Bookkeeper Training

Presented By:

Archdiocese of Miami Health Plan

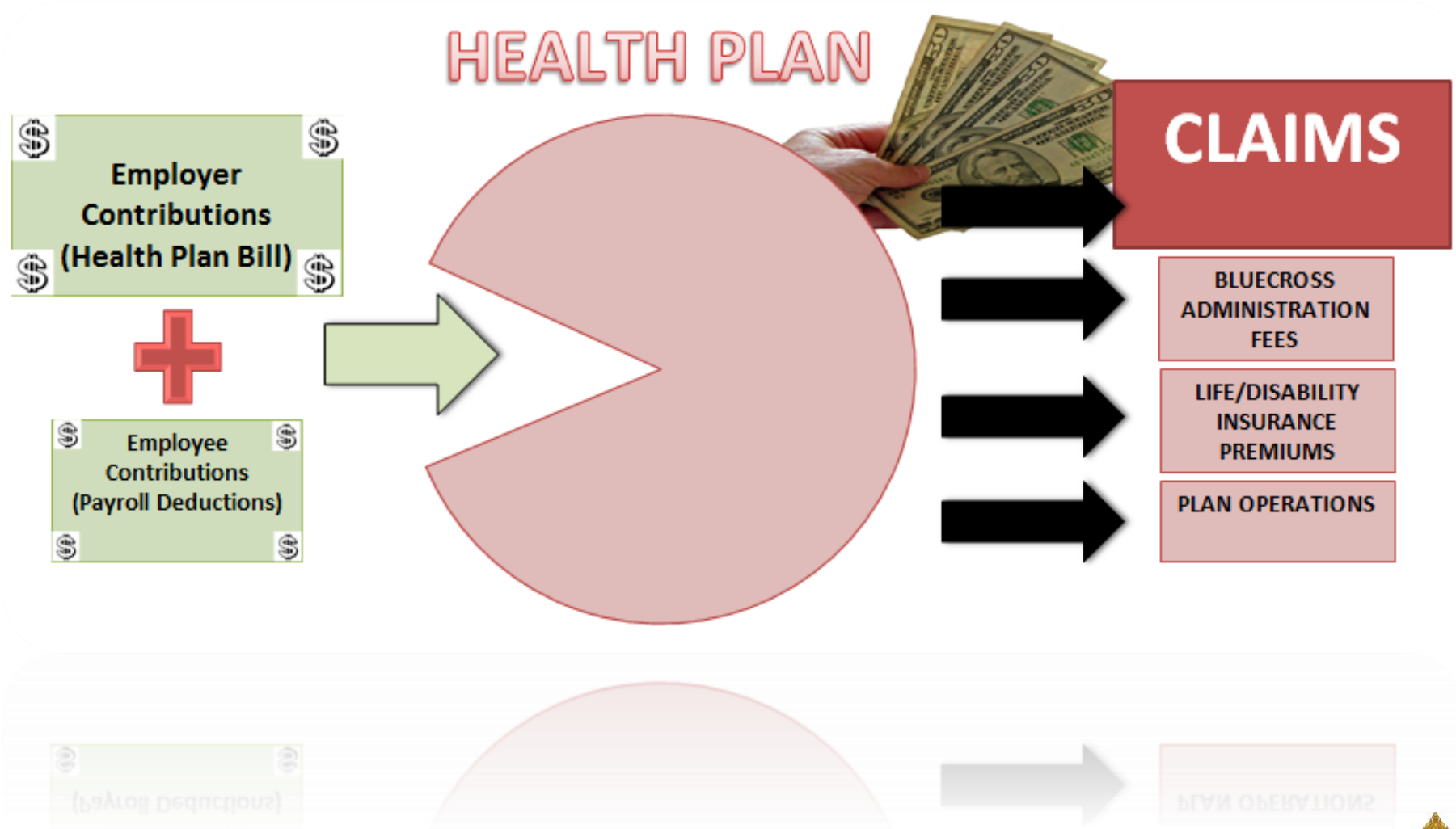
October 24, 2014

Location: Archdiocese of Miami Pastoral Center

Archdiocese of Miami Health Plan

- Established by the Archbishop of Miami in 1969 to provide benefits to the employees of the Archdiocese.
  - Governed by a Board of Trustees under the Archbishop's guidance.
- The Health Plan is a self-funded, non-ERISA Church plan.
- The Health Plan office is responsible for management of the plans, in accordance with contracts, policies, government regulations and church doctrine.
- Support is given to entity administrators in providing appropriate benefits to more than 7,000 employees at 300 locations.

Where Does the Money Go?


HEALTH PLAN
Employer Contributions (Health Plan Bill)
Employee Contributions (Payroll Deductions)
CLAIMS
BLUECROSS ADMINISTRATION FEES
LIFE/DISABILITY INSURANCE PREMIUMS
PLAN OPERATIONS

Health Plan Features

EMPLOYER PAID BENEFITS	EMPLOYER/ EMPLOYEE PAID BENEFITS	VOLUNTARY EMPLOYEE PAID BENEFITS	ADDITIONAL FEATURES
Basic Life Insurance	PPO Medical Plan	PPO/HMO Dental Plan	FMLA Administration
Accidental Death & Dismemberment	HMO Medical Plan	EyeMed Select Prepaid Vision Plan	Disability Coordination
Long-Term Disability	HMO Value Medical Plan	Supplemental Life, Spouse Life/ Short Term Disability Insurance	403 (b)
		Critical Illness Insurance	Wellness

Health Plan Eligibility

An active lay employee directly employed in the regular business of and compensated for services by the Archdiocese of Miami or entities of the Archdiocese and classified as either:

1. **Full-time regular employee, whose budgeted scheduled workweek is forty (40) hours; OR**
2. **Part-time regular employee, whose budgeted scheduled workweek is less than forty (40) hours but at least 30 hours per week.**

Dependent Eligibility

Spouse

- Your lawful spouse.

Children

- Children from birth to age 26
- Children over age 26 incapable of self support
- Children between the ages of 26 and 30
  - Unmarried without dependents of their own; and
  - A Florida resident or a student; and
  - Not covered under any other health plan or policy; and
  - Not entitled to coverage under Medicare

Basic Life/AD&D Insurance
-The Hartford-

The Archdiocese of Miami provides benefit-eligible employees with $15,000 of basic term life insurance and an additional $15,000 of accidental death and dismemberment (AD&D) insurance.

- It is important to have a beneficiary on file with up to date and accurate contact information
- The Basic Life insurance can be converted to an Individual Conversion Policy through Hartford Life

Long-Term Disability
-The Hartford-

Benefit-eligible employees are eligible for Long-Term Disability

- If disability continues past 90 days
  - LTD benefits begin
  - Monthly benefit is equal to 61% of base salary
  - Must be totally disabled (Defined by LTD Policy)
  - Pre-Existing Condition exclusions apply
  - Payments are reduced by Social Security, pension or other disability income
  - Max benefit of $7,000 per month

Medical
-Florida Blue-

BlueChoice PPO Medical Plan

- Allows In-Network and Out-of-Network benefits
  - Lower cost to employees at the In-network level
- Annual deductible and coinsurance

BlueCare HMO Standard Medical Plan

- In-Network services only
- Copay structure
- Primary Care Physician (PCP) must be selected
  - No benefits for out-of-network providers except in emergency

BlueCare HMO Medical Value Plan

- In-Network services only
- Annual deductible, copayment and coinsurance features
- Primary Care Physician (PCP) must be selected

Medical

	BlueChoice PPO Plan Deductible/Coinsurance Plan In-Network / Out-of-Network	BlueCare HMO Standard Plan 100% coverage after copay In-Network only	BlueCare HMO Value Plan Copay / Deductible / Coinsurance In-Network only
Calendar Year Deductible	$600 individual $1,800 family	no deductible	$500 individual $1,000 family
Coinsurance	80% network/50% non-network	no coinsurance	70% in network only
Office Visits	80% network/50% non-network after deductible	Primary Care $15 Blue Physician Recognition Network $25 BlueCare Specialist Physician $50 Specialist	Primary Care $20 Blue Physician Recognition Network $30 BlueCare Specialist Physician $60 Specialist
Maximum Calendar Year Out-of-Pocket	$4,000 individual $8,000 family	$2,500 individual $5,000 family	$4,000 individual $8,000 family
Preventive Care	$0 deductible; 100% in-network $600 deductible; 50% non-network	$0 copay	$0 copay covered 100% network
Inpatient Hospital Services	80% network/50% non-network after deductible additional $300 per admission deductible at non-network hospitals	$300 copay per day maximum charge of five days	80% network/50% non-network after deductible
Outpatient Hospital Services **(includes Ambulatory Surgery Center)**	80% network/50% non-network after deductible	$250 copay	80% network/50% non-network after deductible
Outpatient Therapy	80% network/50% non-network after deductible	$25 copay	80% network/50% non-network after deductible

Medical

	BlueChoice PPO Plan Deductible/Coinsurance Plan In-Network / Out-of-Network	BlueCare HMO Standard Plan 100% coverage after copay In-Network only	BlueCare HMO Value Plan Copay / Deductible / Coinsurance In-Network only
Emergency Room Care	$50 copay, then $600 deductible/80% coinsurance	$250 copay in-network and non-network	$250 copay in-network and non-network
Urgent Care Center	80% network/50% non-network after deductible	$50 copay	$60 copay
Lab & X-Ray Services	80% network/50% non-network after deductible	$0 copay * $50 copay ** $200 copay ***	$0 copay * $50 copay ** $200 copay ***
Advanced Imaging			
Outpatient Hospital	80% network/50% non-network after deductible	$250 copay	$250 copay
Freestanding Facility	80% network/50% non-network deductible waived	$50 copay	$50 copay
Retail Pharmacy Program	network only		
Generic Drugs	$10 copay	$7 copay	$10 copay
Preferred Brand Name Drugs	$50 copay	$40 copay	$40 copay
Non-Preferred Brand Name Drugs	$75 copay	$65 copay	$60 copay
Maximum Supply	30 days	30 days	30 days
Mail Order Pharmacy Program			
Generic Drugs	$20 copay	$14 copay	$20 copay
Preferred Brand Name Drugs	$100 copay	$80 copay	$80 copay
Non-Preferred Brand Name Drugs	$150 copay	$130 copay	$120 copay
Maximum Supply	90 days	90 days	90 days

Introducing the Blue Physician Recognition Network (BPR)

- Smaller, selective network
  - Contracts physicians demonstrating commitment to:
    - Quality
    - Patient-centered care
- HMO Standard and HMO Value Plan participants receive a discount for visiting a Blue Physician Recognition Primary Care Physician (PCP)

Plan	PCP Copayment	Reduced to…
HMO Standard Plan	$25	$15
HMO Value Plan	$30	$20

Dental
-Florida Combined Life-

BlueDental Choice PPO Plan

- Allows In-Network and Out-of-Network benefits
  - Lower cost to employees at the In-network level
- Annual deductible, coinsurance and annual maximum benefit

BlueDental Care Prepaid HMO

- In-Network services only
- Copay structure
- Primary Care Dentist must be selected

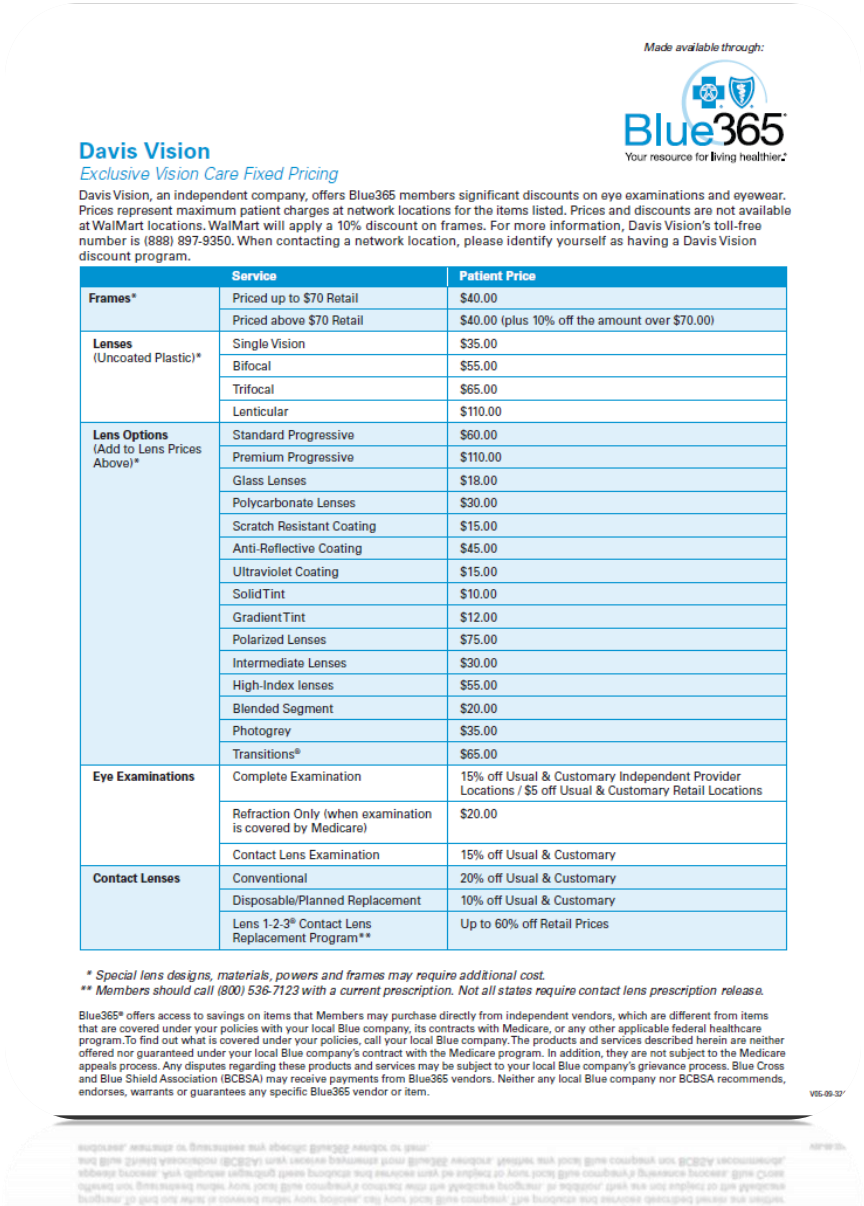
Vision Plan Overview

Category	Monthly Rates
Employee only	$ 5.56
Employee & Spouse	$ 10.88
Employee & Children	$ 10.65
Employee & Family	$ 15.98

	EyeMed Select Network	Out of Network
Exam	$10 Deductible	No Deductible Up to $30
Eye Glass Lenses	$20 Deductible	No Deductible Up to $30
Annual Eye Exam	Covered in full	No Deductible Up to $30
Frames	$130	Up to $65

EyeMed
VISION CARE®

Davis Vision



Made available through:

Blue365
Your resource for living healthier.

Davis Vision

Exclusive Vision Care Fixed Pricing

Davis Vision, an independent company, offers Blue365 members significant discounts on eye examinations and eyewear. Prices represent maximum patient charges at network locations for the items listed. Prices and discounts are not available at WalMart locations. WalMart will apply a 10% discount on frames. For more information, Davis Vision's toll-free number is (888) 897-9350. When contacting a network location, please identify yourself as having a Davis Vision discount program.

	Service	Patient Price
Frames*	Priced up to $70 Retail	$40.00
	Priced above $70 Retail	$40.00 (plus 10% off the amount over $70.00)
Lenses (Uncoated Plastic)*	Single Vision	$35.00
	Bifocal	$55.00
	Trifocal	$65.00
	Lenticular	$110.00
Lens Options (Add to Lens Prices Above)*	Standard Progressive	$60.00
	Premium Progressive	$110.00
	Glass Lenses	$18.00
	Polycarbonate Lenses	$30.00
	Scratch Resistant Coating	$15.00
	Anti-Reflective Coating	$45.00
	Ultraviolet Coating	$15.00
	SolidTint	$10.00
	GradientTint	$12.00
	Polarized Lenses	$75.00
	Intermediate Lenses	$30.00
	High-Index lenses	$55.00
	Blended Segment	$20.00
	Photogrey	$35.00
	Transitions®	$65.00
Eye Examinations	Complete Examination	15% off Usual & Customary Independent Provider Locations / $5 off Usual & Customary Retail Locations
	Refraction Only (when examination is covered by Medicare)	$20.00
	Contact Lens Examination	15% off Usual & Customary
Contact Lenses	Conventional	20% off Usual & Customary
	Disposable/Planned Replacement	10% off Usual & Customary
	Lens 1-2-3® Contact Lens Replacement Program**	Up to 60% off Retail Prices

** Special lens designs, materials, powers and frames may require additional cost.*
*** Members should call (800) 536-7123 with a current prescription. Not all states require contact lens prescription release.*

Blue365® offers access to savings on items that Members may purchase directly from independent vendors, which are different from items that are covered under your policies with your local Blue company, its contracts with Medicare, or any other applicable federal healthcare program.To find out what is covered under your policies, call your local Blue company.The products and services described herein are neither offered nor guaranteed under your local Blue company's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to your local Blue company's grievance process. Blue Cross and Blue Shield Association (BCBSA) may receive payments from Blue365 vendors. Neither any local Blue company nor BCBSA recommends, endorses, warrants or guarantees any specific Blue365 vendor or item.

V05-09-32

- Free Discount Program
  - Frames
  - Lenses
  - Lens Options
  - Eye Exams
  - Contact Lenses

Critical Illness

- Voluntary Plan
- Lump sum benefit when you are diagnosed with a critical illness
- Underwritten by AFLAC

Benefit features
Benefits paid directly to you unless you choose otherwise
Coverage available for you, your spouse and dependent children
Coverage is portable
No medical questions up to $30,000
Benefits not reduced after age 70

Critical Illness

What is a critical illness?	
Critical Illnesses **Covered at 100%**	**Specified Critical Illnesses** **Covered at 100%**
Cancer (Internal or Invasive)	Coma
Heart Attack	Paralysis
Major Organ Transplant	Sever Burn
Kidney Failure (End-Stage)	Loss of Sight
Stroke (Ischemic or Hemorrhagic)	Loss of Hearing
	Loss of Speech
	Benign Brain Tumor

What Surgeries are Covered at 100%?
Coronary Artery Bypass Surgery
Mitral valve Replacement or Repair
Aortic Valve Replacement or Repair
Surgical Treatment of Abdominal Aortic Aneurysm

CRITICAL ILLNESS BENEFIT ILLUSTRATIONS

Critical Illness Event Illustration 1: Heart Attack

An example of an estimated average cost to traditional health insurers for the first 90 days following a heart attack is $39,000**.

** (source from the American Heart Association)

DIRECT COST	PPO PLAN	STANDARD PLAN	VALUE PLAN
Medical Cost – Estimated Example	$ 39,000	$ 39,000	$ 39,000
Health Insurance Pays - Estimated	35,000	36,500	35,000
Medical Cost You Pay (Deductibles/copay-Estimated)	**4,000**	**2,500**	**4,000**
With Critical Illness of $10,000 Benefit PAID TO YOU	**$ 10,000**	**$ 10,000**	**$ 10,000**
Estimated remaining money to pay for household bills and/or loss of income	**$ 6,000**	**$ 7,500**	**$ 6,000**

Example of Plan Selection and Cost

Employee + Spouse		Employee Only	
Age 50-54 Non-smokers		***Age 55-59 Non-smokers***	
Benefit Amount: Employee	*$10,000*	*Benefit Amount: Employee*	*$10,000*
Spouse	*$5,000*	*Spouse*	*-0-*
Dependent	*$5,000*	*Dependent*	*$5,000*
Monthly Premium		*Monthly Premium*	
Employee	*25.45*	*Employee*	*38.15*
Spouse	*13.60*	*Spouse*	*0.00*
Total Monthly Cost	***$ 39.05***	***Total Monthly Cost***	***$ 38.15***

DEPENDENT(S) COVERED AT NO COST

Critical Illness Event Illustration 2: Breast Cancer

An example of an estimated average cost to traditional health insurers for non-major breast cancer is $66,000**.

** (Jon Gabel, senior fellow in the health care research department at the National Opinion Research Center office in Bethesda, Md. Everyday Health 5-17-2010)

DIRECT COST	PPO PLAN	STANDARD PLAN	VALUE PLAN
Medical Cost – Estimated Example	$ 66,000	$ 66,000	$ 66,000
Health Insurance Pays - Estimated	62,000	63,500	62,000
Medical Cost You Pay (Deductibles/copay-Estimated)	**4,000**	**2,500**	**4,000**
With Critical Illness of $15,000 Benefit PAID TO YOU	**$ 15,000**	**$ 15,000**	**$ 15,000**
Estimated remaining money to pay for household bills and/or loss of income	**$ 11,000**	**$ 12,500**	**$ 11,000**

Example of Plan Selection and Cost

Employee + Spouse		Employee Only	
Age 45-49 Non-smokers		***Age 45-49 Non-smokers***	
Benefit Amount: Employee	*$15,000*	*Benefit Amount: Employee*	*$15,000*
Spouse	*$7,500*	*Spouse*	*-0-*
Dependent	*$7,500*	*Dependent*	*$5,000*
Monthly Premium		*Monthly Premium*	
Employee	*26.80*	*Employee*	*26.80*
Spouse	*14.28*	*Spouse*	*0.00*
Total Monthly Cost	***$ 41.08***	***Total Monthly Cost***	***$ 26.80***

DEPENDENT(S) COVERED AT NO COST

Supplemental Life Insurance

- Employees can purchase up to $100,000 of life insurance with no medical questions
  - If elected within 30 days of hire
    - Can also purchase up to $30,000 of spousal coverage without medical questions
- Employees can also purchase up to $300,000 of life insurance for themselves and up to $150,000 for their spouse
  - Medical questions are required
- The employee has the option, after separation of employment, to purchase and individual conversion policy.
  - Employee is billed directly
  - Administered by the Hartford

Voluntary Short-Term Disability -The Hartford-

- If elected within 30 days of hire date
  - No medical questions will be required
- If elected at a later time
  - Can apply any time
  - Medial questions will be required
  - Possibility of denial
- STD coverage pays a benefit equal to 66.67% of base weekly pay
  - $600 max per week
  - Up to 13 weeks
  - Payments start on first day you're injured or the 8th day of an illness

Voluntary Short-Term Disability Calculation

HOW TO CALCULATE YOUR MONTHLY COST

1. Divide your annual salary by 52 _____
2. Multiply the amount in step 1 by .667 _____
   (if greater than $600, enter $600)
3. Divide the amount in step 2 by 10 _____
4. Multiply amount in step 3 by the rate in the box
   (This is your monthly cost) _____

AGE	RATE
29 and under	$ 0.56
30-34	$ 0.57
35-39	$ 0.58
40-44	$ 0.69
45-49	$ 0.74
50-54	$ 0.89
55-59	$ 1.16
60-64	$ 1.42
65+	$ 1.60

Example:
Salary: $30,000
Age: 38

1) **$30,000/52= $576.92**
2) **$576.92 X .667= $384.81**
3) **$384.81/10= $38.48**
4) **$38.48 X $0.58= $22.32 (Monthly Cost)**

2014-2015 Health Plan Rates

2014-2015 Archdiocese of Miami Health Plan

Monthly Contributions Effective July 1, 2014

Employer Contribution

Clergy

Base Plan	$ 1,287.00

Religious

Religious Plan	$ 632.00
Retired Religious Plan	$ 393.00

Laity

Medical (All Plans)	$ 468.00

Active Laity, Clergy and Religious

Life/ADD&D/LTD	$ 14.00

Active Employees (Medical)

	BlueChoice PPO Plan	BlueCare HMO Standard Plan	BlueCare HMO Value Plan
Employee Only	$ 270.00	$ 103.00	$ 20.00
Employee & Spouse	$ 826.00	$ 417.00	$ 258.00
Employee & Child (ren)	$ 751.00	$ 360.00	$ 213.00
Employee & Family	$ 1,010.00	$ 589.00	$ 397.00
Each Child 26-30	$ 738.00	$ 571.00	$ 488.00

Active Employees (Dental/Vision)

	BlueChoice PPO Dental	BlueCare HMO Dental	EyeMed Voluntary
Employee Only	$ 50.00	$ 14.00	$ 5.56
Employee & Spouse	$ 106.00	$ 28.00	$ 10.88
Employee & Child (ren)	$ 95.00	$ 23.00	$ 10.65
Employee & Family	$ 134.00	$ 40.00	$ 15.98

Clergy/Retired Clergy

Base Plan

Clergy/Retired Clergy	$ 0.00

Buy-Up Plan

Clergy/Retired Clergy	$ 120.00

Religious/Retired Religious

Religious Plan

Religious	$ 0.00

Retired Religious Plan

Retired Religious	$ 0.00

Active Laity, Clergy and Religious

Life/AD&D/LTD

Employee Cost	$ 0.00

2014-2015 Health Plan Rates

Continuation Plan (Medical)

	BlueChoice PPO Plan	BlueCare HMO Plan	BlueCare HMO Value
Employee Only	$ 752.00	$ 582.00	$ 497.00
Employee & Spouse	$ 1,319.00	$ 902.00	$ 740.00
Employee & Child (ren)	$ 1,243.00	$ 844.00	$ 694.00
Employee & Family	$ 1,507.00	$ 1,078.00	$ 882.00
Each Child 26-30	$ 752.00	$ 582.00	$ 497.00

Continuation Plan (Dental)

	BlueCare HMO	BlueChoice PPO
Employee Only	$ 15.00	$ 51.00
Employee & Spouse	$ 29.00	$ 107.00
Employee & Child (ren)	$ 23.00	$ 97.00
Employee & Family	$ 41.00	$ 136.00

Retiree with Medicare (Medical)

	BlueChoice PPO Plan	Medicare Advantage PPO
Employee Only	$ 515.00	$ 415.55
Spouse	$ 515.00	$ 415.55

Retiree without Medicare (Medical)

	BlueChoice PPO Plan	BlueCare HMO Standard	BlueCare HMO Value Plan
Employee Only	$ 738.00	$ 571.00	$ 488.00
Employee & Spouse	$ 1294.00	$ 885.00	$ 726.00
Employee & Child (ren)	$ 1219.00	$ 828.00	$ 681.00
Employee & Family	$ 1,478.00	$ 1057.00	$ 865.00
Each Child 26-30	$ 738.00	$ 571.00	$ 488.00

Retiree (Dental/Vision)

	BlueChoice PPO Dental Plan	BlueCare HMO Dental Plan	EyeMed Voluntary Vision Plan
Employee Only	$ 50.00	$ 14.00	$ 5.56
Employee & Spouse	$ 106.00	$ 28.00	$ 10.88
Employee & Child (ren)	$ 95.00	$ 23.00	$ 10.6
Employee & Family	$ 134.00	$ 40.00	$ 15.9

Enrollment Timing

INITIAL ELIGIBILITY PERIOD

- MEDICAL
- DENTAL
- BASIC LIFE/AD&D
- LONG TERM DISABILITY
- SHORT TERM DISABILITY (WITHOUT PROOF OF GOOD HEALTH)
- VOLUNTARY SUPPLEMENTAL LIFE
  - UP TO $100,000 FOR EMPLOYEE AND UP TO $30,000 FOR SPOUSE WITHOUT PROOF OF GOOD HEALTH
  - UP TO $300,000 FOR EMPLOYEE AND UP TO $150,000 WITH PROOF OF GOOD HEALTH
- CRITICAL ILLNESS
  - UP TO $30,000 FOR EMPLOYEE AND UP TO $15,000 FOR SPOUSE WITHOUT PROOF OF GOOD HEALTH

THE SPOUSE CAN NOT HAVE MORE THAN 50% OF THE EMPLOYEE'S VOLUNTARY SUPPLEMENTAL LIFE

Effective Hire Date → **30 DAYS**

ANNUAL ENROLLMENT

- MEDICAL
- DENTAL
- SHORT TERM DISABILITY (WITH PROOF OF GOOD HEALTH)
- VOLUNTARY SUPPLEMENTAL LIFE
  - UP TO $100,000 FOR EMPLOYEE AND UP TO $30,000 FOR SPOUSE WITH PROOF OF GOOD HEALTH
  - UP TO $300,000 FOR EMPLOYEE AND UP TO $150,000 WITH PROOF OF GOOD HEALTH
- CRITICAL ILLNESS
  - UP TO $30,000 FOR EMPLOYEEAND UP TO $15,000 FOR SPOUSE WITHOUT PROOF OF GOOD HEALTH

THE SPOUSE CAN NOT HAVE MORE THAN 50% OF THE EMPLOYEE'S VOLUNTARY SUPPLEMENTAL LIFE

Annually → **MAY**

EFFECTIVE JULY 1ST

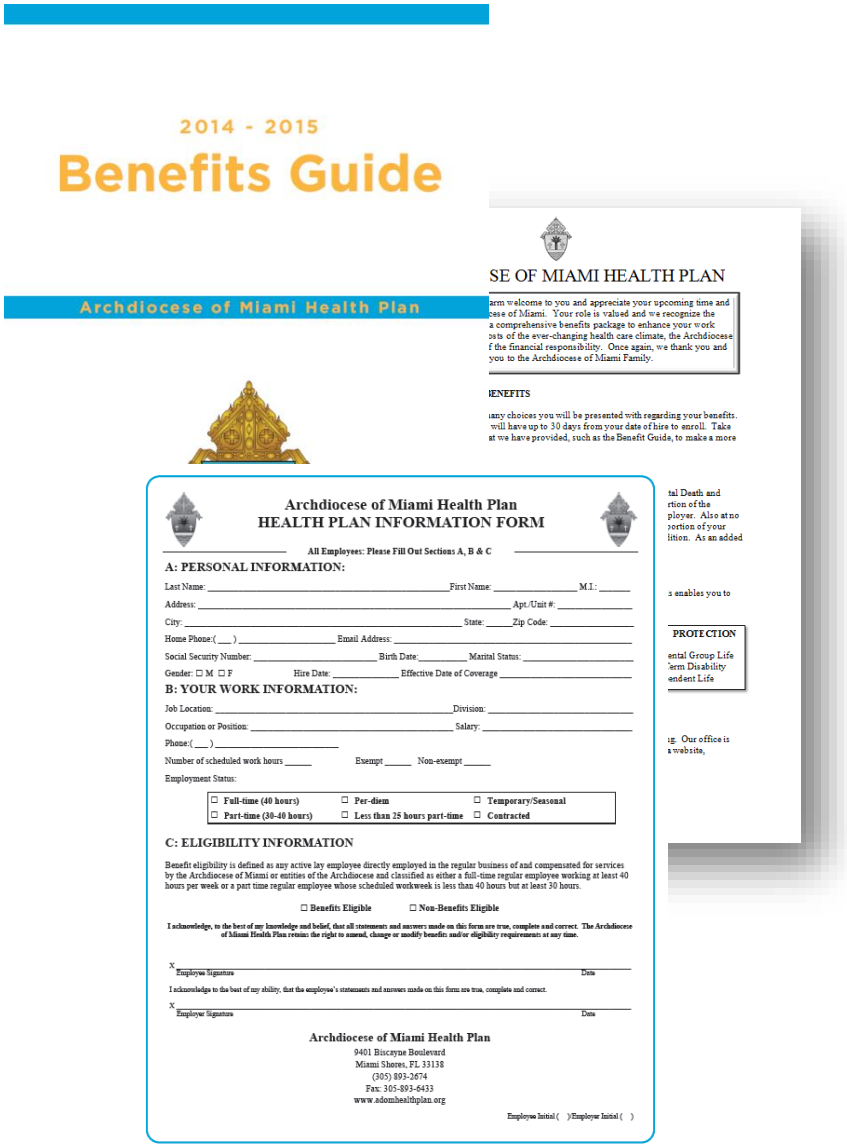
SPECIAL ENROLLMENT

- MEDICAL
- DENTAL
- SHORT TERM DISABILITY (WITH PROOF OF GOOD HEALTH)
- VOLUNTARY SUPPLEMENTAL LIFE
  - UP TO $100,000 FOR EMPLOYEE AND UP TO $30,000 FOR SPOUSE WITH PROOF OF GOOD HEALTH
  - UP TO $300,000 FOR EMPLOYEE AND UP TO $150,000 WITH PROOF OF GOOD HEALTH
- CRITICAL ILLNESS
  - UP TO $30,000 FOR EMPLOYEE AND UP TO $15,000 FOR SPOUSE WITHOUT PROOF OF GOOD HEALTH

THE SPOUSE CAN NOT HAVE MORE THAN 50% OF THE EMPLOYEE'S VOLUNTARY SUPPLEMENTAL LIFE

Life Event → **30 DAYS**

New Hire



All benefit eligible employees should be provided a new hire kit

- ❑ Contact the Health Plan for supplies

Contains

- ❑ Welcome Letter
- ❑ Notice of Special Enrollment Rights
- ❑ Health Plan Information Form
- ❑ Benefit Calculation Sheet
- ❑ Marketplace Notice

Note: The effective date is the day following 30 days of employment.

New Employees

All new employees regardless of hours must complete:

Health Plan Information Form

Archdiocese of Miami Health Plan
HEALTH PLAN INFORMATION FORM

All Employees: Please Fill Out Sections A, B & C

A: PERSONAL INFORMATION:

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

Home Phone:(___) _____ Email Address: _____

Social Security Number: _____ Birth Date:_____ Marital Status: _____

Gender: ☐ M ☐ F Hire Date: _____ Effective Date of Coverage _____

B: YOUR WORK INFORMATION:

Job Location: _____ Division: _____

Occupation or Position: _____ Salary: _____

Phone:(___) _____

Number of scheduled work hours _____ Exempt _____ Non-exempt _____

Employment Status:

☐ Full-time (40 hours)	☐ Per-diem	☐ Temporary/Seasonal
☐ Part-time (30-40 hours)	☐ Less than 25 hours part-time	☐ Contracted

C: ELIGIBILITY INFORMATION

Benefit eligibility is defined as any active lay employee directly employed in the regular business of and compensated for services by the Archdiocese of Miami or entities of the Archdiocese and classified as either a full-time regular employee working at least 40 hours per week or a part time regular employee whose scheduled workweek is less than 40 hours but at least 30 hours.

☐ Benefits Eligible ☐ Non-Benefits Eligible

I acknowledge, to the best of my knowledge and belief, that all statements and answers made on this form are true, complete and correct. The Archdiocese of Miami Health Plan retains the right to amend, change or modify benefits and/or eligibility requirements at any time.

X _____
Employee Signature Date

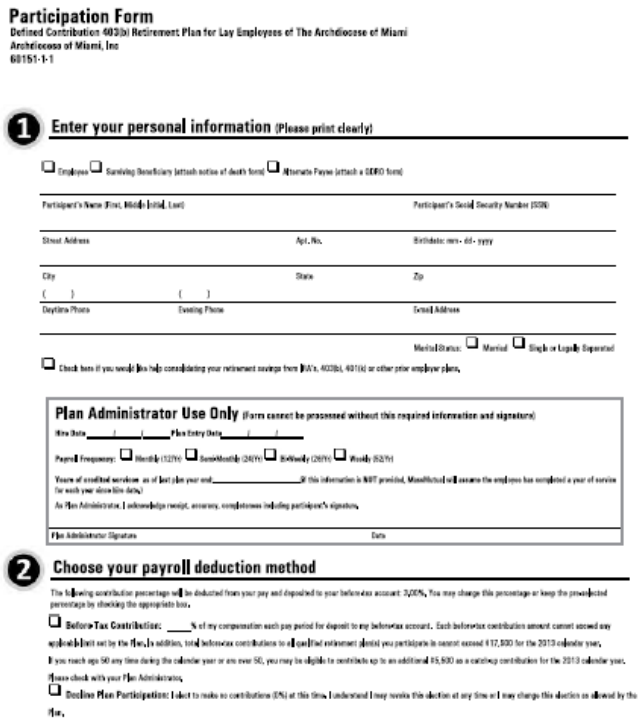
I acknowledge to the best of my ability, that the employee's statements and answers made on this form are true, complete and correct.

X _____
Employer Signature Date

Archdiocese of Miami Health Plan
9401 Biscayne Boulevard
Miami Shores, FL 33138
(305) 893-2674
Fax: 305-893-6433
www.adomhealthplan.org

Employee Initial ( )/Employee Initial ( )

403 (b) Participation Form



Participation Form
Defined Contribution 403(b) Retirement Plan for Lay Employees of The Archdiocese of Miami
Archdiocese of Miami, Inc
60151-1-1

1 Enter your personal information (Please print clearly)

☐ Employee ☐ Surviving Beneficiary (attach notice of death form) ☐ Alternate Payee (attach a QDRO form)

Participant's Name (First, Middle Initial, Last) Participant's Social Security Number (SSN)

Street Address Apt. No. Birthdate: mm - dd - yyyy

City State Zip

( ) ( )
Daytime Phone Evening Phone Email Address

Marital Status: ☐ Married ☐ Single or Legally Separated

☐ Check here if you would like help consolidating your retirement savings from IRA's, 403(b), 401(k) or other prior employer plans.

Plan Administrator Use Only (Form cannot be processed without this required information and signature)

Hire Date ___/___/___ Plan Entry Date ___/___/___

Payroll Frequency: ☐ Monthly (12/Yr) ☐ SemiMonthly (24/Yr) ☐ BiWeekly (26/Yr) ☐ Weekly (52/Yr)

Years of credited service as of last plan year end _____ If this information is NOT provided, Mass Mutual will assume the employee has completed a year of service for each year shown (no data).

As Plan Administrator, I acknowledge receipt, accuracy, completeness including participant's signature.

Plan Administrator Signature Date

2 Choose your payroll deduction method

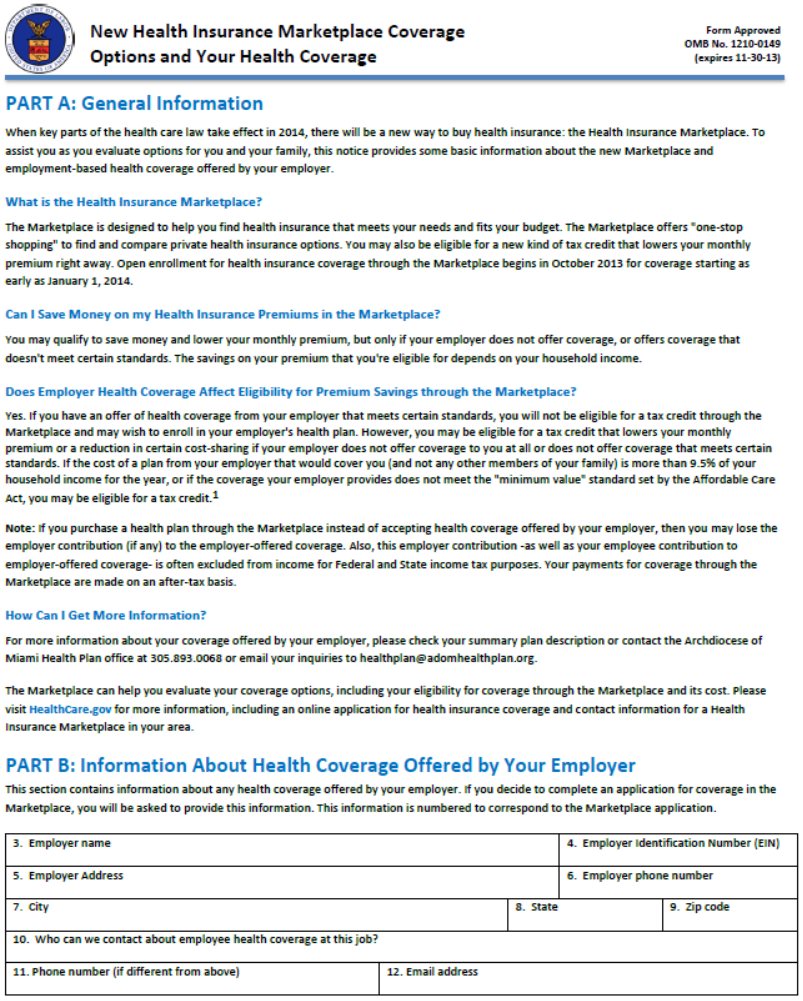
The following contribution percentage will be deducted from your pay and deposited to your before-tax account: 3.00%. You may change this percentage or keep the preselected percentage by checking the appropriate box.

☐ **Before-Tax Contribution:** ____% of my compensation each pay period for deposit to my before-tax account. Each before-tax contribution amount cannot exceed any applicable limit set by the Plan. In addition, total before-tax contributions to all qualified retirement plan(s) you participate in cannot exceed $17,500 for the 2013 calendar year.

If you reach age 50 any time during the calendar year or are over 50, you may be eligible to contribute up to an additional $5,500 as a catch-up contribution for the 2013 calendar year. Please check with your Plan Administrator.

☐ **Decline Plan Participation:** I elect to make no contributions (0%) at this time. I understand I may revoke this election at any time or I may change this election as allowed by the Plan.

New Health Insurance Marketplace Notification



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-13)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Archdiocese of Miami Health Plan office at 305.893.0068 or email your inquiries to healthplan@adomhealthplan.org.

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		4. Employer Identification Number (EIN)
5. Employer Address		6. Employer phone number
7. City	8. State	9. Zip code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

1 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.

As of October 1, 2013, Health Care Reform requires all employers to provide information on marketplace coverage to all employees.

- An employee, for this requirement, will be one that is issued a W-2.
- Can be distributed in New Hire Kit
  - Responsibility of the bookkeeper
- Must be provided to employee within 14 days of hire
- System of form receipt is open to your processes and procedures

Note: The Archdiocese of Miami Health Plan is compliant with all Health Care Reform to date. Any changes or new requirements will be communicated.

THE ARCHDIOCESE OF MIAMI HEALTH PLAN

NOTICE OF SPECIAL ENROLLMENT RIGHTS

You must be given a written description of special enrollment rights by the date you are offered the opportunity to enroll. Notice of Special Enrollment Rights must be given to an employee who declines group health coverage during his/her initial eligibility period. You should return a signed copy of this notice to your employer if you decline coverage because you have other health coverage.

If you decline enrollment for yourself or your dependents (including your spouse) because of the health insurance coverage, you may in the future be able to enroll yourself and your dependents in a health care plan offered by your employer, provided that you request enrollment, by submission of an individual application to Blue Cross and Blue Shield of Florida, Inc. (BCBSF) and/or Health Options, Inc. (HOI), within 30 days after the other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment, by submission of and individual application to BCBSF/HOI, within 30 days after the marriage, birth, adoption, or placement for adoption.

The effective date of coverage for and individual and/or dependents as a result of marriage, birth, adoption, or placement for adoption is the date of the event.

If you and/or your dependents decline enrollment because you have coverage under another group health plan or other health insurance coverage, you are required to complete the statement below and return it to your Group Administrator. If you fail to do so, you may not be entitled to special enrollment in your employer's group health plan when your other coverage terminates.

Please understand that you will not be entitled to special enrollment if loss of eligibility for coverage is the result of termination of coverage for failure to pay premiums on a timely basis or for cause. Voluntary Termination of Coverage does not constitute loss of eligibility of coverage.

NOTE: For purposes of clarification, cause is defined as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. Loss of eligibility for coverage is defined as loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment or the discontinuance of any contributions toward the health coverage plan by the employer.

☐ I hereby certify that I am declining enrollment in my employer's group health plan for ☐ myself and/or ☐ dependents because I or they currently **have** other care coverage; or

☐ I hereby certify that I am declining enrollment in my employer's group health plan and I **do not** currently have other health care coverage.

Printed name	Date
Signature	Social Security Number
Group Name	Group #

15741-0604R SR

Each eligible employee must be enrolled for Basic Life/AD&D and Long Term Disability.

Every new benefits-eligible employee must complete a Health Plan Information Form

Archdiocese of Miami Health Plan
HEALTH PLAN INFORMATION FORM

All Employees: Please Fill Out Sections A, B & C

A: PERSONAL INFORMATION:

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

Home Phone:(___) _____ Email Address: _____

Social Security Number: _____ Birth Date:_____ Marital Status: _____

Gender: ☐ M ☐ F Hire Date: _____ Effective Date of Coverage _____

B: YOUR WORK INFORMATION:

Job Location: _____ Division: _____

Occupation or Position: _____ Salary: _____

Phone:(___) _____

Number of scheduled work hours _____ Exempt _____ Non-exempt _____

Employment Status:

☐ Full-time (40 hours)	☐ Per-diem	☐ Temporary/Seasonal
☐ Part-time (30-40 hours)	☐ Less than 25 hours part-time	☐ Contracted

C: ELIGIBILITY INFORMATION

Benefit eligibility is defined as any active lay employee directly employed in the regular business of and compensated for services by the Archdiocese of Miami or entities of the Archdiocese and classified as either a full-time regular employee working at least 40 hours per week or a part time regular employee whose scheduled workweek is less than 40 hours but at least 30 hours.

☐ Benefits Eligible ☐ Non-Benefits Eligible

I acknowledge, to the best of my knowledge and belief, that all statements and answers made on this form are true, complete and correct. The Archdiocese of Miami Health Plan retains the right to amend, change or modify benefits and/or eligibility requirements at any time.

X _____
Employee Signature Date

I acknowledge to the best of my ability, that the employee's statements and answers made on this form are true, complete and correct.

X _____
Employer Signature Date

Archdiocese of Miami Health Plan
9401 Biscayne Boulevard
Miami Shores, FL 33138
(305) 893-2674
Fax: 305-893-6433
www.adomhealthplan.org

Employee Initial ( )/Employer Initial ( )

Health Plan Information Form

Archdiocese of Miami Health Plan
HEALTH PLAN INFORMATION FORM

All Employees: Please Fill Out Sections A, B & C

A: PERSONAL INFORMATION:

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

Home Phone:(___) _____ Email Address: _____

Social Security Number: _____ Birth Date:_____ Marital Status: _____

Gender: ☐ M ☐ F Hire Date: _____ Effective Date of Coverage _____

B: YOUR WORK INFORMATION:

Job Location: _____ Division: _____

Occupation or Position: _____ Salary: _____

Phone:(___) _____

Number of scheduled work hours _____ Exempt _____ Non-exempt _____

Employment Status:

☐ Full-time (40 hours)	☐ Per-diem	☐ Temporary/Seasonal
☐ Part-time (30-40 hours)	☐ Less than 25 hours part-time	☐ Contracted

C: ELIGIBILITY INFORMATION

Benefit eligibility is defined as any active lay employee directly employed in the regular business of and compensated for services by the Archdiocese of Miami or entities of the Archdiocese and classified as either a full-time regular employee working at least 40 hours per week or a part time regular employee whose scheduled workweek is less than 40 hours but at least 30 hours.

☐ Benefits Eligible ☐ Non-Benefits Eligible

I acknowledge, to the best of my knowledge and belief, that all statements and answers made on this form are true, complete and correct. The Archdiocese of Miami Health Plan retains the right to amend, change or modify benefits and/or eligibility requirements at any time.

x _____
Employee Signature Date

I acknowledge to the best of my ability, that the employee's statements and answers made on this form are true, complete and correct.

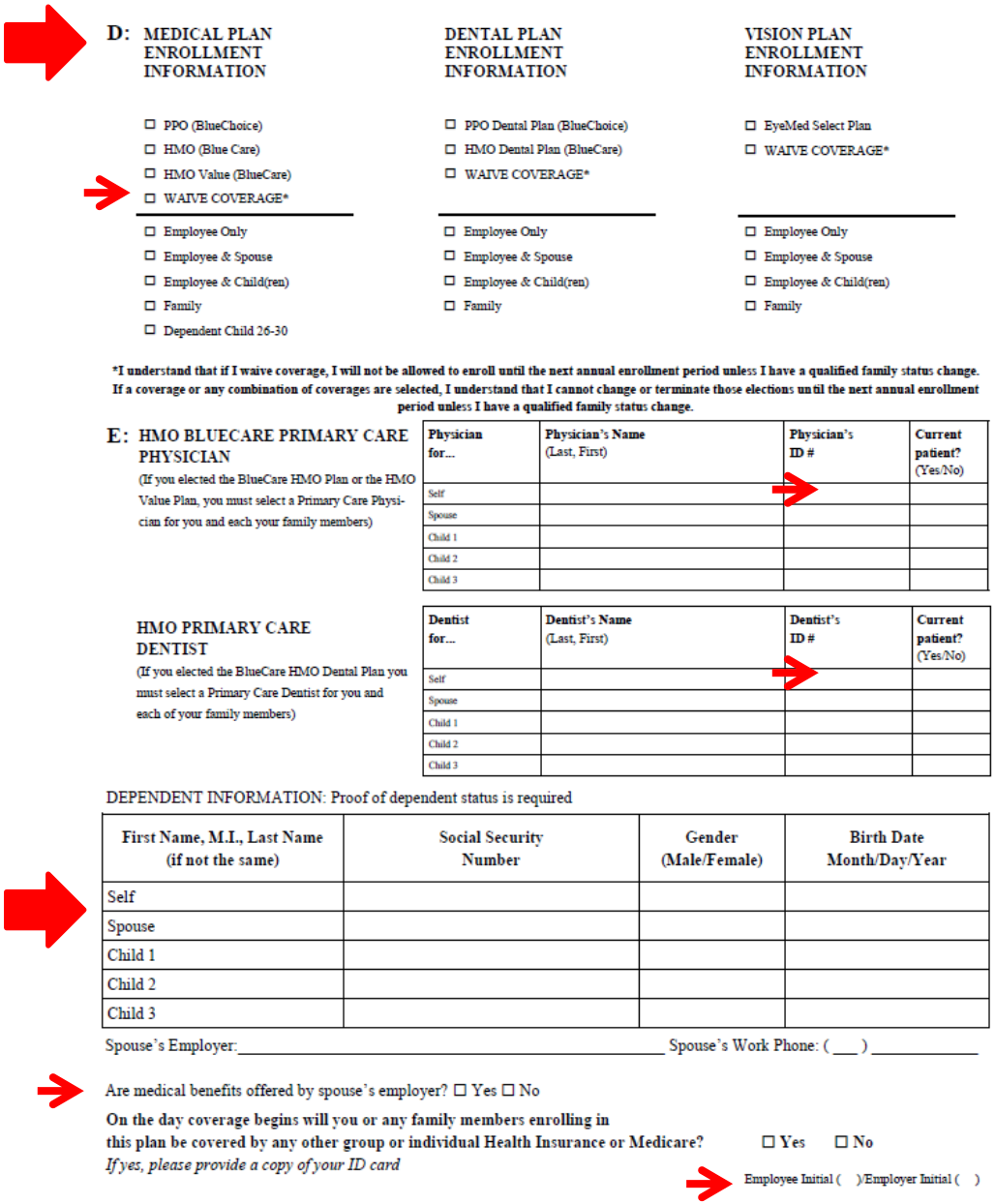
x _____
Employer Signature Date

Archdiocese of Miami Health Plan
9401 Biscayne Boulevard
Miami Shores, FL 33138
(305) 893-2674
Fax: 305-893-6433
www.adomhealthplan.org

Employee Initial ( )/Employer Initial ( )

Used for new hires to establish an employee record.

1. Ensure the employee completes all personal information (Sections A, B and C)
2. Ensure the employee accepts or declines all coverage offered
3. Ensure that the employee provides a PCP/Dentist ID Number
   - HMO Medical and/or HMO Dental
4. Ensure it is signed by:
   - Bookkeeper
   - Employee
5. Ensure all supporting documentation is included



D: MEDICAL PLAN ENROLLMENT INFORMATION

- ☐ PPO (BlueChoice)
- ☐ HMO (Blue Care)
- ☐ HMO Value (BlueCare)
- ☐ WAIVE COVERAGE*

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Family
- ☐ Dependent Child 26-30

DENTAL PLAN ENROLLMENT INFORMATION

- ☐ PPO Dental Plan (BlueChoice)
- ☐ HMO Dental Plan (BlueCare)
- ☐ WAIVE COVERAGE*

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Family

VISION PLAN ENROLLMENT INFORMATION

- ☐ EyeMed Select Plan
- ☐ WAIVE COVERAGE*

- ☐ Employee Only
- ☐ Employee & Spouse
- ☐ Employee & Child(ren)
- ☐ Family

***I understand that if I waive coverage, I will not be allowed to enroll until the next annual enrollment period unless I have a qualified family status change. If a coverage or any combination of coverages are selected, I understand that I cannot change or terminate those elections until the next annual enrollment period unless I have a qualified family status change.**

E: HMO BLUECARE PRIMARY CARE PHYSICIAN

(If you elected the BlueCare HMO Plan or the HMO Value Plan, you must select a Primary Care Physician for you and each your family members)

Physician for...	Physician's Name (Last, First)	Physician's ID #	Current patient? (Yes/No)
Self			
Spouse			
Child 1			
Child 2			
Child 3			

HMO PRIMARY CARE DENTIST

(If you elected the BlueCare HMO Dental Plan you must select a Primary Care Dentist for you and each of your family members)

Dentist for...	Dentist's Name (Last, First)	Dentist's ID #	Current patient? (Yes/No)
Self			
Spouse			
Child 1			
Child 2			
Child 3			

DEPENDENT INFORMATION: Proof of dependent status is required

First Name, M.I., Last Name (if not the same)	Social Security Number	Gender (Male/Female)	Birth Date Month/Day/Year
Self			
Spouse			
Child 1			
Child 2			
Child 3			

Spouse's Employer:_____ Spouse's Work Phone: (___) _____

Are medical benefits offered by spouse's employer? ☐ Yes ☐ No

On the day coverage begins will you or any family members enrolling in this plan be covered by any other group or individual Health Insurance or Medicare? ☐ Yes ☐ No

If yes, please provide a copy of your ID card

Employee Initial ( )/Employer Initial ( )

- Ensure the employee accepts or declines all coverage offered
- Ensure that the employee provides a PCP/Dentist ID Number
  - HMO Medical and/or HMO Dental
  - 10-digit national ID#
- Provide dependent info with supporting documentation
  - Birth Certificate
  - Adoption Papers
  - Marriage License
- Confirm with employee if spouse has coverage available through another employer if applicable
- Initial on bottom
  - Employee
  - Bookkeeper

F: BASIC LIFE, AD&D, LONG TERM DISABILITY:

Benefits eligible employees are provided $15,000 of group term Basic Life insurance and $15,000 of Accidental Death and Dismemberment insurance. At age 65, these reduce to $10,000; at age 70 to $7,500. Please designate a beneficiary below. Refer to the policy for benefit limitations and/or exclusions. Please note that a beneficiary cannot be changed by a power of attorney.

Primary Beneficiary Name	Address	Relationship to you	Benefit %

Secondary Beneficiary Name	Address	Relationship to you	Benefit %

G: ADDITIONAL INSURANCE OPTIONS:

Supplemental Life Insurance

☐I elect to enroll for supplemental life insurance:

☐ For Myself		☐ For My Spouse	
☐ $10,000	☐ $60,000	☐ $5,000	☐ $20,000
☐ $20,000	☐ $70,000	☐ $10,000	☐ $25,000
☐ $30,000	☐ $80,000	☐ $15,000	☐ $30,000
☐ $40,000	☐ $90,000		
☐ $50,000	☐ $100,000		

Spouse Date of Birth ___/___/___

☐ I decline to enroll for supplemental life insurance and understand if I elect to apply in the future, medical questions will be required and coverage may be denied by the carrier.

Child(ren) Life Insurance Benefit ☐ Yes ☐ No

Short-Term Disability Insurance

☐I elect to enroll for short-term disability insurance.

☐ I decline to enroll for short-term disability insurance and understand if I elect to apply in the future, medical questions will be required and coverage may be denied by the carrier.

Critical Illness Insurance

☐I elect to enroll for Critical Illness Insurance:

☐ For Myself		☐ For My Spouse	
☐ $ 5,000	☐ $20,000	☐ $ 5,000	☐ $12,500
☐ $10,000	☐ $25,000	☐ $ 7,500	☐ $15,000
☐ $15,000	☐ $30,000	☐ $10,000	
Are you a tobacco smoker? ☐ Yes ☐ No		Are you a tobacco smoker? ☐ Yes ☐ No	

☐ I decline to enroll for critical illness insurance and understand if I elect to apply in the future, medical questions will be required and coverage may be denied by the carrier.

Please refer to the rate sheet and/or the Archdiocese of Miami Health Plan Benefit guide for information about the most current rates.

Employee Initial ( )/Employer Initial ( )

- Beneficiary info is needed
- Employee must accept or decline all coverage offered
- Initial on bottom of page
  - Employee
  - Bookkeeper
- Supplemental Life Guarantee Issue
  - Additional amounts
    - Attach completed Personal Health Application

H: EMPLOYEE CONTRIBUTIONS

The following chart is available to log the costs of all the elected benefits offered by the Archdiocese of Miami in this Health Plan Information form. For an accurate understanding of the future deductions that will be removed from your paycheck, please verify your selections with your employer.

Category	Cost
Medical	
Dental	
Vision	
Supplemental Life Insurance	
Short Term Disability Insurance	
Critical Illness Insurance	
TOTAL	

I: AGREEMENT / PAYROLL DEDUCTION AUTHORIZATION

I acknowledge that the above information represents my enrollment choices. I understand that by signing this form I am electing to reduce my compensation in exchange for elected coverage (if employee contributions are required). I further understand my medical and/or dental elections cannot change until a future annual enrollment period or qualified family status change occurs (I must notify the Health Plan office within 30 days of status change). Proof will be required. I represent to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. A non-response in any area will be considered as waived coverage. I understand the actual benefits and benefit descriptions are governed solely by the relevant plan documents and contracts. The Archdiocese of Miami Health Plan retains the right to amend, change or modify benefits at any time.

X _____
Employee Signature Date

I acknowledge to the best of my ability, that the employee's statements and answers made on this form are true, complete and correct.

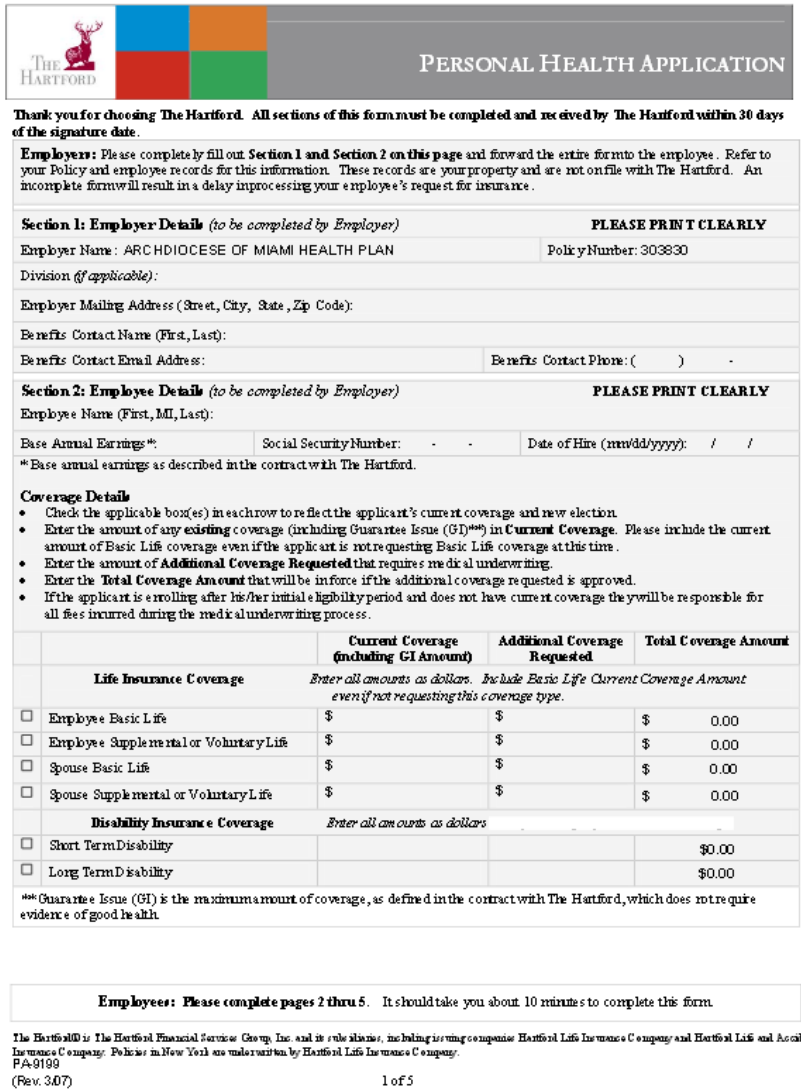
X _____
Employer Signature Title/Position Date

Archdiocese of Miami Health Plan
9401 Biscayne Boulevard
Miami Shores, FL 33138
(305) 893-2674
Fax: 305-893-6433
www.adomhealthplan.org

Employee Initial ( )/Employer Initial ( )

- A contribution check list has been provided for the employee to review the costs.
- Employee and employer must sign and date.
  - Forms without signature cannot be processed.

Hartford Personal Health Application



PERSONAL HEALTH APPLICATION

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please complete *by* fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employer Name: ARCHDIOCESE OF MIAMI HEALTH PLAN | Policy Number: 303830

Division *(if applicable)*:

Employer Mailing Address (Street, City, State, Zip Code):

Benefits Contact Name (First, Last):

Benefits Contact Email Address: | Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name (First, MI, Last):

Base Annual Earnings*: | Social Security Number: - - | Date of Hire (mm/dd/yyyy): / /

*Base annual earnings as described in the contract with The Hartford.

Coverage Details

- Check the applicable box(es) in each row to reflect the applicant's current coverage and new election.
- Enter the amount of any **existing** coverage (including Guarantee Issue (GI)**) in **Current Coverage**. Please include the current amount of Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** that requires medical underwriting.
- Enter the **Total Coverage Amount** that will be in force if the additional coverage requested is approved.
- If the applicant is enrolling after his/her initial eligibility period and does not have current coverage they will be responsible for all fees incurred during the medical underwriting process.

		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Life Insurance Coverage	*Enter all amounts as dollars. Include Basic Life Current Coverage Amount even if not requesting this coverage type.*		
☐	Employee Basic Life	$	$	$ 0.00
☐	Employee Supplemental or Voluntary Life	$	$	$ 0.00
☐	Spouse Basic Life	$	$	$ 0.00
☐	Spouse Supplemental or Voluntary Life	$	$	$ 0.00
	Disability Insurance Coverage	*Enter all amounts as dollars*		
☐	Short Term Disability			$0.00
☐	Long Term Disability			$0.00

**Guarantee Issue (GI) is the maximum amount of coverage, as defined in the contract with The Hartford, which does not require evidence of good health.

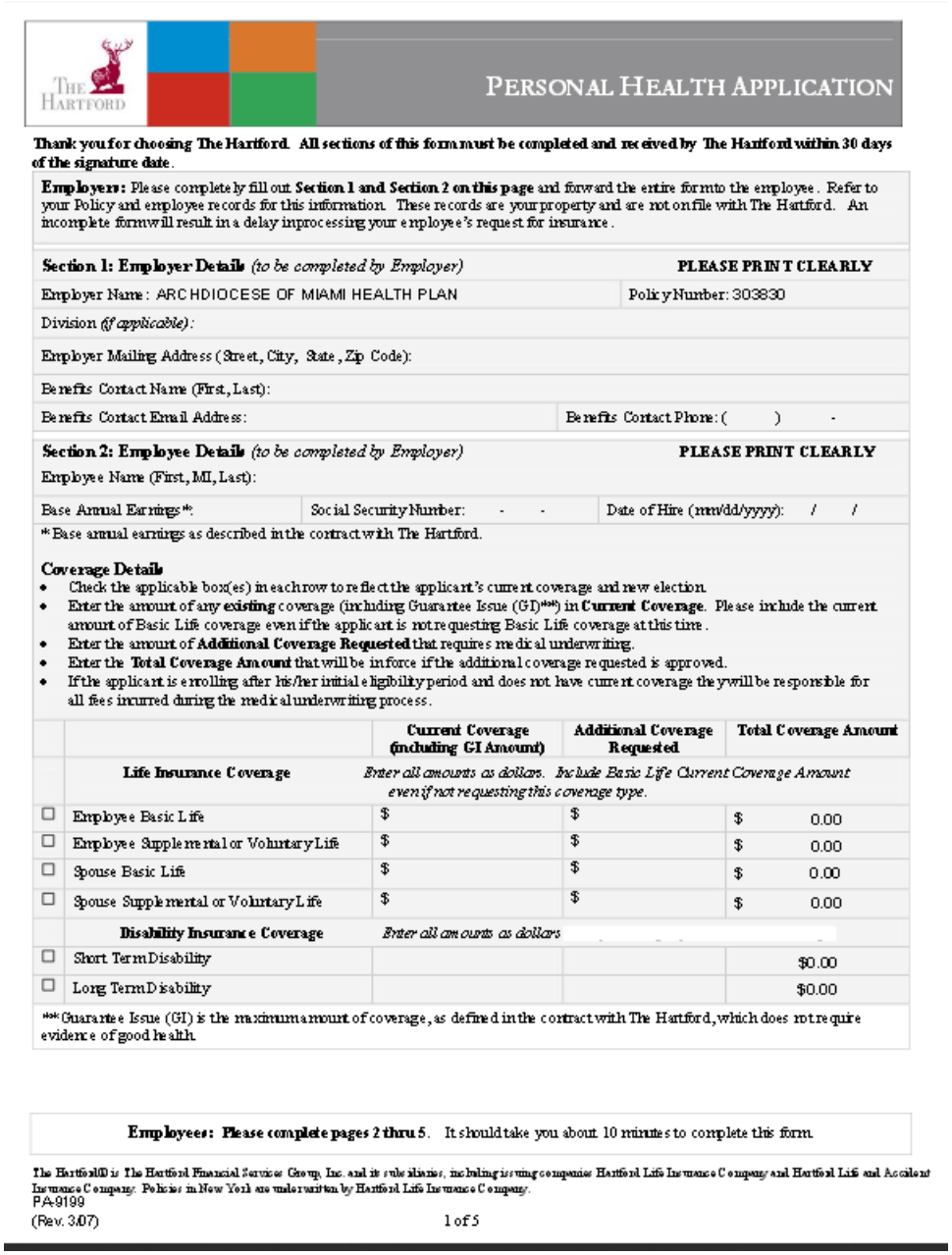
Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies in New York are underwritten by Hartford Life Insurance Company.

PA-9199

(Rev. 3.07) 1 of 5

- Used for Voluntary Supplemental Term Life:
  - During initial enrollment period
    - In amount over $100,000 for employee
    - In amount over $30,000 for spouse
  - After initial enrollment for any amount above the Basic Life Insurance amount of $15,000
    - Carrier my deny coverage



PERSONAL HEALTH APPLICATION

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employer Name: ARCHDIOCESE OF MIAMI HEALTH PLAN | Policy Number: 303830

Division *(if applicable)*:

Employer Mailing Address (Street, City, State, Zip Code):

Benefits Contact Name (First, Last):

Benefits Contact Email Address: | Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name (First, MI, Last):

Base Annual Earnings*: | Social Security Number: - - | Date of Hire (mm/dd/yyyy): / /

*Base annual earnings as described in the contract with The Hartford.

Coverage Details

- Check the applicable box(es) in each row to reflect the applicant's current coverage and new election.
- Enter the amount of any **existing** coverage (including Guarantee Issue (GI)**) in **Current Coverage**. Please include the current amount of Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** that requires medical underwriting.
- Enter the **Total Coverage Amount** that will be in force if the additional coverage requested is approved.
- If the applicant is enrolling after his/her initial eligibility period and does not have current coverage they will be responsible for all fees incurred during the medical underwriting process.

		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Life Insurance Coverage	*Enter all amounts as dollars. Include Basic Life Current Coverage Amount even if not requesting this coverage type.*		
☐	Employee Basic Life	$	$	$ 0.00
☐	Employee Supplemental or Voluntary Life	$	$	$ 0.00
☐	Spouse Basic Life	$	$	$ 0.00
☐	Spouse Supplemental or Voluntary Life	$	$	$ 0.00
	Disability Insurance Coverage	*Enter all amounts as dollars*		
☐	Short Term Disability			$0.00
☐	Long Term Disability			$0.00

**Guarantee Issue (GI) is the maximum amount of coverage, as defined in the contract with The Hartford, which does not require evidence of good health.

Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including insuring companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies in New York are underwritten by Hartford Life Insurance Company.

PA-9199

(Rev. 3.07) 1 of 5

If employee elects supplemental life insurance and/or Short-Term-Disability that requires a Personal Health Application, provide it with the appropriate Health Plan forms.

- Personal Health Application are located in the Bookkeeper sections of www.adomhealthplan.org or can be order by our Disability Coordinator:
  - Brenda LM@adomhealthplan.org

2014-2015 Archdiocese of Miami Health Plan

Employer Contribution

Laity

Medical (All Plans)	$ 468.00
Life/ADD&D/LTD	$ 14.00

Employer Contribution

Active Employees (Medical)

	BlueChoice PPO Plan	BlueCare HMO Standard Plan	BlueCare HMO Value Plan
Employee Only	$ 270.00	$ 103.00	$ 20.00
Employee & Spouse	$ 826.00	$ 417.00	$ 258.00
Employee & Child (ren)	$ 751.00	$ 360.00	$ 213.00
Employee & Family	$ 1,010.00	$ 589.00	$ 397.00
Each Child 26-30	$ 738.00	$ 571.00	$ 488.00

Active Employees (Dental/Vision)

	BlueChoice PPO Dental Plan	BlueCare HMO Dental Plan	EyeMed Voluntary Vision Plan
Employee Only	$ 50.00	$ 14.00	$ 5.56
Employee & Spouse	$ 106.00	$ 28.00	$ 10.88
Employee & Child (ren)	$ 95.00	$ 23.00	$ 10.65
Employee & Family	$ 134.00	$ 40.00	$ 15.98

Active Employees (Employer Paid Benefits)

	Life/AD&D/LTD
Employee Cost	$ 0.00

Group Critical Illness Costs

Non-Tobacco — **Employee**

AGES	$ 5,000	$ 10,000	$ 15,000	$ 20,000	$ 25,000	$ 30,000
18-24	$ 4.00	$ 6.25	$ 8.50	$ 10.75	$ 13.00	$ 15.25
25-29	$ 4.60	$ 7.45	$ 10.30	$ 13.15	$ 16.00	$ 18.85
30-34	$ 5.05	$ 8.35	$ 11.65	$ 14.95	$ 18.25	$ 21.55
35-39	$ 5.60	$ 9.45	$ 13.30	$ 17.15	$ 21.00	$ 24.85
40-44	$ 8.15	$ 14.55	$ 20.95	$ 27.35	$ 33.75	$ 40.15
45-49	$ 10.10	$ 18.45	$ 26.80	$ 35.15	$ 43.50	$ 51.85
50-54	$ 13.60	$ 25.45	$ 37.30	$ 49.15	$ 61.00	$ 72.85
55-59	$ 19.95	$ 38.15	$ 56.35	$ 74.55	$ 92.75	$ 110.95
60-60	$ 40.80	$ 79.85	$ 118.90	$ 157.95	$ 197.00	$ 236.05
Over 69	$ 44.60	$ 87.45	$ 130.30	$ 173.15	$ 216.00	$ 258.85

Spouse

$ 5,000	$ 7,500	$ 10,000	$ 12,500	$ 15,000
$ 4.00	$ 5.13	$ 6.25	$ 7.38	$ 8.50
$ 4.60	$ 6.03	$ 7.45	$ 8.88	$ 10.30
$ 5.05	$ 6.70	$ 8.35	$ 10.00	$ 11.65
$ 5.60	$ 7.53	$ 9.45	$ 11.38	$ 13.30
$ 8.15	$ 11.35	$ 14.55	$ 17.75	$ 20.95
$ 10.10	$ 14.28	$ 18.45	$ 22.63	$ 26.80
$ 13.60	$ 19.53	$ 25.45	$ 31.38	$ 37.30
$ 19.95	$ 29.05	$ 38.15	$ 47.25	$ 56.35
$ 40.80	$ 60.33	$ 79.85	$ 99.38	$ 118.90
$ 44.60	$ 66.03	$ 87.45	$ 108.88	$ 130.30

Tobacco — **Employee**

AGES	$ 5,000	$ 10,000	$ 15,000	$ 20,000	$ 25,000	$ 30,000
18-24	$ 4.80	$ 7.85	$ 10.90	$ 13.95	$ 17.00	$ 20.05
25-29	$ 5.70	$ 9.65	$ 13.60	$ 17.55	$ 21.50	$ 25.45
30-34	$ 6.55	$ 11.35	$ 16.15	$ 20.95	$ 25.75	$ 30.55
35-39	$ 7.55	$ 13.35	$ 19.15	$ 24.95	$ 30.75	$ 36.55
40-44	$ 11.60	$ 21.45	$ 31.30	$ 41.15	$ 51.00	$ 60.85
45-49	$ 14.90	$ 28.05	$ 41.20	$ 54.35	$ 67.50	$ 80.65
50-54	$ 20.65	$ 39.55	$ 58.45	$ 77.35	$ 96.25	$ 115.15
55-59	$ 31.70	$ 61.65	$ 91.60	$ 121.55	$ 151.50	$ 181.45
60-60	$ 74.85	$ 147.95	$ 221.05	$ 294.15	$ 367.25	$ 440.35
Over 69	$ 78.65	$ 155.55	$ 232.45	$ 309.35	$ 386.25	$ 463.15

Spouse

$ 5,000	$ 7,500	$ 10,000	$ 12,500	$ 15,000
$ 4.80	$ 6.33	$ 7.85	$ 9.38	$ 10.90
$ 5.70	$ 7.68	$ 9.65	$ 11.63	$ 13.60
$ 6.55	$ 8.95	$ 11.35	$ 13.75	$ 16.15
$ 7.55	$ 10.45	$ 13.35	$ 16.25	$ 19.15
$ 11.60	$ 16.53	$ 21.45	$ 26.38	$ 31.30
$ 14.90	$ 21.48	$ 28.05	$ 34.63	$ 41.20
$ 20.65	$ 30.10	$ 39.55	$ 49.00	$ 58.45
$ 31.70	$ 46.68	$ 61.65	$ 76.63	$ 91.60
$ 74.85	$ 111.40	$ 147.95	$ 184.50	$ 221.05
$ 78.65	$ 117.10	$ 155.55	$ 194.00	$ 232.45

Rate Worksheet

Annual Enrollment

ANNUAL ENROLLMENT

- MEDICAL
- DENTAL
- SHORT TERM DISABILITY (WITH PROOF OF GOOD HEALTH)
- VOLUNTARY SUPPLEMENTAL LIFE
  - UP TO $100,000 FOR EMPLOYEE AND UP TO $30,000 FOR SPOUSE WITH PROOF OF GOOD HEALTH
  - UP TO $300,000 FOR EMPLOYEE AND UP TO $150,000 WITH PROOF OF GOOD HEALTH
- CRITICAL ILLNESS
  - UP TO $30,000 FOR EMPLOYEEAND UP TO $15,000 FOR SPOUSE WITHOUT PROOF OF GOOD HEALTH

THE SPOUSE CAN NOT HAVE MORE THAN 50% OF THE EMPLOYEE'S VOLUNTARY SUPPLEMENTAL LIFE

Annually

MAY

EFFECTIVE JULY 1ST

Annual Enrollment Overview

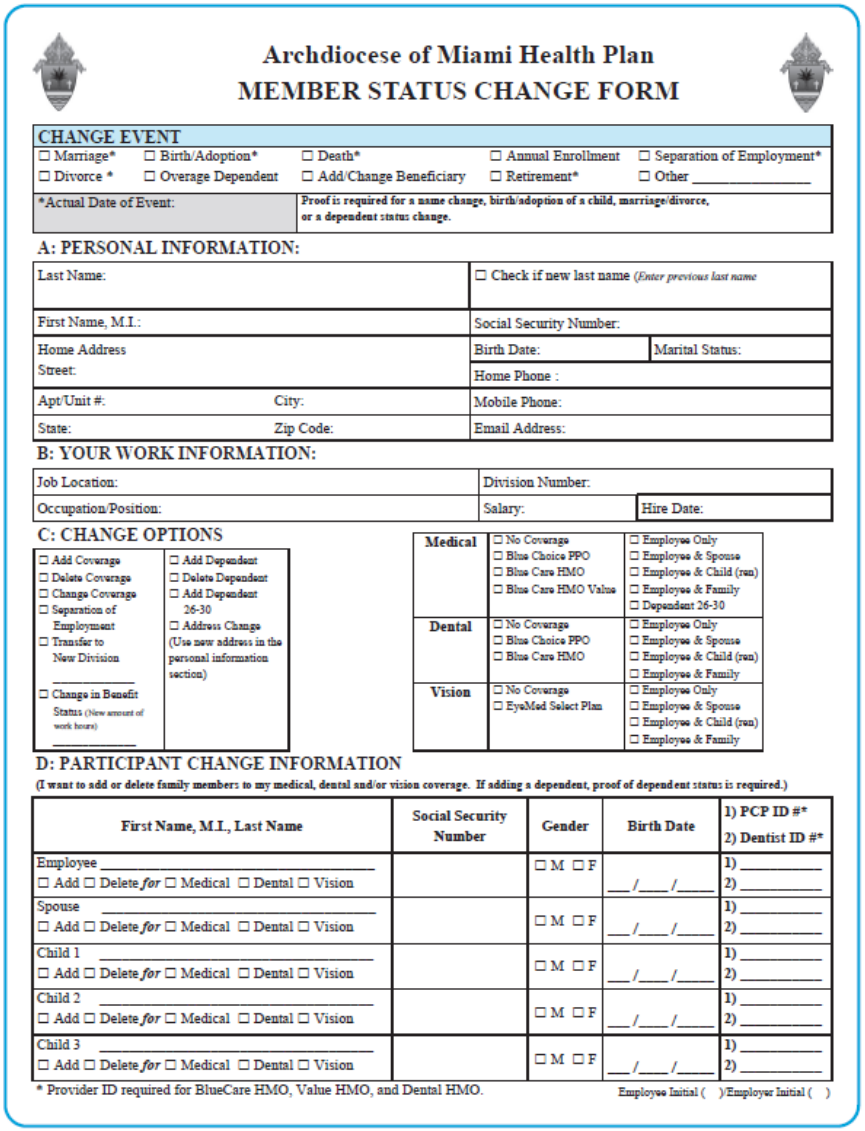
Bookkeeper meetings:
March

Enrollment Material Sent:
Mid April

Annual Enrollment opens:
May 1st

Annual Enrollment closes:
May 31st

Member Status Change Form



Archdiocese of Miami Health Plan
MEMBER STATUS CHANGE FORM

CHANGE EVENT

☐ Marriage* ☐ Birth/Adoption* ☐ Death* ☐ Annual Enrollment ☐ Separation of Employment*
☐ Divorce * ☐ Overage Dependent ☐ Add/Change Beneficiary ☐ Retirement* ☐ Other _____

*Actual Date of Event: | Proof is required for a name change, birth/adoption of a child, marriage/divorce, or a dependent status change.

A: PERSONAL INFORMATION:

Last Name:		☐ Check if new last name *(Enter previous last name*	
First Name, M.I.:		Social Security Number:	
Home Address Street:		Birth Date:	Marital Status:
		Home Phone :	
Apt/Unit #:	City:	Mobile Phone:	
State:	Zip Code:	Email Address:	

B: YOUR WORK INFORMATION:

Job Location:	Division Number:	
Occupation/Position:	Salary:	Hire Date:

C: CHANGE OPTIONS

☐ Add Coverage ☐ Delete Coverage ☐ Change Coverage ☐ Separation of Employment ☐ Transfer to New Division _____ ☐ Change in Benefit Status (New amount of work hours) _____	☐ Add Dependent ☐ Delete Dependent ☐ Add Dependent 26-30 ☐ Address Change (Use new address in the personal information section)

Medical	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO ☐ Blue Care HMO Value	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family ☐ Dependent 26-30
Dental	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family
Vision	☐ No Coverage ☐ EyeMed Select Plan	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family

D: PARTICIPANT CHANGE INFORMATION

(I want to add or delete family members to my medical, dental and/or vision coverage. If adding a dependent, proof of dependent status is required.)

First Name, M.I., Last Name	Social Security Number	Gender	Birth Date	1) PCP ID #* 2) Dentist ID #*
Employee _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Spouse _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Child 1 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Child 2 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Child 3 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____

* Provider ID required for BlueCare HMO, Value HMO, and Dental HMO.

Employee Initial ( )/Employer Initial ( )

To make changes to an existing employee record such as:

- Name
- Benefits (Add/Delete)
  - New hires
  - Special Enrollments
  - Annual Enrollments
- Address
- Beneficiary

Ensure that the employee and bookkeeper signature is provided in order for a change to be processed unless:

- An employee has separated employment and is unable to sign
  - The bookkeeper's signature will be sufficient

Archdiocese of Miami Health Plan
MEMBER STATUS CHANGE FORM

CHANGE EVENT				
☐ Marriage*	☐ Birth/Adoption*	☐ Death*	☐ Annual Enrollment	☐ Separation of Employment*
☐ Divorce *	☐ Overage Dependent	☐ Add/Change Beneficiary	☐ Retirement*	☐ Other _____

*Actual Date of Event:	**Proof is required for a name change, birth/adoption of a child, marriage/divorce, or a dependent status change.**

A: PERSONAL INFORMATION:

Last Name:		☐ Check if new last name *(Enter previous last name*	
First Name, M.I.:		Social Security Number:	
Home Address Street:		Birth Date:	Marital Status:
		Home Phone :	
Apt/Unit #:	City:	Mobile Phone:	
State:	Zip Code:	Email Address:	

B: YOUR WORK INFORMATION:

Job Location:	Division Number:	
Occupation/Position:	Salary:	Hire Date:

C: CHANGE OPTIONS

☐ Add Coverage ☐ Delete Coverage ☐ Change Coverage ☐ Separation of Employment ☐ Transfer to New Division _____ ☐ Change in Benefit Status (New amount of work hours) _____	☐ Add Dependent ☐ Delete Dependent ☐ Add Dependent 26-30 ☐ Address Change (Use new address in the personal information section)

Medical	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO ☐ Blue Care HMO Value	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family ☐ Dependent 26-30
Dental	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family
Vision	☐ No Coverage ☐ EyeMed Select Plan	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family

D: PARTICIPANT CHANGE INFORMATION

(I want to add or delete family members to my medical, dental and/or vision coverage. If adding a dependent, proof of dependent status is required.)

First Name, M.I., Last Name	Social Security Number	Gender	Birth Date	1) PCP ID #* 2) Dentist ID #*
Employee _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/____	1) _____ 2) _____
Spouse _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/____	1) _____ 2) _____
Child 1 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/____	1) _____ 2) _____
Child 2 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/____	1) _____ 2) _____
Child 3 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/____	1) _____ 2) _____

* Provider ID required for BlueCare HMO, Value HMO, and Dental HMO.

Employee Initial ( )/Employer Initial ( )

E: VOLUNTARY BENEFITS

Attach the appropriate medical questionnaire. The insurance carriers reserve the right to deny your life, disability and/or critical illness insurance application.

Supplemental Life Insurance

When applying for supplemental life, your total amount of insurance selected is combined with the employer-paid $15,000 basic life insurance. The combined total of the employer paid basic life insurance and supplemental life insurance, can not be in excess of the $300,000 maximum benefit.

☐ I am applying for supplemental life insurance and a Hartford Personal Health Application is attached.

☐ I would like to terminate supplemental life for: (I acknowledge if I wish to re-apply at a later date, medical questions will be required and coverage may be denied by the carrier.)

☐ Employee
☐ Spouse
☐ One Child
☐ All Children

(Employee must be participating in the supplemental life insurance in order for spouse and/or child (ren) to be eligible to participate.

☐ For Myself

☐ $10,000	☐ $60,000	☐ $110,000	☐ $160,000	☐ $210,000	☐ $260,000
☐ $20,000	☐ $70,000	☐ $120,000	☐ $170,000	☐ $220,000	☐ $270,000
☐ $30,000	☐ $80,000	☐ $130,000	☐ $180,000	☐ $230,000	☐ $280,000
☐ $40,000	☐ $90,000	☐ $140,000	☐ $190,000	☐ $240,000	☐ $290,000
☐ $50,000	☐ $100,000	☐ $150,000	☐ $200,000	☐ $250,000	☐ $300,000

☐ For My Spouse (Spouse Date of Birth) ____ / ____ / ____

☐ $ 5,000	☐ $ 30,000	☐ $ 55,000	☐ $ 80,000	☐ $ 105,000	☐ $130,000
☐ $ 10,000	☐ $ 35,000	☐ $ 60,000	☐ $ 85,000	☐ $ 110,000	☐ $135,000
☐ $ 15,000	☐ $ 40,000	☐ $ 65,000	☐ $ 90,000	☐ $ 115,000	☐ $140,000
☐ $ 20,000	☐ $ 45,000	☐ $ 70,000	☐ $ 95,000	☐ $ 120,000	☐ $145,000
☐ $ 25,000	☐ $ 50,000	☐ $ 75,000	☐ $100,000	☐ $ 125,000	☐ $150,000

☐ For My Child(ren) (Monthly cost is $0.79 per child)

Ages 15 day but less than 6 months	Age 6 months or older
$1,000 Benefit	$2,500 Benefit

Short-Term Disability Insurance

(Available to employee only)

☐ I elect to enroll for short-term disability insurance and a Hartford Personal Health Application is attached.

☐ I would like to terminate short-term disability insurance (I acknowledge if I wish to re-apply at a later date, medical questions will be required and coverage may be denied by the carrier.)

Critical Illness Insurance (Annual Enrollment Only)

☐ I elect to enroll for critical illness insurance:

☐ For Myself

☐ $ 5,000	☐ $20,000
☐ $10,000	☐ $25,000
☐ $15,000	☐ $30,000

Have you used tobacco within the last 12 months?
☐ Yes ☐ No

☐ For My Spouse

☐ $5,000	☐ $12,500
☐ $7,500	☐ $15,000
☐ $10,000	

Have you used tobacco within the last 12 months?
☐ Yes ☐ No

F: BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY:			
Name:	Relationship:	Beneficiary %:	
Address:	City:	State:	Zip Code:

SECONDARY BENEFICIARY:			
Name:	Relationship:	Beneficiary %:	
Address:	City:	State:	Zip Code:

G: AGREEMENT / PAYROLL DEDUCTION AUTHORIZATION

I acknowledge that the above information represents my enrollment choices. I understand that by signing this form I am electing to reduce my compensation in exchange for elected coverage (if employee contributions are required). I further understand my medical and/or dental elections cannot change until a future annual enrollment period or qualified family status change occurs (I must notify the Health Plan office within 30 days of status change). Proof will be required. I represent to the best of my knowledge and belief, all statements and answers made on this form are true, complete and correct. A non-response in any area will be considered as waived coverage. I understand the actual benefits and benefit descriptions are governed solely by the relevant plan documents and contracts. The Archdiocese of Miami Health Plan retains the right to amend, change or modify benefits at any time.

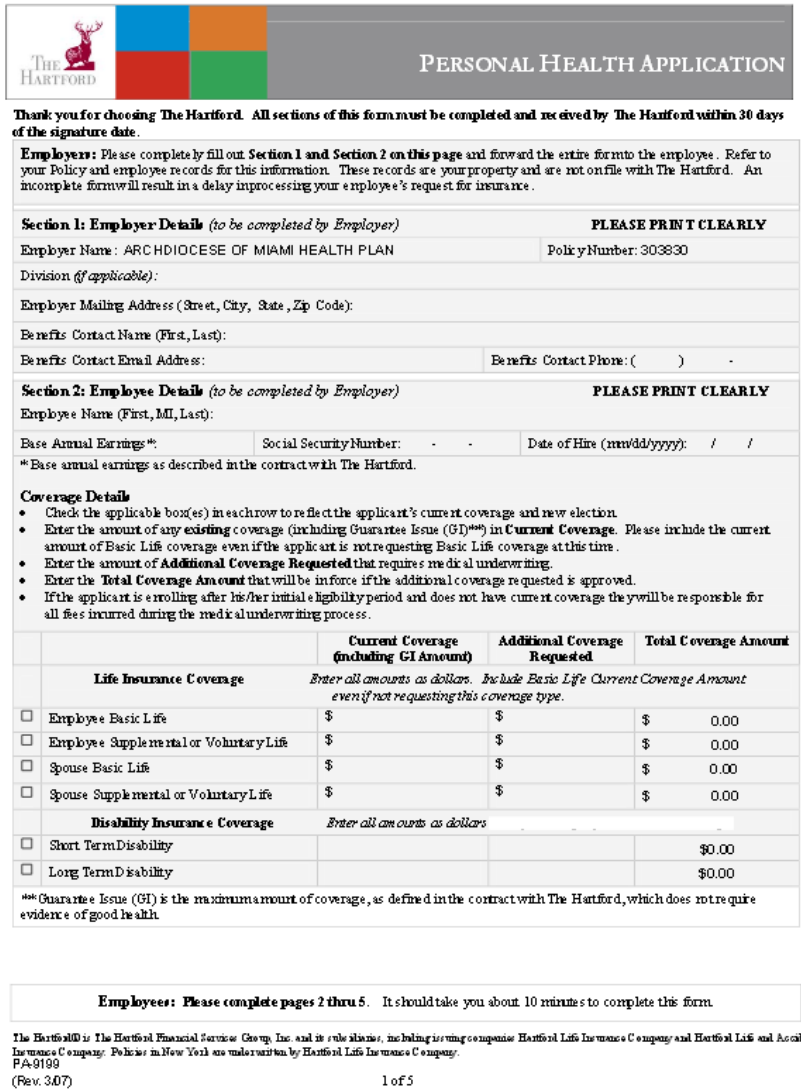
X _____
Employee Signature Date

I acknowledge to the best of my ability, that the employee's statements and answers made on this form are true, complete and correct.

X _____
Employer Signature Title/Position Date

Archdiocese of Miami Health Plan, 9401 Biscayne Boulevard, Miami Shores, FL 33138
(305) 893-2674 • www.adomhealthplan.org

Hartford Personal Health Application



PERSONAL HEALTH APPLICATION

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please complete *by* fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employer Name: ARCHDIOCESE OF MIAMI HEALTH PLAN | Policy Number: 303830

Division *(if applicable)*:

Employer Mailing Address (Street, City, State, Zip Code):

Benefits Contact Name (First, Last):

Benefits Contact Email Address: | Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name (First, MI, Last):

Base Annual Earnings*: | Social Security Number: - - | Date of Hire (mm/dd/yyyy): / /

*Base annual earnings as described in the contract with The Hartford.

Coverage Details

- Check the applicable box(es) in each row to reflect the applicant's current coverage and new election.
- Enter the amount of any **existing** coverage (including Guarantee Issue (GI)**) in **Current Coverage**. Please include the current amount of Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** that requires medical underwriting.
- Enter the **Total Coverage Amount** that will be in force if the additional coverage requested is approved.
- If the applicant is enrolling after his/her initial eligibility period and does not have current coverage they will be responsible for all fees incurred during the medical underwriting process.

		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Life Insurance Coverage	*Enter all amounts as dollars. Include Basic Life Current Coverage Amount even if not requesting this coverage type.*		
☐	Employee Basic Life	$	$	$ 0.00
☐	Employee Supplemental or Voluntary Life	$	$	$ 0.00
☐	Spouse Basic Life	$	$	$ 0.00
☐	Spouse Supplemental or Voluntary Life	$	$	$ 0.00
	Disability Insurance Coverage	*Enter all amounts as dollars*		
☐	Short Term Disability			$0.00
☐	Long Term Disability			$0.00

**Guarantee Issue (GI) is the maximum amount of coverage, as defined in the contract with The Hartford, which does not require evidence of good health.

Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies in New York are underwritten by Hartford Life Insurance Company.

PA-9199

(Rev. 3.07) 1 of 5

- Used for Voluntary Supplemental Term Life:
  - During initial enrollment period
    - In amount over $100,000 for employee
    - In amount over $30,000 for spouse
  - After initial enrollment for any amount above the Basic Life Insurance amount of $15,000
    - Carrier my deny coverage

Changes

SPECIAL ENROLLMENT

- MEDICAL
- DENTAL
- SHORT TERM DISABILITY (WITH PROOF OF GOOD HEALTH)
- VOLUNTARY SUPPLEMENTAL LIFE
  - UP TO $100,000 FOR EMPLOYEE AND UP TO $30,000 FOR SPOUSE WITH PROOF OF GOOD HEALTH
  - UP TO $300,000 FOR EMPLOYEE AND UP TO $150,000 WITH PROOF OF GOOD HEALTH
- CRITICAL ILLNESS
  - UP TO $30,000 FOR EMPLOYEE AND UP TO $15,000 FOR SPOUSE WITHOUT PROOF OF GOOD HEALTH

THE SPOUSE CAN NOT HAVE MORE THAN 50% OF THE EMPLOYEE'S VOLUNTARY SUPPLEMENTAL LIFE

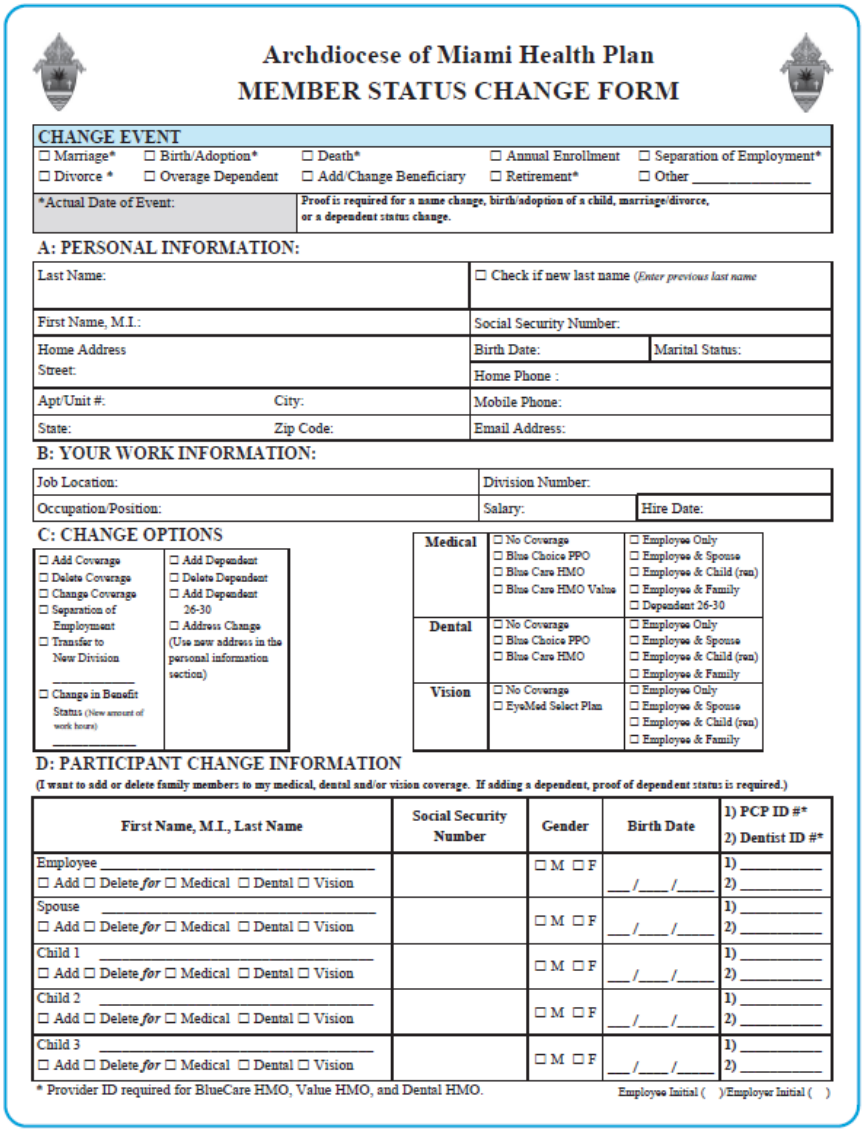
Life Event

30 DAYS

You may apply for coverage outside of your Initial Enrollment Period and the Annual Enrollment Period as a result of a special enrollment event.

Loss of Coverage under…	Caused by…	Archdiocese of Miami Health Plan Enrollment Form due within…
a group health plan or COBRA Continuation	• exhaustion of COBRA/Continuation • termination of employment • education in the number of hours you work • reaching or exceeding the lifetime maximum of all benefits under other health coverage • the employer stopped offering group health coverage • death of your spouse • divorce or legal separation • employer contributions toward such coverage are terminated	30 days of the date coverage was terminated
A Children's Health Insurance Program or Medicaid	• loss of eligibility for such coverage • becoming eligible for the optional state premium assistance program	60 days of the date coverage was terminated
Adding Coverage…	• your marriage • your getting a new dependent through birth, adoption or placement in anticipation of adoption • court order for coverage of a minor	30 days of the date of the event

Member Status Change Form



Archdiocese of Miami Health Plan
MEMBER STATUS CHANGE FORM

CHANGE EVENT

☐ Marriage* ☐ Birth/Adoption* ☐ Death* ☐ Annual Enrollment ☐ Separation of Employment*
☐ Divorce * ☐ Overage Dependent ☐ Add/Change Beneficiary ☐ Retirement* ☐ Other _____

*Actual Date of Event: | Proof is required for a name change, birth/adoption of a child, marriage/divorce, or a dependent status change.

A: PERSONAL INFORMATION:

Last Name:		☐ Check if new last name *(Enter previous last name*	
First Name, M.I.:		Social Security Number:	
Home Address Street:		Birth Date:	Marital Status:
		Home Phone :	
Apt/Unit #:	City:	Mobile Phone:	
State:	Zip Code:	Email Address:	

B: YOUR WORK INFORMATION:

Job Location:	Division Number:	
Occupation/Position:	Salary:	Hire Date:

C: CHANGE OPTIONS

☐ Add Coverage ☐ Delete Coverage ☐ Change Coverage ☐ Separation of Employment ☐ Transfer to New Division _____ ☐ Change in Benefit Status (New amount of work hours) _____	☐ Add Dependent ☐ Delete Dependent ☐ Add Dependent 26-30 ☐ Address Change (Use new address in the personal information section)

Medical	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO ☐ Blue Care HMO Value	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family ☐ Dependent 26-30
Dental	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family
Vision	☐ No Coverage ☐ EyeMed Select Plan	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family

D: PARTICIPANT CHANGE INFORMATION

(I want to add or delete family members to my medical, dental and/or vision coverage. If adding a dependent, proof of dependent status is required.)

First Name, M.I., Last Name	Social Security Number	Gender	Birth Date	1) PCP ID #* 2) Dentist ID #*
Employee _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Spouse _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Child 1 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Child 2 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____
Child 3 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	__/__/____	1) _____ 2) _____

* Provider ID required for BlueCare HMO, Value HMO, and Dental HMO.

Employee Initial ( )/Employer Initial ( )

To make changes to an existing employee record such as:

- Name
- Benefits (Add/Delete)
  - New hires
  - Special Enrollments
  - Annual Enrollments
- Address
- Beneficiary

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- An employee has separated employment and is unable to sign
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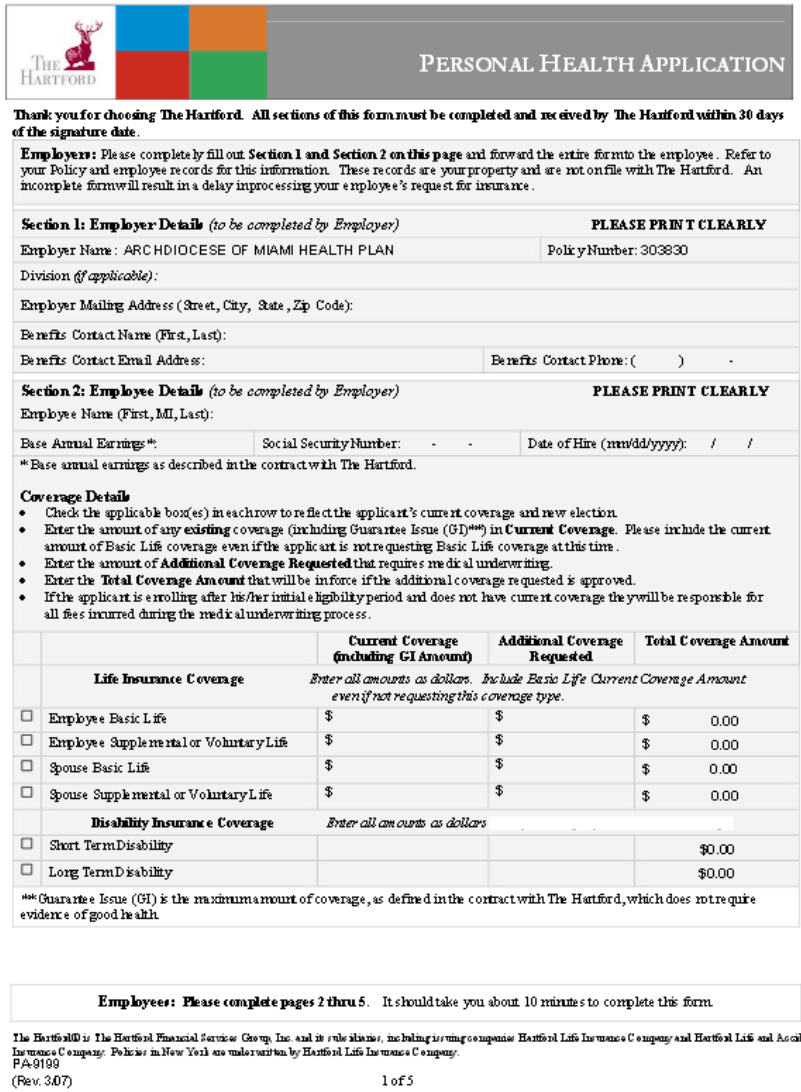
Hartford Personal Health Application



PERSONAL HEALTH APPLICATION

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Employer Name: ARCHDIOCESE OF MIAMI HEALTH PLAN | Policy Number: 303830

Division *(if applicable)*:

Employer Mailing Address (Street, City, State, Zip Code):

Benefits Contact Name (First, Last):

Benefits Contact Email Address: | Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name (First, MI, Last):

Base Annual Earnings*: | Social Security Number: - - | Date of Hire (mm/dd/yyyy): / /

*Base annual earnings as described in the contract with The Hartford.

Coverage Details

- Check the applicable box(es) in each row to reflect the applicant's current coverage and new election.
- Enter the amount of any **existing** coverage (including Guarantee Issue (GI)**) in **Current Coverage**. Please include the current amount of Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** that requires medical underwriting.
- Enter the **Total Coverage Amount** that will be in force if the additional coverage requested is approved.
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		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Life Insurance Coverage	*Enter all amounts as dollars. Include Basic Life Current Coverage Amount even if not requesting this coverage type.*		
☐	Employee Basic Life	$	$	$ 0.00
☐	Employee Supplemental or Voluntary Life	$	$	$ 0.00
☐	Spouse Basic Life	$	$	$ 0.00
☐	Spouse Supplemental or Voluntary Life	$	$	$ 0.00
	Disability Insurance Coverage	*Enter all amounts as dollars*		
☐	Short Term Disability			$0.00
☐	Long Term Disability			$0.00

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Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

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PA-9199

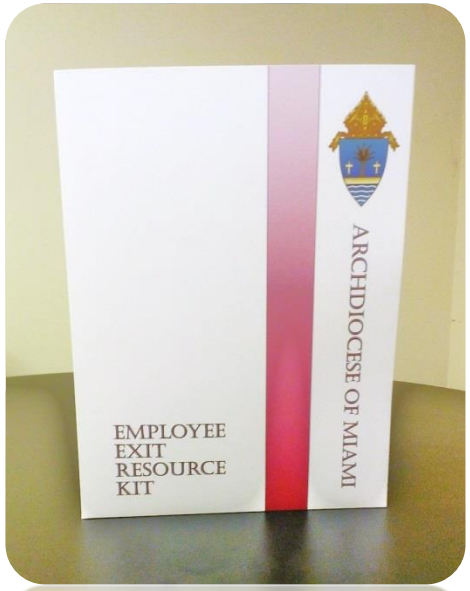
(Rev. 3.07) 1 of 5

- Used for Voluntary Supplemental Term Life:
  - During initial enrollment period
    - In amount over $100,000 for employee
    - In amount over $30,000 for spouse
  - After initial enrollment for any amount above the Basic Life Insurance amount of $15,000
    - Carrier my deny coverage

Separations

Terminated employees should receive an Exit Resource Kit:

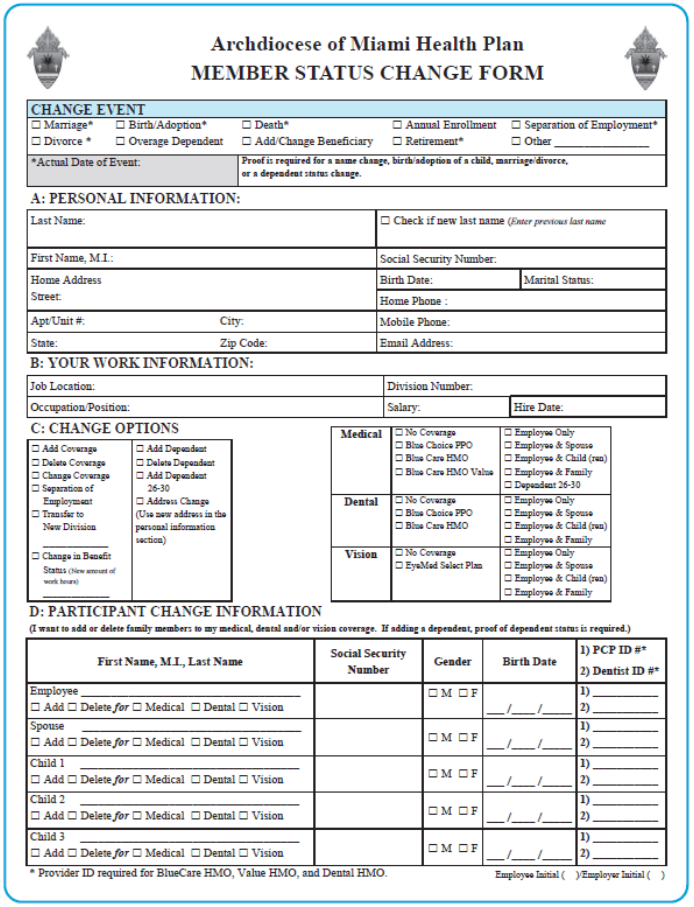
- Separation letter
- Continuation Plan Notification
- Right to Health Coverage Documentation
- Important Contact Sheet
- Member Status Change Form
- Life Conversion Form



The bookkeeper is responsible for providing a complete and signed Member Status Form to the Health Plan Office.

It is very important to provide termination information in a timely manner to avoid a delay in processing and billing errors. Please note the Health Plan can not issue credit for more than one month contributions.

Member Status Change Form (Separation of Employment)



Archdiocese of Miami Health Plan
MEMBER STATUS CHANGE FORM

CHANGE EVENT

☐ Marriage* ☐ Birth/Adoption* ☐ Death* ☐ Annual Enrollment ☐ Separation of Employment*
☐ Divorce * ☐ Overage Dependent ☐ Add/Change Beneficiary ☐ Retirement* ☐ Other _____

*Actual Date of Event: | Proof is required for a name change, birth/adoption of a child, marriage/divorce, or a dependent status change.

A: PERSONAL INFORMATION:

Last Name:	☐ Check if new last name (*Enter previous last name*)
First Name, M.I.:	Social Security Number:
Home Address Street:	Birth Date: / Marital Status:
Apt/Unit #: City:	Home Phone :
State: Zip Code:	Mobile Phone:
	Email Address:

B: YOUR WORK INFORMATION:

Job Location:	Division Number:	
Occupation/Position:	Salary:	Hire Date:

C: CHANGE OPTIONS

☐ Add Coverage
☐ Delete Coverage
☐ Change Coverage
☐ Separation of Employment
☐ Transfer to New Division _____
☐ Change in Benefit Status (New amount of work hours) _____

☐ Add Dependent
☐ Delete Dependent
☐ Add Dependent 26-30
☐ Address Change (Use new address in the personal information section)

Medical	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO ☐ Blue Care HMO Value	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family ☐ Dependent 26-30
Dental	☐ No Coverage ☐ Blue Choice PPO ☐ Blue Care HMO	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family
Vision	☐ No Coverage ☐ EyeMed Select Plan	☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child (ren) ☐ Employee & Family

D: PARTICIPANT CHANGE INFORMATION

(I want to add or delete family members to my medical, dental and/or vision coverage. If adding a dependent, proof of dependent status is required.)

First Name, M.I., Last Name	Social Security Number	Gender	Birth Date	1) PCP ID #* 2) Dentist ID #*
Employee _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/___	1) _____ 2) _____
Spouse _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/___	1) _____ 2) _____
Child 1 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/___	1) _____ 2) _____
Child 2 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/___	1) _____ 2) _____
Child 3 _____ ☐ Add ☐ Delete *for* ☐ Medical ☐ Dental ☐ Vision		☐ M ☐ F	___/___/___	1) _____ 2) _____

* Provider ID required for BlueCare HMO, Value HMO, and Dental HMO.

Employee Initial ( )/Employer Initial ( )

- Select "Terminate All Coverage" to indicate that all benefits are to be terminated .
  - Not necessary to delete every category
- Date of Change is the actual date of employee separation and is required.
- Effective Date of Change is the date benefits will end
  - Example: Employee is separated on September 17. Their benefits will end at the end on the last day of the month, September 30.
- Employee's signature is not required.

Continuation Plan

If you are a lay employee, spouse or dependent and are currently covered by the Archdiocese of Miami Health Plan, you can continue your coverage for up to 12 months after the date you ceased to be eligible for coverage if you:

- are no longer eligible for coverage under the Archdiocese of Miami Health Plan
- are not enrolled in Medicare or any other Governmental Health Plan
- are not enrolled in coverage under another group health plan or individual health plan
- Pay monthly contributions

Retiree Plan

Retiree Benefits

- A Retiree is an employee who begins receiving an Archdiocese of Miami pension benefit immediately upon retirement from the Archdiocese of Miami, and who was employed by the Archdiocese of Miami and was a Covered Plan Participant on the day immediately prior to retirement.

- A one-time benefit election is made at the time of retirement; the Retiree Plan does not have an Annual Enrolment period.

- Coverage begins on the date eligible.

Retiree Benefits

- Retirees have an option to Purchase Medical and Dental through the Archdiocese of Miami Health Plan for themselves and eligible dependents:
  - Medical-Florida Blue
    - Archdiocese PPO
    - Advantage Medicare PPO
  - Dental-Florida Combined Life
    - Archdiocese PPO
    - Archdiocese HMO
- Medicare is primary and the Health Plan is secondary
- Retirees can continue their basic and supplemental life insurance benefits
  - Basic Life is $7,500 at $1.50 per month
  - Supplemental Life is $5,000
    - Cost is based on age

Cafeteria Plan

Section 125 Cafeteria Plan

- A "Cafeteria Plan" is an employee benefits program written in accordance with Section 125 of the Internal Revenue Code.
- Section 125 plans allow certain qualified expenses to be paid on a pre-tax basis.
- Benefit design of a Section 125 plan can range from a simple Premium Only Plan (POP) to a broader benefit plan with Flexible Spending Accounts (FSA).
- The Archdiocese of Miami's Section 125 Plan provides for pre-tax contributions of qualified benefits through a salary reduction agreement.

Salary Reduction Agreement

ARCHDIOCESE OF MIAMI CAFETERIA PLAN
SALARY REDUCTION AGREEMENT

Name: _____ S.S.#: _____

I have reviewed the terms of the Archdiocese of Cafeteria Plan ("the Plan"). I understand that I may elect coverage beginning _____.

ELECTION OF PRE-TAX AND AFTER - TAX BENEFITS

I elect to pay my required contributions for health care coverage on the tax basis indicated below under the Archdiocese of Miami's Cafeteria Plan. This election replaces any prior election(s) I have made.

Medical Plan Contributions	□ Pre-Tax	□ After – Tax
Dental Plan Contributions	□ Pre-Tax	□ After – Tax
Supplemental Life Insurance up to $50,000	□ Pre-Tax	□ After – Tax
Supplemental Life Insurance over $50,000		□ After – Tax
Spouse Life Insurance		□ After – Tax
Dependent Life Insurance		□ After – Tax
Short Term Disability Insurance		□ After – Tax
Critical Illness Insurance		□ After – Tax

☐ I have been provided with a schedule of required contributions.

☐ I understand that except for a Change in Status for the applicable coverage in the Plan, I cannot change my election of pre-tax benefits until the next Annual Enrollment period.

AGREEMENT

I agree that if I selected Pre-Tax Benefits above, my salary will be reduced by the amount of my required contribution for benefits I have selected under the Plan, and that salary reductions will continue for each pay period until this election is changed or terminated. I agree that if I selected After-Tax Benefits my required contributions will be deduction in equal amounts from my paychecks on an after-tax basis during the year until this election is changed or terminated. I understand that:

- I cannot change or revoke my election prior to the next Annual Enrollment period, unless I experience a Change in Status as defined in the Plan (e.g., birth of a child, divorce, marriage, etc.), and my election change (or revocation) is on account of and is consistent with the Change in Status, as described in the Plan.
- I must complete a separate Benefits Enrollment Form before the benefits I have selected will become effective. (e.g. Archdiocese of Miami Health Plan Enrollment Form)
- Under current law salary reduction contributions are not counted when determining FICA earnings. If an employee earns less than the Social Security base wage, his eventual Social Security benefits could be slightly reduced. The value of income and FICA tax savings will normally exceed any eventual reduction in Social Security benefits.
- Each year during the Annual Enrollment period, I will have an opportunity to change my election. If I do not complete and return a new Salary Reduction Agreement at that time, this election will continue unchanged until I make a new election under the terms of the Plan.

I have read and agree to the terms in this Agreement and in the Archdiocese of Miami's Cafeteria Plan.

_____ _____
Employee's Signature Date

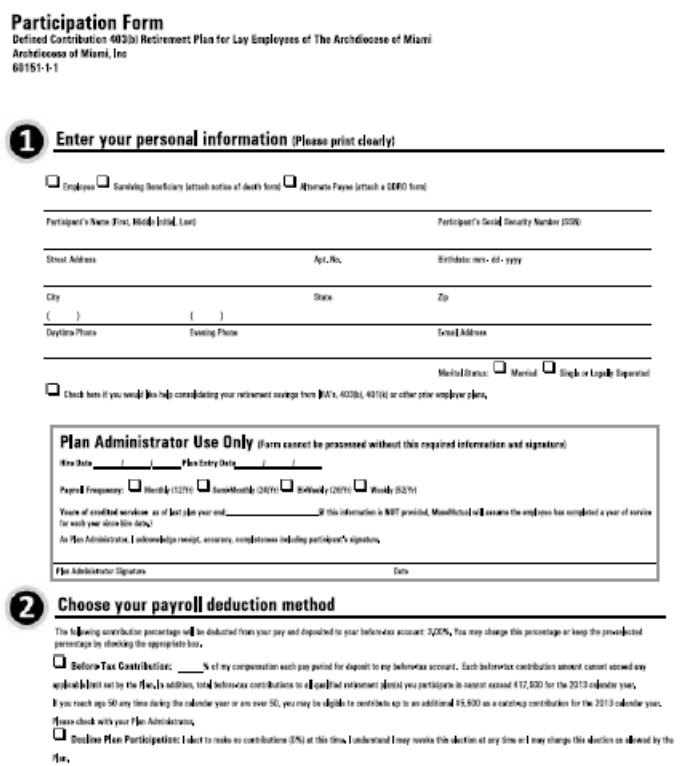
_____ _____
Witness Date

Check Your Bill!!!

Eligibility data is electronically transmitted to vendors and carriers weekly.

403 (b) Administration

403 (b) & Health Plan Processes



Participation Form
Defined Contribution 403(b) Retirement Plan for Lay Employees of The Archdiocese of Miami
Archdiocese of Miami, Inc
68151-1-1

1 **Enter your personal information** (Please print clearly)

☐ Employee ☐ Surviving Beneficiary (attach notice of death form) ☐ Alternate Payee (attach a QDRO form)

Participant's Name (First, Middle Initial, Last) | Participant's Social Security Number (SSN)

Street Address | Apt. No. | Birthdate: mm - dd - yyyy

City | State | Zip

( ) | ( )
Daytime Phone | Evening Phone | Email Address

Marital Status: ☐ Married ☐ Single or Legally Separated

☐ Check here if you would like help consolidating your retirement savings from IRA's, 403(b), 401(k) or other prior employer plans.

Plan Administrator Use Only (Form cannot be processed without this required information and signature)

Hire Date ___/___/___ Plan Entry Date ___/___/___

Payroll Frequency: ☐ Monthly (12/Yr) ☐ SemiMonthly (24/Yr) ☐ BiWeekly (26/Yr) ☐ Weekly (52/Yr)

Years of credited service as of last plan year end _____ (If this information is NOT provided, MassMutual will assume the employee has completed a year of service for each year since hire date.)

As Plan Administrator, I acknowledge receipt, accuracy, completeness including participant's signature.

Plan Administrator Signature | Date

2 **Choose your payroll deduction method**

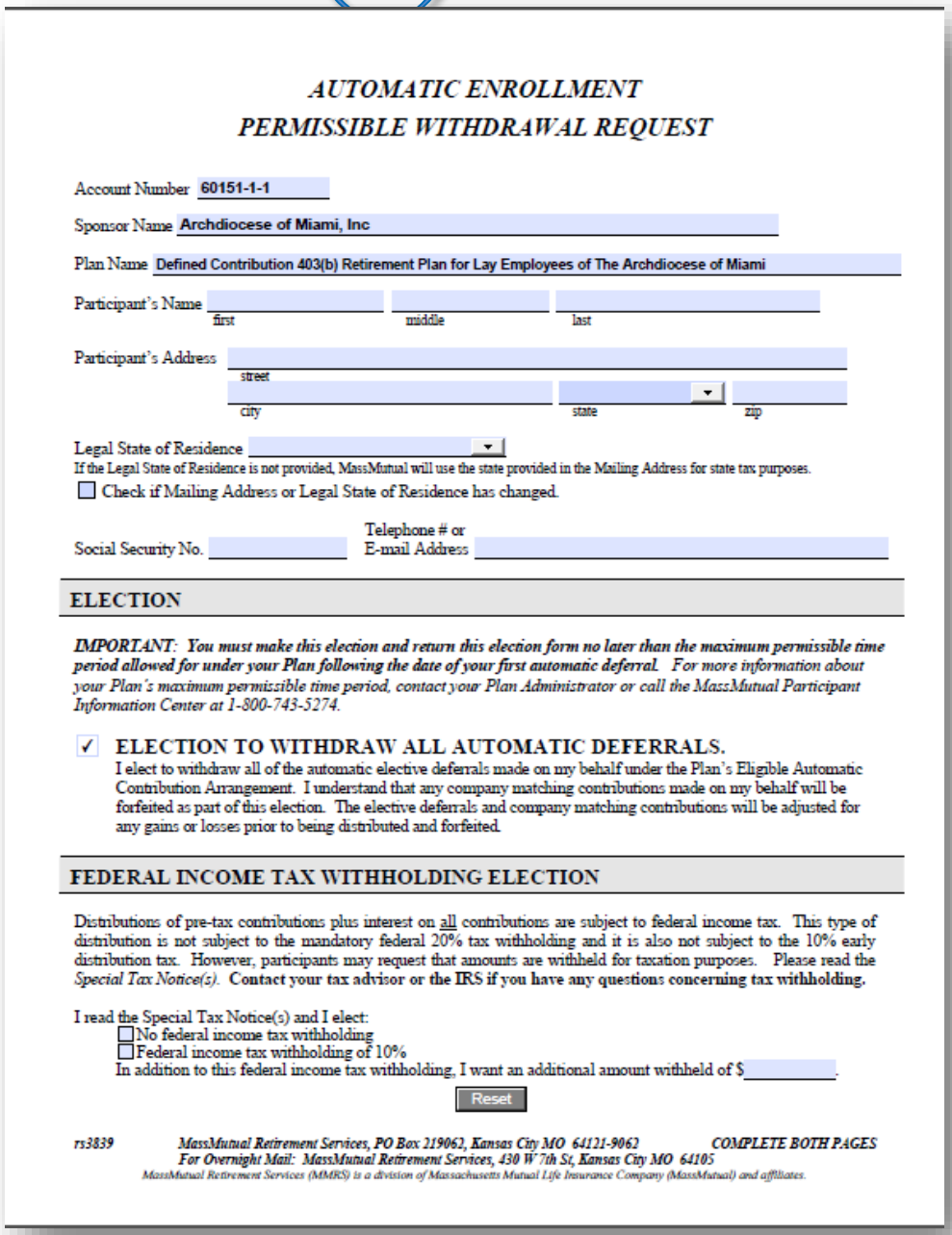
The following contribution percentage will be deducted from your pay and deposited to your before-tax account: 3.00%. You may change this percentage or keep the preselected percentage by checking the appropriate box.

☐ **Before-Tax Contribution:** ____% of my compensation each pay period for deposit to my before-tax account. Each before-tax contribution amount cannot exceed any applicable limit set by the Plan. In addition, total before-tax contributions to all qualified retirement plan(s) you participate in cannot exceed $17,500 for the 2013 calendar year. If you reach age 50 any time during the calendar year or are over 50, you may be eligible to contribute up to an additional $5,500 as a catch-up contribution for the 2013 calendar year. Please check with your Plan Administrator.

☐ **Decline Plan Participation:** I elect to make no contributions (0%) at this time. I understand I may revoke this election at any time or I may change this election as allowed by the Plan.

- Every new hire must be provided a MassMutual 403 (b) enrollment booklet
- Provide original form to Health Plan office and keep copy for your records. If employee does not complete, you must complete to auto enroll at 3% deferral.

403 (b) Auto Enrollment Form



AUTOMATIC ENROLLMENT
PERMISSIBLE WITHDRAWAL REQUEST

Account Number 60151-1-1

Sponsor Name Archdiocese of Miami, Inc

Plan Name Defined Contribution 403(b) Retirement Plan for Lay Employees of The Archdiocese of Miami

Participant's Name _____ (first) _____ (middle) _____ (last)

Participant's Address _____ (street)
_____ (city) _____ (state) _____ (zip)

Legal State of Residence _____
If the Legal State of Residence is not provided, MassMutual will use the state provided in the Mailing Address for state tax purposes.
☐ Check if Mailing Address or Legal State of Residence has changed.

Social Security No. _____ Telephone # or E-mail Address _____

ELECTION

IMPORTANT: ***You must make this election and return this election form no later than the maximum permissible time period allowed for under your Plan following the date of your first automatic deferral.*** *For more information about your Plan's maximum permissible time period, contact your Plan Administrator or call the MassMutual Participant Information Center at 1-800-743-5274.*

✓ **ELECTION TO WITHDRAW ALL AUTOMATIC DEFERRALS.**
I elect to withdraw all of the automatic elective deferrals made on my behalf under the Plan's Eligible Automatic Contribution Arrangement. I understand that any company matching contributions made on my behalf will be forfeited as part of this election. The elective deferrals and company matching contributions will be adjusted for any gains or losses prior to being distributed and forfeited.

FEDERAL INCOME TAX WITHHOLDING ELECTION

Distributions of pre-tax contributions plus interest on all contributions are subject to federal income tax. This type of distribution is not subject to the mandatory federal 20% tax withholding and it is also not subject to the 10% early distribution tax. However, participants may request that amounts are withheld for taxation purposes. Please read the *Special Tax Notice(s).* **Contact your tax advisor or the IRS if you have any questions concerning tax withholding.**

I read the Special Tax Notice(s) and I elect:
☐ No federal income tax withholding
☐ Federal income tax withholding of 10%
In addition to this federal income tax withholding, I want an additional amount withheld of $_____.

Reset

rs3839 *MassMutual Retirement Services, PO Box 219062, Kansas City MO 64121-9062* *COMPLETE BOTH PAGES*
For Overnight Mail: MassMutual Retirement Services, 430 W 7th St, Kansas City MO 64105
MassMutual Retirement Services (MMRS) is a division of Massachusetts Mutual Life Insurance Company (MassMutual) and affiliates.

Form is used for employees that were automatically enrolled and do not wish to participate.

- Must be completed within 30 days for return of funds

STATE INCOME TAX WITHHOLDING

Contact your tax advisor or your state's tax department if you have any questions concerning state tax withholding. Refer to the *State Tax Information* document for important information regarding State Withholding in your Legal State of Residence. If you make an election that is not in compliance with your state's regulations, MassMutual will default to your state's requirements.

No State Tax Withholding Election

☐ I have read the *State Tax Information* document and I elect to have no state income tax withheld from my payment(s).

Voluntary State Income Tax Withholding

☐ I have read the *State Tax Information* document and I elect to have the following voluntary state income tax withheld from my payment(s) (choose one):

____%

$_____ (whole dollar amount)

☐ based on my state's tax table formula, if applicable (MassMutual will apply the default tax allowance)

Additional State Income Tax Withholding

☐ I have read the *State Tax Information* document and I elect to have an additional ___% or $_____ (whole dollar amount) state income tax withheld from my payment(s).

SIGNATURES

Reset Print

_____ _____/_____/_____

Participant Date

I, the Plan Administrator, verify that the above information is correct and certify that the plan allows for such distribution.

_____ _____/_____/_____

Plan Administrator Date

403 (b) Participation Form

Participation Form
Defined Contribution 403(b) Retirement Plan for Lay Employees of The Archdiocese of Miami
Archdiocese of Miami, Inc
60151-1-1

1 Enter your personal information (Please print clearly)

☐ Employee ☐ Surviving Beneficiary (attach notice of death form) ☐ Alternate Payee (attach a QDRO form)

Participant's Name (First, Middle Initial, Last) | Participant's Social Security Number (SSN)

Street Address | Apt. No. | Birthdate: mm - dd - yyyy

City | State | Zip

( ) Daytime Phone | ( ) Evening Phone | E-mail Address

Marital Status: ☐ Married ☐ Single or Legally Separated

Plan Administrator Use Only (Form cannot be processed without this required information and signature)

Hire Date ___/___/___ Plan Entry Date___/___/___

Payroll Frequency: ☐ Monthly (12/Yr) ☐ Semi-Monthly (24/Yr) ☐ Bi-Weekly (26/Yr) ☐ Weekly (52/Yr)

Years of credited services as of last plan year end:_____(if this information is NOT provided, MassMutual will assume the employee has completed a year of service for each year since hire date.)

As Plan Administrator, I acknowledge receipt, accuracy, completeness including participant's signature.

Plan Administrator Signature | Date

2 Choose your payroll deduction method

The following contribution percentage will be deducted from your pay and deposited to your before-tax account: 3.00%. You may change this percentage or keep the pre-selected percentage by checking the appropriate box.

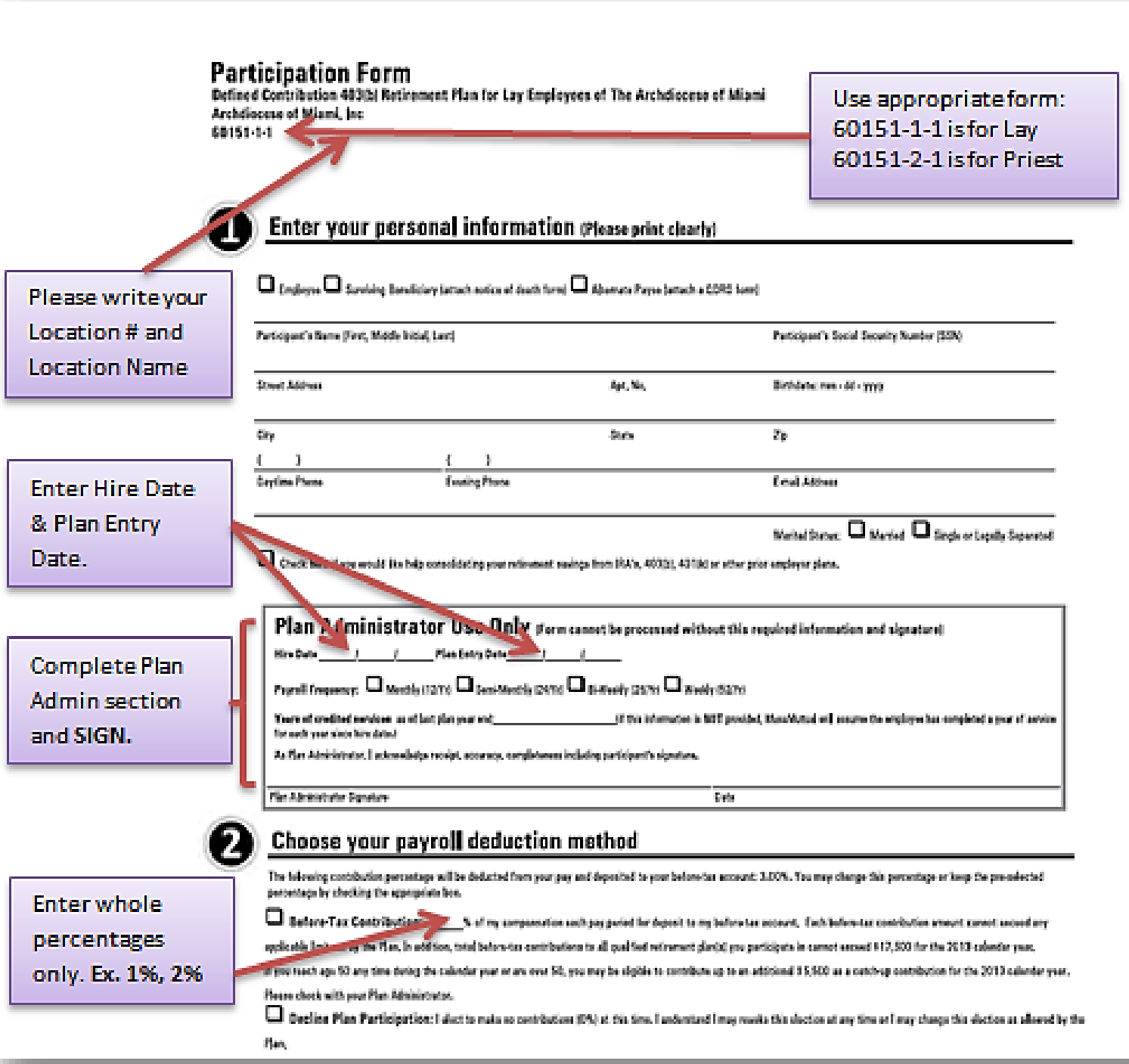
☐ **Before-Tax Contribution:** ____% of my compensation each pay period for deposit to my before-tax account. Each before-tax contribution amount cannot exceed any applicable limit set by the Plan. In addition, total before-tax contributions to all qualified retirement plan(s) you participate in cannot exceed $17,500 for the 2014 calendar year.

If you reach age 50 any time during the calendar year or are over 50, you may be eligible to contribute up to an additional $5,500 as a catch-up contribution for the 2014 calendar year. Please check with your Plan Administrator.

☐ **Decline Plan Participation:** I elect to make no contributions (0%) at this time. I understand I may revoke this election at any time or I may change this election as allowed by the Plan.

Used for new hires to establish a MassMutual Account

- If employee does not complete this form, you must complete to automatically enroll them at 3% deferral.



Participation Form
Defined Contribution 403(b) Retirement Plan for Lay Employees of The Archdiocese of Miami
Archdiocese of Miami, Inc
60151-1-1

Use appropriate form:
60151-1-1 is for Lay
60151-2-1 is for Priest

Please write your Location # and Location Name

1 Enter your personal information (Please print clearly)

☐ Employee ☐ Surviving Beneficiary (attach notice of death form) ☐ Alternate Payee (attach a QDRO form)

Participant's Name (First, Middle Initial, Last) | Participant's Social Security Number (SSN)

Street Address | Apt. No. | Birthdate: mm - dd - yyyy

City | State | Zip

( ) Daytime Phone | ( ) Evening Phone | Email Address

Marital Status: ☐ Married ☐ Single or Legally Separated

☐ Check here if you would like help consolidating your retirement savings from IRA's, 403(b), 457(b) or other prior employer plans.

Enter Hire Date & Plan Entry Date.

Complete Plan Admin section and SIGN.

Plan Administrator Use Only (Form cannot be processed without this required information and signature)

Hire Date ___/___/___ Plan Entry Date ___/___/___

Payroll Frequency: ☐ Monthly (12/Yr) ☐ Semi-Monthly (24/Yr) ☐ Bi-Weekly (26/Yr) ☐ Weekly (52/Yr)

Years of credited service as of last plan year end: _____ (If this information is NOT provided, MassMutual will assume the employee has completed a year of service for each year since hire date)

As Plan Administrator, I acknowledge receipt, accuracy, completeness including participant's signature.

Plan Administrator Signature | Date

2 Choose your payroll deduction method

The following contribution percentage will be deducted from your pay and deposited to your before-tax account: 3.00%. You may change this percentage or keep the pre-selected percentage by checking the appropriate box.

☐ Before-Tax Contribution: ____% of my compensation each pay period for deposit to my before-tax account. Each before-tax contribution amount cannot exceed any applicable limit imposed by the Plan. In addition, total before-tax contributions to all qualified retirement plan(s) you participate in cannot exceed $17,500 for the 2013 calendar year. If you reach age 50 any time during the calendar year or are over 50, you may be eligible to contribute up to an additional $5,500 as a catch-up contribution for the 2013 calendar year. Please check with your Plan Administrator.

Enter whole percentages only. Ex. 1%, 2%

☐ Decline Plan Participation: I elect to make no contributions (0%) at this time. I understand I may revoke this election at any time or I may change this election as allowed by the Plan.

If the employee decides to contribute, they must choose one investment option on page 2.

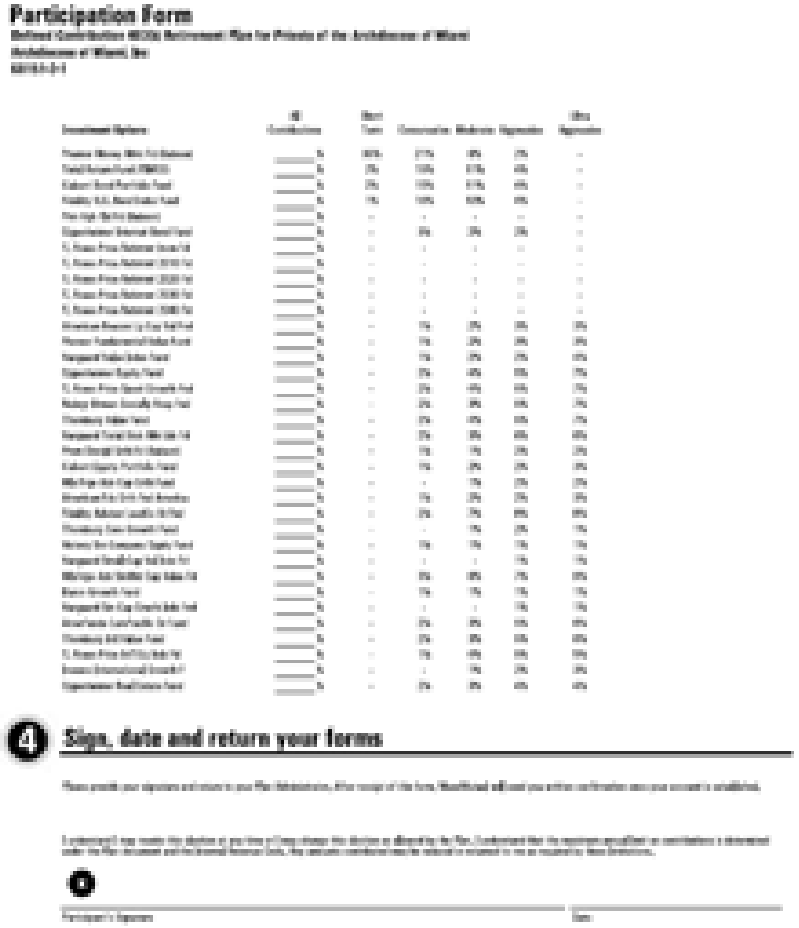
3 Choose one of the investment strategies below

A: Age-Based Investment Option

B: Custom Portfolio Investment Option

C: Individual Fund Option

If the employee chooses to do their own investment strategy, they must complete page 3 and all investments combined must equal 100%.



Participation Form

Investment Options	% Contributions	Short Term	Conservative	Moderate	Aggressive	Ultra Aggressive
	%	85%	27%	8%	2%	-
	%	2%	10%	21%	6%	-
	%	2%	10%	21%	6%	-
	%	1%	10%	50%	9%	-
	%	-	-	-	-	-
	%	-	3%	3%	2%	-
	%	-	-	-	-	-
	%	-	-	-	-	-
	%	-	-	-	-	-
	%	-	-	-	-	-
	%	-	-	-	-	-
	%	-	1%	3%	3%	3%
	%	-	1%	3%	3%	3%
	%	-	1%	3%	3%	6%
	%	-	2%	6%	5%	7%
	%	-	2%	6%	5%	7%
	%	-	2%	6%	5%	7%
	%	-	2%	6%	5%	7%
	%	-	2%	6%	5%	6%
	%	-	1%	2%	2%	2%
	%	-	1%	3%	2%	3%
	%	-	-	1%	2%	2%
	%	-	1%	3%	2%	3%
	%	-	2%	7%	6%	6%
	%	-	-	1%	2%	1%
	%	-	1%	1%	1%	1%
	%	-	-	-	1%	1%
	%	-	2%	6%	1%	6%
	%	-	1%	1%	1%	1%
	%	-	-	-	1%	1%
	%	-	2%	6%	5%	6%
	%	-	2%	6%	5%	6%
	%	-	1%	6%	5%	5%
	%	-	-	1%	2%	3%
	%	-	2%	6%	4%	6%

4 Sign, date and return your forms

Participant's Signature

Date

403 (b) Payroll Spreadsheet and Payment

- Each payroll a 403 (b) contribution spreadsheet is populated with the data needed to transmit employee deferrals and employer match amounts into each employee's MassMutual account.
- Please include payroll date and check number.
- Completed spreadsheets are sent to 403b@adomhealthplan.org Please keep a copy for your records.
- Payment is sent to WellsFargo via check, transfer or ACH debit.
  - Please verify the payment amount matches the total (deferral and match) amount on your spreadsheet.
- Spreadsheets and payment must be sent as soon as is "feasible".

403 (b) -Contribution Spreadsheet-

DIVISION	SSN	LNAME	FNAME	PAY FREQUENCY	DOB	DOH	EMPLOYEE TYPE	GROSS PAY
1111	111-11-1111	Smith	Joe	Bi-Weekly	1/1/1990	5/12/2013	LAY	1000
1111	222-22-2222	Priestly	Tom	Monthly	2/2/1970	3/22/2000	PRIEST	2200
1111	333-33-3333	Externpriestly	Tim	Semi-Monthly	1/5/1980	2/5/1999	EXTERN PRIEST	2150
							TOTALS	

EMPLOYEE DEFERRALS	MATCHING FUNDS	EXTERN PRIEST CONTRIBUTION	ADDRESS	CITY/ST/ZIP
60	30	0	1111 Holy Lane	Miami, FL 33333
60	30	0	2222 Heaven Lane	Miami, FL 33333
0	0	291.67	3333 Grace Rd.	Miami, FL 33333
120	60	291.67		
CHECK SENT DATE	10/3/2013			
CHECK NUMBER	1111			
CHECK AMOUNT	$ 471.67			

- Please provide complete SSN, Entity Division, Employee Type
- Verify employer matches
- Please do not insert/use formulas
- Please remove terminated employees

403 (b) Match Example

If you contribute…	Your contribution per pay period	ADOM's match per pay period	Total contribution per pay period
2%	2%	1%	3%
4%	4%	2%	6%
6%	6%	3%	9%
10%	10%	3%	13%

403 (b) Where do I find…

- MassMutual packet for new employees?
  - Call MassMutual Customer Service at (800) 309-3539
  - Send an Information Request Form to the Health Plan
  - Email Cabraham@adomhealthplan.org
  - Download from www.adomhealthplan.org
- MassMutual Rollover forms?
  - Call the MassMutual Rollover Department at (888) 526-6905

Special Considerations for Priests

Priest Enrollment Form

Archdiocese of Miami Health Plan

INFORMATION FORM

A: PERSONAL INFORMATION:

Last Name:		
First Name, M.I.:		Social Security Number:
Home Address :		Birth Date:
		Home Phone :
Apt/Unit #:	City:	Mobile Phone:
State:	Zip Code:	Email Address:

B: MEDICAL PLAN: (Please select one of the following options)

- ❑ **Base Medical Plan** - paid by entity contribution
- ❑ **Buy - Up Medical Plan** - $120 per month personal contribution

A Dental PPO Plan is included with Medical Plan participation, however, the Dental benefit does not increase the Buy-Up Plan.

C: OTHER CARRIER LIABILITY INFORMATION:

If you have other medical or dental coverage, please provide the following:

Name of Insurance Company:	Phone #:

D: BENEFICIARY DESIGNATION FOR:

Basic Life, AD&D and Long-Term Disability (Please designate a beneficiary below)

PRIMARY BENEFICIARY:			
Name:	Relationship:	Beneficiary %:	
Address:	City:	State:	Zip Code:

SECONDARY BENEFICIARY:			
Name:	Relationship:	Beneficiary %:	
Address:	City:	State:	Zip Code:

E. ADDITIONAL INSURANCE OPTIONS:

- **Voluntary Supplemental Life Insurance**

The Archdiocese of Miami Health Plan provides the opportunity for you to purchase up to $300,000 additional group term life insurance protection.

If you enroll within 30 days of your eligibility date, you may purchase up to $100,000 without answering medical questions and apply for up to $300,000 with medical questions. If you do not enroll within 30 days of your eligibility date and wish to enroll later, medical questions will be required for all amounts. Any amounts subject to medical questions may be denied by the carrier.

Supplemental life amounts are subject to the following federal age-reduction schedule; at age 65 the face amount reduces to 65% of the full amount; age 70 to 45%; age 75 to 30%; and at age 80 to 20%.

An accelerated benefit provision is included, which allows payment of 50% of the face amount or $50,000, whichever is less, in the event you are diagnosed terminally ill.

- **Voluntary Supplemental Life Insurance (Continued)**

❑ I elect to enroll for supplemental life insurance ❑ I decline to enroll for supplemental life insurance and understand if I elect to apply in the future, medical questions will be required and coverage may be denied by the carrier.

Please select amount of supplemental life insurance.					
Up to $100,000 without Medical Questions		Amounts over $100,000 will require Medical Questions and additional coverage my be denied by the carrier.			
☐ $10,000	☐ $60,000	☐ $110,000	☐ $160,000	☐ $210,000	☐ $260,000
☐ $20,000	☐ $70,000	☐ $120,000	☐ $170,000	☐ $220,000	☐ $270,000
☐ $30,000	☐ $80,000	☐ $130,000	☐ $180,000	☐ $230,000	☐ $280,000
☐ $40,000	☐ $90,000	☐ $140,000	☐ $190,000	☐ $240,000	☐ $290,000
☐ $50,000	☐ $100,000	☐ $150,000	☐ $200,000	☐ $250,000	☐ $300,000

Example: To calculate the rate of $50,000 of life insurance on a 35-year-old, you would multiply 5 X $1.48 to get the monthly cost of $7.40.

Monthly Rates per $10,000 of Coverage	
AGE	RATE
< 30	$ 0.82
30-34	$ 1.02
35-39	$ 1.48
40-44	$ 2.10
45-49	$ 3.83
50-54	$ 5.82
55-59	$ 8.66
60-64	$ 12.70
65-69	$ 18.78
70+	$ 34.17

- **Critical Illness Insurance**

Coverage is underwritten by Continental American Insurance Company (CAIC). CAIC is a wholly-owned subsidiary of Aflac Incorporated.

❑ I decline to enroll for critical illness insurance and understand I can only apply for coverage during annual open enrollment, new hire and/or a qualified life change event.

❑ I elect to enroll for Critical Illness Insurance:

❑ Employee Face Amount ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000

Have you used tobacco products in the last 12 months? ☐ Yes ☐ No

Does this coverage replace or change any existing insurance? ☐ Yes ☐ No If yes, provide carrier and policy number: _____

CERTIFICATION: I have read the completed Application and I realize any false statement or misrepresentation in the Application may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Application is approved and the necessary premium is paid. Coverage will not become effective unless you are employed full-time on the enrollment date and on the effective date. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Please refer to the rate sheet and/or the Archdiocese of Miami Health Plan Priest Benefit guide for information about the most current rates.

F. ENROLLMENT AGREEMENT:

I understand that by signing this form, I *may* be electing to increase my contribution rates in exchange for special coverage(s). To the best of my knowledge, all statements and answers are true.

X_____

Signature Date

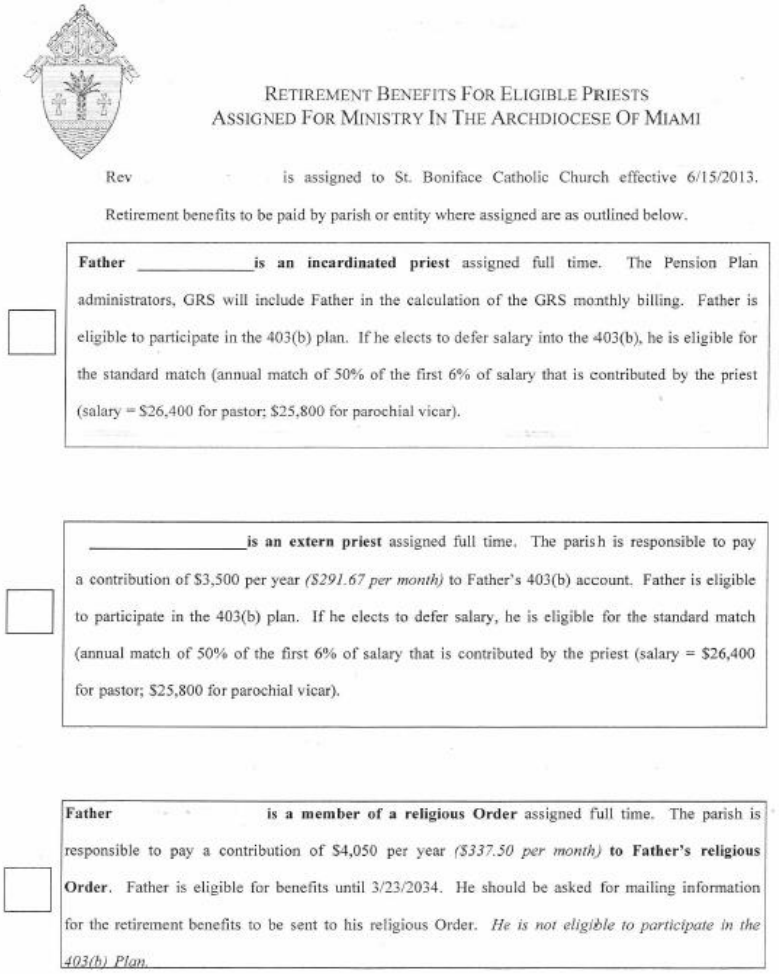
X_____/_____/_____

Employee Signature Title Date

A non-response in any area will be considered as waived coverage. All actual benefits and benefit descriptions are governed solely by the relevant plan documents and contracts. The Archdiocese of Miami Health Plan retains the right to amend, change or modify benefits at any time.

Special Considerations for Priests-

Priest 403 (b) assignment form



RETIREMENT BENEFITS FOR ELIGIBLE PRIESTS
ASSIGNED FOR MINISTRY IN THE ARCHDIOCESE OF MIAMI

Rev _____ is assigned to St. Boniface Catholic Church effective 6/15/2013.

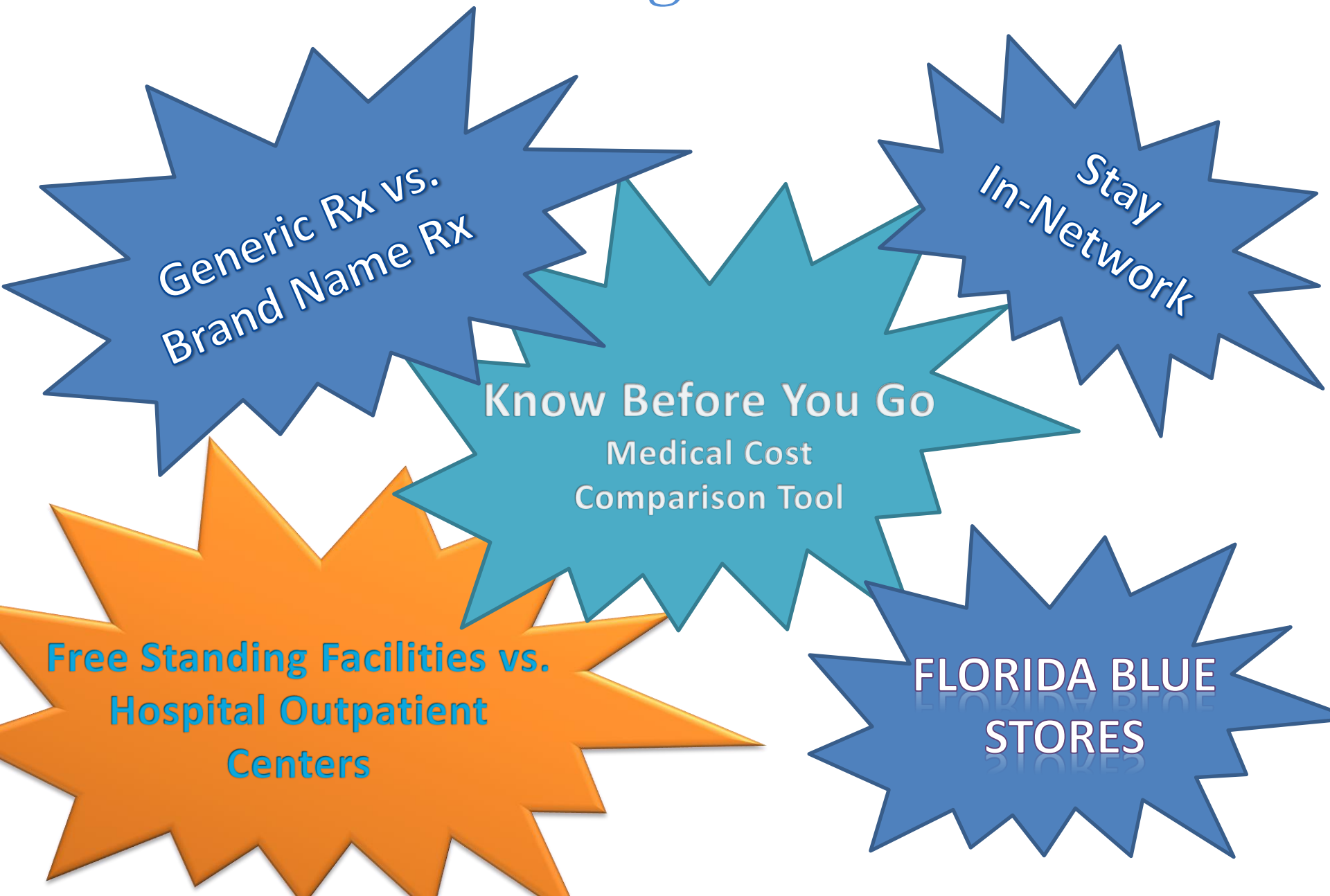
Retirement benefits to be paid by parish or entity where assigned are as outlined below.

☐ **Father _____ is an incardinated priest** assigned full time. The Pension Plan administrators, GRS will include Father in the calculation of the GRS monthly billing. Father is eligible to participate in the 403(b) plan. If he elects to defer salary into the 403(b), he is eligible for the standard match (annual match of 50% of the first 6% of salary that is contributed by the priest (salary = $26,400 for pastor; $25,800 for parochial vicar).

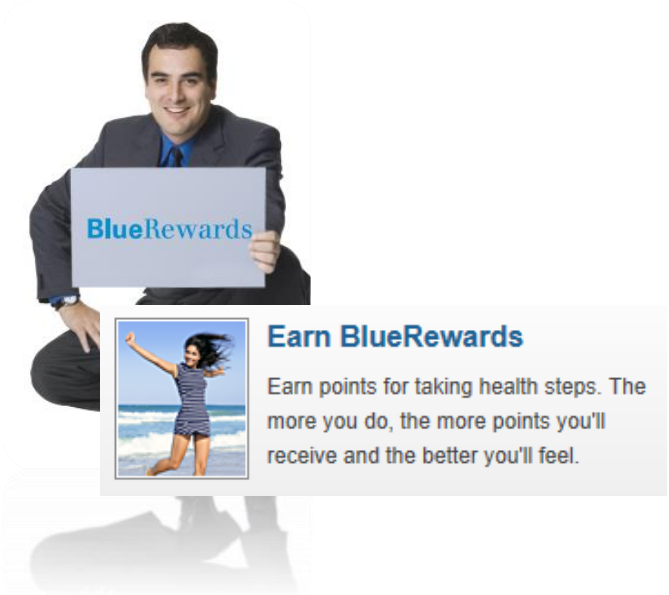
☐ _____ **is an extern priest** assigned full time. The parish is responsible to pay a contribution of $3,500 per year *($291.67 per month)* to Father's 403(b) account. Father is eligible to participate in the 403(b) plan. If he elects to defer salary, he is eligible for the standard match (annual match of 50% of the first 6% of salary that is contributed by the priest (salary = $26,400 for pastor; $25,800 for parochial vicar).

☐ **Father _____ is a member of a religious Order** assigned full time. The parish is responsible to pay a contribution of $4,050 per year *($337.50 per month)* **to Father's religious Order**. Father is eligible for benefits until 3/23/2034. He should be asked for mailing information for the retirement benefits to be sent to his religious Order. *He is not eligible to participate in the 403(b) Plan.*

Get More Bang for Your Buck!



BlueRewards Program



- New Rewards Program
- Point system with automatic reward generation
- Health improvement programs
- Health tracking systems
- Much, much more!

BlueRewards Program

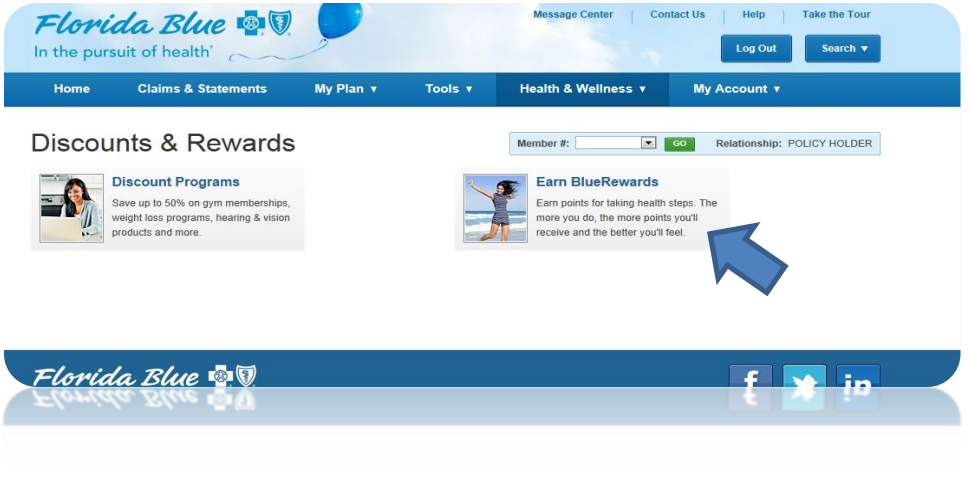
	How often do I have to do this?	Points that you earn	Where do I go to do this?
Get Assessed!			
Complete Personal Health Assessment	Once	75	Florida Blue Centers/ FloridaBlue.com
Normal BMI (18.5-24.9)	Once	50	Florida Blue Centers/ FloridaBlue.com
Non-tobacco user	Once	50	Anywhere...you can do it!
Get Tools!			
Watch personal health record video	Once	10	Health & Wellness Video @ www.FloridaBlue.com
Get Moving!			
Enter Data in Your Personalized Exercise Tracker	Bi-Weekly	10	WebMD through Your Personal Florida Blue Account

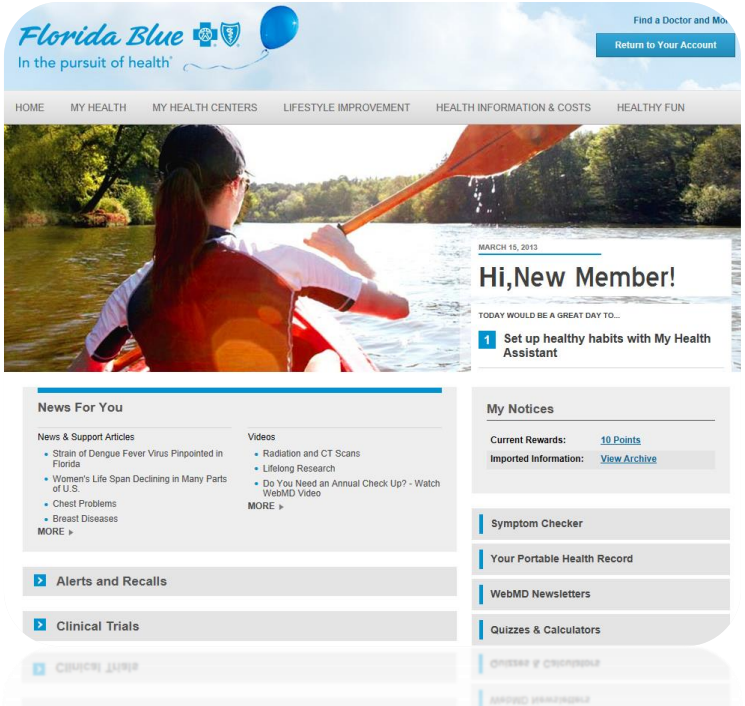
150 Points get you a $25 gift card!

BlueRewards Program

1) Access BlueRewards through your FloridaBlue personalized account.

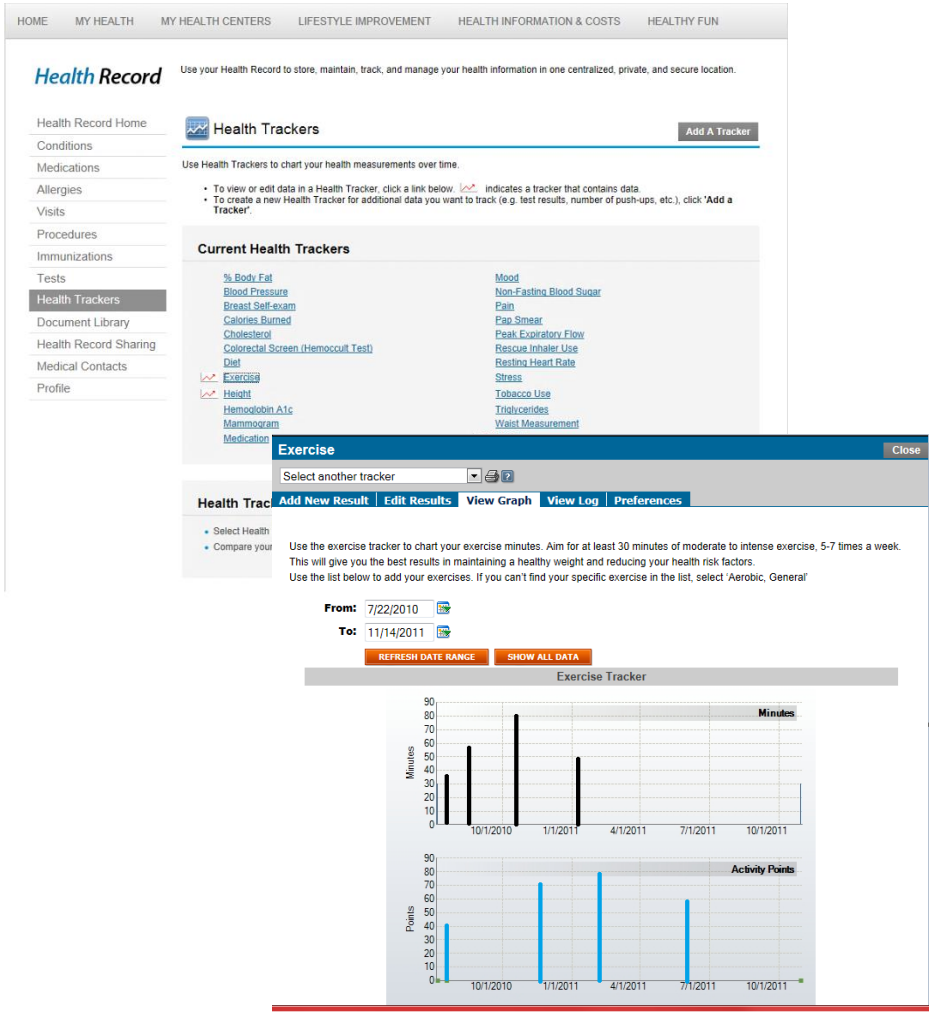
2) Click on Earn BlueRewards to go to your personalized home page.





3) Explore, get healthy and earn points for your gift card!

BlueRewards Program



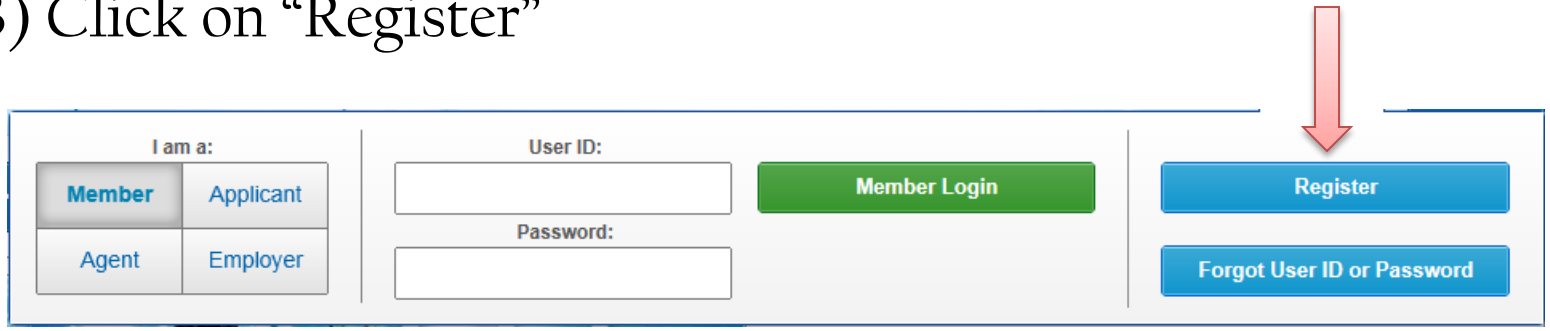
- Health Record System
- Various Health Tracking Options
  - Blood Pressure
  - Mammogram
  - Medication
  - Exercise

How to Create a Florida Blue Account

1) Visit www.floridablue.com

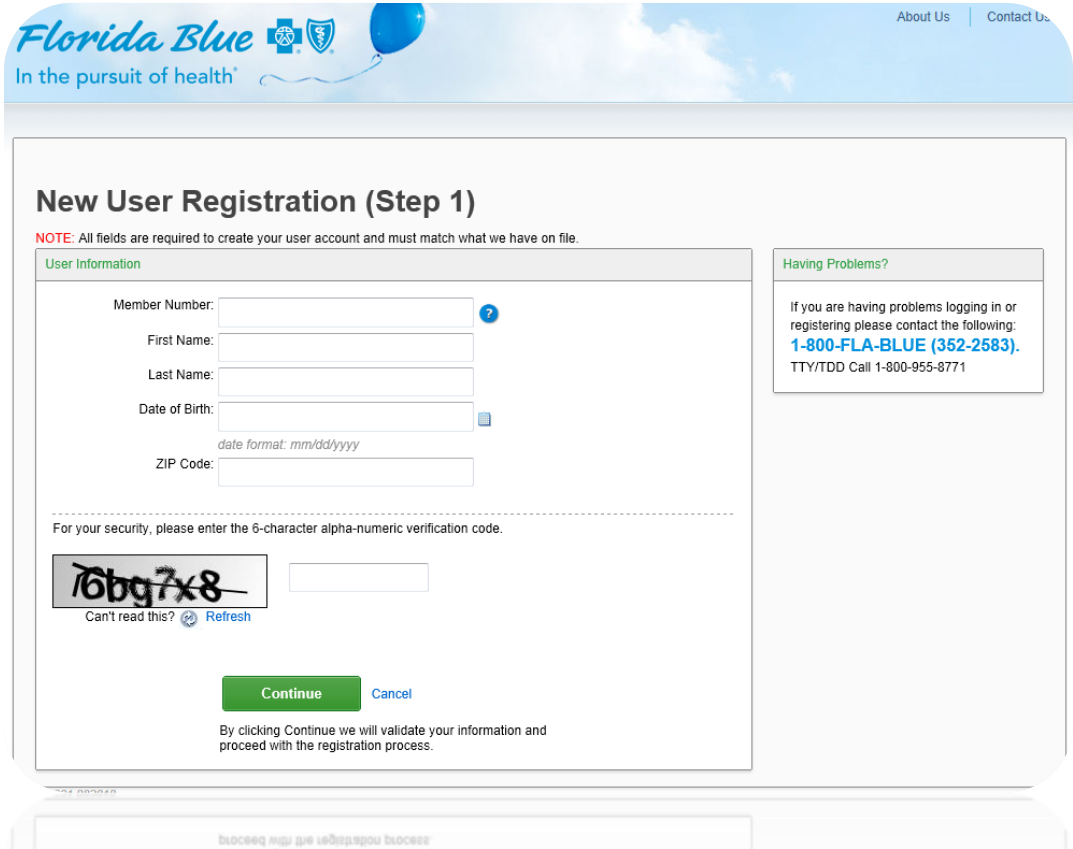
2) Click on "Login"

3) Click on "Register"



How to Create a Florida Blue Account

4) Follow the New Registration prompts and you are in!



Pre Natal Program

The Healthy Addition program is a free service for expected mothers provided by BlueCross BlueShield of Florida.

- Pregnancy risk screening and monitoring
- Education on healthy lifestyle and dietary habits
- Prenatal information sent directly to participant's home.

Free Prenatal Vitamins!

Know Before You Go

Know Before You Go is a cost and quality comparison service for plan members.

- Shop, compare and estimate your medical costs
- Compare quality of care
- Savings opportunities
- Easy access to information
  - ❖ Online through your FloridaBlue Account
  - ❖ Care consultant 1-888-476-2227
  - ❖ Visit Florida Blue centers

Cost Comparison Example*

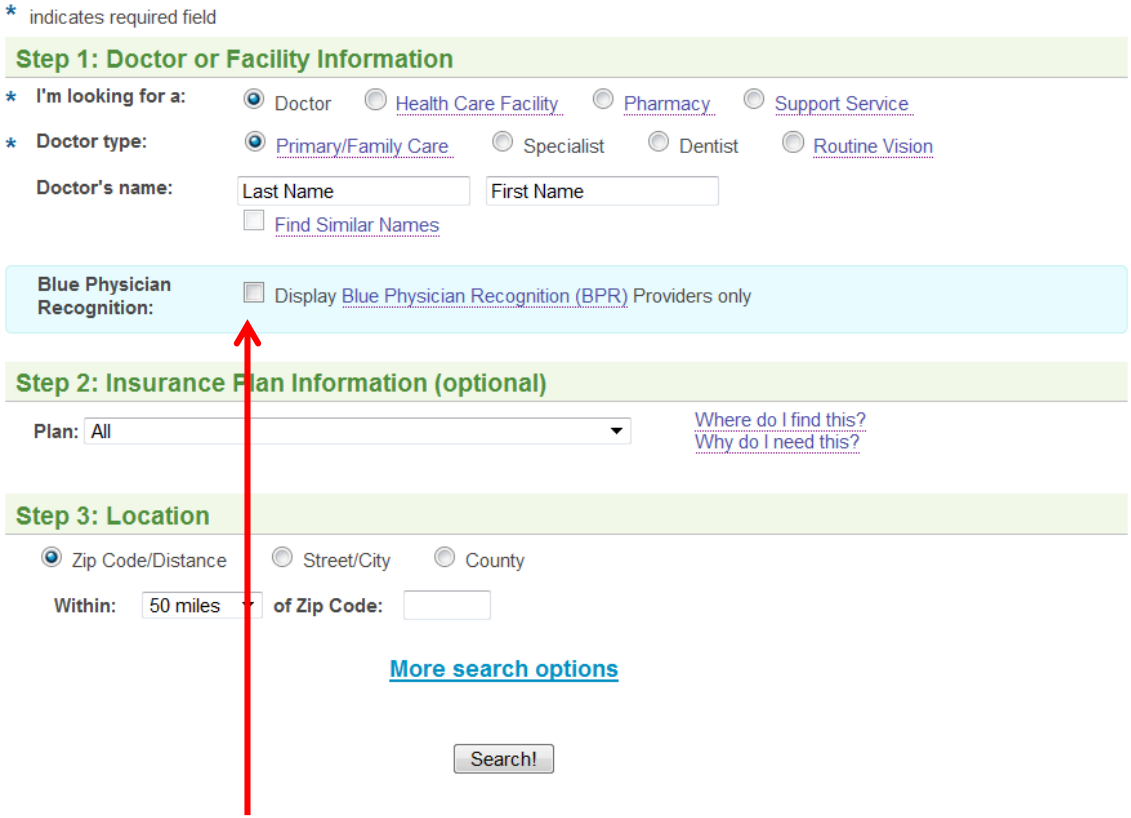
SURGERY Inpatient or Outpatient **Select** back, leg, pelvis & more!	**Number of Procedures Per Year**—based on the surgery you selected	**Cost Range**—your actual cost can be estimated by a Care Consultant
Health Care Facility A	600	$21,710 - $24,423
Health Care Facility B	500	$17,752 - $19,970
Health Care Facility C	300	$13,197 - $15,395

Introducing the Blue Physician Recognition Network (BPR)

- Smaller, selective network
  - Contracts physicians demonstrating commitment to:
    - Quality
    - Patient-centered care
- HMO Standard and HMO Value Plan participants receive a discount for visiting a Blue Physician Recognition Primary Care Physician (PCP)

Plan	PCP Copayment	Reduced to…
HMO Standard Plan	$25	$15
HMO Value Plan	$30	$20

Locating Participating Doctors/Facilities



To find a doctor in the Blue Physician Recognition Program, check the "Display BRP Providers only" option.

Provider

BlueCare HMO Standard/Value
Blue Choice PPO
BlueDental Care Prepaid (HMO)
BlueDental Choice (PPO)

1) Choose "Doctor"

2) Choose "Primary/Family Care", "Specialist", or "Dentist"

3) Choose your Plan
HMO BlueCare
PPO BlueChoice

You can also...

4) Search by "Doctor's name", "Plan" and/or "Location"

5) Select Search!

Facility

1) Choose "Health Care Facility"

2) Choose "Hospitals", "Walk-in Medical Clinics", "X-Ray/Imaging", or "Labs"

3) Choose your Plan
HMO BlueCare
PPO BlueChoice

You can also...

4) Search by "Plan" and/or "Location"

5) Select Search!

Locating Participating Doctors/Facilities

Smaller, selective network that contracts physicians who demonstrate a commitment to delivering quality and patient-centered care.

- HMO Standard and HMO Value Plans copayment for Primary Care Physician are reduced when visiting a BPR primary care physician.

Florida Blue Retail Centers

Three convenient locations

- North Miami Beach at Keystone Plaza
- The Falls in Miami
- Sawgrass Mills in Sunrise

Face to face service

- Get a snapshot of your health
- Cost saving tips
- Get answers to member benefits
- Much more!

Member Discount Programs

Blue365
Your resource for living healthier.℠

Health Management

Healthyroads
Nutrisystem
anytime health.com
Jenny Craig
eDiets

Vision Discounts

LasikPlus VISION CENTER
QualSight LASIK
DAVIS VISION SEE LIFE

Healthy Finances

H&R BLOCK

Member Discount Programs

Blue365
Your resource for living healthier.

Hearing Discounts

TruHearing
Bringing You the Sounds of Life

Beltone
Helping the world hear better

Senior Discounts

SENIORLINK CARE

Fitness

Reebok

snap FITNESS 24-7
fast · convenient · affordable

POLAR
LISTEN TO YOUR BODY

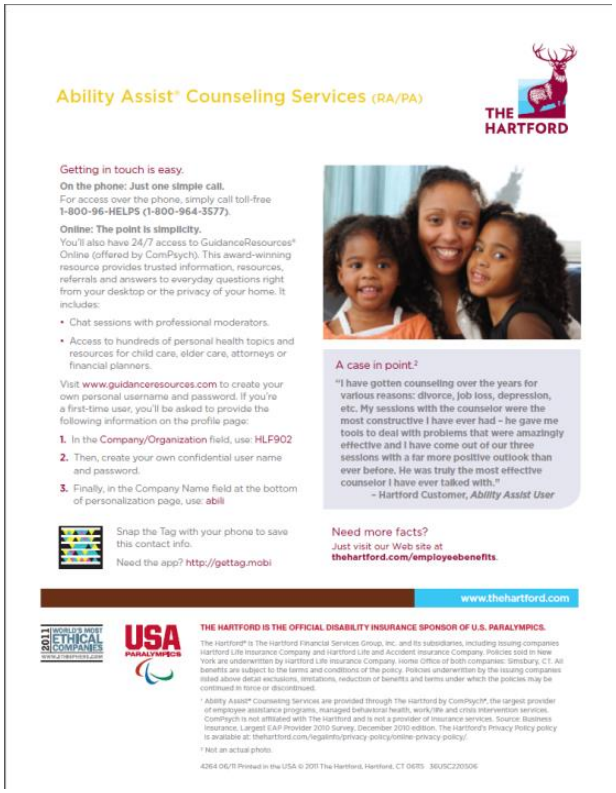
SPORTLINE

healthways fitness your way

ANYTIME FITNESS

BODYMEDIA®

THE HARTFORD (Value Added Benefits)



Ability Assist® Counseling Services (RA/PA)

THE HARTFORD

Getting in touch is easy.

On the phone: Just one simple call.
For access over the phone, simply call toll-free **1-800-96-HELPS (1-800-964-3577).**

Online: The point is simplicity.
You'll also have 24/7 access to GuidanceResources® Online (offered by ComPsych). This award-winning resource provides trusted information, resources, referrals and answers to everyday questions right from your desktop or the privacy of your home. It includes:

- Chat sessions with professional moderators.
- Access to hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

Visit www.guidanceresources.com to create your own personal username and password. If you're a first-time user, you'll be asked to provide the following information on the profile page:

1. In the Company/Organization field, use: HLF902
2. Then, create your own confidential user name and password.
3. Finally, in the Company Name field at the bottom of personalization page, use: abili

Snap the Tag with your phone to save this contact info.
Need the app? http://gettag.mobi

A case in point.[2]

"I have gotten counseling over the years for various reasons: divorce, job loss, depression, etc. My sessions with the counselor were the most constructive I have ever had – he gave me tools to deal with problems that were amazingly effective and I have come out of our three sessions with a far more positive outlook than ever before. He was truly the most effective counselor I have ever talked with."
– Hartford Customer, *Ability Assist User*

Need more facts?
Just visit our Web site at **thehartford.com/employeebenefits.**

www.thehartford.com

2011 WORLD'S MOST ETHICAL COMPANIES

USA PARALYMPICS

THE HARTFORD IS THE OFFICIAL DISABILITY INSURANCE SPONSOR OF U.S. PARALYMPICS.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

[1] Ability Assist® Counseling Services are provided through The Hartford by ComPsych®, the largest provider of employee assistance programs, managed behavioral health, work/life and crisis intervention services. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. Source: Business Insurance, Largest EAP Provider 2010 Survey, December 2010 edition. The Hartford's Privacy Policy policy is available at: thehartford.com/legalinfo/privacy-policy/online-privacy-policy/.

[2] Not an actual photo.

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BENEFICIARY ASSIST® COUNSELING SERVICES

THE HARTFORD

Getting through a loss is hard.
Getting support to cope is easy.

The loss of a loved one can leave you feeling overwhelmed. In addition to grief, you may have financial and legal worries. Questions you can't easily answer alone. And maybe some unresolved issues. If you're covered under The Hartford's **Group Life or Accident insurance policy**, you have access to Beneficiary Assist® counseling services provided by ComPsych.[1]

Professional help after a loss or terminal illness.

Beneficiary Assist provides you, your eligible beneficiaries and immediate family members with unlimited 24/7 phone access to help related to the death of yourself or a loved one. That includes:

- Legal advice, financial planning and emotional counseling for up to one year from the date the claim is filed.
- Up to five face-to-face sessions or equivalent professional time for one service or a combination.

Handling a spectrum of needs with compassion and expertise.

Because Beneficiary Assist covers a spectrum of concerns, you and your beneficiaries will have a convenient, single source for the following needs.

Emotional or grief counseling. ComPsych GuidanceExperts℠ are master's and doctoral level clinicians who'll listen to your concerns with compassion and refer you to the right resources for:

- Grief and loss.
- Stress, anxiety and depression.
- Relationship/marital conflict.
- Problems with children.
- Job pressures.
- Substance abuse.

(continued on next page)

Prepare today.
Help protect tomorrow.

Case illustration: Solid footing.[2]

Greg's sudden death at the age of 42 came as an enormous blow to his wife, Sharon. Besides the shock and grief, Sharon had to struggle with debt and claims to Greg's estate by children from a former marriage. She went back and forth between anger and depression.

Through Beneficiary Assist, she was able to link up with counselors who listened compassionately and referred her to a grief expert. She also used the legal and financial counseling resources to get solid answers to complex questions.

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES

THE HARTFORD

Even the best planned trips can be full of surprises.

The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

If you are covered under a Hartford Group Policy, you and your family have access to Travel Assistance Services provided by Europ Assistance USA.[1]

With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

Good to go: Multilingual assistance 24/7.

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less.[2,3]

As long as you contact Europ Assistance USA at the time of need, you could be approved for up to $1 million in covered services.[4]

Services from here to there.

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the chart on the back of this page.

Identity theft assistance, too.

Identity theft, America's fast growing crime, victimizes almost 10 million American consumers each year.[5] Europ Assistance USA helps protect you and your family from its consequences 24/7,[2] at home and when you travel.

In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft.

(continued on next page)

Prepare today.
Help protect tomorrow.

Case illustration: Help a world away.[3]

As a Human Resource Professional, Tammy had always been on the coordinating end of travel services helping her company's employees; but when her daughter was hurt while traveling with her school group in Italy, she suddenly found herself in a different position.

Using the travel assistance medical referral, medical monitoring, and repatriation services from Europ Assistance USA, Tammy's daughter was able to receive immediate medical treatment and was evacuated within 48 hours. The Europ Assistance USA Case Manager helped Tammy through some of the most stressful days she's experienced as a mother and provided care for her daughter when she couldn't.

TRAVEL ASSISTANCE

THE HARTFORD

Snap the Tag with your phone to save this contact info.
Need the app?
http://gettag.mobi

Ability Assist

Beneficiary Assist

Employee Travel Assistance Program

THE HARTFORD
(Claim Assistance Info)

GROUP BENEFITS

THE HARTFORD

How to File a Claim

FILE A CLAIM WITH CONFIDENCE.

ARCHDIOCESE OF MIAMI HEALTH PLAN

Your disability and leave management programs are managed by The Hartford, a leader in disability and leave services. They are user-friendly benefits that provide essential support services while you're away from your workplace.

Policy # 303830

The Hartford makes it easy to file a claim. Just follow these steps.

STEP 1 Know when it's time to file a claim or, request a leave.

If you're absent from work, we can advise you on when to file your claim or, request a leave. If your absence is scheduled, such as an upcoming hospital stay, simply call us within 30 days of your last day at work. If unscheduled, please call us as soon as possible.

STEP 2 Have this information ready.

- Name, address, policy number, and other key identification information.
- Name of your department and last day of active full-time work.
- Your manager's or HR Representative's name and phone number.
- The nature of your claim.
- Your treating physician's name, address, and phone and fax numbers.

STEP 3 Make the call.

With your information handy, call The Hartford at 866-957-6913
You'll be assisted by a caring professional who'll take your information, answer your questions and file your claim.

TO FILE A CLAIM OR, REQUEST A LEAVE, CALL THIS NUMBER:

866-957-6913

Policy # 303830

THE HARTFORD

PLEASE CUT

If you're absent from work we can advise you on when to file a claim or, request a leave. If your absence is scheduled, such as an upcoming hospital stay, call within 30 days of your last day of work. If unscheduled, please call us as soon as possible.

Expertise without equal.
Benefits without burden.

THE HARTFORD

THE HARTFORD (Value Added Benefits)

Funeral Planning and Concierge Services

THE HARTFORD

A trusted advisor during the worst of times.

We can't always predict, but we can prepare.

Find out more about The Hartford's Funeral and Concierge Services by calling **1-866-854-5429**.

Or visit **www.everestfuneral.com/hartford** and use this code: **HFEVLC**

Case illustration: A shoulder to lean on.[2]

June had always thought that she and her husband would spend their golden years together. So when he began to lose his battle with pancreatic cancer, she was completely unprepared. However, June had a knowledgeable and trusted resource: Everest services were included as part of her insurance program.

Her Everest advisor assisted with every aspect of the funeral planning process, giving June peace of mind during this stressful time. And she received an expedited life insurance payment within a week of her husband's death, which helped ease many of the family's financial pressures. Everest's services relieved June of some of the stress that comes with loss, allowing her to focus on her family.

Need more facts?

Just visit our Web site at **thehartford.com/employeebenefits**.

www.thehartford.com

2011 WORLD'S MOST ETHICAL COMPANIES WWW.ETHISPHERE.COM

USA PARALYMPICS

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[1] Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. PriceFinder is a service mark of Everest Information Services, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates.

[2] June is a Hartford Customer. Not an actual photo.

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ESTATEGUIDANCE® WILL SERVICES

THE HARTFORD

Create a simple will from the convenience of your desktop.

Whether your assets are few or many, it's important to have a will. It's the only way to ensure that your intentions will be honored in the event of your death. A will states your wishes about who will inherit your property, who will be the guardian of your children, and who will manage your estate. Without a will, those decisions may be left to others.

An easy and empowering solution.

As a covered employee under a Hartford Group Life insurance policy, you have access to EstateGuidance® Will Services provided by ComPsych®.[1] It helps you create a simple, legally binding will quickly and conveniently online, saving you the time and expense of a private legal consultation. Other advantages include:

- Online assistance from licensed attorneys should you have questions.
- The ability to save drafts for up to six months. During this period, you can revise your will at no cost, as long as you haven't already printed or downloaded it.
- Additional estate planning services are also available for purchase, including the creation of living wills and trusts, guidance about divorce proceedings, and durable power of attorney.

Quick answers to key questions.

Where there's a will, there are bound to be questions. Here are answers to four common ones.

"Isn't will preparation complicated?" Not with EstateGuidance®. You'll be asked a series of questions online that are used to compose your will. In many states, you need only add your signature to make the will valid.

"What if I have questions as I'm creating my will?" The online education center provides answers regarding family law. You can also access fully licensed attorneys who'll respond to you online.

(continued on next page)

Case illustration: The final word.[3]

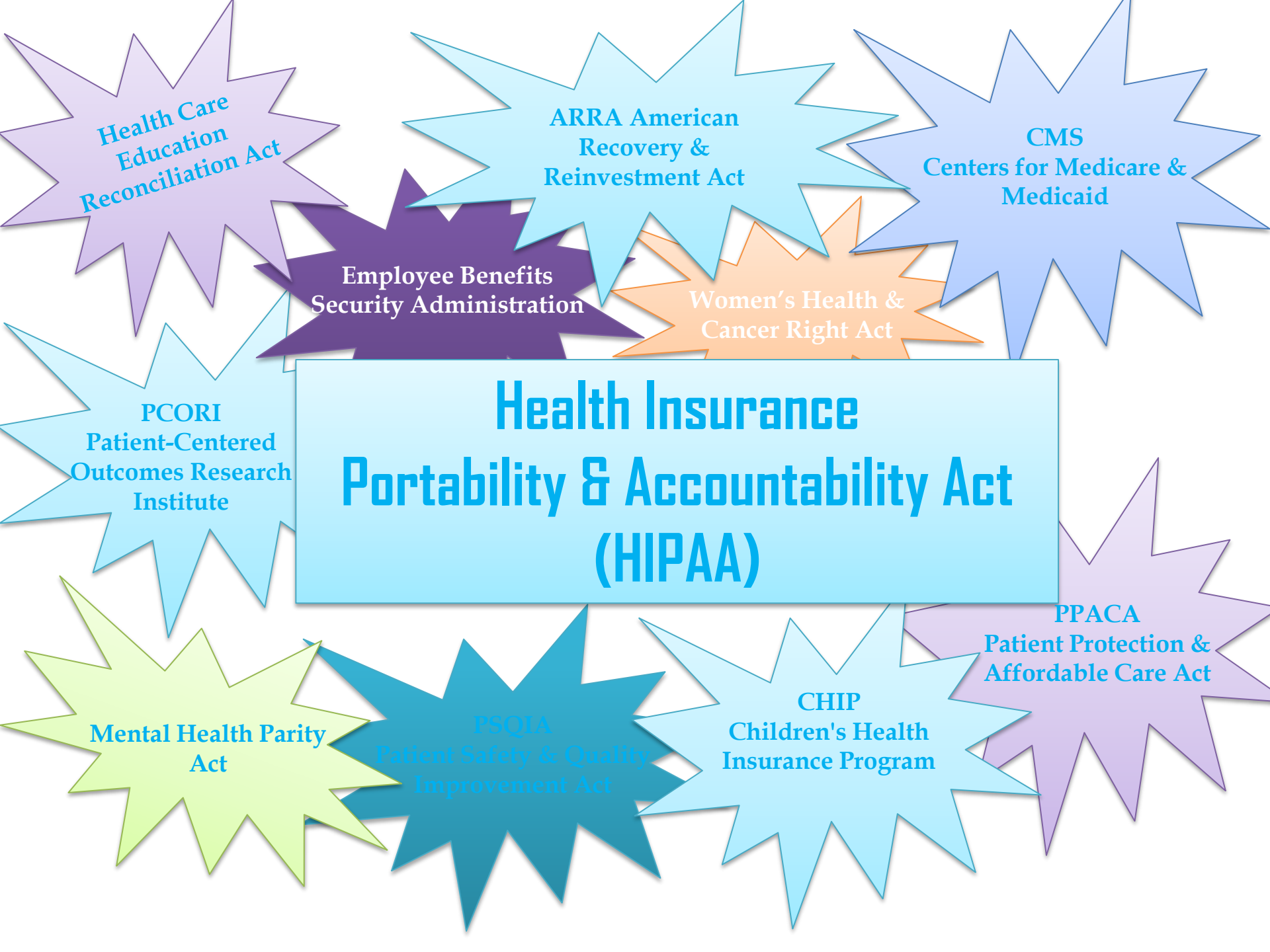
Laura was the single parent of a six-year-old daughter, Amy. She worried that if she were to die, her modest but hard-earned assets would not be available to her daughter.

The cost of a legal will seemed beyond her means until she discovered EstateGuidance® through her group life insurance provider. With it, she was able to appoint her older sister as executor of her will and name her brother and sister-in-law as Amy's legal guardians. She felt better knowing that she would have the final word in protecting her daughter's best interests.

Prepare today.
Help protect tomorrow.

Funeral Planning & Concierge Services

Estate Guidance & Will Services


Health Care Education Reconciliation Act
ARRA American Recovery & Reinvestment Act
CMS Centers for Medicare & Medicaid
Employee Benefits Security Administration
Women's Health & Cancer Right Act
PCORI Patient-Centered Outcomes Research Institute
Health Insurance Portability & Accountability Act (HIPAA)
PPACA Patient Protection & Affordable Care Act
Mental Health Parity Act
PSQIA Patient Safety & Quality Improvement Act
CHIP Children's Health Insurance Program

Protected Health Information (PHI)

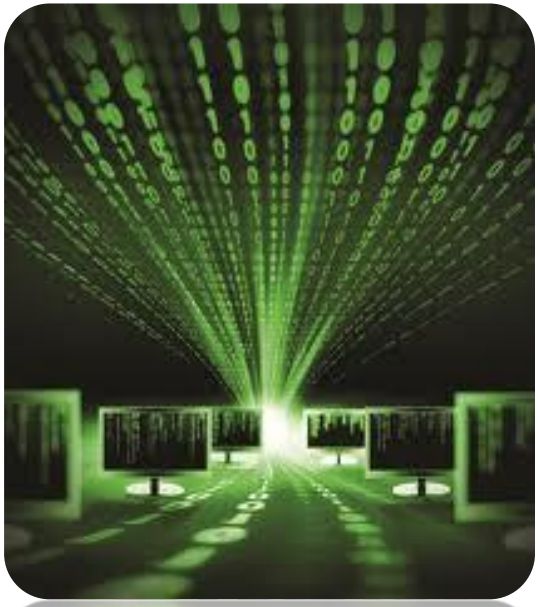
1. Names
2. All geographical identifiers smaller than a state
3. Dates (other than year) directly related to an individual
4. Phone numbers
5. Fax numbers
6. Email addresses
7. Social Security Numbers
8. Medical Record numbers
9. Health insurance beneficiary numbers
10. Account numbers
11. Certificate/license numbers

Protected Health Information (PHI)

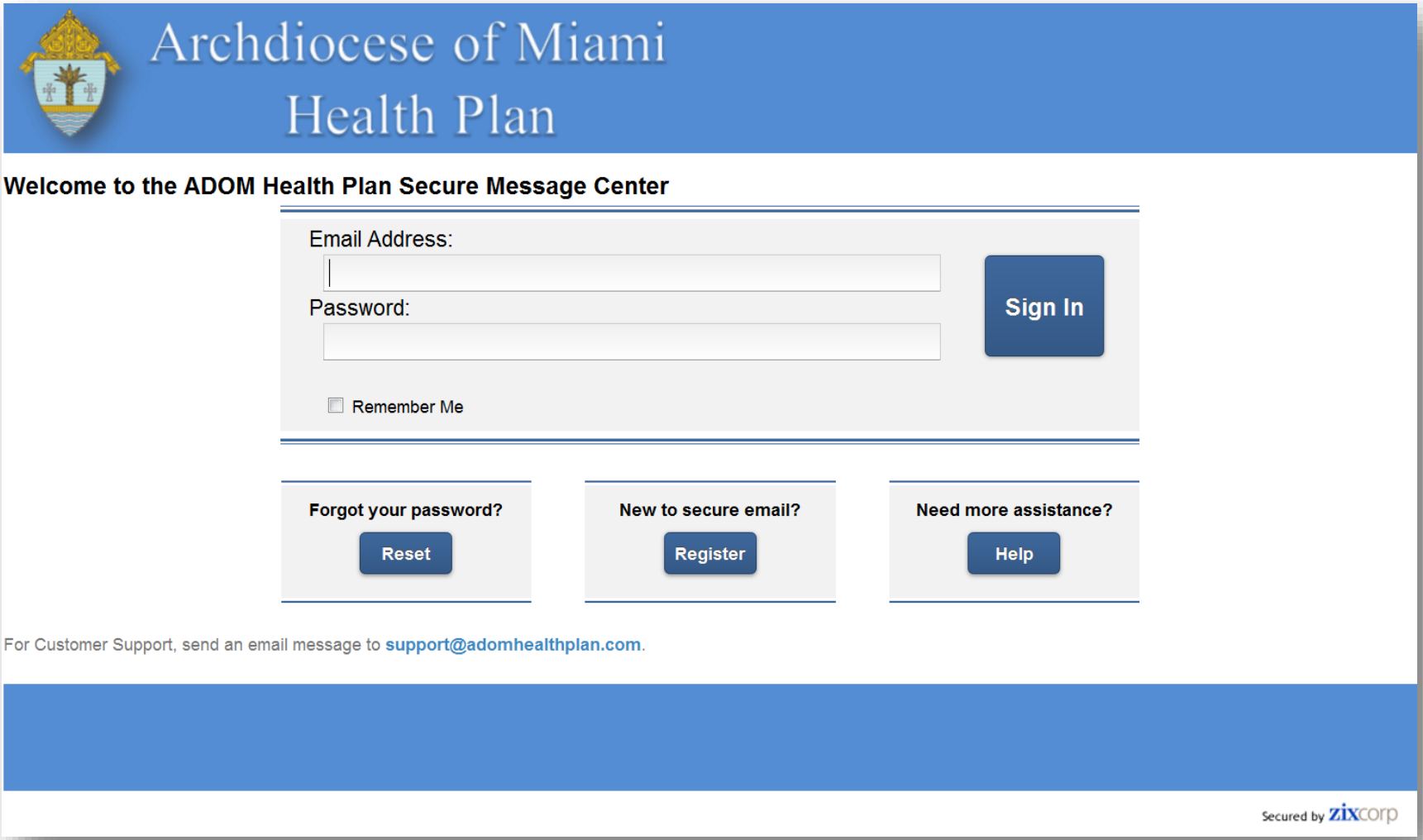
12. Vehicle identifiers and serial numbers, including license plan numbers
13. Device identifiers and serial numbers;
14. Web Uniform Resource Locators (URLs)
15. Internet Protocol (IP) address numbers
16. Biometric identifiers, including finger, retinal and voice prints
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data

Secure Data Transfer

Encrypted email accounts available through the Health Plan or you can directly access the Secure Message Center at www.adomhealthplan.org in the bookkeeper section.



Click on the “Secure Email Portal” Link



Register and then transfer encrypted data to the Archdiocese of Miami Health Plan 24/7!

Health Plan Website

www.adomhealthplan.org

- Updated Benefit Related Forms
- Benefit Overviews
- New Brainshark Benefit Tutorial
- Informative links
- And much more…

Bookkeepers Only Access

www.adomhealthplan.org

1) Visit www.adomhealthplan.org
2) Click on the “Bookkeeper Log in” tab

Bookkeepers Only Access

3) Enter the username and password at the "Log In" Screen.
4) Click the "Log In" tab

USERNAME: bookkeeper
PASSWORD: bookkeeper

NO CAPS

Your Support Team

We are located at the Archdiocese of Miami Pastoral Center:

Archdiocese of Miami Health Plan
9401 Biscayne Boulevard
Miami Shores, FL 33138
Phone: 305.893.2674 Fax: 305.893.6433

Contact	Extension	Department
Main Line	3000	Health Plan
Susan	3001	Administration
Edie	3002	Priest Management
Chris	3003	Finance/IT
Patricia	3004	Priest Management
Sugeily	3005	Eligibility
Liz	3006	Disability/Leave Management
Miriam	3007	Eligibility
Daniel	3008	Marketing/Operations
Carleen	3009	403 (b)

Questions

Leave Management

Presented By:
Leave Management through the
Archdiocese of Miami Health Plan
October 24, 2014
Location: Archdiocese of Miami Pastoral Center

The Hartford:
Integrated Disability & Leave Services

The Hartford administers:

- Family Medical Leave
- Short Term Disability
- Long Term Disability

Note: All processes have been combined to provide seamless, consistent disability administration to all employees.

FMLA

Family & Medical Leave Act

Provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period to eligible, covered employees for the following reasons:

- birth and care of the eligible employee's child, or placement for adoption or foster care of a child with the employee
- care of an immediate family member (spouse, child, parent) who has a serious health condition
- care of the employee's own serious health condition. It also requires that employee's group health benefits be maintained during the leave
- military exigency; or
- care of a service member injured in the line of duty

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What Are The Eligibility Requirements?

Have completed 12 months of service with the employer.

Have worked 1250 hours of service in the 12 months preceding the leave.

And are an:
Active full time regular employees scheduled to work 40 hours per week; or part time regular employees scheduled to work at least 30 hours per week are eligible to participate.

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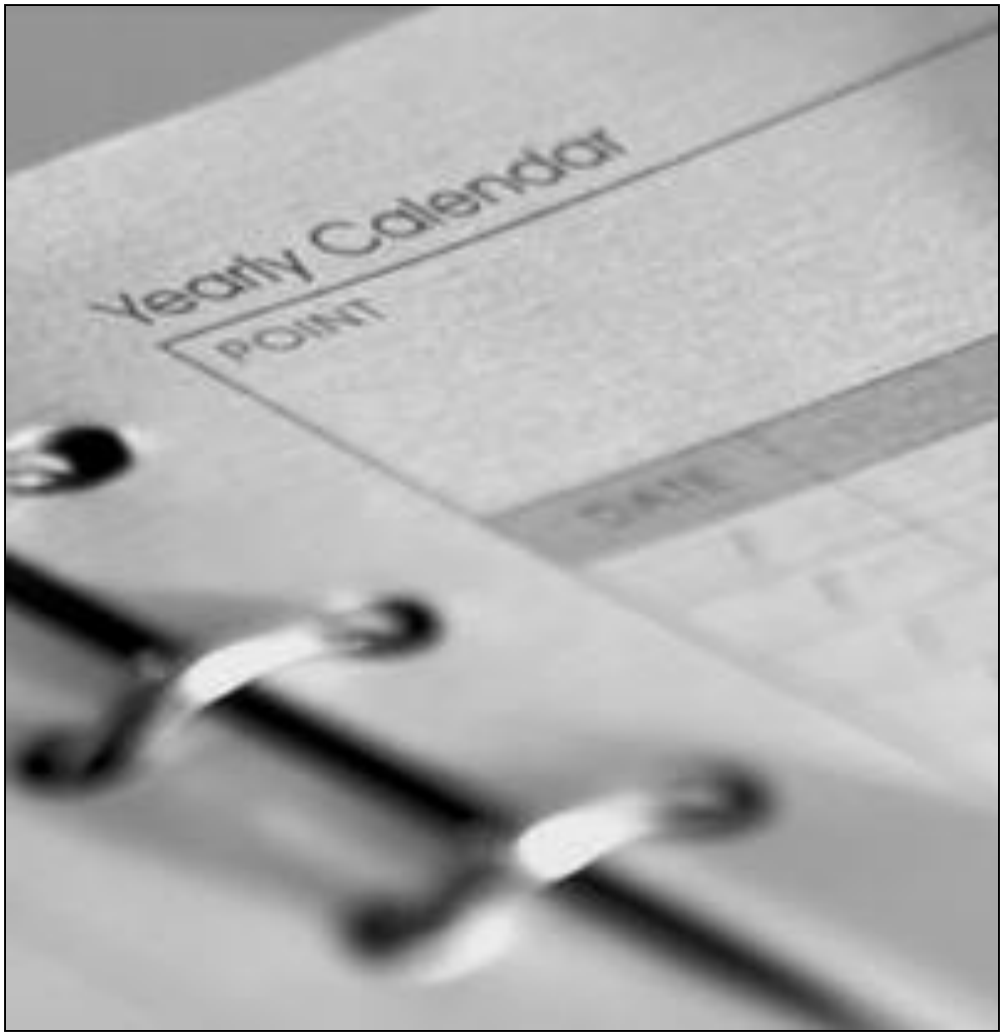
FMLA Provisions

- Up to 12 weeks of job-protected leave in a 12-month period (26 weeks in a single 12-month period for military caregiver leave)
- Return to the same or equivalent position at the end of the leave
- Retention of health insurance benefits in force at the start of the leave (**employee must pay any premiums required as an active employee**)

12-Month Tracking Period for FMLA



- Employers must designate one tracking period and apply it consistently for all employees. Archdiocese of Miami Health Plan uses a 12 month rolling backward method for tracking.
- Some states require a specific tracking period.
- Employers must give employees 60-days written notice if they change their tracking method.
- If an employer does not select a 12-month tracking period, the employee can select the method they want used to track their leave.

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FMLA Procedures

- Employee action
  - If employee will be absent or foresees absence for more than three consecutive days
    - Employee contacts the Hartford
    - Must be due to a serious health condition- employee unable to work
- Bookkeeper actions
  - Contact the Hartford if you believe employee will be absent for more than three full consecutive days

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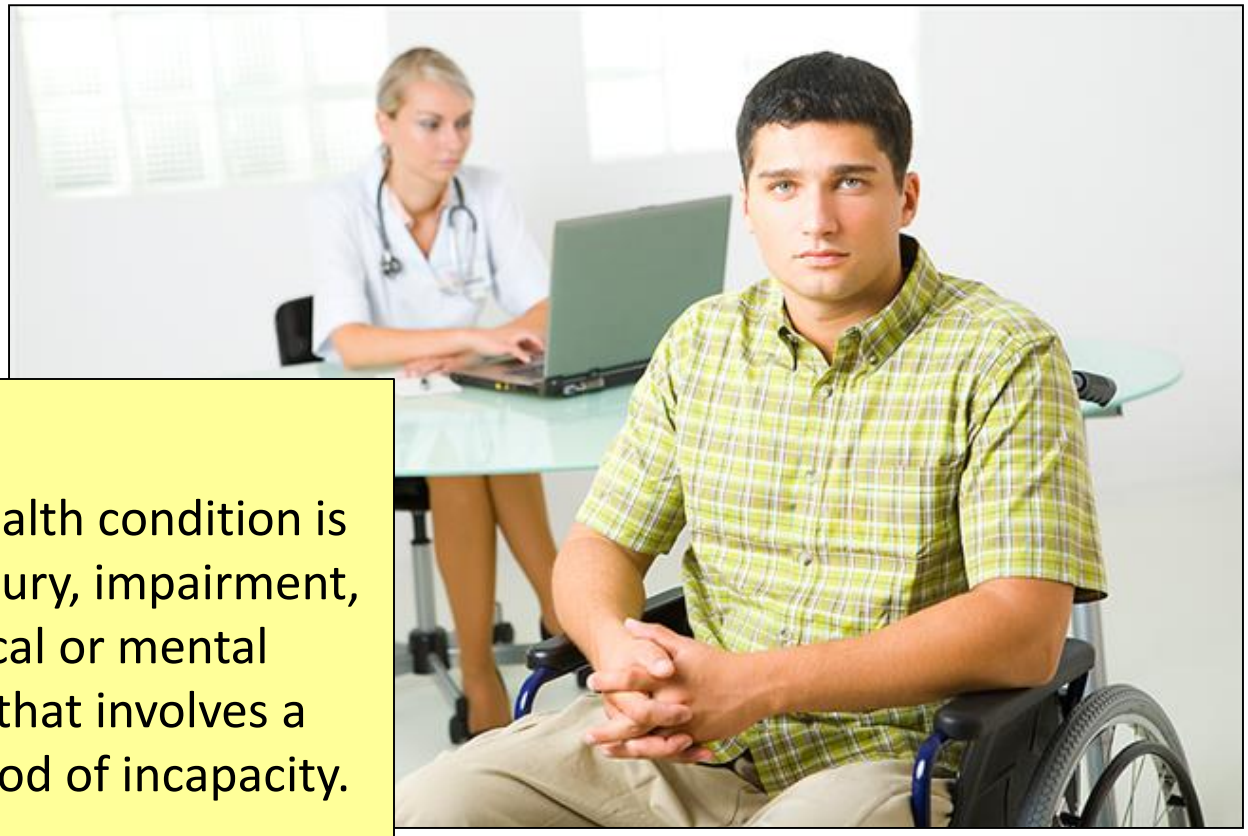
Serious Health Condition



A serious health condition is an illness, injury, impairment, or physical or mental condition that involves a defined period of incapacity.

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“Serious Health Condition” Includes:

(but not limited to)

- An illness, injury, impairment or physical or mental condition that involves inpatient care or continuing treatment by a health care provider
- Incapacity of more than three consecutive calendar days (with continuing treatment by a health care provider):
  - **Treatment two or more times within 30 days of incapacity – two visits must occur within 30 days of incapacity and first in-person visit must occur within 7 days of incapacity**
  - **Treatment on at least one occasion with continuing treatment. In-person visit must occur within first 7 days of incapacity**
- Chronic conditions – two visits to healthcare provider per year
- Pregnancy or prenatal care
- Inpatient treatment in a hospital, residential medical facility, or hospice for employee or family member
- Any absence to receive multiple treatments (and a period of recovery) for a condition that would likely result in an absence of more than three days if untreated
- Permanent and long-term incapacity for conditions which treatment may not be effective (eg: Alzheimer’s, stroke, cancer, terminal diseases, etc.)

Certification

- Employee has 15 business days to submit medical certification or necessary documentation to support request for leave.
- Incomplete/Insufficient certifications must be returned to the employee allowing them 10 business days to cure the deficiency. If not returned, leave request may be denied.
- Failure to provide documentation in a timely manner can result in delay or denial of the leave.
- In the event late medical certification is received, we will reach out to HR to inquire on whether the leave should be re-opened.

Archdiocese of Miami: FMLA Protocol Overview

- Prepare a file for the employee on FMLA/STD with the following information:
  - employee's date of hire
  - yearly salary
  - amount last paid to employee
  - amount of hours worked per week
  - employee's occupation title.
- Keep log of employee's time out
- Keep log of employee's sick time and vacation time used during FMLA and STD
  - Unused sick time must be applied as employee pay for a maximum of ten days from categorized event
    - 1st Day of Accident
    - 8th Day Illness
    - No accrual of vacation time or sick time during this period
  - All accrued, unused vacation time must be uses after all available sick time is used.
  - If employee has more that 10 sick days available, use remaining sick days after all vacation days are used

Things to Remember

- Medical documentation may not be sufficient for a STD claim; however, it may be enough for a FML claim
- Only STD claims can be appealed
- Direct questions about FML and/or state leave denials to the LM Analyst at The Hartford
- If STD is approved and the employee is eligible, the FML and/or state leave event will automatically run concurrent with the STD approval period
- An employee can have more than one active leave at any time. However, an employee cannot have more than 12 weeks of leave in a 12 month period (however, state leave may be an exception as well as military caregiver leave)
- It is OK for the supervisor/HR Representative to stay connected to the employee while they are out on leave
- Contact the Hartford prior to making any adverse employment decisions to ensure you have the most up to date information

The Hartford's Responsibilities

- Answer employee questions on leave process and applicable leave available
- Determine eligibility (ERR/LMC)
- Provide required correspondence and notices for Federal and State Leaves
- Keep employer informed of leave status; email information to employer designated contacts
- Evaluate certifying documentation and make leave determinations (ERR/LMC)
- Track leave time taken against time available
- Request recertification as appropriate (ERR/LMC)
- Provide employee and employer with notice of extension of leave(s), job protected leave(s) approaching exhaust, and job protected leave time exhaustion
- Call employee 5 business days prior to end of approved leave to determine return to work or if extension is needed

ERR=Entity Response Required

LMC=Leave Management Coordination

Employer Responsibilities

(but not limited to)

- Fiduciary responsibility (LM/Entity)
- Maintaining a leave policy that meets federal and state requirements and making the policy available to all employees (LM/Entity)
- Posting employee notices (LM/Entity)
- Providing The Hartford with an eligibility file that meets Hartford specifications (LM)
- Returning employees to work when their leave has ended (Entity)
- Obtaining return to work documentation from employee (LM/Entity)
- Collecting premiums for benefits coverage while employees are on unpaid leave (Entity)
- Making employment decisions when employees do not return to work after exhausting leave entitlement (Entity)

LM=Leave Management through the Archdiocese of Miami

Entity=Individual entity representative

Employee Responsibilities

- Provide notice of the need for leave
  - ❑ 30 days notice if need for leave is foreseeable
  - ❑ If less than 30 days as soon as practicable, generally same day or next business day
  - ❑ NOTE: Calling in "sick" without providing additional information may be sufficient notice to trigger an employer's obligation under the FMLA
- Provide necessary documentation to support the need for leave
  - **Assist employee by providing information in a timely manner when requested by Leave Management and/or the Hartford.**
- Make premium payments for health and welfare benefits while out on an unpaid leave
- Make a "reasonable effort" to schedule intermittent leave so it is least disruptive to their employer

Voluntary Short-Term Disability

- You can elect Short-term disability insurance:
  - With no medical questions if you enroll within 30 days of hire
  - With medical questions at any time thereafter, and coverage may be denied by the carrier
- Short Term Disability pays a benefit equal to 66.67% of your base weekly pay
  - $600 max per week
  - Up to 13 weeks
  - Payments start on first day of an injury or the 8th day of an illness
  - Pre-Existing condition limitation of 4 weeks benefits

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Long-Term Disability

- All full-time employees are provided Long-Term Disability Insurance
  - No cost to your employee
  - Income protection if your employee is ill or injured and
  - unable to work
- If disability continues past 90 days
  - LTD benefits begin
  - Monthly benefits equal to 61% of base salary
  - Must be totally disabled (Defined by LTD Plan)
  - Pre-Existing Condition exclusions apply
  - Payments are reduced by Social Security, pension or other disability income you receive
  - Max benefit of $7,000 per month maximum

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THE HARTFORD:
Claim Integration Process

SHORT TERM/LONG TERM DISABILITY

- Claim system interfaces with the FMLA system
- STD Team gathers necessary claim information
  - Claimant is advised that this is the start of the process
- STD Team gathers medical information from physician
- Analysts receives completed claim and makes STD determination
- Refers claim to Long Term Disability area if applicable

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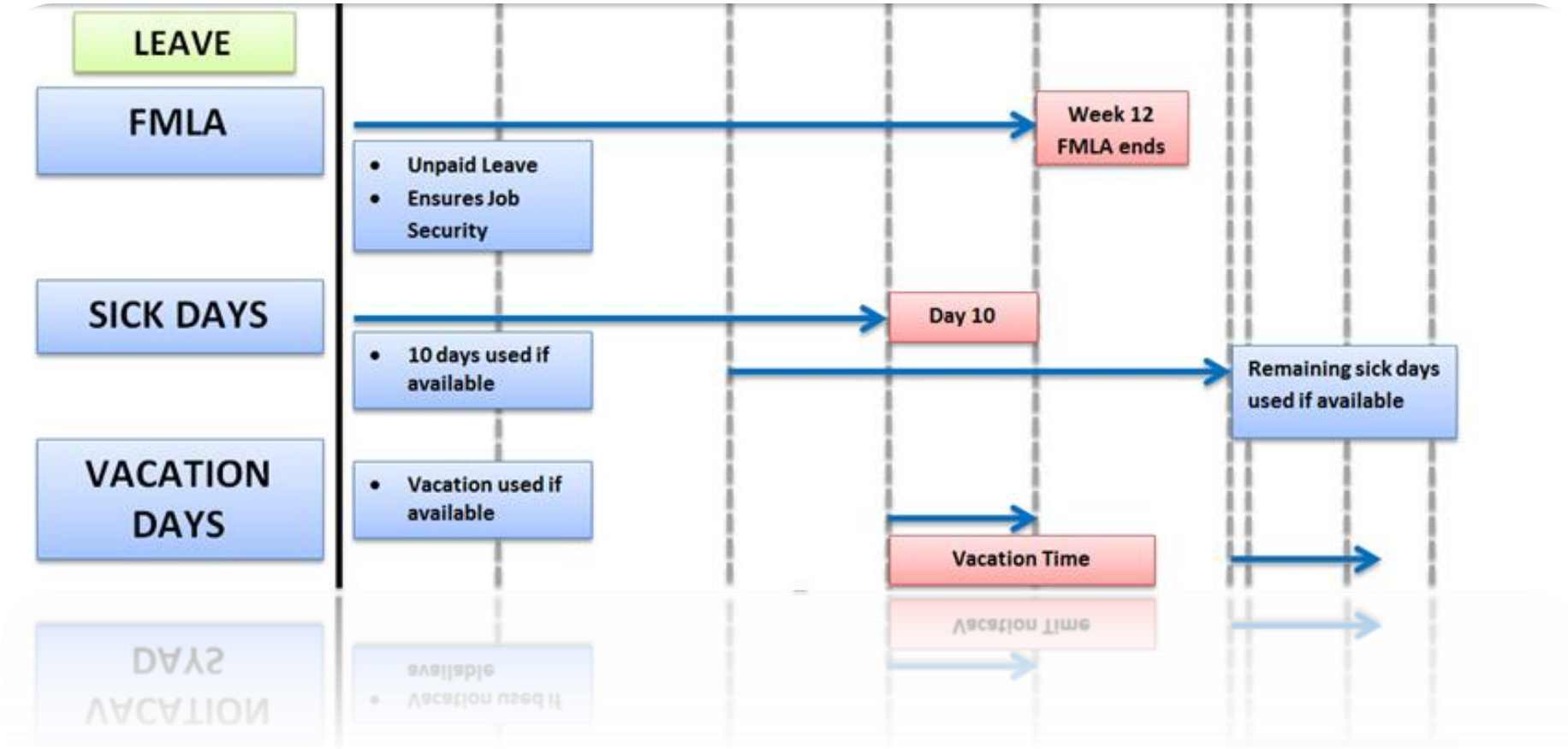
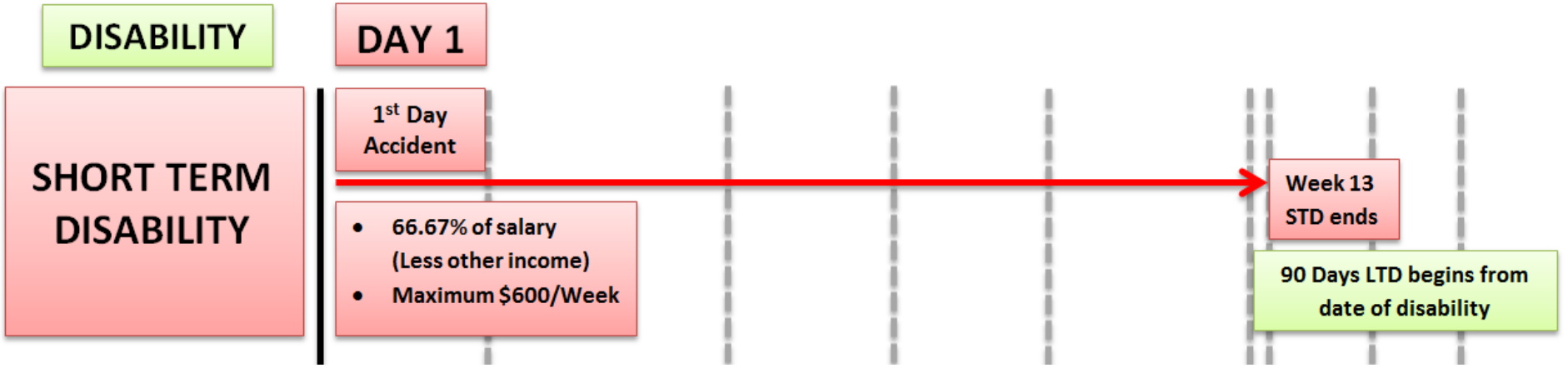
Leave Coordination: Leave

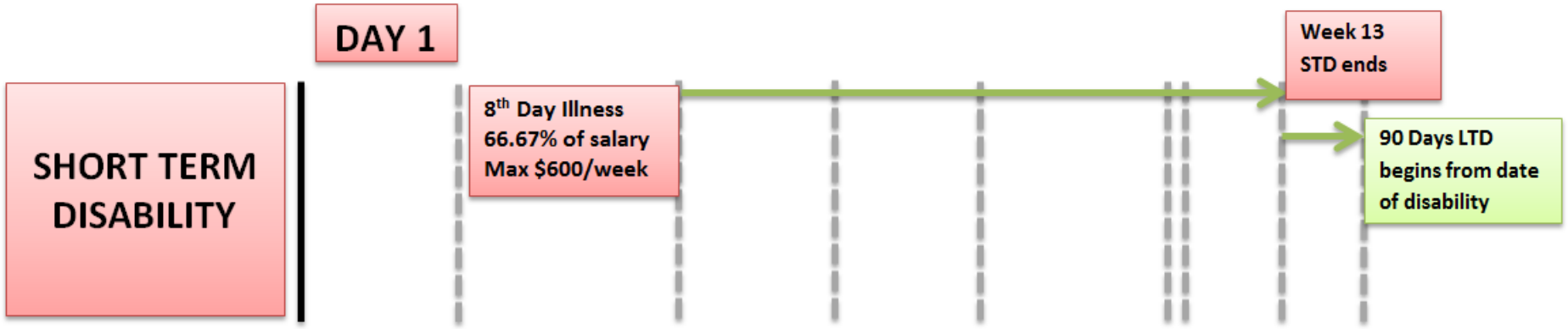


Tracking/Benefit Payment (Short Term Disability): Accident



Tracking	Day 1 - 10	Day 11	Interim	Week 13 (Day 91)
Voluntary Short Term Disability	Mandatory sick time applied first 10 days Disability benefits become payable as of date of accident	Mandatory vacation time applied	Mandatory remaining sick time applied	Short Term Disability ends on 91st day from accident (date of disability)
Benefit Payable	66.67% of Salary (less) other income (Sick pay/Social Security) : Max pay per week is $600			
Notes	FMLA time tracking starts on 1st day of accident			

Tracking/Benefit Payment (Short Term Disability): Illness



Tracking	Day 1 – 10	Day 11	Interim	Week 13 (Day 91)
Voluntary Short Term Disability	Mandatory sick time applied first 10 days Disability benefits become payable on 8th day of illness	Mandatory vacation time applied	Mandatory remaining sick time applied	Short Term Disability Ends on 91st day from 1st day of illness (date of disability)
Benefit Payable	66.67% of Salary (less) other income (Sick pay/Social Security) : Max pay per week is $600			
Notes	FMLA time tracking starts on 1th day an employee is categorized as sick.			

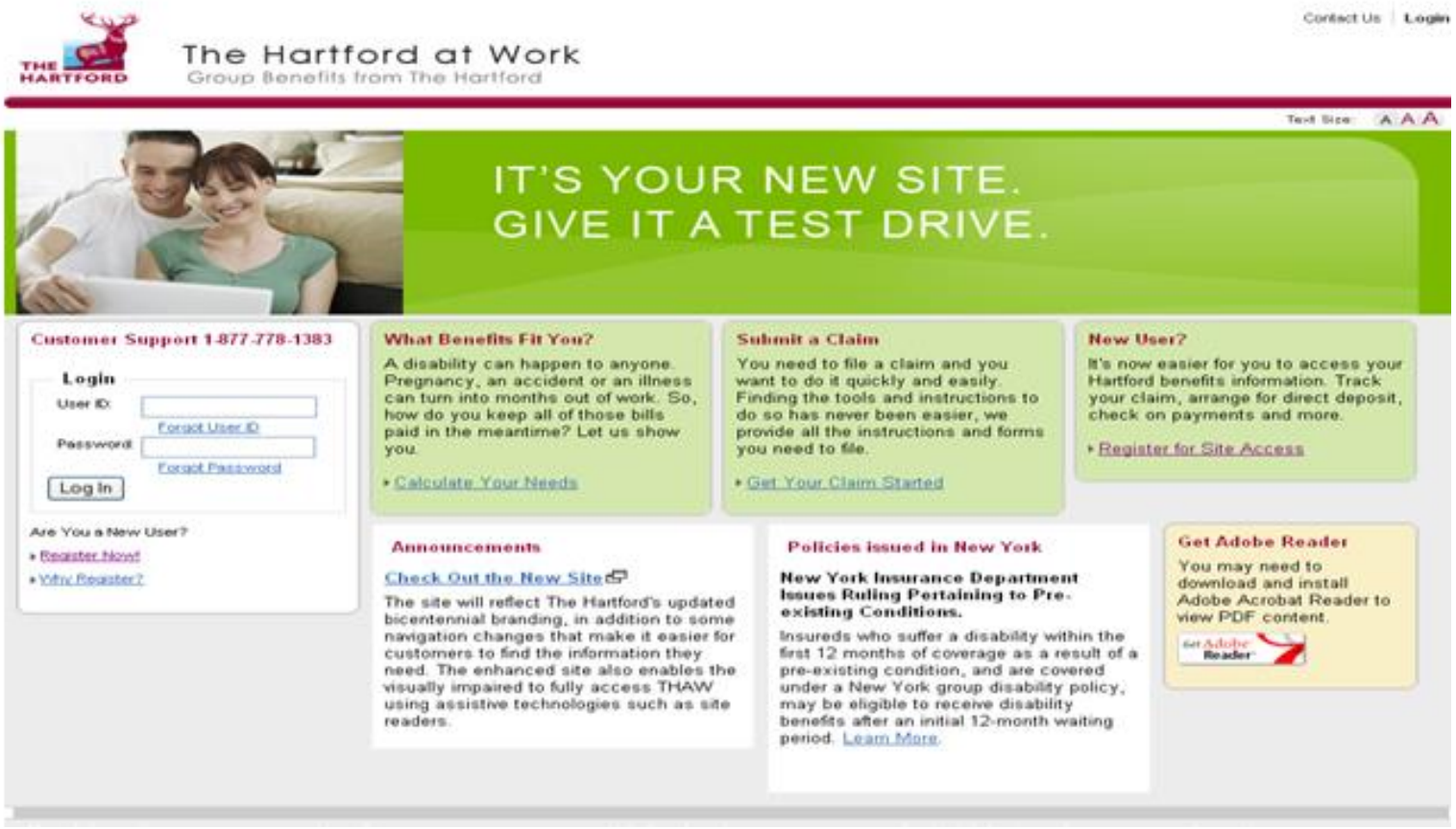
Tracking/Benefit Payment (Long Term Disability)

Tracking	Day 91 →
Employer Paid Long Term Disability	• Tracking ends (Separation Completed) • No further actions from employer
Benefit Payable	61% of Salary (less) other income (Sick pay/Pension/Social Security): Max benefit per month is $7,000; minimum $100.
Notes	• FMLA protection is exhausted at week 12 • LTD begins on 91st day of disability

Leave Coordination: Disability

The Hartford at Work: Available 24/7 for Your Employees

The Hartford at Work is a secure Web site where your employees can access status information to help them make informed decisions about their benefits.

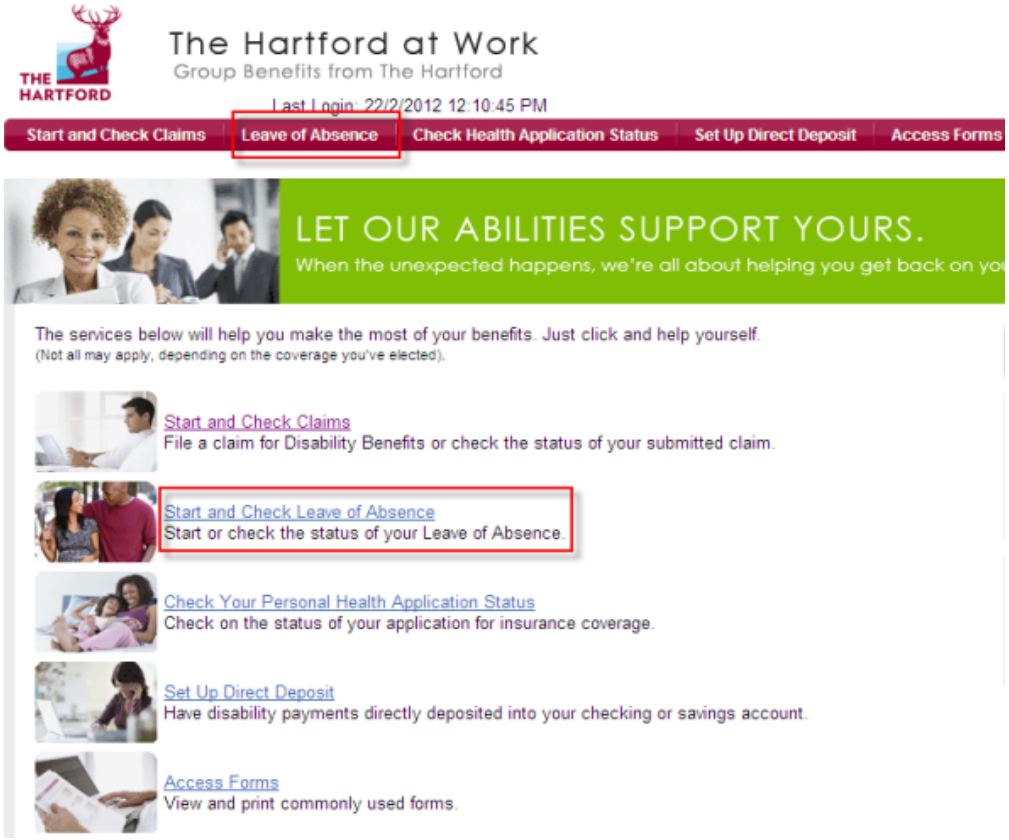


THAW – Leave of Absence Overview

- Employees who have already registered on THAW to view STD/LTD information will have access to Leave of Absence information using their existing login
- Employees who submit a new telephonic Leave of Absence request will receive a Registration letter from THAW with instructions on how to register
- For questions on registering or access into THAW please call 877-778-1383
- Employees will be able to view letters on THAW
- Employees will be able to enter new FML only leaves on THAW for both themselves and to care for family members, STD claims running concurrent with LM will continue to be supported by THAW
- Employees will be able to enter intermittent time/dates on THAW
- Employees can inquire on leave status on THAW

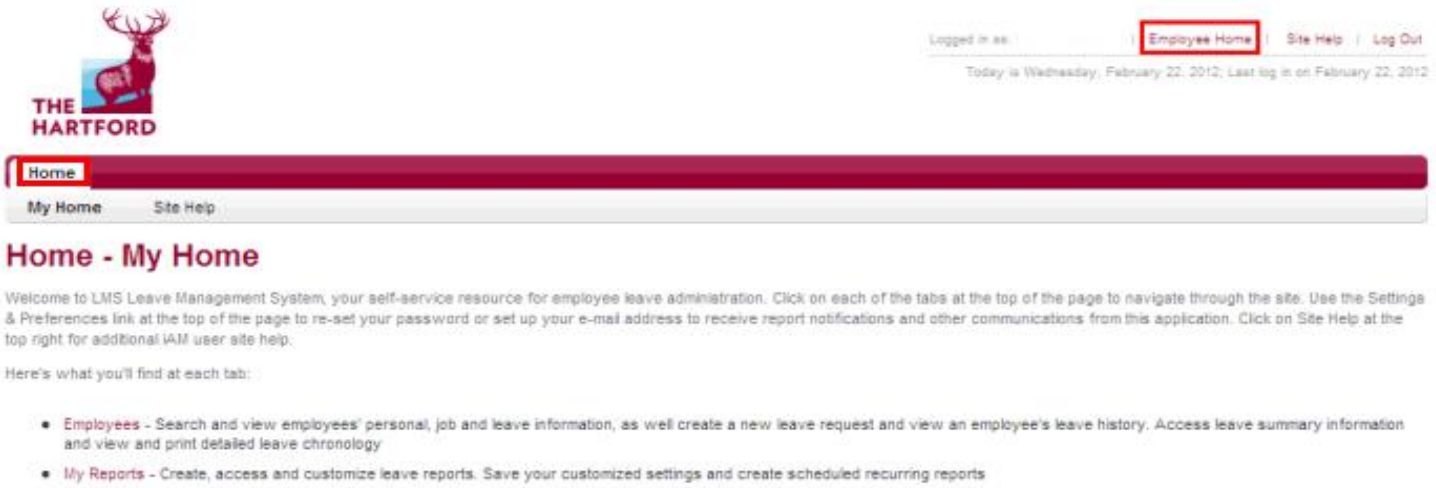
THAW – Leave of Absence – What is different on THAW

After logging into THAW, a user will see a link to Leave of Absence at the top of the screen and a link "Start and Check Leave of Absence" on the main page:



THAW – Leave of Absence

- When the user clicks on any of the three available links a new window will open and will display the employee's leave information. The employee will only be able to see their own information.
- The user can click on the Leave ID to see more detailed information about their Leave of Absence.
- The user can create a new leave only request by clicking "Create New Leave Request" and follow the steps.
- If the user clicks on the "Home" tab they will be redirected to the "Home-My Home" page.
- If the user clicks on the "Employees" or "My Reports" links they will receive an error message "Page cannot be displayed" because they do not have permissions to access. To get back to their own information they should click on the "Employee Home" link in the top right of the screen.



Hartford Value Added Services

Life Conversations

Funeral Planning and Concierge Services

- Resources in the event or preparation for a loss

Estate Guidance Will Services

- Create a will online
- Support online from licensed attorneys

Beneficiary Counseling Services

- Compassionate expertise to help you or your beneficiaries
  - Assist with:
  - Emotional Issues
  - Financial Issues
  - Legal Issues

Life Conversations

Travel Assistance Services & ID Theft Protection

- Pre-trip information
- Access to medical professionals across globe
  - When traveling 100+ miles away
  - 90 days or less
- ID Theft Protection
  - Available 24/7
  - Home or away
  - Caseworkers available to help resolve issues

Ability Assist Counseling Services

- Available to Long-Term Disability participants
- Professional counseling for:
  - Financial Issues
  - Legal Issues
  - Emotional Issues

Life Conversations

- **MyTomorrow**
  - Multimedia experience
    - User friendly information for:
    - Short-Term Disability
    - Long-Term Disability
    - Accidental Death & Dismemberment
    - Life Insurance
    - Personalized experience

To access all the **Hartford LifeConversations** Information visit:
www.thehartford.com/employee-group-benefits/value-added-services

Questions

Employer Mandate Requirements

Affordable Care Act
Applicable Large Employer

All entities of the Archdiocese of Miami, under controlled group status as defined by the ACA, must comply with the Employer Shared Responsibility Mandate on July 1, 2015 (first renewal date following January 1, 2015).

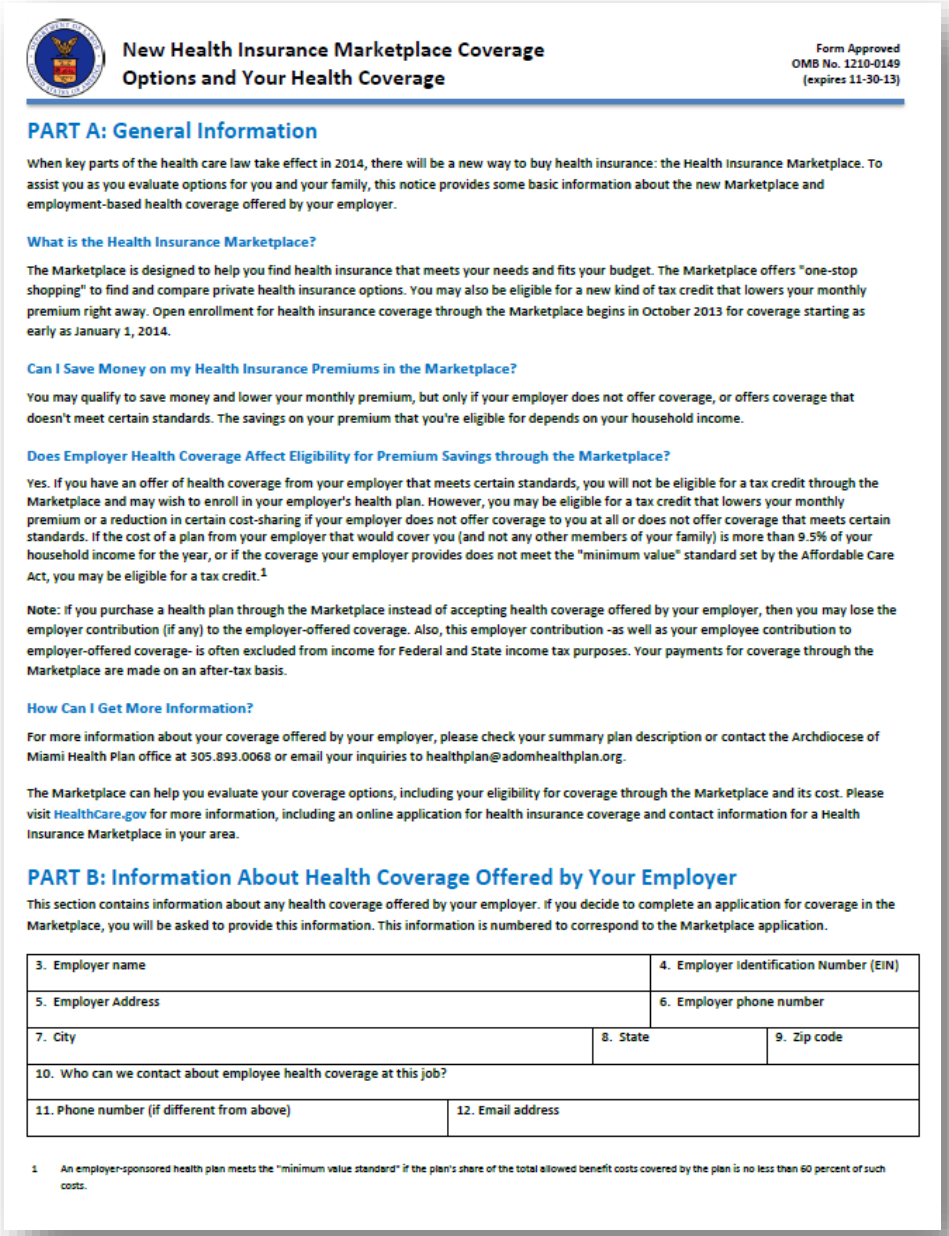
Employer Shared Responsibility

- Must offer coverage to 95% of all eligible employees
- Must offer coverage to children (except foster and step-children), but not spouses
- Penalty is $2,000 per person
- Must offer affordable coverage
  - ❖ Employee cost for single coverage cannot exceed 9.5% of compensation
- Must offer **Minimum Value** coverage
  - ❖ Plan must pay for at least 60% of cost of benefits, comparable to Bronze Plan
- Penalty for each is $3,000 per person

HMO Value Plan is affordable and Minimum Value

AFFORDABLE CARE ACT

New Health Insurance Marketplace Notification



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-13)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Archdiocese of Miami Health Plan office at 305.893.0068 or email your inquiries to healthplan@adomhealthplan.org.

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		4. Employer Identification Number (EIN)
5. Employer Address		6. Employer phone number
7. City	8. State	9. Zip code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

1 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.

As of October 1, 2013, Health Care Reform requires all employers to provide information on marketplace coverage to all employees.

- An employee, for this requirement, will be one that is issued a W-2.
- Can be distributed in New Hire Kit
  - Responsibility of the bookkeeper
- Must be provided to employee within 14 days of hire
- System of form receipt is open to your processes and procedures

Employer Shared Responsibility Employee Categories

- **Full-Time Employee** – Hired to work at least 30 hours per week or 130 hours per month
- **Part-Time Employee** – Hired to work less than an average of 30 hours per week
- **Variable Hour Employee** – As of the date of hire, the employer cannot reasonable determine average hours
- **Seasonal Employee** – An employee who is in a position for which the customary annual employment is 6 months or less

AFFORDABLE CARE ACT

Employer Shared Responsibility Archdiocese of Miami: Employee Categories

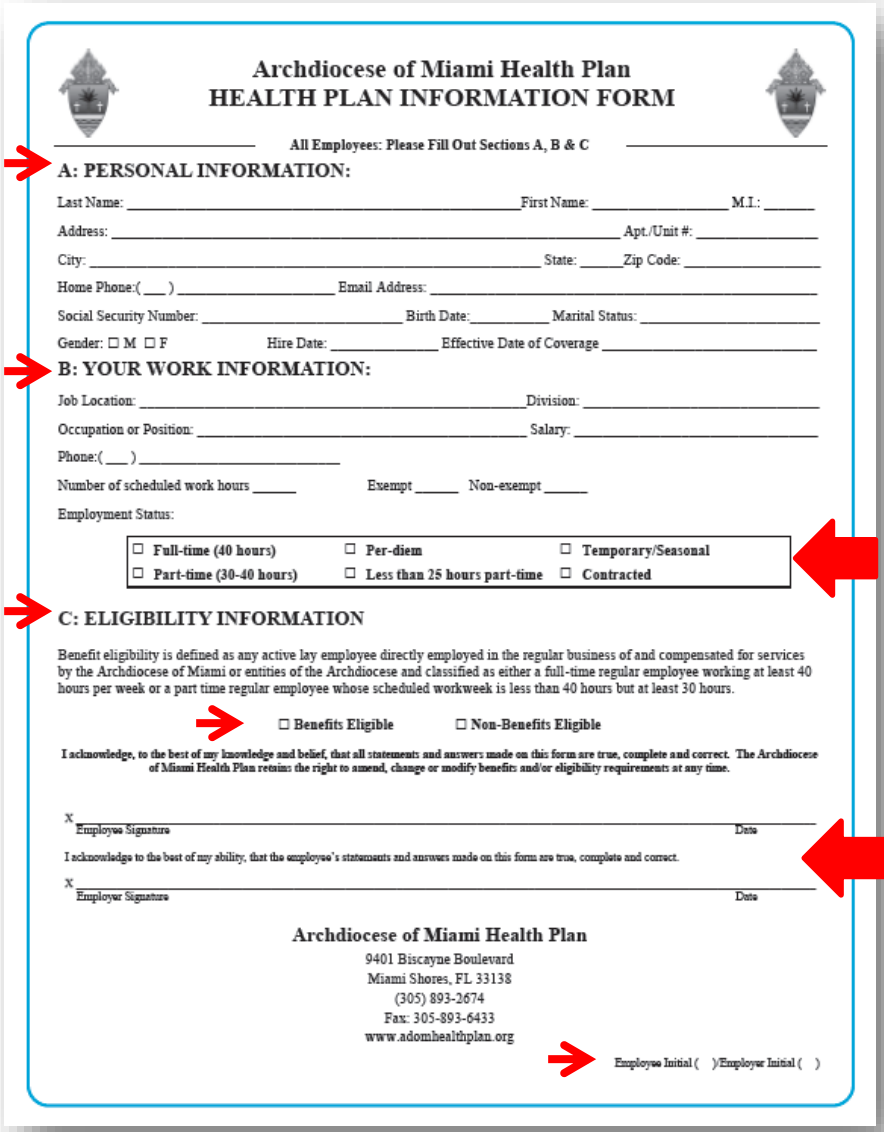
- Full-Time working 40 hours
- Part-Time working between 30 and 40 hours
- Part-Time working less than 25 hours
- Per Diem
- Contracted (primarily teachers)
- Temporary/Seasonal

Employer Shared Responsibility Employee Categories

Employment Status	Employer Shared Responsibility Category
Full Time 40 hours	Full Time
Part Time 30 to 40 hours	Full Time
Part Time less than 25 (30) hours	Part Time
Per Diem	Variable Hour
Contracted	Full Time
Temporary/Seasonal	Seasonal

AFFORDABLE CARE ACT

Health Plan Information Form



Archdiocese of Miami Health Plan
HEALTH PLAN INFORMATION FORM

All Employees: Please Fill Out Sections A, B & C

A: PERSONAL INFORMATION:

Last Name: _____ First Name: _____ M.I.: _____

Address: _____ Apt./Unit #: _____

City: _____ State: _____ Zip Code: _____

Home Phone:(___) _____ Email Address: _____

Social Security Number: _____ Birth Date:_____ Marital Status: _____

Gender: ☐ M ☐ F Hire Date: _____ Effective Date of Coverage _____

B: YOUR WORK INFORMATION:

Job Location: _____ Division: _____

Occupation or Position: _____ Salary: _____

Phone:(___) _____

Number of scheduled work hours _____ Exempt _____ Non-exempt _____

Employment Status:

☐ Full-time (40 hours)	☐ Per-diem	☐ Temporary/Seasonal
☐ Part-time (30-40 hours)	☐ Less than 25 hours part-time	☐ Contracted

C: ELIGIBILITY INFORMATION

Benefit eligibility is defined as any active lay employee directly employed in the regular business of and compensated for services by the Archdiocese of Miami or entities of the Archdiocese and classified as either a full-time regular employee working at least 40 hours per week or a part time regular employee whose scheduled workweek is less than 40 hours but at least 30 hours.

☐ Benefits Eligible ☐ Non-Benefits Eligible

I acknowledge, to the best of my knowledge and belief, that all statements and answers made on this form are true, complete and correct. The Archdiocese of Miami Health Plan retains the right to amend, change or modify benefits and/or eligibility requirements at any time.

X _____
Employee Signature Date

I acknowledge to the best of my ability, that the employee's statements and answers made on this form are true, complete and correct.

X _____
Employer Signature Date

Archdiocese of Miami Health Plan
9401 Biscayne Boulevard
Miami Shores, FL 33138
(305) 893-2674
Fax: 305-893-6433
www.adomhealthplan.org

Employee Initial ( )/Employer Initial ( )

Used for new hires to establish an employee record.

- Ensure **all employees** complete every section on the first page (Sections A, B and C)
- Confirm the Employee's Status and their Eligibility Status
  - Benefits Eligible
  - Non-Benefits Eligible
- Ensure first page is signed and initialed by:
  - Bookkeeper
  - Employee

Employer Shared Responsibility Hours of Service

- For hourly employees, hours of service include:
  - **Hours Worked** – Each hour for which the employee is paid, or entitled to payment, “for the performance of duties”; and
  - **Paid time Off** – Each hour for which the employee is **paid**, **or entitled to payment**, due to (1) vacation, (2) holiday, (3) illness, (4) incapacity (including disability), (5) layoff, (6) jury duty, (7) military duty, or (8) leave of absence

AFFORDABLE CARE ACT

Employer Shared Responsibility Hours of Service

- Please note “Hours of Service” are for all hours for which an employee **is paid**
- Other hours worked calculations, such as eligibility for Family Medical Leave or under the Fair Labor Standards Act, track only the hours an employee **actually works**

AFFORDABLE CARE ACT

Employer Shared Responsibility Hours of Service

- For non-hourly employees, hours of service may be calculated using one of three possible methods:

1. **Actual Hours** – Count actual hours of service worked “from records”, as well as other non-worked hours for which he or she is paid, or entitled to payment
2. **Days-Worked Equivalency** – Credit 8 hours of service per day for each day for which the employee would be credited with at least 1 hour of service
3. **Weeks-Worked Equivalency – Credit 40 hours of service per week for each week for which the employee would be credited with at least one hour of daily service**

AFFORDABLE CARE ACT

Employer Shared Responsibility Identifying Full-Time Employees

- Final regulations require use of one of two methods to identify full-time (Benefits Eligible) employees:
  1. Monthly measurement method
  2. Look-back method
- For purposes of the annual calculation and reporting, the Archdiocese of Miami will be using the Look-back method.
- If an employee works at two or more entities, one will act as the primary entity for reporting purposes.

AFFORDABLE CARE ACT

Employer Shared Responsibility Look-Back Method

- The Look-Back Method uses safe harbors for variable hour, seasonal and part-time employees

✓ **Measurement Period (MP)** – Allows employers an opportunity to look-back at the hours worked by an employee to determine health plan eligibility or continued eligibility

July 1, 2014 – April 1, 2015 ; April 2, 2015 – April 2, 2016

✓ **Administrative Period (AP)** – The period used by the employer to perform administrative duties related to counting hours and, where applicable, making an offer of coverage

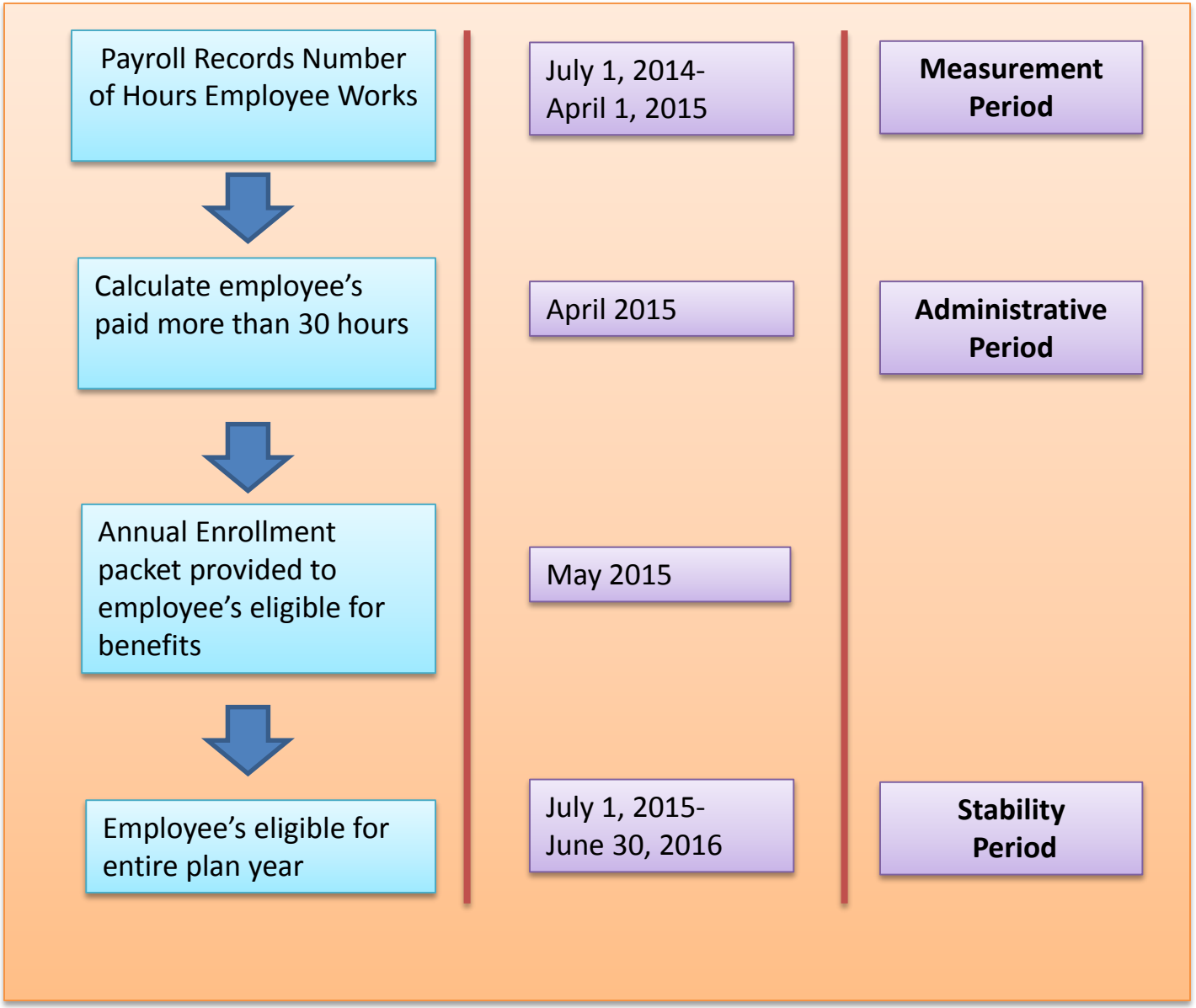
April 2, 2015 – June 30, 2015

✓ **Stability Period (SP)** – The period following a measurement period (and AP, if applicable) during which employees determined to average 30 hours or more per week during a measurement period are offered coverage

July 1, 2015 – June 30, 2016 Plan Year

AFFORDABLE CARE ACT

Employer Mandate Reporting Requirement



Employer Shared Responsibility Look-Back Method

- **Ongoing Employees** – Employees who have been employed one "Standard Measurement Period", ie; **July 1, 2014 (or earlier) through April 2, 2015**

Will be included in Standard calculations.

- New employees, ie;

Hired after July 1, 2014

Will have an individual Initial Measurement Period beginning on their start date.

AFFORDABLE CARE ACT

Employer Shared Responsibility Look-Back Method: Ongoing Employees

- If an employee works an average of 30 or more hours per week during the period July 1, 2014 – April 1, 2015, they are eligible for benefits for the entire July 1, 2015 – June 30, 2016 plan year.
- If an employee does not work an average of 30 or more hours per week during the period July 1, 2014 – April 1, 2015, they are not eligible for benefits for the entire July 1, 2015 – June 30, 2016 plan year.
- All other eligibility rules apply – Change in Status, Special Enrollment, etc.

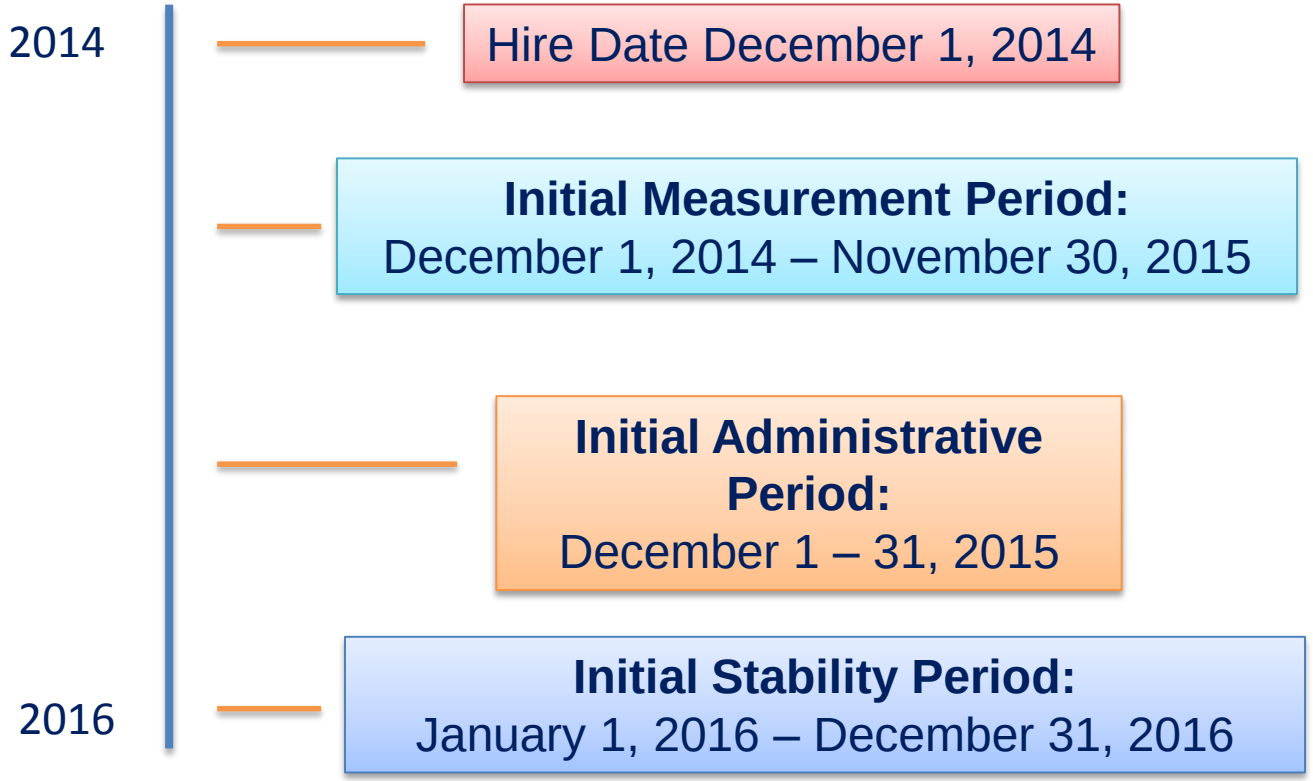
AFFORDABLE CARE ACT

Employer Shared Responsibility
New Employees

- New employees will have an individual consecutive 12 month Initial Measurement Period beginning on their hire date;
- Followed by a 30 day Administrative Period to offer and enroll for coverage;
- Eligibility will continue for 12 months.

Employer Shared Responsibility New Employees

Example:

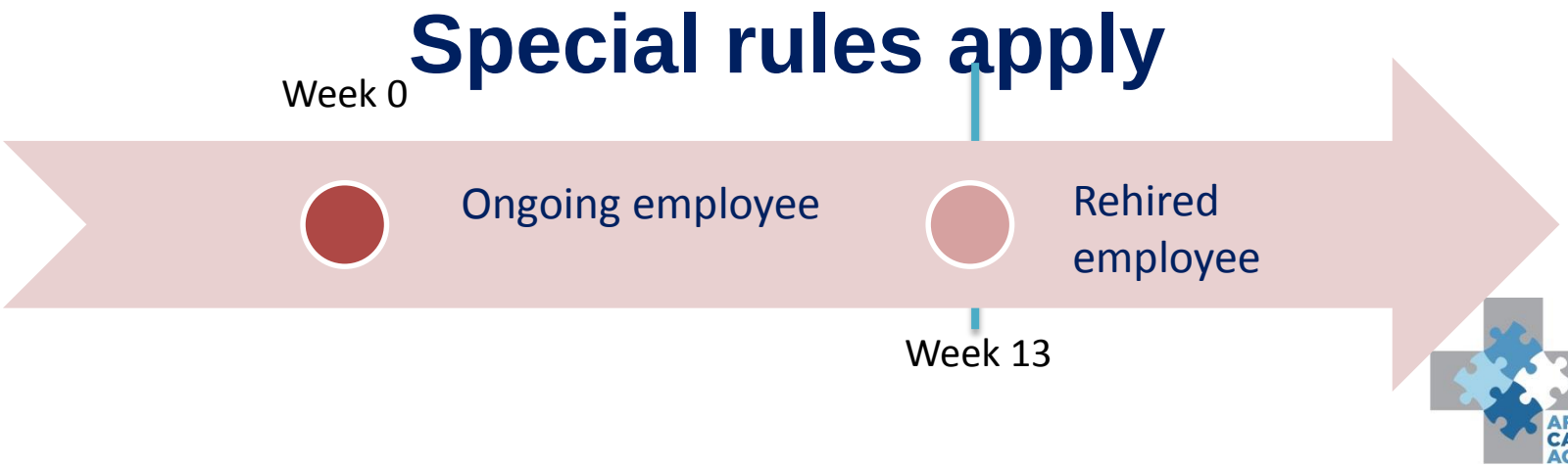


- **Transition new employee from "Initial" to "Standard"**
- **Measurement periods will overlap**

AFFORDABLE CARE ACT

Employer Shared Responsibility Rehired Employees

- If an employee has a break in service of 13 weeks or less (26 weeks for academic institutions), they can be considered an ongoing employee.
- If an employee has a break in service of 13 weeks or more (26 weeks for academic institutions), they can be considered a rehired employee, with a new Initial Measurement Period.



Employer Shared Responsibility Bona Fide Volunteers

- A Bona Fide Volunteer is any volunteer whose compensation is limited to:

1) Reimbursement (or reasonable allowance) for reasonable expenses incurred in service;
2) Reasonable benefits, including length of service awards, and nominal fees, customarily paid by similar entities for volunteer services

Maximum allowable is no more than 19% of market value/wage.

Special Issues
Adjunct Professors
Student Employees, other than work study
Foreign Employment
On-Call Employees

AFFORDABLE CARE ACT

Employer Shared Responsibility Next Steps

- Classify all employees per Archdiocese classifications as soon as possible
- Ensure the Health Plan has an Information Form on file for all employees
- Determine how hours will be tracked beginning July 1, 2014

AFFORDABLE CARE ACT

IRS Fees/Reporting

AFFORDABLE CARE ACT

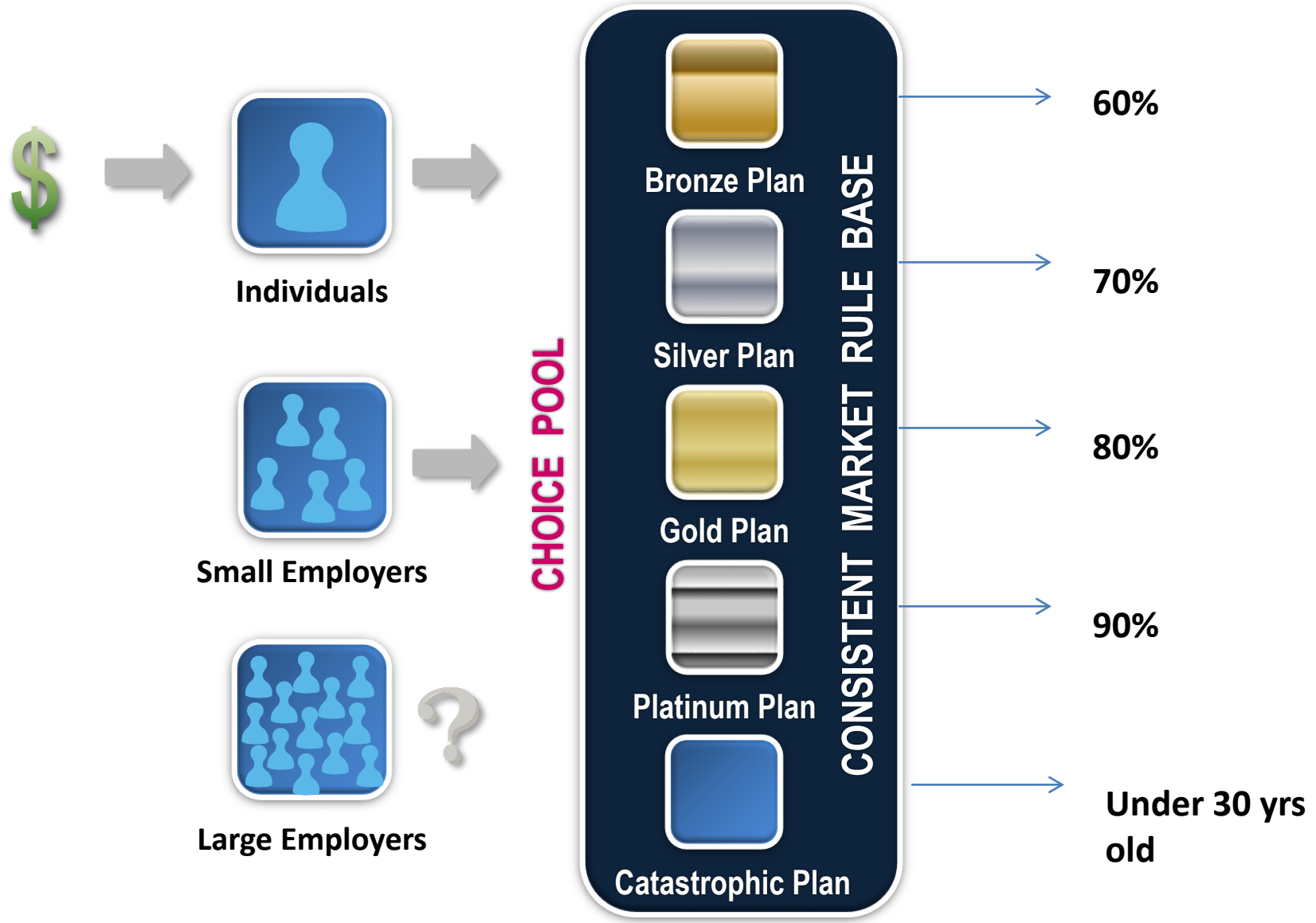
W-2 Reporting

DELAYED

DELAYED

- 2012 Form W-2s must report cost of employer-provided insurance in Box 12, Code DD
  - Amount reported is not taxable income
  - Include portions paid by both employer and employee
  - IRS provided chart to show what items to include/exclude (attached)
- Methods to calculate "cost"
  - COBRA rate (less 2%): Use methodology used to set COBRA rates
  - Premium Charged Method: Use premium charged by insurer for the employee's coverage (e.g., employee, family) for each period
- Temporarily delayed for self-funded plans not subject to Federal COBRA
  - May change by future guidance
  - Wouldn't be required until tax year beginning at least 6 months after guidance issued

Marketplace Exchanges



Individual Penalty Tax

Penalty amount is the greater of*:

Year	Flat Dollar Amount** (max of 300 % for family)	% of Household Income
• 2014	• $95	• 1.0
• 2015	• $325	• 2.0
• 2016	• $695	• 2.5
• After 2016	• $695, indexed for inflation in $50 increments	• 2.5

**Capped at the national average of the annual cost of a bronze level health insurance plan, for the family size, offered through the state exchange.*

***Halved for dependents under age 18 (but do not halve when determining 300% cap on dollar amount for those NOT insured by taxpayer)*

Fees

- Patient Centered Outcomes Research Institute Fee
  - $1 per average number of covered lives for 1st year
    - Built in to rates/budget
  - Due July 31, 2014 for plan year July 1, 2012 – June 30, 2013
- Transitional Reinsurance Program Fee
  - $5.25 per month ($66 per member per year) for 2014
    - Decreases to $44 per member per year in 2015
    - Built in to rates/budget
  - Due in January 2105 for the 2014 calendar year

AFFORDABLE CARE ACT

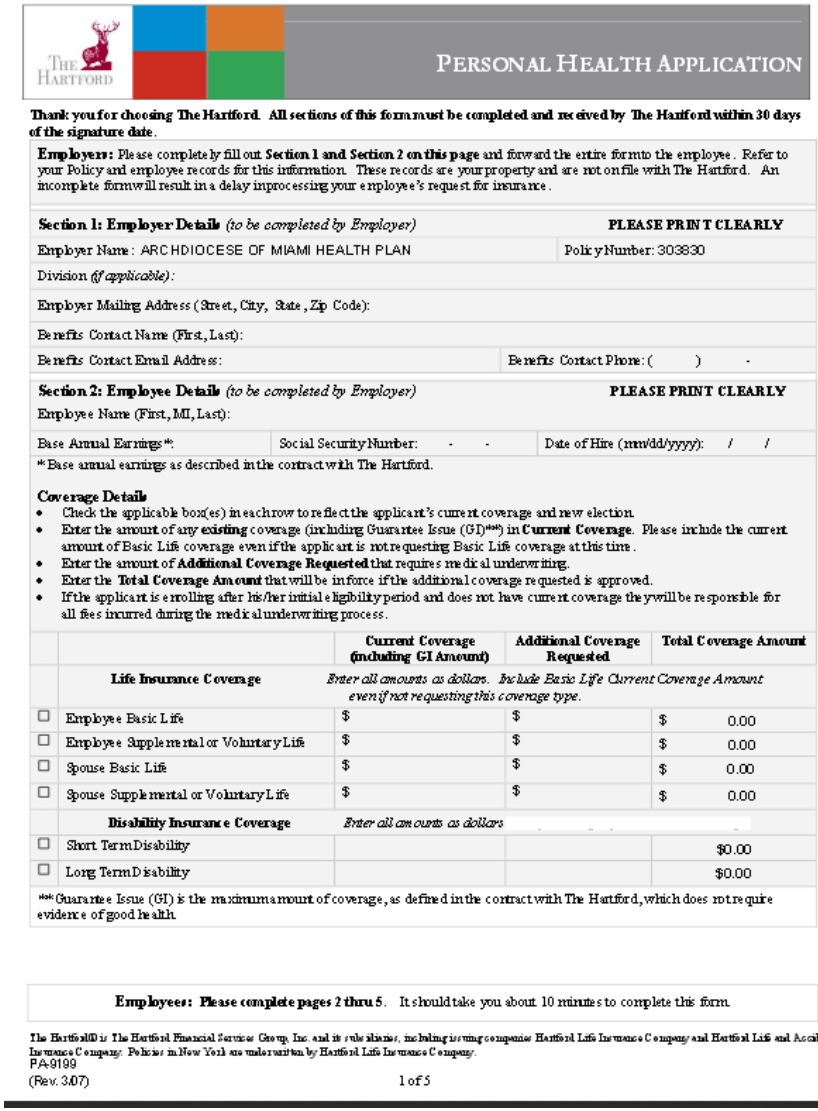
6055 Minimum Essential Coverage (MEC) Reporting

- Plan sponsors must report to both IRS and Individuals
- Must generally report: Name, address and EIN of the reporting entity; name, address and TIN (or DOB) of each primary insured/employee covered; name and TIN of each individual covered under plan; and the months in which each covered individual was enrolled
- Due dates for 2015 calendar year:
  - To IRS: February 29, 2016 (or March 31, 2016 for electronic filers (which is required if more high-volume filers)
  - To individuals: February 1, 2016 (because January 31, 2016 is a Sunday)

6056 Applicable Large Employer (ALE) Reporting

- Plan sponsors with 50 or more full-time (equivalent) employees must report to both IRS and Individuals
- Must generally report:
  - Name, address and EIN of the ALE member and contact information;
  - Certification as to whether ALE member offered the opportunity to enroll in MEC;
  - Months during the calendar year during which coverage under the plan was available;
  - Each FTE's share of the lowest cost monthly premium (self-only) for coverage providing minimum value
  - Number of FTEs for each month during calendar year, and their name, address and TIN, and the month(s) during which they were covered under the plan
- Due dates for 2015 calendar year:
  - To IRS: February 29, 2016 (or March 31, 2016 for electronic filers (which is required if more high-volume filers)
  - To individuals: February 1, 2016 (because January 31, 2016 is a Sunday)

Hartford Personal Health Application



PERSONAL HEALTH APPLICATION

Thank you for choosing The Hartford. All sections of this form must be completed and received by The Hartford within 30 days of the signature date.

Employers: Please completely fill out **Section 1 and Section 2 on this page** and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with The Hartford. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1: Employer Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employer Name: ARCHDIOCESE OF MIAMI HEALTH PLAN | Policy Number: 303830

Division *(if applicable)*:

Employer Mailing Address (Street, City, State, Zip Code):

Benefits Contact Name (First, Last):

Benefits Contact Email Address: | Benefits Contact Phone: ( ) -

Section 2: Employee Details *(to be completed by Employer)* **PLEASE PRINT CLEARLY**

Employee Name (First, MI, Last):

Base Annual Earnings*: | Social Security Number: - - | Date of Hire (mm/dd/yyyy): / /

*Base annual earnings as described in the contract with The Hartford.

Coverage Details

- Check the applicable box(es) in each row to reflect the applicant's current coverage and new election.
- Enter the amount of any **existing** coverage (including Guarantee Issue (GI)**) in **Current Coverage**. Please include the current amount of Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
- Enter the amount of **Additional Coverage Requested** that requires medical underwriting.
- Enter the **Total Coverage Amount** that will be in force if the additional coverage requested is approved.
- If the applicant is enrolling after his/her initial eligibility period and does not have current coverage they will be responsible for all fees incurred during the medical underwriting process.

		Current Coverage (including GI Amount)	Additional Coverage Requested	Total Coverage Amount
	Life Insurance Coverage	*Enter all amounts as dollars. Include Basic Life Current Coverage Amount even if not requesting this coverage type.*		
☐	Employee Basic Life	$	$	$ 0.00
☐	Employee Supplemental or Voluntary Life	$	$	$ 0.00
☐	Spouse Basic Life	$	$	$ 0.00
☐	Spouse Supplemental or Voluntary Life	$	$	$ 0.00
	Disability Insurance Coverage	*Enter all amounts as dollars*		
☐	Short Term Disability			$0.00
☐	Long Term Disability			$0.00

**Guarantee Issue (GI) is the maximum amount of coverage, as defined in the contract with The Hartford, which does not require evidence of good health.

Employees: Please complete pages 2 thru 5. It should take you about 10 minutes to complete this form.

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PA-9199

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- Used for Voluntary Supplemental Term Life:
  - During initial enrollment period
    - In amount over $100,000 for employee
    - In amount over $30,000 for spouse
  - After initial enrollment for any amount above the Basic Life Insurance amount of $15,000
    - Carrier my deny coverage

Questions for Health Care Reform