2025 | All Lay Employees

Benefits Guide

Inside

Contacts 2
Eligibility 3
Medical 4
Telemedicine 11
Employee Assistance Program 15
Flexible Spending Account 9
Dental 11
Life/AD&D 13
Long-Term Disability 14
Discount Program 15
Healthcare Tips 19
Know Where to Go for Care 20
Benefit Terms 21
Diocese of Winona-Rochester Health Plan: Important Disclosures & Notices 22

Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Welcome

At the Catholic Diocese of Winona-Rochester, your well-being is our top priority, and we are pleased to offer a range of benefits designed to support your physical, emotional and spiritual well-being. Our benefits are thoughtfully designed to care for you and your family. We are committed to fostering a supportive and nurturing environment that helps you thrive.

Thank you for being a part of our community. May your time with us be blessed with growth, joy, and peace.

How to Enroll

- **Current Employees:** Open enrollment, which usually occurs in early November, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 30 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.

Enroll online through ParishSoft!

Scan QR code or visit
https://bit.ly/dowr-g-enroll

Need Help?

Reach out to the Bookkeeper at your location.

For additional assistance, reach out to Amelia Jajowka at ajajowka@dowr.org.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Medicare Part D Notice: If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **26** for details.

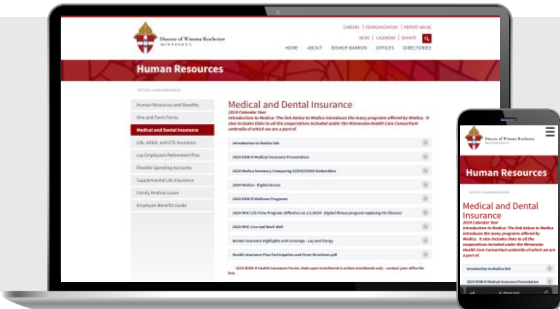
Contacts

Diocese of Winona-Rochester Benefits Contact	
Bookkeeper or Benefits Coordinator	Please reach out to your designated Bookkeeper. If you need additional assistance, you can contact Amelia Jajowka, Employee Benefits Coordinator, at ajajowka@dowr.org

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	Medica	877-347-0282	www.medica.com
Dental Insurance	Delta Dental	800-553-9536	www.DeltaDentalMN.com
Life and Long-Term Disability	Unum	800-445-0402	www.unum.com
Accidental Death & Dismemberment	Mutual of Omaha	800-228-7104	www.mutualofomaha.com
Flexible Spending Account	Wex	866-451-3399	www.wexinc.com

Learn more about your benefits!

Scan QR code or visit
https://bit.ly/dowr-g-resources



Eligibility

Employee Eligibility

Employees working for any parish, school, or other institution under the jurisdiction of the Bishop of Winona-Rochester are eligible for diocesan benefits if they work at least 20 hours a week or work at least half-time during the academic year, regardless of job title.

- **Medical and Dental:** These coverages will take effect the first of the month coincident with or next following the date of active employment.
- **Other Coverages:*** All other coverages will take effect the first of the month coincident with or next following the date of active employment.

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of "Eligible Dependents"

Medical and Dental Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26**. This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page 9 for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a "spouse", and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.

Medical

Medica CompleteHealth Network

Locate an in-network provider near you at www.medica.com/MedicaCompleteHealth or call 877-252-5564.

Medica CompleteHealth provides trusted Mayo Clinic care close to home, whether that means primary care or specialty care services. You have access to more than 20 hospitals and 60 clinics without the need for referrals. Providers include MCHS locations, Mayo Clinic Primary care in Rochester and Kasson, Northfield Hospital & Clinics, and Winona Health Services. You can manage your care and access your health information securely through the Mayo Clinic patient portal.

Medical	$2,500 PPO		$5,000 HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$2,500	$5,000	$5,000	$10,000
Family	$5,000	$10,000	$10,000	$20,000
Coinsurance (Plan Pays/You Pay)	80% / 20%	60% / 40%	100%	50% / 50%
Annual Out-of-Pocket Maximum				
Individual	$5,000	$10,000	$5,000	$20,000
Family	$10,000	$20,000	$10,000	$40,000
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	Covered 100%	50%	Covered 100%	Covered 100%
Telemedicine Visit	20%	50%	0% After Deductible	50% After Deductible
Primary Care Office Visit	20%	50%	0% After Deductible	50% After Deductible
Specialist Office Visit	20%	50%	0% After Deductible	50% After Deductible
Urgent Care	20%	50%	0% After Deductible	50% After Deductible
Emergency Room	20%	20%	0% After Deductible	0% After Deductible
Hospitalization	20%	50%	0% After Deductible	50% After Deductible
Prescription Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Out-of-Pocket Maximum				
Individual	$750		Included in Medical	
Family	$1,500			
Generic Drugs	25%	25%	0% After Deductible	Not Covered
Preferred Brand Name Drugs	25%	25%	0% After Deductible	Not Covered
Non-Preferred Brand Name Drugs	Not Covered	Not Covered	0% After Deductible	Not Covered
Tier 4	25%	Not Covered	0% After Deductible	Not Covered

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail

PLAN DETAILS

Medica CompleteHealth[SM]

(featuring care at Mayo Clinic)

Advanced Care Built Around You

Medica CompleteHealth connects you with the world's leading medical experts to meet your health care needs. And we'll work together to make finding care as easy as possible for you.

An Experience You'll Love

- **Direct access to specialists** in the Medica CompleteHealth network without a referral. If your primary care provider decides you need specialty care in the Mayo Clinic Health System or more complex care at Mayo Clinic in Rochester, they'll make arrangements for you.
- **Wellness programs and services** to help you and your family live healthy lifestyles, including topics like diet and exercise at **MayoClinicHealthSystem.org/Wellness-Hub.**
- **Coordinated care** and tailored support after a hospital stay or emergency room visit.
- **A patient portal** to help you manage your care and secure, easy access to your health information. To create your Mayo Clinic patient portal account go to **MayoClinicHealthSystem.org/Patient-Online-Services** or download the Mayo Clinic app from Google Play or the App Store.

Access to the new Primary Care On Demand app for 24/7/365 care, including video visits with your doctor. Learn more and download the new mobile app: **PrimaryCareOnDemand.MayoClinic.org**

Get the care you need – when and where you need it

- **Direct access** to more than 20 hospitals and 60 clinics, including Mayo Clinic Health System locations in southern Minnesota and western Wisconsin, Mayo Clinic Primary Care in Rochester and Kasson, Northfield Hospital & Clinics, and Winona Health Services.
- **Nurse advisors** you can reach 24/7/365. Just call the number on the back of your Medica ID card.
- **A Travel Program Network** you can use when outside the service area (Minnesota, North Dakota, South Dakota, and western Wisconsin). The network is one of the largest in the country. And if you're a parent, even better: It covers your children when they're away at school. Emergency care services for students seeking care outside the ACO service area but within Medica's service area are covered at the in-network benefit level. For other health care services, they'll need to access care from a Medica CompleteHealth network provider for in-network benefits to apply.

Accountability to deliver better health + better care

Medica CompleteHealth is an Accountable Care Organization (ACO). What that means is simple: We collaborate with a network or team of providers (like clinics, hospitals, doctors, and specialists) to give you coordinated, high-quality care at a lower cost. When you get care from your ACO, you can feel better knowing that your provider team is dedicated to getting you the care you need, at the right place, and at the right time.

Get the most value by staying in-network

Remember to see providers in the Medica CompleteHealth network. If you get care outside the network, your costs will be much higher. You can find network providers here: **Medica.com/MedicaCompleteHealth.**

Need to change your clinic?

If you need to change to a clinic in the Medica CompleteHealth network, just follow these simple steps:

1. **Choose a primary care provider**. This is a doctor, nurse practitioner, or physician's assistant who will manage your total care. Primary care providers know your health history and can direct you to specialists, hospitals, and other health care providers, if needed.
2. **Transfer medical records from your previous clinic**. This helps your new providers know about your previous health conditions and treatments.
3. **Manage your prescriptions**. You may need to see your new provider before you can refill your prescriptions. To check on remaining refills, call your pharmacy. The pharmacist can contact your prescribing provider about the refill.

Create a Mayo Clinic patient portal account. Safely manage your health information and appointments: Go to **MayoClinicHealthSystem.org/Patient-Online-Services** or download the Mayo Clinic App from Google Play or the App Store.

Scan the code above with your phone's camera to find care options in your network.

Mayo Clinic® is an independent, nonprofit health care provider offering network access to its providers and health services. Mayo, Mayo Clinic, Mayo Clinic Health System and the triple-shield logo are registered trademarks and service marks of Mayo Clinic.

Have questions? We're here to help.

Want to know more about your benefits? Have another question? Call **1 (877) 252-5564 (TTY: 711)**

You can reach us Monday – Friday, 7am – 8pm CT (Closed 8am – 9am, Thursdays) and Saturday, 9am – 3pm CT. To get information about your benefits, go to **Medica.com/MedicaCompleteHealth**

Medical

Medica Choice Passport National Network

Locate an in-network provider near you at www.medica.com/find-care or call 800-952-3455.

This coverage gives you access to a national network with more than one million primary and specialty care providers in the network without a referral, and a plan that's easy to use, no matter where you are. This network allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	$2,500 PPO		$5,000 HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$2,500	$2,500	$5,000	$5,000
Family	$5,000	$5,000	$10,000	$10,000
Coinsurance (Plan Pays/You Pay)	80% / 20%	60% / 40%	100%	100%
Annual Out-of-Pocket Maximum				
Individual	$5,000	$5,000	$5,000	$5,000
Family	$10,000	$10,000	$10,000	$10,000
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care	Covered 100%	40%	Covered 100%	Covered 100%
Telemedicine Visit	20%	40%	0% After Deductible	0% After Deductible
Primary Care Office Visit	20%	40%	0% After Deductible	0% After Deductible
Specialist Office Visit	20%	40%	0% After Deductible	0% After Deductible
Urgent Care	20%	40%	0% After Deductible	0% After Deductible
Emergency Room	20%	20%	0% After Deductible	0% After Deductible
Hospitalization	20%	40%	0% After Deductible	0% After Deductible
Prescription Drugs	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Out-of-Pocket Maximum				
Individual	$750		Included in Medical	
Family	$1,500			
Generic Drugs	25%	25%	0% After Deductible	Not Covered
Preferred Brand Name Drugs	25%	25%	0% After Deductible	Not Covered
Non-Preferred Brand Name Drugs	Not Covered	Not Covered	0% After Deductible	Not Covered
Tier 4	25%	Not Covered	0% After Deductible	Not Covered

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

PLAN DETAILS

Medica Choice® Passport

The Right Care for You. Wherever You Go.

Medica Choice Passport gives you access to a large, national network with more than one million providers. If you're in your hometown or across the country, you can connect with the providers you know and trust to get the care you need.

An Experience You'll Love

- Direct access to any primary or specialty care provider in the Medica Choice Passport network without a referral.
- Exceptional network discounts and a member experience that focuses on you.

Travel with peace of mind. You'll find in-network providers in every corner of the country.

Access to virtual and behavioral health care options, and wellness extras to help you stay healthy and feel better.

Scan the code above with your phone's camera to find care options in your network. You'll need to select your specific Passport Plan.

Have questions? We're here to help.

Want to know more about your benefits? Have another question? Call Member Services at the number on the back of your Medica ID card **(TTY: 711)**

You can reach us Monday – Friday, 7am – 8pm CT (Closed 8am – 9am, Thursdays) and Saturday, 9am – 3pm CT. To get information about your benefits, go to **Medica.com/FindCare** and select your *Medica Choice Passport* plan.

Medica.

Information for Those Eligible for Medicare

What are my options once I turn 65?

If you continue to work full-time, you may remain on the company medical plan as long as you meet the eligibility requirements. However, you may also be eligible for Medicare A & B, a Medicare Supplement and Medicare D.

Please read the summary below and explore your options to determine what is best in your situation.

Multiple Medicare Resources Available

Next Level Planning and Wealth Management

- Get advice from Licensed insurance agents at no cost or obligation to enroll
- Explore plans from numerous health insurance companies
- Learn more about Medicare and be guided through the process
- 1 on 1 assistance with benefit and financial planning
- Call (414) 369-6628 or visit www.NLPWM.com

Connect with a Medicare consultant.

- (414) 369-6620
- www.nlpm.com

Our Medicare library is available 24/7 online. Here you can browse videos, download guides/presentations, listen to an agent and access information at your convenience.

Visit the Medicare library: www.employeenavigator.com/benefits/Account/Login

Login using the following credentials:

- USERNAME: Medicare
- PASSWORD: Benefits65

You may also complete the **Permission to Contact Form** to speak to an agent and receive assistance with questions related to Medicare as well as explore affordable options available based on your specific needs. Use your phone's camera to scan the QR code, or enter this link in your web browser to complete the Permission to Contact Form –

Want NLP to reach out?

Scan QR code or visit:
https://app.smartsheet.com/b/form/9f83ac0937fe480b8d110c7c09a77ed3

https://app.smartsheet.com/b/form/9f83ac0937fe480b8d110c7c09a77ed3

It is important to note that **Medicare resources and options vary by state.** Each state has a **SHIP** (Senior Health Insurance Information Program) that offers free education and assistance specific to their state. To find your state resource and get the number to speak to a licensed counselor, you may either **visit: www.shiptacenter.org, call 877-839-2675 or email: info@shiptacenter.org.**

Additional Information (Government resources):

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.Medicare.gov

How else can Next Level Planning assist you?

Financial, Retirement & Estate Planning

Health Insurance

Business Planning & Executive Benefits

Insurance & Investments

Financial Education

Flexible Spending Account

Wex

*Available to employees enrolled in the **Diocese of Winona-Rochester medical plans**.*

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2025 annual contribution limit	$3,300

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

Limited-Purpose FSA

If you contribute to an HSA, you are only eligible to use a Health FSA for dental and vision expenses only.

2025 annual contribution limit	$3,300

Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Summer day camp
- Before and after school programs
- Elder care

2025 annual contribution limit	Married (Filing separately)	$2,500
	Single/Married (Filing jointly)	$5,000

Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa

Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

Telemedicine

Amwell or Virtuwell

Available to employees enrolled in the ***Diocese of Winona-Rochester medical plans****.*

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions.

Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.[1]

When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Access care wherever you are!

Check care options at mhc2.welcometomedica.com/home

Get the treatment you need:

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore throat
- Pink eye
- Urinary tract infections

[1] Prescription services may not be available in all states.

Dental

Delta Dental

Employees who enroll in either of the Medica medical plans are automatically enrolled in dental coverage through Delta Dental. This coverage is not available as a stand-alone benefit, and cannot be purchased separate from the medical coverage.

Dental	Delta Dental PPO Network	Delta Dental Premier Network	Non-Participating* Network
Annual Deductible		$50 per individual $150 per family	
Annual Benefit Maximum		$1,500	
Lifetime Orthodontia Maximum		$1,000	
Plan Pays	**Delta Dental PPO Network**	**Delta Dental Premier Network**	**Non-Participating* Network**
Preventive Care (Deductible waived)	100% Covered	100% Covered	100% Covered
Basic	80%	80%	80%
Major	50%	50%	50%
Orthodontia	50%	50%	50%

Locate an in-network provider near you at www.deltadentalmn.org/find-a-dentist or call 800-448-3815.

* Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Life/AD&D

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life - Unum	
Benefit Amount	**Employee:** Up to $50,000*
Benefit Cost	**Employer-paid – No cost to you!**

Voluntary Term Life - Unum	
Benefit Amount	**Employee:** Up to $500,000 **Spouse:** Up to 100% of employee amount, not to exceed $500,000^ **Child(ren):** Up to $10,000^
Guaranteed Issue Amount[A]	**Employee:** $200,000 **Spouse:** $25,000
Benefit Cost	**To view your personalized rates, refer to your benefit highlight sheet or intranet for details.**

Accidental Death & Dismemberment – Mutual of Omaha	
Benefit Amount	**1.5 x your annual salary, up to $50,000**
Benefit Cost	**Employer-paid – No cost to you!**

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

Definition of “Eligible Dependents”
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.

^ Dependent elections require employee enrollment and may be limited by employee volume.

A If you enroll when first eligible, you may receive up to the listed amount without having to answer medical questions.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Long-Term Disability

Unum

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

The Diocese of Winona-Rochester believes that protecting your income is important, which is why you will be automatically enrolled in long-term disability coverage once eligible.

Long-Term Disability	
Benefit Amount	Replaces 60% of earnings, up to a $5,000 benefit per month
Benefit Begins	After a period of 90 days
Benefit Duration	Up to Social Security normal retirement age (SSNRA)
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period

Long-Term Disability Cost	Employer-paid – No cost to you!

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Employee Assistance Program

Unum

Available to all employees.

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you and your family, including parents and parents-in-law, find solutions and peace of mind.

Confidential Support

- Alcohol or substance abuse
- Childcare
- Eldercare
- Financial problems
- Gambling addiction
- Grief and loss
- Job pressures
- Mental health
- Legal concerns
- Relationships

Connect with a counselor.

800-854-1446

www.unum.com/lifebalance

Receive up to 3 FREE in-person counseling sessions!

If you need additional support, the EAP team will try to refer you to resources that are affordable or covered by your medical insurance.

Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Discount Program			
Shop for a Variety of Coupons & Deals from these Categories:	Apparel Auto Buying Automotive Beauty & Fragrance Books, Movies, & Music Business Perks Cell Phones Education Electronics Financial Wellness Flowers & Gifts Food Health & Wellness Hobbies & Creative Arts	Home & Garden Home Services Insurance & Protection Services Jewelry & Watches Movie Tickets Office & Business Pets Real Estate & Moving Services Sports & Outdoors Tickets & Entertainment Toys, Kids & Babies Travel	
Popular Discounted Brands*	Avis Canon Casper Columbia	Dell Enterprise Holiday Inn	Home Chef HP Ray-Ban
Benefit Cost	Included in our partnership with Cottingham & Butler – no cost to you!		

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at https://cottinghambutler.perkspot.com.

Unlock discounts for you and your family!

Visit: https://cottinghambutler.perkspot.com

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alters: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

Additional Benefits

The benefits listed below are available to you at no additional cost!

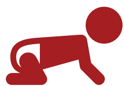
My Health Rewards

Available to all employees covered under our Medical policies.

Earn points with My Health Rewards, an online tool that helps you take small steps to reach your health goals. As a subscriber, you can earn up to $345, and any covered dependents 18 years and older can earn up to $225 in rewards each year. Download the free Virgin Pulse app to get started.

Medica

Medica.com/MHC



Ovia Health

Available to all employees covered under any of our medical plans.

Support for your parenthood journey. Ovia Health guides you through your pregnancy, parenting and reproductive health journey. Get clinically-backed content and unlimited support from Ovia's team of health coaches, registered nurses, and certified nurse midwives.

Download the apps:

Ovia (reproductive health)

Ovia Pregnancy

Ovia Parenting

Life Time® Digital Fitness Program

Available to all employees covered under any of our medical plans.

Stay fit anywhere, anytime. Kickstart healthy habits with a Life Time Digital membership at no additional cost to you. Download the app to get started.

www.Medica.com/LifeTime

Omada

Available to all employees covered under any of our medical plans.

Personalized support to reach your health goals. Omada's digital health programs give you the tools and support you need.

- Omada for Prevention
- Omada for Diabetes
- Omada for Joint & Muscle Health

www.OmadaHealth.com/MHC

Hearing Aid Discount

Available to all employees covered under our Medical policies.

Two great options to choose from: Amplifon and Start Hearing. 60-day risk-free trial from either company and free batteries.

Amplifon

888-831-4388

amplifonusa.com/medica

Start Hearing

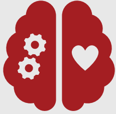
855-687-4924

Starthearing.com/partners/medica

Behavioral Health Resources

Available to all employees covered under any of our medical plans.

If you're having behavioral health concerns, there are resources to support you.



- **Medica Behavioral Health** offers services that include mental health and substance abuse support. Call **(800) 848-8327** any time to talk with a care advocate.
- **Self Care by AbleTo** is an on-demand support app to help with stress and emotional well-being. Visit **AbleTo.com/Begin** and tap "Get Started", then enter "Medica" when asked for your access code. Or, download the **AbleTo** app on your device to begin your journey.
- **Family Support Program + Navigator** offers resources and support for caregivers of children (ages 0 – 18) with complex behavioral health needs. Call **(877) 495-9422** or visit **LiveAndWorkWell.com**.
- **Talkspace** helps you work with a licensed therapist anywhere, anytime. Send private messages (text or voice) or schedule live video sessions. Go to **Talkspace.com/Connect** , select "Medica" in the drop-down menu under "Use my Insurance Benefits", and answer a few questions to get started.

Medica
Medica.com/SignIn

Healthcare Tips

Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

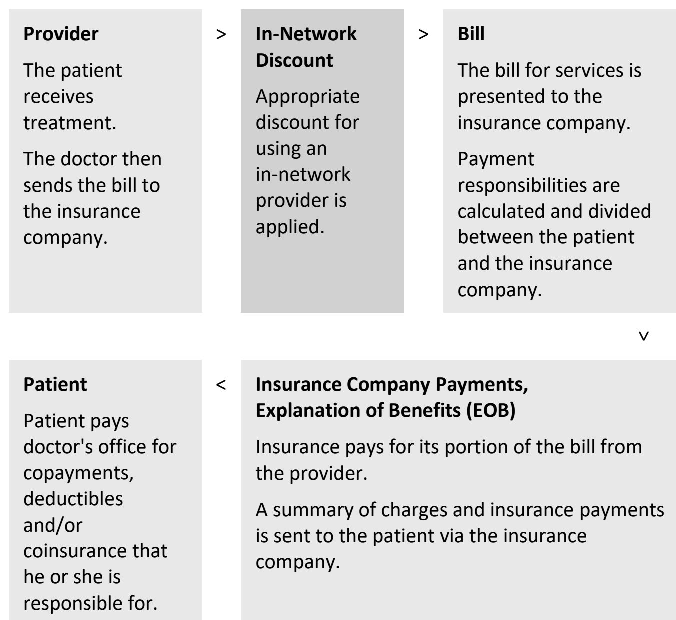
- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.



Take advantage of preventive care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Diocese of Winona-Rochester Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2024. V 0.4.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
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

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

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

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

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

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

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

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

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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

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

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

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

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

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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 ❖

Women's Health and Cancer Rights Act of 1998

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.
- 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 this plan. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers

offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may 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). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

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

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 8.39% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

How Can Individuals Get More Information?

For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

* 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% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)

If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

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

HIPAA Notice of Privacy Practices
The Diocese of Winona-Rochester Group Medical Plan (the "Plan"), which includes medical, dental and flexible spending account coverages offered under the Diocese of Winona-Rochester Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Diocese of Winona-Rochester has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
Diocese of Winona-Rochester is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and

disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Diocese of Winona-Rochester, 2907 Jeremiah Lane NW, Rochester MN 55901, 507-858-1250.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Diocese of Winona-Rochester, 2907 Jeremiah Lane NW, Rochester MN 55901, 507-858-1250. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Diocese of Winona-Rochester, 2907 Jeremiah Lane NW, Rochester MN 55901, 507-858-1250. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Diocese of Winona-Rochester, 2907 Jeremiah Lane NW, Rochester MN 55901, 507-858-1250. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Diocese of Winona-Rochester, 2907 Jeremiah Lane NW, Rochester MN 55901, 507-858-1250. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Diocese of Winona-Rochester, 2907 Jeremiah Lane NW, Rochester MN 55901, 507-858-1250 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Diocese of Winona-Rochester, 2907 Jeremiah Lane NW, Rochester MN 55901, 507-858-1250. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Diocese of Winona-Rochester Health Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Diocese of Winona-Rochester 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. Diocese of Winona-Rochester has determined that the prescription drug coverage offered by the Diocese of Winona-Rochester 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 Diocese of Winona-Rochester coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Diocese of Winona-Rochester 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 Diocese of Winona-Rochester 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 Diocese of Winona-Rochester 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: 10/29/2024
Name of Entity/Sender: Diocese of Winona-Rochester
Contact--Position/Office: Human Resources
Address: 2907 Jeremiah Lane NW, Rochester MN 55901
Phone Number: 507-858-1250 ❖

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Benefits Guide