI that is not created by the Plan, not maintained by the Plan, not available for inspection, or that is accurate and complete. The Plan will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your personal representative, must state the reasons for the amendment request, and must sent to the Privacy Office at the address below. If the Plan denies your amendment request, the Plan will provide you with its basis for the denial, advise you of your right to prepare a statement of disagreement which it will place with your PHI, and describe how you may file a complaint with the Plan or the Secretary of the US Department of Health and Human Services. The Plan may limit the length of your statement of disagreement and submit its own rebuttal to accompany your statement of disagreement. If the Plan accepts your amendment request, it must make a reasonable effort to provide the amendment to persons you identify as needing the amendment or persons it believes would rely on your unamended PHI to your detriment.

Right to Request an Accounting for Disclosures of Your PHI – You have the right to request an accounting of disclosures of your PHI that the Plan makes. Your request for an accounting of disclosures must state a time period that may not be longer than six years and may not include dates before April 14, 2004. Not all disclosures of your PHI must be included in the accounting of the disclosures. Examples of disclosures that the Plan is required to account for include those pursuant to valid legal process, or for law enforcement purposes. Examples of disclosures that are not subject to an accounting include those made to carry out the Plan's payment or health care operations, or those made with your authorization. To be considered, your accounting requests must be in writing and signed by you or your personal representative, and sent to the Privacy Office at the address below. The first accounting in any 12-month period is free; however, the Plan may charge you a fee for each subsequent accounting you request within the same 12-month period.

Right to Place Restrictions on the Use and Disclosure of Your PHI – You have the right to request restrictions on certain of the Plan's uses and disclosures of your PHI for payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that the Plan not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. The Plan is not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. The Plan retains the right to terminate an agreed-to restriction if it believes such termination is appropriate. In the event of a termination by the Plan, it will notify you of the termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting the Plan through the Privacy Office at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be

left on voice mail or sent to a particular address. The Plan is required to accommodate reasonable requests if you inform the Plan that disclosure of all or part of your information could place you in danger. The Plan may grant other requests for confidential communications in its sole discretion. Requests for confidential communications must be in writing, signed by you or your personal representative, and sent to the Privacy Office at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting the Privacy Office at the telephone number or address below.

Right to Notice of Breach - You have the right to receive notice if your PHI is improperly used or disclosed as a result of a breach of unsecured PHI.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with the Plan through the Privacy Office in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact our Privacy Office by writing to:

Privacy Office/Human Resources Department
835 N. Rush Street
Chicago, Illinois 60611

This Notice is effective November 1, 2013.

Prescription Drug Benefits

When you enroll in one of the Archdiocese of Chicago medical plans, your coverage automatically includes a prescription drug benefit. Express Scripts is the administrator for the prescription drug plan for all of the medical plans.

Express Scripts offers both a retail and mail order pharmacy program, where you pay a copay for each prescription you fill.

- **Retail:** You can fill up to a 30-day supply of your prescription at a network pharmacy.
- **Mail order:** You can fill up to a 90-day supply of your prescription through the mail order pharmacy program.

Getting the Most out of Your Rx Benefits at the Lowest Possible Cost…

1. Always tell your doctor what your prescription drug coverage is, and ask him or her to prescribe a generic equivalent whenever possible.
2. Always ask your pharmacist if there is a generic equivalent to any brand-name medication your doctor has prescribed, or if there is a brand-name formulary or generic equivalent to any non-formulary medication your doctor has prescribed. Your pharmacist will generally call your doctor to get his or her approval to fill your prescription with a lower cost drug.
3. Use local, retail pharmacies ONLY to fill prescriptions you need to take on a temporary basis.
4. ALWAYS use the mail order program to fill prescriptions for maintenance medications or other drugs you may need to take for an extended period.
5. Use of the mail order drug program could save you 27% versus retail, or more than one full 90-day prescription for FREE!

Be sure to visit **www.express-scripts.com** to find mail order forms and the list of generic, formulary brand-name and non-formulary brand-name prescription drugs. You can also set up a Express Scripts account to review your prescription history, learn more about your medications, and request refills on your mail order prescriptions.

Express Scripts Specialty Pharmacy

If you use specialty medications, Express Scripts also offers a Special Care Pharmacy for certain conditions like anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency and rheumatoid arthritis. You can receive:

- Up to a 90-day supply from mail order
- Access to nurses who are trained in specialty prescription drugs
- 24/7 availability from a specialty pharmacist resource for any questions you might have
- Coordination of home care and other health care services

Contact Express Scripts at **800.899.2675** if you have any questions.

Using the Prescription Drug Program

Under our prescription drug program, there are three categories of drugs. How much you pay depends on the drug type.

Generic — These drugs are labeled with the medication's basic chemical name and usually have brand-name equivalents. They have the same active ingredients and must meet the same FDA standards for quality, strength, purity and stability as their brand-name counterparts.

Preferred Brand-Name — These drugs have been selected by Express Scripts for the formulary list based on safety and efficacy. They may or may not have a generic equivalent. They cost more than generics, but less than non-formulary brand-name drugs.

Non-Preferred Brand-Name — These drugs generally have either an equally effective generic equivalent and/or one (or more) formulary brand-name option. They usually are the most expensive option.

PRESCRIPTION DRUG COPAYS *(July 1, 2015 – June 30, 2016)*

Effective July 1, 2015, employee co-pays for all health plan options will be limited to a plan year out-of-pocket maximum of $1,000 for single coverage and $2,000 for family coverage. Once this maximum is satisfied, the plan pays 100% with no employee cost share.

	All Medical Plans	
	Retail (up to a 30-day supply)	**Mail Order (up to a 90-day supply)**
Generic	$6	$13
Brand-Name*	$29	$63
Non-Formulary Brand-Name *	$45	$98

** If a formulary or non-formulary brand-name prescription drug is chosen when a generic alternative is available, you'll pay the brand-name copay plus 50% of the cost difference between the brand-name and the generic prescription drug.*

Did You Know?

Your local retailers, such as Walmart, Target, Costco and other national chains, now carry certain generic prescription drugs for as low as $4 a month and as low as $10 for a 90-day supply! These rates are separate and apart from the Express Scripts benefit plan.

Visit today to find the kinds of generic medications you need most to help improve:

- Allergies
- Asthma
- Cholesterol
- Diabetes
- Gastrointestinal health
- Heart health and blood pressure
- Mental health
- Thyroid conditions

Consider your local retailer for generic prescription drugs. It's another money-saving alternative worth pursuing for you and your family.

Your Vision Care Benefits

Affordable vision benefits are automatically offered to you and your eligible dependents when you enroll in any of the medical plans.

- If you enroll in the medical PPO Plan, you'll receive vision care through the Vision Service Plan (VSP). To find a VSP doctor, go to **www.vsp.com** or call **800.877.7195**.
- If you enroll in the medical HMO Illinois Plan or the Blue Advantage HMO Plan, you'll receive discounts through Davis Vision. To find a Davis Vision doctor or for more information about the laser vision correction discount through the TLC/TruVision network, go to **www.bcbsil.com** or call **877.393.8844**. **Be sure to tell your Davis Vision provider that you have coverage with Blue Cross to get the best prices on eyeglass frames.**

VISION PLAN COMPARISON

	PPO Members – VSP		HMO Members – Davis Vision
	In-network	**Out-of-network**	**In-network**
Annual exams — every 12 months	$10 copay	$45 maximum allowance	$0 copay
Lenses — every 12 months			Davis Vision offers an allowance, plus discounts off retail cost, toward the purchase of eyeglasses (frames and standard spectacle lenses) and/or contact lenses, once every 12 or 24 months.
Basic	$10 copay	$10 copay	
Single	$10 copay	$30 maximum allowance	
Bifocal	$10 copay	$50 maximum allowance	
Trifocal	$10 copay	$65 maximum allowance	
Frames — every 24 months	$170 allowance	$70 allowance	
Contact lenses — in lieu of glasses	$170 allowance	$105 allowance	

Your Dental Plan Benefits

You have two dental plans from which to choose. Guardian Dental administers both dental plans — a Dental PPO and Dental HMO plan.

Dental PPO Plan

The Dental PPO Plan provides comprehensive coverage for a variety of dental care needs and gives you the freedom to choose any licensed dentist. However, if you select a dentist who is in the PPO network, your costs will likely be less because in-network dentists charge a lower fee for their services. If you visit a dentist out-of-network, you'll pay more and you will be responsible for any charges that are over the maximum plan allowance.

The deductibles and coinsurance percentages are the same whether you use in-network or out-of-network dentists. For a listing of all network dentists in your area, please go to **www.GuardianAnytime.com** or call **866.302.4542**.

Dental HMO

Under the Dental HMO Plan, you have in-network benefits only (orthodontia benefits are also provided per the schedule of benefits). To determine if your current dentist participates in the network, or to find a new, in-network dentist, visit **www.GuardianAnytime.com** or call **866.494.4542**. The schedule of benefits is available from your local administrator and is also posted on the HR website.

College Tuition Benefit Rewards Program

Starting with the 2015 Plan Year, a College Tuition Benefit Rewards Program is offered through Guardian Dental. All benefits eligible employees who are enrolled in the dental insurance plan (PPO or DHMO) are eligible for this benefit program. This program can be used for eligible children, grandchildren, nieces, and nephews of a benefits eligible employee enrolled in the Guardian Dental Plan. To learn more about the program and how to get started, go to: **www.Guardian.CollegeTuitionBenefit.com** to set up your account. If you have any questions, visit the website or contact College Tuition Benefit directly at **215.839.0119.**

DENTAL PLAN COMPARISON

	Dental PPO Plan		Dental HMO Plan
	In-network	**Out-of-network**	**In-network only**
Annual deductible	$50/person each plan year (3 person maximum)	$100/person each plan year (3 person maximum)	$0
Maximum benefit (excluding deductible)	$1,500/person*		Unlimited
Diagnostic and preventive care	100% (no deductible)	100% (no deductible)	$5 copay for each office visit
Basic services (fillings, root canals, extractions, etc.)	80% after deductible	80% after deductible	See Schedule of Benefits for coverage details
Major services (crowns, dentures, bridgework, etc.)	50% after deductible	50% after deductible	
Orthodontia	Not covered	Not covered	See Schedule of Benefits for coverage details

* *You pay 100% of any cost over maximum benefit of $1,500. If total claims paid for any year are less than $700, you may carry over a portion of your unused benefit into subsequent years ($350, or $500 if in-network providers are used exclusively). You can accumulate up to $1,250 in carry-over bank for each covered person.*

YOUR COST FOR COVERAGE *(July 1, 2015 – June 30, 2016)*

	Guardian Monthly Dental Employee Contribution Amounts	
	Individual	**Family**
PPO	$38.50	$110.00
HMO	$13.50	$32.00

Flexible Spending Accounts

The Archdiocese of Chicago encourages you to enroll in the flexible spending accounts (FSAs) to save on your health care and dependent care expenses. The money you deposit into an FSA is deducted from your paycheck, without paying federal, state or Social Security taxes. This lowers your taxable income and saves you money!

The FSA Plan is administered by Benefits Allocation Systems (BAS). They are designed to reimburse you for eligible health care and dependent care expenses. You can set aside up to $2,500 a year for a Health Care FSA and up to $5,000 ($2,500 if married and filing separate tax returns) for a Dependent Care FSA. You can enroll in this plan at the time of hire or during annual open enrollment.

July 2015 FSA Open Enrollment and Plan Year

Please note that the FSA open enrollment and plan year will now be the same as the rest of your benefit plans effective July 1, 2015.

FSA open enrollment is **May 18 – June 2, 2015**. You must actively enroll and elect the amount of pre-tax money you would like to save for your health care and dependent care expenses.

Eligible expenses under the Health Care FSA include:

- Deductibles and copays for health care, prescription drugs, dental and vision care expenses
- Medical equipment
- Hearing tests and aids
- Speech and physical therapy
- Lasik corrective eye surgery
- Orthodontia

Eligible expenses under the Dependent Care FSA include:

- Baby-sitting or day care expenses for a dependent child under the age of 13 so that you (and your spouse) can work or attend school full-time
- Expenses for the care of a spouse, parent or other dependent who spends at least eight hours a day in your home, is incapable of self-care and qualifies as a dependent on your income taxes

Note: Over-the-counter medicines such as cough syrup, aspirin and allergy medications, are no longer eligible expenses. Effective January 1, 2011, your purchase of these products is no longer reimbursable from FSA plans as a result of changes under the Affordable Care Act. The plan does not cover expenses for treatment and procedures that are contradictory to the beliefs of the Catholic Church.

Remember, you are unable to transfer money from one FSA account to another and you must enroll each year to participate. Your elections do not roll over from one year to the next.

FSA Carryover provision

Unused funds in the Health Care FSA at the end of the plan year (6/30/15) will be carried over to the next plan year, up to a maximum of $500, given you enroll in the Health Care FSA for the succeeding plan year. This will not effect the maximum amount you can contribute in the next plan year.

Flexible Spending Accounts

To Enroll:

- Logon to **www.MyEnroll.com** and follow links to enroll in the FSA Plan.
- For information about logging into the MyEnroll system, see the first section of this booklet.

MyEnroll FSA Screen Shot

The FSA enrollment screen will also display a button that will enable you to enroll in the Dependent Care FSA.

Important Dates to Keep in Mind	
May 18, 2015 – June 2, 2015	Open enrollment for 2015/2016 FSA
June 30, 2015	Last day to incur eligible expenses for 2014/2015 FSA Plan year
July 1, 2015	New FSA Plan year begins – Paycheck deductions begin

After You Enroll

After you enroll in the Health Care FSA, you automatically receive the FSA Card loaded with the full dollar amount of your annual FSA election. The Benefits Card works like a bank debit card except that it is linked to your Health Care FSA. You can use the card to pay most health care providers directly at the time of purchase. **Be sure to save all of your FSA receipts. You may be required to document the eligibility of an expense at a later date.**

When you incur an eligible expense, simply swipe your card at the point of sale. The amount of your purchase is deducted directly from your Health Care FSA balance and paid to the provider.

You can use your Benefits Card at most medical providers that display the MasterCard® logo. The Benefits Card will only be accepted at qualified merchant types related directly to health care and will not be accepted at other locations like gas stations or convenience stores. You can use your Benefits Card at pharmacies that have an Information Inventory Approval System (IIAS) in place. This enables FSA-eligible products to be separated from non-FSA-eligible products so that only eligible products are allowed to be purchased with your card. **Be sure to save all of your FSA receipts. You may be required to document the eligibility of an expense at a later date.**

Life Insurance

Life insurance coverage is an important part of your comprehensive benefits package. It provides financial protection for your family in the event of your death. The insurance carrier is Dearborn National.

The following table summarizes your life insurance benefits.

Benefit	Your Benefit
Basic life coverage	• Paid by the Archdiocese • Automatically provided on the first of the month following completion of 30 days of employment • One times your annualized salary rounded to the next $1000 • You will need to name your beneficiary on the MyEnroll system
Supplemental life coverage	• Your cost, paid on an after-tax basis, is based on your age and coverage amount • Elect 1, 2, 3 or 4 times your salary • Evidence of Insurability (EOI) guidelines: - The overall maximum life insurance coverage (basic and supplemental combined) is $1,000,000. - If you are electing 1 times or increasing from 1 to 2 times your salary coverage, EOI is not required as long as the total coverage (basic and supplemental combined) is not above $500,000. - If you are electing an amount over the Guaranteed Issue Limit, an EOI is required. The EOI form will be mailed directly to the employee by the insurance carrier.

What Is Evidence of Insurability?

Evidence of Insurability (EOI) is a statement that provides information about a person's health status. Whenever you increase your Supplemental Life Insurance by more than the Guaranteed Issue Limit, EOI is required by Dearborn National. See the summary plan description for more details. If EOI is required, you'll need to complete and return the proper documentation to Dearborn National. The amounts that exceeded the Guaranteed Issue Limit will take effect once an evidence of insurability is approved.

Name Your Beneficiary

Please be certain that you have named a beneficiary on the MyEnroll system. You may name more than one beneficiary and you may also assign different percentages of your benefit provided they don't exceed 100%. Remember: The Archdiocese automatically provides Basic Life Insurance of one times your annualized salary at no cost to you. If you do not know whether you have named a beneficiary or if you wish to revise your current beneficiary designations, you may do so on **MyEnroll.com**.

Disability Insurance

When an illness or non-work-related injury prevents you from working for a period of time, disability coverage provides an income replacement benefit. The Archdiocese of Chicago provides long-term disability coverage at no cost to you. If you enroll in the voluntary Short-Term Disability plan, you pay the cost of the premium based on your age and the weekly benefit amount you select. The insurance carrier is Dearborn National.

The following table summarizes your disability benefits:

	Short-Term Disability (STD)	Long-Term Disability (LTD)
Elimination period	30-day elimination (waiting) period before you can receive payments	180-day elimination (waiting) period before you can receive payments
Who pays the premium cost	You pay the cost of coverage if elected	The Archdiocese of Chicago
Benefit amount	• Weekly benefit for up to 22 weeks of disability • You select a weekly benefit amount in increments of $25 (minimum $100; maximum $1,250), up to 60% of covered earnings	Monthly benefit equal to 66 ⅔% of your monthly salary
Additional eligibility requirement	Minimum salary of $15,000 annually	None

NOTE: The plan includes a pre-existing condition exclusion. A pre-existing condition means any sickness or injury for which you were diagnosed or treated by a legally qualified physician with consultation, advice or treatment occurring during the three (3) months immediately prior to your effective date of insurance. Benefits will not be paid for a disability caused by or resulting from a pre-existing condition unless you have been actively at work for one (1) full day following the end of twelve (12) consecutive months from the date you became insured.

Retirement Benefits

IMPORTANT NOTE FOR EMPLOYEES PLANNING TO RETIRE BEFORE THEY ARE ELIGIBLE FOR MEDICARE COVERAGE:

Terminating/retiring employees are eligible to extend their HMO Illinois, Blue Advantage HMO or Blue Cross & Blue Shield PPO health coverage, for themselves and their covered dependents, for up to 18 months, or until they become eligible for some other group health plan, including Medicare. For those participating in the PPO Plan, no health benefits are available beyond that 18 month period. However, those participating in the HMO Illinois or Blue Advantage HMO plans can transfer to a direct pay relationship with the HMO provider for an indefinite period, so long as they apply for conversion within 31 days of the date their HMO coverage is terminated. Therefore, if you plan to retire in the coming plan year and will need to extend your health coverage for more than 18 months, you may want to switch to one of the HMO plans at the annual Open Enrollment periods that occurs prior to the expiration of your extended health coverage. You will be allowed to switch to a different health plan at Open Enrollment even while on extended coverage.

Defined Benefit Pension Plan

For employees hired on or before June 30, 2007, the defined benefit pension plan has been frozen at the level of benefits accrued through June 30, 2007. Employees who were participants in the defined benefit pension plan who were not vested as of June 30, 2007 will continue to accrue vesting service if they remain employed in a benefit eligible position. Employees must have completed 5 full years of continuous service in a benefit eligible position to have a vested benefit. For more information regarding the defined benefit pension plan, please call **312.534.5314**.

Employees hired into a benefit eligible position on or after July 1, 2007 are not eligible for the defined benefit pension plan.

Share Plan

Effective July 1, 2007, the Archdiocese of Chicago implemented the Share Plan contribution to replace the defined benefit pension plan for all full-time and benefits-eligible part-time employees. Under the Share Plan, the Archdiocese will make a quarterly contribution to the eligible employees' 403(b) retirement plan accounts based on total gross earnings. For eligible employees hired on or before June 30, 2007, the quarterly contribution will be an age-weighted percentage of the employee's gross earnings, and that percentage will increase as employees advance in age, based on age as of January 1st each year, in accordance with the following table:

Age	Contribution %	Age	Contribution %	Age	Contribution %
21-36	1.25	**46**	2.68	**56**	5.78
37	1.338	**47**	2.89	**57**	6.24
38	1.445	**48**	3.12	**58**	6.74
39	1.56	**49**	3.37	**59**	7.27
40	1.69	**50**	3.64	**60**	7.86
41	1.82	**51**	3.93	**61**	8.48
42	1.97	**52**	4.25	**62**	9.16
43	2.12	**53**	4.59	**63**	9.90
44	2.29	**54**	4.95	**64**	10.69
45	2.48	**55**	5.35	**65 and over**	11.546

Share Plan contributions for employees who became eligible or were hired on or after July 1, 2007 will be based on a flat percentage of gross earnings, regardless of age. The flat contribution may range from 1.25% to 5.0% as determined annually by the Archdiocese. The Share Plan will have a 5-year cliff vesting schedule; eligible employees will be fully vested after 5 consecutive years of benefits-eligible service, but will have no vesting for less than 5 consecutive years of benefits-eligible service.

Share Plan contributions will be invested in the appropriate Target Retirement Date option based on the employee's age and projected retirement date, as follows:

Birth Date Year Range	Vanguard Target Retirement Option
Before 1942	Vanguard Target Retirement Income Fund
1943 to 1947	Vanguard Target Retirement 2010 Fund
1948 to 1952	Vanguard Target Retirement 2015 Fund
1953 to 1957	Vanguard Target Retirement 2020 Fund
1958 to 1962	Vanguard Target Retirement 2025 Fund
1963 to 1967	Vanguard Target Retirement 2030 Fund
1968 to 1972	Vanguard Target Retirement 2035 Fund
1973 to 1977	Vanguard Target Retirement 2040 Fund
1978 to 1982	Vanguard Target Retirement 2045 Fund
1983 to 1988	Vanguard Target Retirement 2050 Fund
1989 to 1993	Vanguard Target Retirement 2055 Fund
1994 to 1998	Vanguard Target Retirement 2060 Fund

403(b) Defined Contribution Retirement Plan

All lay employees may contribute to the 403(b) plan, administered by MassMutual, through payroll deferrals. For full-time and benefits-eligible part-time employees, the Archdiocese will match employee contributions at $0.50 per $1.00 for the first 4% of annual gross earnings contributed. Employees may contribute any percentage of their gross earnings up to statutory limits, but only the first 4% of earnings are eligible for matching contributions. Employee contributions are pre-tax for state and federal taxes, but post-tax for FICA and Medicare taxes. Non-benefits eligible employees may participate in the pre-tax retirement savings opportunity provided by the 403(b) plan, but are not eligible for employer matching contributions.

403(b) Automatic Enrollment

The 403(b) plan includes an Auto Enrollment feature to help employees increase their savings and maximize the employer match. All newly hired benefits eligible employees are automatically enrolled at 3% in the 403(b) plan. Employees may choose to opt out of the 403(b) plan, or may choose to participate at a contribution level other than 3%, by contacting MassMutual directly. Employees who are auto enrolled in the plan have 90 days to opt out of the plan with a refund of their contributions. After 90 days, you may elect to stop contributing to the plan, but contributions already made will stay in your account.

You are always fully vested in your employee contributions and any earnings on those contributions. However, vesting in the employer matching contributions will be at the rate of 25% per year of benefits-eligible service, so that you will be fully vested after 4 years. Those wishing to change their deferral election may do so by contacting MassMutual via their participant website at **www.retiresmart.com** or by calling their toll-free line at **800.743.5274.**

403(b) Automatic Deferral Increase

In 2009, the Archdiocese implemented the Auto Deferral Increase feature. Under this feature every January 1st, benefits-eligible employees participating in the 403(b) plan at a level below 4% will have their deferral increased by 1%.

Employees who have set their deferral election at 0% or at any level above 4% will not be affected by the Auto Deferral Increase.

Any employee who has not opted out and is not currently participating at or above 4% will have their deduction increased by 1%. For example:

- 1% will increase to 2%
- 2% will increase to 3%
- 3% will increase to 4%

Any employee who DOES NOT want to have their deferral percentage automatically increased AND has not previously opted out of auto enrollment MUST contact MassMutual and elect otherwise. Elections can be made via the participant website, RetireSmart, at **www.retiresmart.com** or by calling the toll-free line at **800.743.5274**.

Remember to make sure your beneficiary designation is on file with MassMutual. Contact MassMutual to confirm, or log in to the RetireSmart website.

Paid Time Off

Vacation Benefits

Vacation benefits for school employees are incorporated into the school calendar. This includes time off with pay during the Christmas season and time off with pay during either the Easter Season or Spring Break. School employees include teachers, teacher aides, librarians and other employees who work the academic year. All non-school, non-exempt employees of the Archdiocese are entitled to 2 weeks paid vacation after one year of eligible service, 3 weeks after 5 years and 4 weeks after 15 years. Exempt non-school employees are entitled to 3 weeks paid vacation after one year of eligible service and 4 weeks after 5 years. Vacation benefits must be used in the year for which they are allocated. However, with supervisory approval, vacation benefits remaining unused at the end of the benefit year (either 12/31 or 6/30, depending on local custom) may be carried over to the next benefit year. In such case, the employee must use the vacation carry-over within the first three months of the new plan year or those vacation days will be forfeited.

Paid Holidays

The number and selection of paid holidays to be celebrated is determined locally, but must be consistent for all similarly situated employees at the same location. For example, the holiday schedule may be different for school and non-school employees at the same location, but all school employees should have the same holidays and all non-school employees should have the same holidays.

Sick Days & Personal Days

School employees are entitled to 10 paid sick days per year to be used for their own illness, or the illness of an immediate family member. Two of these days may also be used for personal reasons. Non-school employees are entitled to 10 paid sick days and 2 personal days each year. Unused sick days are not compensable at the end of the year, nor may they be used as additional vacation days. However, unused sick days will carry over from year to year, up to a maximum accumulation of 120 days.

Additional Benefits

Professional Growth Allowance

Lay and Religious principals, teachers, and parish ministers are eligible for the professional growth allowance as stipulated in the Compensation Guidelines published annually. The allowance, up to $1,200.00 for fiscal year 2015-16, is intended for programs selected by the employee and approved by his or her supervisor. It is not intended to pay for programs or training required by the employer. With few exceptions, non-faculty school employees and those employees not engaged in professional parish ministry are not entitled to a professional growth allowance. The professional growth allowance is not to be used for the purchase of computers, cell phones or other equipment.

Retreat

All Religious employees, lay principals and professional lay parish ministers are entitled to up to 5 days off with pay each year to participate in a structured religious retreat. The cost of the retreat is to be paid by the employee. However, the professional growth allowance may be used to pay for the cost of the retreat.

Allowance on Graves and Crypts

Catholic Cemeteries provides Archdiocesan employees a discount on graves and crypts. The discount applies to selections for employees, spouses and dependent children. Discounts do not apply to siblings, grandparents, in-laws or other extended family members. Details are available from Human Resources, **312.534.5360**.

Statutory Benefits

The Archdiocese provides Worker's Compensation Insurance for its employees to cover medical expenses and/or lost wages resulting from on-the-job injuries or illnesses. Such expenses must not be submitted to the employee health benefit carrier. Please report any accidents as soon as possible, and submit any related bills to your supervisor for submission to our Worker's Compensation administrators.

Though not required by law to do so, the Archdiocese of Chicago voluntarily participates in the Illinois Unemployment Compensation program on a reimbursing basis. This means that while benefits are paid out by the state, the parish, school or agency must reimburse the state for the total amount of any benefits paid. Teachers who have been offered a contract for the next school year and other school employees who are expected to return for the next school year are not eligible for unemployment compensation benefits over the summer break.

Medicare Information for All Health Benefit Plans

1. If you are age 65 or older and you have earned the required number of quarters for Social Security benefits within the specified time frame, you are eligible for Medicare Part A at no cost. If you have not earned the required number of quarters for Social Security, you may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. Federal legislation requires that active employees, age 65 and over, be given the option to elect either the Employer's Plan as primary or Medicare as primary. If you elect the benefits of the Employer's Plan as primary, the Employer's Plan will provide benefits equivalent to the benefits available to individuals under age 65. If you elect Medicare as your primary coverage, you must drop your coverage through our programs. Although you have the option to elect either the Employer's Plan primary or Medicare, in most cases you will have better coverage if you retain the Employer's Plan as primary and Medicare as your secondary plan. Check with the Social Security Administration office for further details.
3. Medicare Part D is optional coverage for prescription drugs. If you are an active participant and Medicare eligible, please know that the Rx plan offered through the Archdiocese is recognized as creditable coverage (better than Medicare's program). As such, as long as you remain on the Archdiocese plan, you will not be penalized should you ever leave the Archdiocese and decide to join a Medicare Part D plan, so long as you provide Medicare with your Notice of Creditable Coverage. The Archdiocese of Chicago will issue such notice to you annually and/or upon your request.
4. Federal legislation also requires that the spouse, age 65 and over, of any active participant be given the option to elect either the Employer's Plan as primary or Medicare as primary. If your spouse elects the benefits of the Employer's Plan as primary, the plan will provide benefits equivalent to the benefits available to individuals under age 65. If your spouse elects Medicare as primary, no benefits will be available under this plan.

NOTE: If you and/or your spouse elect the Archdiocese plan to be primary, you should file all claims with your medical plan first. Once you receive your payment and/or Explanation of Benefits from Blue Cross and Blue Shield, then file your claim with Medicare.

Medicare Part D Creditable Coverage Notice

As the plan sponsor of the Archdiocese of Chicago medical plan, the Archdiocese of Chicago is required to provide this notice to Medicare-eligible employees, retirees and dependents. This notice has information about your current prescription drug coverage with the Archdiocese of Chicago and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is included in the following pages.

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Archdiocese of Chicago coverage will not be affected. You may be covered by both programs. Your cost for the Archdiocese of Chicago's medical plans will not decrease if you enroll in Medicare Part D.

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

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

If you drop or lose your current coverage with the Archdiocese of Chicago and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (penalty) to join a Medicare drug plan later.

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

For More Information about Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail each year from Medicare after you reach age 65. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for the telephone number) for personalized help.
- Call **800.MEDICARE (800.633.4227)**. TTY users should call **877.486.2048**.

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

Questions About This Notice

Contact the Archdiocese of Chicago's HR at **hr@archchicago.com** or **312.534.5360** for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Note: You will receive a copy of this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Archdiocese of Chicago changes. You may also request a copy of the notice at any time.

Remember:

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

CONTACT INFORMATION

	Benefit Plan Contact	Telephone Number	Website
Medical benefits	Blue Cross Blue Shield of Illinois	888.979.4516 - PPO Plan 800.892.2803 - HMO Plans	www.bcbsil.com
Prescription drug benefit	Express Scripts	800.899.2675	www.express-scripts.com
Dental benefits	Guardian Dental	866.302.4542 - PPO Plan 866.494.4542 - HMO Plan	www.GuardianAnytime.com
College Tuition Benefit Rewards Program	Guardian Life Insurance Company	215.839.0119	www.Guardian.CollegeTuitionBenefit.com
PPO vision plan	VSP	800.877.7195	www.vsp.com
HMO vision plan	Davis Vision	800.892.2803 or 877.393.8844	www.bcbsil.com or www.davisvision.com
Life and disability insurance	Dearborn National/ Human Resources	800.945.5513 or 312.534.5314	www.myenroll.com
Flexible spending accounts	BAS MyEnroll/Human Resources	800.945.5513	www.myenroll.com
Frozen defined benefit pension plan	Human Resources	312.534.5314	http://hr.archchicago.org
403(b) defined contribution plan	MassMutual	800.743.5274	www.retiresmart.com
Paid holidays; sick, personal and retreat days; vacation benefits; and professional growth allowance	Human Resources	312.534.5360	http://hr.archchicago.org
Discounts on graves and crypts at Catholic Cemeteries	Catholic Cemeteries	708.449.6100	www.catholiccemeterieschicago.org


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