ARCHDIOCESE OF

NEW ORLEANS

BENEFITS GUIDE

2026

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more options for both medical and prescription drug coverage.Ě Please see the Notice of Creditable Coverage beginning on page 36 for more information.

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

Benefits Overview

The Archdiocese of New Orleans is proud to offer a comprehensive benefits package to eligible full and part- time staff who work a regular schedule of at least 20 hours per week. The complete benefits package is briefly summarized in this booklet. Please visit the ANO Staff Benefits Information page for detailed information on each of these plans.

https://nolacatholic.org/open-enrollment-2025-2026

Benefit Offerings:

- Medical
- Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Dental
- Vision
- Basic Life and AD&D
- Short-Term Disability
- Long-Term Disability
- Employee Assistance
- Critical Illness, Accident, Hospital Indemnity
- Alternative Coverage Options: FedLogic and SGIA Medicare

Eligibility:

Staff Members who regularly work 20 or more hours per week are eligible to participate in the benefits program on the 1st of the month following date of hire. For many benefits, staff may also choose to enroll eligible dependents.

Eligible dependents for coverage may include:

- Your legal spouse as recognized by the Catholic Church
- Your dependent children up to age 26
- Disabled dependents of any age (with appropriate documentation)

Important Information:

The premiums by pay period may be found in the enrollment system, benefitsCONNECT, or by calling the Benefit Advocacy Center.

Our Mission

Impelled by Christ's call and inspired by the Holy Spirit through the work of the Ninth General Synod, the ministries of the Archdiocese of New Orleans, in union with the Archbishop and with one another, serve the people of the parishes, schools and organizations of the Archdiocese in enabling them to encounter Jesus and to witness with joy.

Newly Hired Benefits-Eligible Staff

For newly hired staff who are benefits-eligible, enrollment information will be given to you by your site Administrator. You will need to complete your enrollment online through benefitsCONNECT or by calling the Benefit Advocacy Center as soon as possible, but no later than 30 days from hire. A new hire's effective date will be the 1st of the month following full time date of hire. Information on how to enroll is found in this guide.

Changes During The Year

You are permitted to make changes to your benefits outside of Open Enrollment if you have a qualified change in status, as defined by the IRS. You must notify the Benefit Advocacy Center within 30 days of the event to make any changes outside of Open Enrollment. Examples include:

» Marriage

» Divorce or Separation

» Birth or placement for adoption of a child

» Death of a spouse or dependent

» Loss or gain of spouse or dependent's medical coverage, through another employer

» Change in your employment status or that of your spouse

» A Qualified Medical Child Support Order

» Entitlement to Medicare or Medicaid

» Loss of Medicaid eligibility

Benefits Contact Directory

Topic	Contact	Phone Number	Website & Network
General Benefits and/ or Enrollment	Benefit Advocacy Center Pam Power Chalana Alexander Landry	833.857.0755 504.310.8793 504.310.8792	bac.anobenefits@ajg.com ppower@arch-no.org hr@arch-no.org
Medical	UMR	800.826.9781	www.UMR.com
HSA / FSA	Voya	833.232.4673	www.myhealthaccountsolutions.voya.com
Dental	Guardian	800.541.7846	www.guardiananytime.com
Vision	Guardian (VSP network)	877.814.8970	www.guardiananytime.com or www.vsp.com
Basic Life and AD& D	Guardian	800.525.4542	www.guardiananytime.com
Short-Term Disability (STD)	Guardian	800.268.2525	www.guardiananytime.com
Long-Term Disability (LTD)	Guardian	800.538.4583	www.guardiananytime.com
Accident	Guardian	800.541.7846	www.guardiananytime.com
Critical Illness / Cancer	Guardian	800.541.7846	www.guardiananytime.com
Hospital Indemnity	Guardian	800.541.7846	www.guardiananytime.com
401(k)	Voya	877.659.6995	https://archdioceseno.voyaplans.com
Employee Assistance Program	Guardian – (ComPsych)	855.239.0743	www.guidanceresources.com
Continuation of Coverage	Amy Jones at Gallagher	334.605.1507	Amy_Jones@ajg.com

You have 2 options to enroll in Benefits:	
Option 1: Enrolling in the online system, benefitsCONNECT	**Option 2:** Calling the Archdiocese Benefits Helpline
Once you have made your final decisions about your benefits for 2026, you can log in to the online enrollment system and make your elections. **Even if you do not want to enroll in any of the benefits, you still need to log in and decline the coverages offered to you.** **Website:** https://enroll.benefitsconnect.net/archofno **Username**: the first 6 letters of your last name (or your entire last name if six letters or less), the first letter of your first name, followed by the last 4 of your SSN (social security number). **Example: John Johnson, xxx-xx-1234** **Username would be johnsoj1234** **Password**: the first time you log in, the password will be your SSN (no spaces or dashes). You will be given the opportunity to change your password after you log in the first time.	Simply call the Benefit Advocacy Center at 833.857.0755 You can call between 7 AM and 6 PM CST You may also email them at bac.anobenefits@ajg.com

Medical Insurance

Whether you have a common cold or will be undergoing surgery, medical benefits cover a range of services and can provide peace of mind to help you offset heath care costs. The Archdiocese of New Orleans offers you the following medical plan options through UMR (A United Healthcare Company). **UMR and Ochsner Health Network have partnered to bring our members a product that provides quality care at an affordable price.**

Benefit	Plan 1 (Buy Up)		Plan 2 (Core)		Plan 3 (HDHP)	
	Ochsner	In-Network	Ochsner	In-Network	Ochsner	In-Network
Annual Deductible						
Employee Only	$750	$1,250	$3,000	$4,500	$2,500	$3,000
Family	$2,250	$3,750	$9,000	$13,500	$5,000	$6,000
Individual w/in a Family	$750	$1,250	$3,000	$4,500	$5,000	$6,000
Annual Out-of-Pocket Maximum						
Employee Only	$1,500	$2,500	$6,000	$8,000	$5,000	$6,000
Family	$4,500	$7,500	$12,000	$16,000	$10,000	$12,000
Coinsurance	10%	20%	20%	30%	20%	30%
HOSPITALIZATION						
Emergency Room *Copay waived if admitted	*$350 Copay		*$350 Copay		20% after deductible	
Inpatient Stay	$400 per day to $1,200 per stay	$500 per day to $1,500 per stay	$400 per day to $1,200 per stay	$500 per day to $1,500 per stay	20% after deductible	30% after deductible
Outpatient Surgery	$400 Copay per surgery	$500 Copay per surgery	$400 Copay per surgery	$500 Copay per surgery	20% after deductible	30% after deductible
OFFICE VISITS						
Primary Care	$25 Copay	$30 Copay	$25 Copay	$30 Copay	20% after deductible	30% after deductible
Specialist	$35 Copay	$45 Copay	$35 Copay	$45 Copay	20% after deductible	30% after deductible
Urgent Care	$45 Copay	$55 Copay	$45 Copay	$55 Copay	20% after deductible	30% after deductible
Wellness	Covered 100%		Covered 100%		Covered 100%	
PRESCRIPTION DRUGS						
Deductible	$0		$150 per person		Integrated with In-network medical deductible	
Copays:						
Generic	$7		$10		20%; $0 after deductible	
Preferred Brand	$30		$60		30% after deductible	
Non-Preferred	$70		$120		30% after deductible	
Specialty	10% (max of $150)		10% after deductible (max of $350)		20% (max of $350)	

Out-of-Network benefits are available at a higher cost. Please see next page for out-of-network benefits.

Medical Insurance (continued)

Below is the Out-of-Network benefits for the three medical plans offered by the Archdiocese of New Orleans. You will see more savings staying in the Ochsner network or In-Network, but many things are still covered Out-of-Network.

Benefit	Plan 1 (Buy Up)	Plan 2 (Core)	Plan 3 (HDHP)
	Out-of-Network Benefits		
Annual Deductible Employee Only Family Individual within a Family	 $5,000 $10,000 $5,000	 $5,000 $10,000 $5,000	 $5,000 $10,000 $10,000
Annual Out-of-Pocket Maximum Employee Only Family	 $10,000 $20,000	 $10,000 $20,000	 $10,000 $20,000
HOSPITALIZATION			
Emergency Room ***waived if admitted**	*$350 Copay	*$350 Copay	20% after deductible
Inpatient Stay	40% after deductible	40% after deductible	20% after deductible
Outpatient Surgery	40% after deductible	40% after deductible	40% after deductible
OFFICE VISITS			
Primary Care	40% after deductible	40% after deductible	40% after deductible
Specialist	40% after deductible	40% after deductible	40% after deductible
Urgent Care	40% after deductible	40% after deductible	40% after deductible
Wellness	Not Covered	Not Covered	Not Covered
PRESCRIPTION DRUGS			
Deductible	$0	$150 per person	N/A
Copays:			
Generic	$7	$10	20%; $0 after deductible
Preferred Brand	$30	$60	20% after deductible
Non-Preferred	$70	$120	20% after deductible
Specialty	10% (max of $150)	10% after deductible (max of $350)	20% (max of $350)

How Do I Know Which Medical Plan is Right for Me?

When you're deciding between your Medical Plan options, you'll want to:

- Identify your anticipated needs for the coming year and what kind of medical services you and your family expect to use
- Assess plan premiums and what your cost will be each payroll
- Compare your options against other available coverage (ex: spouse's employer) and compare the expenses of each plan
- Consider electing an FSA or HSA to help offset deductible costs through pre-tax contributions

Buy-Up	Core	HDHP
This plan may be good for you and your family if you want the consistency of copays and a low deductible. This plan is also a good option if you anticipate having surgery, having a child, or have expensive prescriptions. **Predictable Costs:** Fixed copays for doctor visits, prescriptions, and emergency room visits simplify budgeting and billing. **Premiums:** Higher premiums than the other plan options, in exchange for copays and the lowest deductible. **Flexible Spending Account (FSA):** You can open an FSA to save pre-tax money for medical expenses, reducing taxable income and having funds ready for healthcare costs.	**This plan may be good for you and your family if you want the consistency of copays, but don't think you'll need to worry about hitting your deductible.** **Predictable Costs:** Fixed copays for doctor visits, prescriptions, and emergency room visits simplify budgeting. **Premiums:** Higher premiums than HDHP but lower than Buy-Up. **Pharmacy Deductible:** Includes a $150 deductible per person for prescriptions, leading to lower premiums compared to the Buy-Up Plan. **Flexible Spending Account (FSA):** You can open an FSA to save pre-tax money for medical expenses, reducing taxable income and having funds ready for healthcare costs.	**This plan may be good for you and your family if you want coverage, but don't go to the doctor often and don't have numerous or expensive prescriptions.** **Deductible:** In an aggregate HDHP, all family members' medical expenses contribute to a single family deductible. Once this combined deductible is met, coinsurance begins. For example, with a $5,000 family deductible, you and your family will pay the full cost of services until you hit your deductible. Any combination of expenses from family members can add up to meet the deductible. This approach reduces financial burden by pooling healthcare expenses. **Premiums:** Premiums are lower than the copay plans. **Health Savings Account (HSA):** You can open an HSA to save pre-tax money for medical expenses, reducing taxable income and having funds ready for healthcare costs.

You Can Save by Visiting an Ochsner Provider or Facility!

UMR and Ochsner Health Network have partnered to bring our members a product that provides quality care at an affordable price.

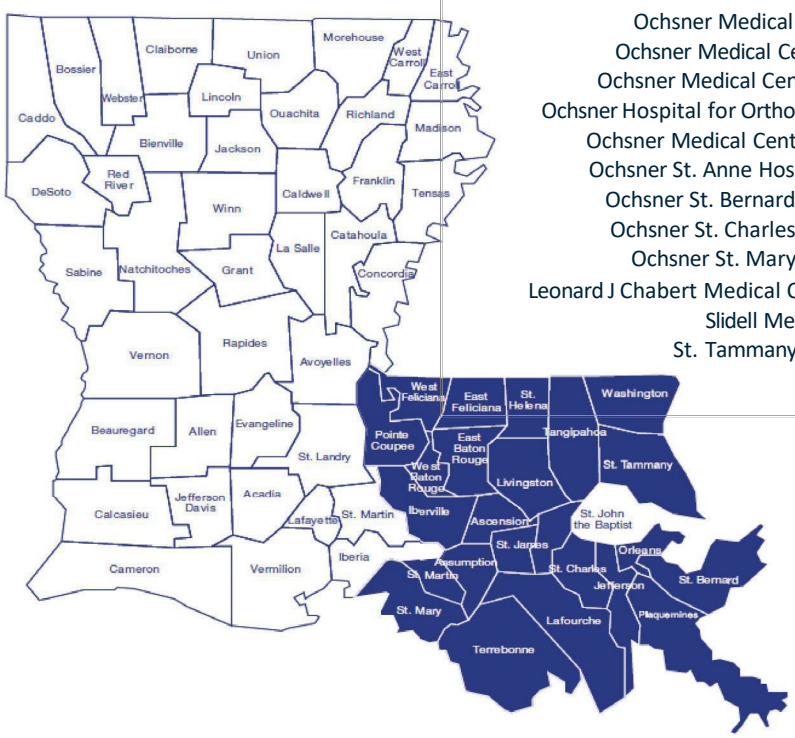
Ochsner Select Plus is an open access, tiered product that promotes the value of a Primary Care Physician and the care coordination that can bring to you overall care.

Go to UMR.com, Find a Provider, UnitedHealthcare Louisiana Select Plus Tiered, Search, Find "View Providers", Enter a Zip Code or City.

Where you go for care can make a difference!

The Select (Tiered)/Select Plus (Tiered) plans are available in the following Louisiana parishes:

- Ascension
- Assumption
- East Baton Rouge
- East Feliciana
- Iberville
- Jefferson
- Lafourche
- Livingston
- Orleans
- Plaquemines
- Pointe Coupee
- St. Bernard
- St. Charles
- St. Helena
- St. James
- St. John the Baptist
- St. Martin
- St. Mary
- St. Tammany
- Tangipahoa
- Terrebonne
- Washington
- West Baton Rouge
- West Feliciana



Ochsner Medical Center – Main Campus
Ochsner Medical Center – Baptist Campus
Ochsner Medical Center Kenner
Ochsner Medical Center Westbank
Ochsner Medical Center Northshore
Ochsner Hospital for Orthopedics & Sports
Ochsner Medical Center Baton Rouge
Ochsner St. Anne Hospital (Raceland)
Ochsner St. Bernard Parish Hospital
Ochsner St. Charles Parish Hospital
Ochsner St. Mary Parish Hospital
Leonard J Chabert Medical Center (Houma)
Slidell Memorial Hospital
St. Tammany Parish Hospital

FAQ's on The Ochsner Tier Savings:

Q: I prefer to stay with my current Doctors who aren't at Ochnser. Will there be any changes or penalties to my existing plan?

A: No, all our current plans will remain the same. UMR has teamed with Ochsner to offer cost savings for those who choose to see an Ochsner Provider or Facility. You are welcome to see anyone you like, and there will be no changes to your existing In-Network benefits.

Q: I am scheduled to have a surgery at an Ochsner Hospital. Am I required to have an Ochnser Primary Care Physician in order to have the incentive?

A: No, the facility alone will trigger the lesser expense. You are not required to have an Ochsner Primary Care Physician to drive your care.

Q: I am on a plan that has a deductible. I see there's a deductible for Ochsner and a deductible for In- Network, do I have to meet both deductibles if all my care isn't at Ochsner?

A: No, the Ochsner deductible applies toward the In-Network deductible. The maximum you will pay toward your deductible is found within the in-network tier as listed in the benefit grid above.

Flexible Spending Account (FSA)

Archdiocese of New Orleans offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

What is an FSA?

Flexible Spending Accounts allow you to reduce your taxable income and set money aside toward the cost of eligible expenses at the same time. You should carefully estimate your contribution amount for the year. FSAs are "use it or lose it" accounts, which means you will lose money left in account after the claim deadline.

Archdiocese of New Orleans will be offering 3 different kinds of FSAs:

- **Health:** A pre-tax benefit account for eligible medical, dental, and vision expenses (Not available if you are also contributing to an HSA.)
- **Dependent Care:** A pre-tax benefit account for eligible dependent care expenses such as daycare, nursery school, and preschool costs, and before and after-school care programs
- **Limited Purpose FSA:** A pre-tax benefit account specifically for those contributing to an HSA account that's restricted to specific expenses.

Advantages of FSAs

- **Wide Range of Eligible Expenses:** FSAs can be used to cover a variety of healthcare expenses, including medical, dental, vision, and prescription costs.
- **Tax Savings**: Contributions to an FSA are made with pre-tax dollars, reducing your taxable income and saving you money on federal, state, and Social Security taxes.

How Do I Sign Up?

Visit **https://myhealthaccountsolutions.voya.com/** to register.

What Can I Use An FSA For?

You can use the money in the account to pay for qualified medical expenses for yourself, your Spouse, or your dependent children (even if they are not covered by your plan). There are thousands of eligible items. The list includes but is not limited to:

- Doctor visits and surgeries
- Prescription drugs
- Dental care and orthodontia
- Vision expenses, such as frames, contacts, prescription sunglasses, etc.

Employees will be billed $2.00 / month for the administrative fee for the FSA.

FSA	
What medical plan can I choose?	Buy Up or Core Plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)
When can I use the funds?	The full amount of funds are available the first day of the plan year
Can I roll over funds each year?	No, this is a use it or lose it" benefit.
How do I pay for eligible expenses?	With your Voya debit card (You can also submit claims for reimbursement online with Voya)
How much can I contribute each year?	$3,400 (A minimum election amount is $350 / year)

Health Savings Account (HSA)

Archdiocese of New Orleans offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

What is an HSA?

An HSA lets you set aside a portion of your paycheck before taxes for healthcare expenses or retirement savings. It offers tax benefits that 401(k)s and IRAs don't, making it a powerful tool for diversifying your retirement portfolio.

Advantages of HSAs

- **Personal Savings:** Your HSA is a personal savings account. Unspent money is yours to keep and can grow over time. Save for emergencies, invest for retirement, or spend on qualified expenses penalty-free. At age 65, you can withdraw funds without penalty for any purpose.
- **Triple-Tax Savings:** Contributions, investment earnings, and withdrawals for eligible expenses are all tax-free.
- **Investment Options:** Invest HSA funds in an interest-bearing account, mutual funds, or a Health Savings Brokerage Account with access to over 30 mutual funds, stocks, and bonds.

How Do I Sign Up?

Scan the QR code or visit **https://myhealthaccountsolutions.voya.com/** to register.

What Can I Use An HSA For?

You can use the money in the account to pay for qualified medical expenses for yourself, your Spouse, or your dependent children (even if they are not covered by your HDHP). There are thousands of eligible items. The list includes but is not limited to:

- Doctor visits and surgeries
- Prescription drugs
- Dental care and orthodontia
- Vision expenses, such as frames, contacts, prescription sunglasses, etc.

Employees will be billed $0.75/ month for the administrative fee for the HSA.

	HSA
What medical plan can I choose?	HDHP
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for the types of expenses that may be eligible)
When can I use the funds?	Funds are available as you contribute to the account
Can I roll over funds each year?	Funds roll over each year and are yours to keep (even if you change jobs)
How do I pay for eligible expenses?	With your Voya debit card (You can also submit claims for reimbursement online with Voya)
How much can I contribute each year?	$4,400 for individual coverage or $8,750 for family coverage, and an additional $1,000 for those over the age of 55.
Can I change my contributions during the year?	Yes, you can log on to Voya to change your HSA contributions at any time

Dental Insurance

Administered by Guardian

Dental benefits are another important element of your overall health. You have a choice of two plans: Basic Low Plan or Preferred High Plan. Both plans are PPO plans, designed to give you the freedom to receive dental care from any licensed dentist of your choice. Both plans offer Maximum Rollover, so you can earn rollover dollars, if you accumulate less than the threshold. Check your Guardian portal for your balance!

PLAN OVERVIEW	Basic Low Plan	Preferred High Plan
Annual Deductible	$50 Individual/$150 Family	$50 Individual/$150 Family
Annual Benefit Maximum	$1,250	$1,250
COINSURANCE		
PREVENTIVE SERVICES		
Oral Exams	Covered at 100%	Covered at 100%
Cleanings - Once every 6 months		
Bitewing X-Rays - Once every 12 months		
BASIC SERVICES		
Fillings	Covered at 80% after deductible	Covered at 80% after deductible
X-Rays other than Bitewings - Once every 60 Months		
Minor Oral Surgery and Simple Extractions		
Palliative Treatment		
Periodontics Treatment		
MAJOR SERVICES		
Inlays, Onlays, and Veneers	Not Covered	Covered at 50% after deductible
Bridges and Dentures		
Single Crowns		
ORTHODONTIA		
Orthodontia Services (dependent children only to age 19)	Not Covered	Covered at 50% after deductible
Lifetime Benefit Maximum	Not Covered	$1,000 Lifetime Max

Employee Contribution (Monthly)		
	Low Plan	High Plan
Employee	$14.66	$29.21
Employee + One	$28.90	$56.59
Employee + 2 or more dependents	$54.01	$99.01

Vision Insurance

Administered by Guardian (VSP network)

Vision coverage is offered by Archdiocese of New Orleans. By practicing healthy eye habits, you and your family members can work toward preserving your vision for the long haul.

Plan Overview			
	Frequency	In Network Member Cost	Out of Network Benefit
Vision Exam	Every 12 months	$10 Copay	Up to $50
Lenses **Single** **Lined Bifocal** **Lined Trifocal** **Lenticular**	Every 12 months	Covered by copay Covered by copay Covered by copay Covered by copay	Covered by copay Covered by copay Covered by copay Covered by copay
Frames	Every 24 months	$130 allowance for frames of your choice and 20% off the amount over allowance.	Up to $48
Elective Contact Lenses ***Contact Lenses in place of lenses and frames**	Every 12 months	Up to $130 allowance	Up to $120

Employee Contribution (Monthly)	
Employee	$7.81
Employee + Spouse	$15.60
Employee + Children	$17.16
Employee + Family	$25.03

Please note: this benefit is not available to employees currently out on Worker's Compensation (WC).

Accident Insurance

Administered by Guardian

Even minor accidents can leave you with major expenses. When accidents happen, they are often followed by a number of bills. Are you prepared? Accident Expense insurance plan pays a cash benefit directly to you in addition to any other benefit or insurance you receive. Even with medical insurance, you still have to meet deductibles and pay for coinsurance. There may be additional costs due to emergency room fees, x-rays, follow-up care and other uncovered services. This plan can help you pay for these and other covered expenses.

For example, accidents as a result of these activities may be covered by this policy:

Football, Baseball, Basketball, Soccer, Tennis, Volleyball, Paintball, Mountain Biking, Motorcycle Riding, Cheerleading, Skateboarding, Automobile Accidents, Hunting, and Boxing

Key features to consider:

» **Guarantee Issue**

» **Pays direct to policyholder to assist with out-of-pocket expenses**

» **Pays in addition to medical insurance benefits**

» **Most sports and extracurricular activities are covered (see policy limitations)**

» **Coverage available for the entire family**

» **Fully Portable**

Commonly Utilized Benefits		
Benefit	Description	Amount
Dr. Appointment	Physician or Urgent Care Visit due to Accident	$150 Physician, $150 Urgent Care
Ambulance	Ground or air transportation	$150 Ground, $1,000 Air
Hospital Admission	Payable when confined for covered accident - Minimum of 24 hours per person	$1,000, $2,000 ICU
Hospital Confinement	Payable when confined for covered accident - Minimum of 24 hours per person	$225 per day, $450 per day ICU
Fracture	Based on schedule	Up to $8,000
Dislocation	Based on schedule	Up to $6,000
Wellness	$50 for Employee and Spouse per calendar year	$50

Employee Rate (Monthly)	
Employee Only	$13.27
Employee + Spouse	$22.20
Employee + Child(ren)	$22.73

To file a claim for reimbursement for Accident Insurance, please contact HR for a Guardian claims form

Please note: this benefit is not available to employees currently out on Worker's Compensation (WC).

Critical Illness Insurance

Administered by Guardian

You may know people who have been affected by a critical illness such as cancer, stroke or heart attack, and witnessed the impact it had on their quality of life. Are you prepared if a critical illness were to happen to you?

Critical Illness insurance can help you when you need it the most. It provides a valuable benefit should you or your family be faced with bills resulting from a critical illness. This benefit is in addition to your medical insurance. It helps fill the financial gaps left by deductibles, coinsurance and other out-of-pocket expenses.

The Guardian Critical Illness lump sum policy payment upon diagnosis include:

Cancer (Internal or Invasive)	100%	**Vascular**	100%
Heart Attack (Myocardial Infraction)	100%	**Benign Brain Tumor**	75%
Stroke	100%	**Organ Failure**	100%
Kidney Failure (End Stage Renal)	100%	**Carcinoma In Situ**	30%
Muscular Dystrophy	100%	**Skin Cancer**	$250 a lifetime
Severe Burn	100%	**Coma**	100%
Paralysis	50% one limb; 100% two limbs	**Loss of Sight, Speech, Hearing**	100%

OTHER CONDITIONS

Cystic Fibrosis	100%	**Cerebral Palsy**	100%
Cleft Lip or Cleft Palate	100%	**Down Syndrome**	100%
Clubbed Foot	100%	**Spina Bifida**	100%
Type 1 Diabetes	100%	**ALS (Lou Geherig's Disease)**	100%

Features:

» Benefits are paid directly to you, unless otherwise assigned.

» Coverage is available for you, your spouse, and dependent children.

» Coverage may be continued (with certain stipulations). That means you can take it with you if you change jobs or retire.

» Guarantee Issue up to the GI amount and No Pre-Existing Condition Limitations.

Employee Rate (Monthly)

EMPLOYEE AMOUNTS

Benefit	<30	30-39	40-49	50-59	60-69	70+
$10,000	$4.90	$6.60	$12.80	$24.40	$42.80	$78.40
$20,000	$9.80	$13.20	$25.60	$48.80	$85.60	$156.80

SPOUSE

Benefit	<30	30-39	40-49	50-59	60-69	70+
$5,000	$2.45	$3.30	$6.40	$12.20	$21.40	$39.20
$10,000	$4.90	$6.60	$12.80	$24.40	$42.80	$78.40

To file a claim for reimbursement for Critical Illness Insurance, please contact HR for a Guardian claims form.

Please note: this benefit is not available to employees currently out on Worker's Compensation (WC).

Hospital Indemnity Insurance

Administered by Guardian

Hospital Indemnity Insurance pays a cash benefit if you or an insured dependent (spouse or child) are confined in a hospital for a covered illness or injury. Out-of-pocket costs from a hospital stay can add up - and most people are surprised to learn that they are responsible for a good portion of the bill. Hospital Indemnity insurance provides a direct benefit in the event of a hospitalization regardless of treatment costs or other insurance coverage. No pre-existing condition limitation.

The benefits are paid in lump sum amounts to you, and can help offset expenses that primary health insurance doesn't cover (like deductibles, co-insurance amounts or copays), or benefits can be used for any non-medical expenses (like housing costs, groceries, car expenses, etc.). This insurance is guaranteed issue coverage - it is available without having to provide information about your or your family's health.

Benefits:

Hospital/ICU Admission	$500 per admission
Hospital/ICU Confinement	$100/$100 per day (limited to 15 days per insured per benefit year)

Plan Features:

» Guarantee Issue and No Pre-Existing Condition Limitations

» Includes treatment of normal pregnancy with no waiting period or pre-existing condition limitations.

» Fully Portable

Employee Rate (Monthly)	
Employee Only	$10.35
Employee + Spouse	$18.83
Employee + Child(ren)	$15 64
Family	$24.12

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

To file a claim for reimbursement for Hospital Indemnity Insurance, please contact HR for a Guardian claims form.

Basic Life and Accidental Death & Dismemberment Insurance

Administered by Guardian

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump- sum payment if you should die while employed by Archdiocese of New Orleans. **Archdiocese of New Orleans provides, at no cost to you, a 2.5 annual earnings, up to a maximum of $200,000. Age Reductions: 35% at age 65, 60% at age 70, 75% at age 75, and 85% at age 80**. Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident.

Supplemental Life and Accidental Death & Dismemberment

You may be able to purchase additional life and AD&D insurance in addition to the company provided coverage. You may also purchase life and AD&D insurance for your dependents. Evidence of Insurability may be required if you are considered a late entrant.

Employee- $150,000 maximum amount; increments of $25,000.

Spouse- A maximum of $25,000

Children- A maximum of $10,000

Employee Voluntary Life and AD&D Election Choices & Monthly Premiums					
Age Bracket	$25,000	$50,000	$75,000	$100,000	$150,000
< 30	$2.00	$4.00	$6.00	$8.00	$12.00
30 - 34	$2.25	$4.50	$6.75	$9.00	$13.50
35 - 39	$2.75	$5.50	$8.25	$11.00	$16.50
40 - 44	$4.00	$8.00	$12.00	$16.00	$24.00
45 - 49	$6.25	$12.50	$18.75	$25.00	$37.50
50 - 54	$9.50	$19.00	$28.50	$38.00	$57.00
55 - 59	$14.25	$28.50	$42.75	$57.00	$85.50
60 - 64	$19.75	$39.50	$59.25	$79.00	$118.50
65 - 69*	Amount may be unavailable due to age reductions; please review the amount you are eligible for and premium online in benefitsCONNECT				
70+*					
Child Rate	$1.00				

Short-Term Disability Insurance

Insured by Guardian

Should you experience an illness or injury that prevents you from working, disability coverage acts as an income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation. The Archdiocese of New Orleans provides Short Term Disability and Long Term Disability coverage through Guardian at no cost to you.

- Benefits begin on the 30th day after your disability and can continue for up to 9 weeks.
- Weekly Benefit Amounts - 60% of weekly covered earnings
- Benefit Maximum - up to $1,000 per week

Long-Term Disability Insurance

Insured by Guardian

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset- you. Archdiocese of New Orleans offers long term disability coverage which provides income when you have been disabled for more than 90 consecutive days. Your benefit is 60% of your monthly earnings, up to $4,000 per month.

Filing a Disability Claim

As soon as you know you will be out of work due to an illness or accident based on your plan's waiting period, follow the simple steps below to file your disability claim. Always reach out to your Site Administrator for more information.

1. You will need the following information to expedite the process:
   - Personal contact and employment information (job title and work location) and Group/Plan ID
   - Reason for the request including date of disability and your last day at work. If for a medical condition, a description of your illness, symptoms and/or diagnosis.
   - Details about your doctor, hospital or client visits (including treatment dates, physician name, phone number, fax number, and area of specialty).
   - List of other claims you filed or will file and banking information if you wish to set up direct deposit.
2. File your claim by visiting https://www.guardianlife.com/forms-and-claims or by calling 888.262.5670.
3. Review your information to make sure it is complete and accurate (incomplete information will delay the process).

What's Next

- Guardian will review your claim and if complete, determinations are typically made within 10 business days.
- If your claim is approved, you will receive an approval letter based on your notification preferences with details about your claim as well as any additional steps that you will need to make while you are on disability.
- Checks will be mailed unless you elected and are eligible for direct deposit (fastest and recommended option).
- Guardian may need to reach out to you, your employer or physician while you are out for verification or requests for medical extension which require additional time to review.

Employee Assistance Program

Administered by Guardian

Life's unpredictable - sometimes it can throw you a curve ball. That's why it's important to know there's help available when you need it. Your Employee Assistance Program (EAP), sponsored by Archdiocese of New Orleans, gives you access to resources you can turn to when the challenges of life are getting the best of you. Things like relationship issues, anxiety, addiction, aging parents to care for. They can all make balancing work and life stressful. This free service is completely confidential, your Archdiocese of New Orleans Leadership Team will never know who calls the EAP.

ComPsych

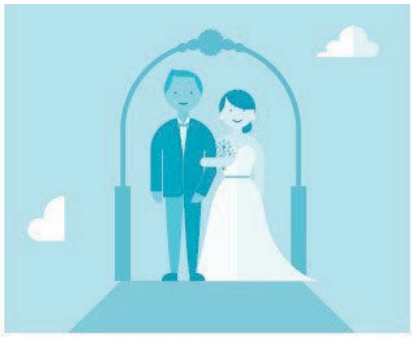
Employee Assistance Program

Connect to a counselor for free support services!

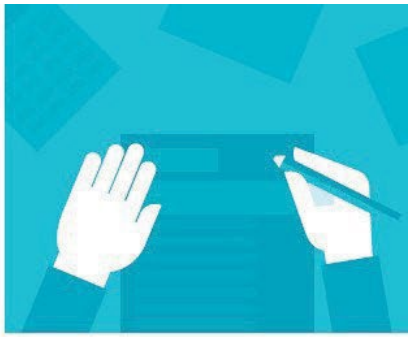
ComPsych Employee Assistance Program offers services to help promote well-being and enhance the quality of life for you and your family. This free service is available to benefit-eligible staff members enrolled in the employer-paid Guardian life or disability products.

Support and guidance is available online for assistance with family and personal issues at www.guidanceresources.com or download the app GuidanceNow and by phone at 855-239-0743.

Jan's mom moved in with her when she wasn't able to live on her own. But she needed care during the day while Jan worked. Jan used her EAP to research senior centers in her area, and found a place where her mom could be around friends and enjoy events and activities. A win-win for Jan and her mom.



Miguel and Molly brought their families together when they got married a year ago. Their children—Miguel's son and Molly's two daughters—were having trouble adjusting to the situation. Counseling resources through Miguel's EAP helped them adjust and begin to thrive as a family.



Jack had always been an easygoing guy, letting the little things roll off his back. But lately, he'd been having trouble dealing with day-to-day issues, and it was affecting his ability to get all his projects done. After doing a self-assessment for stress provided by his EAP, he knew it was time to get professional help. Now, Jack has a better handle on how to manage his everyday challenges.

Extra Benefits

As a benefits-eligible employee, there are several additional benefits available to you that serve as a supplement to your core coverage.

Guardian's TravelAid

Whether you are one hundred or thousands of miles away from home, TravelAid provides a combination of global travel assistance services: Call **410.453.6330** to utilize this benefit.

- **Prevention before travel:** Before leaving home, you can get travel alerts and destination information, pre- travel immunization information, international medical insurance and claims administration and travel medical kits.
- **Emergency response**: Get access to 24/7 multilingual assistance for help with travel arrangements, lost documents and replacement of prescriptions and credit cards.
- **Worldwide physician and hospital referrals:** Receive guidance on doctors, dentists, hospitals and facilities, multilingual services at medical facilities and patient accommodations.
- **Medical transportation:** Along with responsive service, the latest equipment and technology are provided.
- **Specialized security resources:** Embassy and consular assistance is available. Personnel are experienced in handling sensitive and complex emergency security situations.

UMR and Your Mobile Device

Mobile Portal

As a UMR member, you can access your benefit and claim information anytime using your mobile device. There's no app to download. Simply log in to umr.com on your smart phone using the same username and password you use for our full site. You can:

- Find a provider on the go
- Look up claims for yourself or an authorized dependent
- View, scan or fax your ID card
- Check your benefits

Teledoc

UMR has partnered with Teladoc to offer anytime access to a national network of U.S. board-certified physicians. Members can connect with network physicians for telephonic or face-to-face, online video consultations 24 hours a day, 365 days a year.

Teladoc's network of state-licensed primary care physicians can diagnose routine, non-emergency, medical problems, recommend treatment and prescribe short-term, non-DEA-controlled medications, when needed. For more information, visit www.teledoc.com or call **800.835.2362.**

UMR DISEASE MANAGEMENT

UMR invites members with chronic health conditions to enroll in coaching with their team of chronic care professionals. Through a series of one-on-one coaching calls, our registered nurse coaches educate and empower members to effectively manage their condition and improve their quality of life. The program is available to members with conditions such as diabetes, hypertension, asthma and more.

Retirement Plans

One of the best benefits of participating in your Plan is the tax break you receive to save for retirement. And because your Plan offers both pre-tax contributions and a Roth 401(k) feature, you can choose whether to receive that tax break today or later on in retirement.

Pre-tax contributions reduce your taxable income dollar-for-dollar which can lower the current federal income tax you pay today. Contributions and any investment earnings, however, are taxed as ordinary income when you receive a distribution from your plan account, typically in retirement.

Roth 401(k) contributions offer no upfront tax savings because they are made with after tax dollars. If you maintain your Roth account for at least five years (the five-year period begins the year you make your initial Roth contribution and is not affected by subsequent Roth contributions), tax-free withdrawals may be taken (on contributions and any earnings on those contributions) from your Roth account:

- By employee: once you reach age 59½ or become disabled.
- By employee's beneficiary: in the event of your death.

Roth 401(k) contributions may be rolled over directly to a Roth IRA with no tax payment. Unlike a Roth IRA, there is no income limit on who may contribute to a Roth 401(k). Therefore, even if you are a highly-compensated employee, you may contribute to the Roth feature of the 401(k).

And if you're seeking tax diversification for your retirement savings, you have the opportunity to make both types of contributions to the Plan.

Your contribution has to be between 3% and 75% with IRS regulations and a match of 3.5% is offered.

To help you build your retirement savings, the Plan includes an automatic escalation feature. This feature will automatically increase your contributions by 1% each year until your contribution rate reaches 8%. Think of auto escalation as a built-in way to help you save a little more every year. Auto escalation occurs every year on, or about, November 4. If your current 401(k) Plan contribution rate is between 0% and 7% of pay (whether those contributions are pre-tax, Roth, afer-tax, or any combination) on November 4, your pre-tax contribution rate will automatically increase to the next higher full percent starting the first full pay period after November 4.
Every November 4 after that, your pre-tax contribution rate will be automatically increased one percentage point. Once you are contributing 8%, auto-escalation will stop. You have the right to opt out of your scheduled auto-escalation. To opt out online, log on to your account at archdioceseno.voya.com and select Contribution & Savings > Manage Contributions, then select "Discontinue your Rate Escalator on file." Or, you can call a Customer Service Associate at 877.659.6995.

Alternative Coverage Options

FEDlogic

The Archdiocese of New Orleans has partnered with FEDlogic to provide federal and state benefit information and advocacy to you and your household members. FEDlogic's team of experienced and compassionate experts offer their knowledge and guidance to help you discover and maximize your federal and state benefits. **Consultations are free, unlimited, and confidential for you and your household members.**

What is FEDlogic?

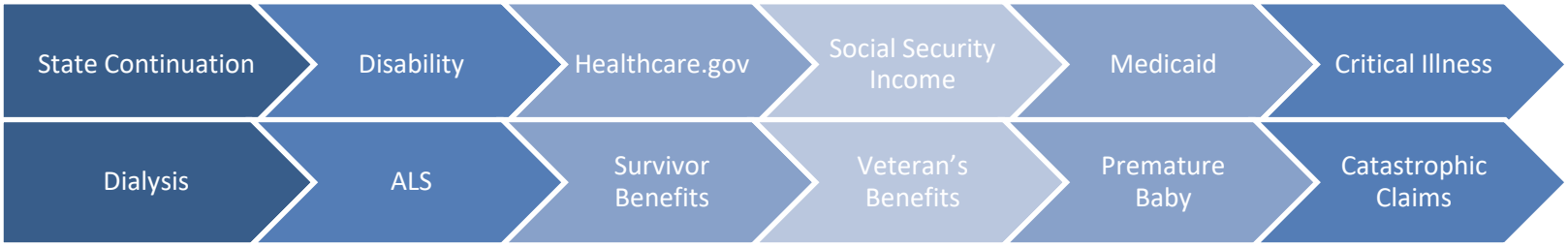
FEDlogic is an advocacy service provided by your employer that gives you access to a team of experts who can assist you in understanding federal and state benefit options. FEDlogic's experts have worked for the Social Security Administration and have spent years mastering these policies from the inside out. Without education and advocacy, many individuals don't take advantage of all the benefits available to them. FEDlogic's experts can provide you with peace of mind, ensuring that you identify and maximize all of your benefits. FEDlogic does not sell, endorse, or promote any products or services. FEDlogic is a team of unbiased advocates with decades of experience, here to help!

Reasons to contact a FEDlogic expert:

- You or a family member have been diagnosed with a critical illness or disability
- You have a child born prematurely and is in the NICU
- You have lost a spouse and need help navigating survivor's benefits
- You are unable to work or have lost affordable health coverage

COMING SOON!

Please look out for information on how to contact FedLogic soon.



SGIA Medicare Consulting – For Those Working 65 + Considering Medicare

Do you have questions such as:

1. How will my employer group health plan work with Medicare?
2. Should I enroll in Medicare and leave my employer group plan?
3. Is Medicare enrollment automatic when I turn 65?
4. How much does Medicare cost compared to my current plan?
5. How do I avoid costly penalties if I stay on my employer's plan?

SGIA Medicare thoroughly understands your Archdiocese health plan and how Medicare can impact your benefit package. We can help you avoid common mistakes that can have lifelong consequences, including penalties. Our service to you is free. We're here to save you time, money, and frustration when making decisions about Medicare. Want to avoid the most common mistakes people make when choosing Medicare? Call or email us for a quick cost comparison because Medicare might save you money.

Many people assume staying on their employer plan is their only option. In many cases, enrolling in a Medicare plan will be a better, less expensive option. Whether you're turning 65 and continuing to work, 65 or older and ready to retire, or your spouse is turning 65, making the most of your Medicare depends on your needs.

Ready to review Medicare Advantage and PDP plans? Click here and get a free quote
For a Medicare supplement quote, contact SGIA at 888-284-3314 or info@sgiamedicare.com

Parental Bonding Leave

If you are a new mom or dad, congratulations! We know how precious those first weeks are in order to get to know your new bundle of joy. That is why we now offer parental bonding leave to all benefits-eligible staff at our parishes and parish schools, administrative offices, programs and ministries and entities owned and/or operated by the Archdiocese.

Here's how it works:

» Benefit: 100% of pay for up to six weeks.

» Please request time off from your supervisor 30 days before the birth or placement through adoption/foster care of your child.

» Your location will approve your leave.

» If both parents work for the same location, each may take a separate parental bonding leave of absence at alternate times, as determined by the location's director and the employees' appropriate supervisor(s).

UMR Maternity Management

UMR's maternity management program provides information and coaching to women considering having a child, prenatal education and guidance to those expecting, and high-risk pregnancy identification to help expectant mothers carry their babies to term. Members may self-enroll online at umr.com or by calling the toll-free number on their medical ID card.

All members who join the maternity management program during their first or second trimester are eligible to receive a gift of their choice. Participants may choose from a selection of high-quality books and other materials containing helpful information about pregnancy, pre-term labor, childbirth, breastfeeding and infant care. Members who enroll during their first or second trimester and successfully complete the program are eligible to receive a UMR-funded $25 gift card.

QUIT WITH US, LA

The Smoking Cessation Trust Management Services (SCTMS) can arrange for you to receive FREE cessation assistance with: doctor visits, group counseling, telephone support, and more. Visit www.smokefreela.org for more.

ARCHDIOCESE OF NEW ORLEANS
Office of Human Resources

Parental Bonding Leave Policy FAQs

These questions and answers accompany the Department's parental bonding leave policy, which is effective on January 1, 2016 and revised on May 1, 2024.

If you have any additional questions, please contact the Human Resources Office.

Parental Bonding Leave Entitlement and Usage

1. What is parental bonding leave?

Effective January 1, 2016 Parental bonding leave may be granted for the birth of a child or the placement through adoption or foster care of a child to either parent. Employees granted this leave will receive full pay for six weeks, commencing at the birth or placement of the child. Employees on the parental bonding leave will not be required to use their accrued sick or vacation leave during the six week paid parental bonding period. Parental bonding leave will run concurrently with the location's paid holidays, summer break schedules and with FMLA leave where it applies. Under no circumstances will paid leave be extended due to such scheduled holidays, FMLA, and break time.

2. Who is eligible for parental bonding leave?

In order to use parental bonding leave, employees must be **benefit eligible.**

3. An employee was HIRED on March 1, 2022 and has given birth to a child on March 20, 2022. Will she be eligible for parental bonding leave on March 20, 2022?

No. Parental bonding leave is available to eligible employees only in connection with the birth or placement (for adoption or foster care) of a child ***that occurs on or after March 20, 2022***. If the employee gives birth on March 20, 2022, there is no entitlement for any parental bonding leave; she would pick up coverage beginning April 1, 2022. **Leave is effective the first day of the month following hire, or the first day of the month following becoming benefit eligible.**

4. Can parental bonding leave be taken intermittently during the 12 months after the birth or placement of a child?

Leave to care for or bond with a newborn child or for a newly placed adopted or foster child may only be taken intermittently with the employer's approval and must conclude within 12 months after the birth or placement.

5. Is an employee required to use his or her annual leave or sick leave before requesting parental bonding leave?

No. An agency may not require an employee to use his or her accrued annual leave or sick leave before requesting parental bonding leave.

6. I currently work a part-time schedule. How much parental bonding leave will I receive?

Benefit eligible employees working part-time schedules may use parental bonding leave. For employees who use leave on an hourly basis (including fractions of an hour), the 6-week parental bonding leave entitlement will be converted to hours based on the employee's scheduled tour of duty. For example, for a part-time employee who works 20 hours weekly, the entitlement will be 120 hours (6 weeks x 20 hours).

7. I am not benefit eligible. May I use parental bonding leave?

No.

8. My spouse works for an Archdiocese Office and I work for another Archdiocese Office. We are expecting a baby in November 2024. Are we each entitled to 6 weeks of parental bonding leave?

Yes. Each eligible parent-employee has a separate 6-week parental bonding leave entitlement. It is also worth noting that parental bonding leave is available only if the employee has a continuing parental role with respect to the child whose birth or placement triggered the leave entitlement. In addition, the use of parental bonding leave is reserved for periods when the employee is engaged in activities directly related to the care of the child whose birth or placement triggered the leave entitlement.

9. An employee delivers twins on July 4, 2024. How much parental bonding leave may the employee receive?

If an employee has multiple children born or placed on the same day, that event is considered to be a single event that initiates a single entitlement of up to 6 weeks of parental bonding leave during the 12-month period following the birth or placement event.

10. What documentation, if any, does an employee need to provide to use parental bonding leave?

When requesting parental bonding leave, an employee must provide appropriate documentation that shows that the employee's use of parental bonding leave is directly connected to a birth or placement that has occurred. Examples of appropriate documentation are provided below.

For parental bonding leave due to childbirth, employees may provide one of the following documents:

- Birth certificate
- Document naming employee as second parent, such as declaration of paternity or court order of filiation
- Appropriate court documents
- Consular report of birth abroad
- Documentation provided by the child's healthcare provider
- Hospital records associated with the delivery

For parental bonding leave due to adoption, employees may provide one of the following documents:

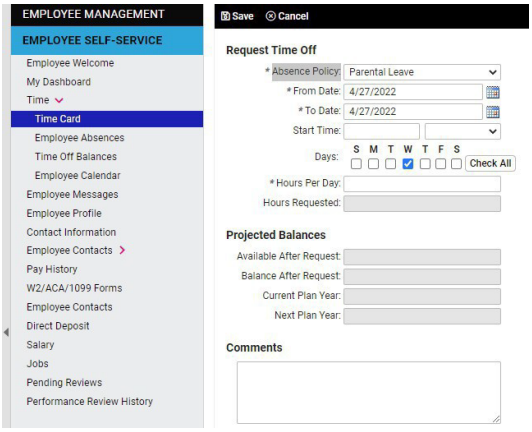
- Documentation provided by the adoption agency confirming the placement and date of placement
- Letter signed by the parent's/parents' attorney confirming the placement and date of placement
- Adoptive placement agreement conformation
- Independent adoption placement agreement (i.e., an agreement between the birth parents and the adoptive parents that a private or open adoption should go forward —generally, there is no adoption agency involved.)

Pay During Parental Bonding Leave

11. Will an employee receive full pay or a percentage of their current pay for parental bonding?

For fathers or parents of a placed/adopted child: The division/school is responsible for paying 100% of the staff member's salary for 6 weeks. Once the 6 weeks is up, the staff person can take accrued sick and/or vacation time. For mothers giving birth: Starting on the day the child is born OR the day the mother goes out on doctor-ordered bed rest, the staff person calls in the STD claim. As STD does not kick in until week 5, the division/school is responsible for 100% of their pay for weeks 1 through 4. For weeks 5 and 6, STD pays 60% of their salary and the division/ school contributes the remaining 40%. If the mother has a caesarian section, STD will pay 60% of the salary for a week 7 and 8. The division/school is not responsible for paying for weeks 7 and 8 as Parental Bonding Leave has ended.

12. How do I code my use of paid parental leave in the timekeeping system?



Retiree Policy

Effective 7/1/2004

Eligibility Requirements - In order to qualify for the retiree benefits an employee must have fifteen (15) years of continuous service with The Archdiocese, and be between the ages of 55 and 65. The benefits are for the retiree and their qualified dependents. The retiree and his/her dependents must be enrolled on The Archdiocese's health plan at the date of retirement. Eligibility in this plan will cease upon Medicare eligibility of the retiree. Upon Medicare eligibility of the retiree, the dependents only (if not eligible for Medicare) will be offered continuation of coverage. If a dependent becomes eligible for Medicare before the retiree, the benefits will cease upon eligibility for the dependent, but will still be available for the retiree if not yet eligible. Only dependents at the time of the retirement are allowed to participate. No future dependents can be added no matter the circumstances.

If an employee meets those requirements, he or she may participate in the retiree plan. Any pre-existing condition restrictions (if applicable) by the health carrier would apply.

Effective Date of Benefits - If the retiree meets the basic requirements, the effective date of retiree benefits will be the first date of the month following date of retirement.

Eligibility Notification - It is the retiree's responsibility to communicate to the employer site, their intent to apply for retiree benefits. The retiree will be required to submit to the employer site (last employed) in writing the retirees intent to elect retiree benefits. The retiree will also be required to fill out the proper paperwork required to submit to the health carrier in order for the health carrier to receive the required forms within 30 days of the retiree date. Any forms submitted after this time will forfeit the retiree's rights to benefits.

Duration of Eligibility - Eligibility for retiree health benefits lasts until Medicare eligibility for the retiree. If the retiree has dependents then continuation will be available under the requirements of continuation. (See Continuation of Coverage Policy) The Archdiocese reserves the right to alter or amend the retiree benefits. The benefits could also be terminated at the discretion of the Archdiocese if retiree benefits significantly impact benefits for the active employees.

Work after Retirement - Should a retiree re-qualify for eligibility in the Archdiocese's active health plan on the basis of hours worked after the date of retirement, the retiree will be transferred to the active health plan for full benefits on the first date of the subsequent eligibility period. When the retiree is considered no longer an active employee, the retiree will be immediately returned to the retiree health plan until Medicare eligible.

Surviving Dependents of Retirees - any surviving dependents of retirees will be offered continuation of coverage for a maximum duration of 12 months as specified under the provisions of continuation of coverage.

Continuation of Coverage Policy

Effective 7/1/2004

Continuation shall only be available to an employee or dependent who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three consecutive months immediately prior to the date of termination.

Continuation shall not be available for any person who is or could be covered by any other arrangement of hospital, surgical, medical coverage for individuals in a group or eligible for Medicare, within 31 days immediately following the date of termination, or whose insurance terminated because of fraud or because he failed to pay any required contribution for the insurance, or who is eligible for continuation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA).

Continuation rights will not apply to dental, vision, or any other benefits provided under the group policy in addition to its hospital, surgical, or major medical benefits. An employee or dependent electing continuation shall pay to the group policyholder or his employer, in advance, the amount of contribution required by the policyholder or employer, but not more than the full group rate for the insurance applicable to an active employee or dependent under the group policy on the due date of each payment. The employee or dependent shall not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or dependent shall make a written election of continuation, on a form furnished by the group policyholder, and pay the first contribution, in advance, to the policyholder or employer on or before the date on which the employee's or dependent's insurance would otherwise terminate. Such form shall be as prescribed in this Section.

Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

» The date 12 months after the date of the employee's or dependent's insurance under the policy would otherwise have terminated

because of termination of employment or membership.

» The date ending the period for which the employee or dependent last makes his required contribution, if he discontinues his contributions.

» The date the employee or dependent becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group the date on which the group policy is terminated

The qualifying events for employees are:

» Voluntary or involuntary termination of employment; or reduction in the number of hours of employment, resulting in a loss of coverage under the policy

The qualifying events for spouse are:

» Voluntary or involuntary termination of the covered employee's employment;

» Reduction in the hours worked by the covered employee, resulting in a loss of coverage under the policy;

» Covered employee's becoming entitled to Medicare;

» Divorce from the covered employee; or

» Death of the covered employee

The qualifying events for dependent children are:

» Loss of "dependent child" status under the plan rules; or

» Death of the covered employee

Women's Health & Cancer Rights Act

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Buy Up (Individual: 20% coinsurance and $1,250 deductible; Family: 20% coinsurance and $3,750 deductible)
Plan 2: Core (Individual: 30% coinsurance and $4,500 deductible; Family: 30% coinsurance and $13,500 deductible)
Plan 3: HDHP (Individual: 30% coinsurance and $3,000 deductible; Family: 30% coinsurance and $6,000 deductible)

If you would like more information on WHCRA benefits, please call Human Resources at 504.310.8793 or ppower@arch-no.org.

Newborns' and Mothers' Health Protection Act

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

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Archdiocese of New Orleans is committed to the privacy of your health information. The administrators of the Archdiocese of New Orleans Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Pam Power – Benefits at 504.310.8793 or ppower@arch-no.org.

HIPAA Special Enrollment Rights

Archdiocese of New Orleans Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Pam Power – Benefits at 504.310.8793 or ppower@arch-no.org.

Important Warning

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

Notice of Creditable Coverage

Important Notice from Archdiocese of New Orleans

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Archdiocese of New Orleans 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 at the end of this notice.

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Archdiocese of New Orleans has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Archdiocese of New Orleans coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Archdiocese of New Orleans coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	**January 01, 2026**
Name of Entity/Sender:	**Archdiocese of New Orleans**
Contact—Position/Office:	**Pam Power – Benefits**
Office Address:	**7887 Walmsley Ave** **New Orleans, Louisiana 70125-3496** **United States**
Phone Number:	**504.310.8793**

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Archdiocese of New Orleans
Pam Power – Benefits
7887 Walmsley Ave
New Orleans, Louisiana 70125-3496
United States
504.310.8793

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income. [1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Pam Power.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Archdiocese of New Orleans		4. Employer Identification Number (EIN) 72-0408911
5. Employer address 7887 Walmsley Ave		6. Employer phone number 504.310.8793
7. City New Orleans	8. State Louisiana	9. ZIP code 70125-3496
10. Who can we contact about employee health coverage at this job? Pam Power		
11. Phone number (if different from above)		12. Email address ppower@arch-no.org

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

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

  X All employees. Eligible employees are: full and part- time staff who work a regular schedule of at least 20 hrs / week.

  Some employees. Eligible employees are:

- With respect to dependents:

  X We do offer coverage. Eligible dependents are: legal spouse, dependent children up to 26, disabled dependents of any age

  ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

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

X Yes (Go to question 15) ☐ No (STOP and return form to employee)

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15. For the lowest cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan?
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

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16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0702**. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, Baltimore, Maryland 21244-1850.

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

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

This benefit summary was prepared by

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