SHORT-TERM DISABILITY

You must work 30 or more hours per week to be eligible for this optional benefit.

Short-term disability insurance provides financial protection for you and your family if you are ill or injured and unable to work. It provides coverage for temporary disabilities as well as short-term coverage in the event you are permanently disabled.

SHORT-TERM DISABILITY COVERAGE:
Once medical certification of your disability has been accepted, you will receive 66 2/3% of your basic weekly earnings up to a maximum benefit of $225 a week. This payment may be in addition to any accrued sick leave pay. Benefit payments will begin on the 14th day of injury or sickness and continue for a maximum of 22 weeks per illness or injury.

As long as you are an eligible employee, this coverage is in effect. If your employment should end for reasons other than illness or temporary disability, your coverage will end at that time.

Short-term disability payments are made **only when work time is missed** due to disability.

Work-related injuries are not covered by short-term disability insurance, but may be covered under workers' compensation insurance.

In the Short-Term Disability Coverage section of your enrollment form, check "Yes" if you wish to purchase this optional coverage.

If you do not wish to purchase this optional coverage, check the appropriate box.

HEALTH INSURANCE AND PORTABILITY ACT (HIPPA)

HIPPA is a federal law that became effective July 1, 1997. This federal legislation made some very significant amendments to the Public Health Service Act (PHSA) and the Internal Revenue Code of 1986. One of the most significant changes is the requirement that employees are provided with a certificate showing evidence of prior health coverage when they leave employment. The insurance provider will furnish this certificate.

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts allow you to save taxes on certain expenses you may incur for health care and dependent care for you and your spouse or eligible dependents. You decide if you want to set up one or both of the following accounts and how much you want to put into them.

- A Health Care Account that can reimburse you for certain health care expenses that are not covered or paid by any medical, dental, or vision-care plan in effect for you and your spouse or eligible dependents.

- A Dependent Care Account that can reimburse you for eligible dependent and child care expenses.

HOW THE ACCOUNTS WORK:
These accounts work very much like a checking account:

1. You decide how much you want to deposit in your account each month. This amount will be deducted from your pay based on pre-tax earnings.

2. Claims are handled by a Third Party Administrator (TPA). You will be able to use your Benefits Card or submit claims directly to Administrative Information Management, Inc. (AIM), 10353 Linn Station Road, Louisville, KY 40223. Forms are available on their website: www.aimadministrator.com or by contacting your AIM Administrator, Michele Cull at (502) 426-1235.

A WORD ABOUT TAXES:
If you elect to deposit money into one (or both) of the flexible spending accounts, those deposits will be deducted from your paycheck on a pre-tax basis. In other words, you will not have to pay federal, state, or Social Security tax on your deposits.

Your tax savings will depend on your income, the amount of your deposits, and your own personal tax situation (exemptions, deductions, etc.).

SPECIAL RULES APPLY:
If you decide to enroll in one (or both) of the flexible spending accounts, you should plan your deposits carefully by reviewing your past expenses and estimating your needs for the plan year. This planning is important because each of the flexible spending accounts is subject to rules established by the Internal Revenue Service. In essence, the following rules apply:

- You cannot transfer money from one account to another.

- You cannot change your deposits during the year unless the change is consistent with a major change in your family status, your employment status, or your spouse's employment status (as previously discussed in this booklet).

- You will forfeit any money remaining in your account(s) at the end of the plan year which is December 31.

To make sure you will not forfeit any money, you should deposit only the amount you think you will need to cover your expenses.

HEALTH CARE ACCOUNT:

The Health Care Account lets you set aside pre-tax money to pay certain health care expenses that are not covered, or paid in full, by any medical, dental, or vision-care plan in effect for you and your spouse or eligible dependents (including medical insurance under the Flexible Benefits Program). Examples include:

- deductibles and co-payments
- nursing care for a specific medical problem
- hearing aids and batteries
- eyeglasses and contact lenses
- dental expenses
- qualified counseling expenses
- prescriptions

Flexible Spending Health Care Accounts may no longer be used to purchase over-the-counter drugs unless prescribed by a doctor. However, eligible participants with diabetes may still use a health care account to pay for insulin without a prescription.

Generally, any health care expense you could otherwise claim as a deduction for income tax purposes may be reimbursed from this account, with the exception of mileage and parking expenses for medical appointments. In addition, a flexible spending account cannot be used to reimburse participants for premiums paid for other health plan coverage, including premiums paid for health coverage under a plan maintained by the employer of the employee's spouse or dependent.

If your spouse is participating in a Health Savings Account (HSA) at their employer, you are not eligible to participate in our Health Care Account.

You should also be aware that health care expenses reimbursed through the Health Care Account **cannot** be claimed as deductions on your income tax return.

DEPENDENT CARE ACCOUNT:

Many working parents and other employees have child care expenses (for children under age 13) or expenses for the care of a disabled spouse, parent, or other family member. The Dependent Care Account lets you set aside pre-tax money to reimburse yourself for those expenses.

To qualify for reimbursement, your dependent care expenses must be incurred for the purpose of enabling you and your spouse (or you alone, if you are not married) to work. If your spouse does not work, you may use this account only if he or she is a full-time student or is not capable of self-care.

Each plan year, you can use the money in your Dependent Care Account to reimburse yourself for eligible dependent care expenses incurred during that year. Examples of eligible expenses include the cost of:

- licensed dependent care center for both children and adults
- nursery school
- dependent care in your home
- dependent care in another person's home (as long as fewer than seven persons are being cared for)

However, you cannot be reimbursed for dependent care provided by your spouse, by a relative being claimed as a dependent on your income tax return, or by any of your children under age 19.

FEDERAL TAX CREDIT VERSUS DEPENDENT CARE ACCOUNT:
If you use day care services, you probably know about the federal tax credit for dependent care expenses. Like the Dependent Care Account, this tax credit reduces the taxes you pay. You cannot use both the tax credit and the Dependent Care Account for the same expenses. In addition, any Dependent Care Account reimbursements must be subtracted from the amount of expenses you can claim for the tax credit.

You must decide which is best for you, the federal tax credit or the Dependent Care Account. Since the actual amount of savings depends on each person's tax situation, it is impossible to provide hard and fast rules. In general, you may find that the federal tax credit will help you save more in federal income taxes. However, since the Dependent Care Account also helps you save on Social Security taxes in addition to federal, state, and local taxes, it usually results in greater total tax savings for most people. You should consult a tax advisor to determine which is better for you, the federal child care tax credit, or the Dependent Care Account.

You should also be aware that to use the tax credit or the Dependent Care Account, you must show on your tax return the name, address, and Social Security number (or other taxpayer identification number) of your dependent care provider. The only exceptions are for certain nonprofit dependent care providers (such as day care centers operated by nonprofit religious or educational organizations).

AMOUNTS YOU MAY PUT INTO YOUR FLEXIBLE SPENDING ACCOUNTS:
Each account has a minimum amount and a maximum amount that you can deposit each calendar year. The minimums and maximums are shown below:

	Minimum per Month	Maximum per Year
Health Care	$75	$2,600
Dependent Care	$75	$5,000 (single or married filing jointly) $2,500 (married filing separately)

Regardless of the maximums shown above for the Dependent Care Account, the deposits you make to that account each year cannot exceed your total annual income or your spouse's total annual income, whichever is less.

If your spouse is a full-time student or is not capable of self-care, IRS guidelines will be used to determine the amount of his or her total annual income for this purpose.

REIMBURSEMENTS FROM YOUR ACCOUNTS:
If you enroll in one (or both) of the flexible spending accounts, you will need to do one of the following to use or be reimbursed for your expenses.

1. Use your Benefits Card.

2. Obtain a claim form from the AIM Website (www.aimadministrator.com).

3. You may fax your claims and information to (502) 426-6569. If your document is large or otherwise not faxable, please mail to AIM's physical address: 10353 Linn Station Road, Louisville, KY 40223.

Note: Reimbursements are made only for expenses incurred while flexible spending accounts are in effect. (e.g., if you establish a Health Care and/or Dependent Care Account effective January 1, you cannot submit receipts for expenses incurred before that date).

WHEN YOUR FLEXIBLE SPENDING ACCOUNTS WILL END:

Your Health Care and/or Dependent Care Account will end on the last day of the month of active employment or on the date you are no longer eligible to participate in the Flexible Benefits Program.

WHEN THIS HAPPENS:

- You will forfeit any money left in your Health Care Account. However, you will have **60 days** in which to submit any claims for health care expenses incurred before the date your employment ended or before the date you became ineligible for the Flexible Benefits Program.

- You may continue to file claims for eligible expenses from your Dependent Care Account for the remainder of the plan year or until there are no funds remaining in your account, whichever occurs first.

WHAT HAPPENS IF MY CLAIM FOR BENEFITS IS DENIED?:

- A Claimant is entitled to a full and fair review of a denied claim.

- You must submit a request for a review of a denied claim to the Plan Administrator within 90 days after you receive written notice of the denial.

- The Plan Administrator makes a decision on review not later than 60 days after the Plan receives a request for review with specific reasons for the decision.

ELECTING FLEXIBLE SPENDING ACCOUNTS

1. In the Flexible Spending Accounts section of your enrollment form, check the appropriate box if you want to establish a Health Care Account, a Dependent Care Account, or both.

2. If you are establishing a Health Care Account, enter the amount you want to deposit each month.

3. If you are establishing a Dependent Care Account, enter the amount you want to deposit each month.

4. If you do not want to establish a Flexible Spending Account, check the appropriate box.

ENROLLMENT CHECK LIST

Please take the following steps to complete your enrollment:

Be sure to supply complete information for each item listed as well as the "Employee Information" section at the top of your form.

Follow the instructions previously provided in this booklet for selecting your benefits.

All employees electing medical dentalRUYLVLRQ insurance for the first time must complete a Humana enrollment application. Employees making changes to their present coverage must complete a Humana Change Form.

4. Return the **signed** Benefit Enrollment Form along with any Humana medical, dental or vision enrollment or change materials.

5. During open enrollment for 2019, the enrollment or change process must be completed online at the Humana website.

In order to ensure benefit coverage, do not delay enrolling.

The plan descriptions contained in this booklet are summaries only. Full details of the Flexible Benefits Program and its benefit options are available through the plan documents and insurance contracts, which define and govern the actual plan benefits. In case of any conflict between this booklet and the plan documents or insurance contracts, the provisions of the applicable plan documents or insurance contracts will control.

Archdiocese of Louisville

2019 Insurance Rate

Sheet

I. MONTHLY PRE-TAX PREMIUMS:

Medical Insurance	
Individual EE	$565.66
Employee +1	$1,131.32
Family	$1,696.98

Vision Insurance	
Individual EE	$7.26
Employee +1	$15.08
Family	$20.60

Dental Insurance	Preventive Plus	Humana PPO	Traditional Preferred
EE	$14.82	$26.84	$35.98
EE+SP	$32.32	$47.44	$71.48
EE+CH	$36.26	$52.64	$72.88
Family	$56.42	$90.20	$118.24

The dental rates were guaranteed for two (2) years ending December 31, 2020

II. MONTHLY AFTER-TAX PREMIUMS:

SHORT-TERM DISABILITY INSURANCE	Cost per $10 of weekly payment
(66 2/3% of salary to a maximum of $225 per week)	$.40

Example:

Employee earning $350 per week is eligible to receive $225 per week in disability income (66 2/3% of $350 to a maximum of $225 per week). Based on $.40 per $10 of weekly coverage (cost to employee is $9 per month).

Employee earning $225 per week is eligible to receive $150 (66 2/3% of $225) in disability income. Based on $.40 per $10 of weekly coverage (cost to employee is $6.00 per month).

CONTINUATION OF BENEFITS (COBRA)

NON-RENEWAL/TERMINATION OF CONTRACT OR EMPLOYMENT:
Any teacher/parish/division staff leaving archdiocesan employment is no longer an employee effective the date of termination/end of contract. **All archdiocesan group benefits cease the last day of the month in which termination occurs or contract ends. For other school-year employees, benefits end on June 30 unless they are under contract or have a promise of employment for the following school year.** For example, benefits for school teachers end on June 30 if they are not under contract for the following school year.

Should any former employee be rehired by an archdiocesan school/parish/division in the future, new applications must be completed for all benefits.

** Continuation Coverage Rights Under COBRA**
Employee and Eligible Dependents

Introduction
This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your eligible dependents, and what you need to do to protect your right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.
If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
  If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the local bookkeeper as soon as possible after the qualifying event occurs. You must provide this notice to *your local bookkeeper*.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a

dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

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

COBRA:
Humana coverage includes COBRA insurance administration, handled by WageWorks. Once the COBRA Qualifying Event Form has been completed and received by WageWorks, you will receive additional information of your COBRA Rights. Participants will be billed directly at home, and at the Archdiocesan group rate plus 2%. The coverage duration period is based upon the qualifying event.

Plan contact information

Archdiocese of Louisville
Personnel Office
3940 Poplar Level Road
Louisville, KY 40213-1463
502-585-3291

CONVERSION PRIVILEGE FOR RELIANCE STANDARD LIFE INSURANCE:
Life insurance coverage may be converted to an individual policy (limited to current level of coverage only). No increase in amount of coverage is allowed. **Archdiocesan group premium rates do not apply** to converted coverage (increase in premium for converted coverage is significant).

An employee who wants to continue current life insurance coverage after termination must contact Reliance Standard within 15 days after benefits end at 1-800-644-1103 or 1-800-351-7500 for details. Participants electing life insurance conversion policies are billed direct at their home address and receive information regarding the plan from the insurance company along with instructions for making monthly premium payments.

FLEXIBLE SPENDING ACCOUNTS
An employee will have 60 days from the end of the month when they ended employment in which to submit claims to AIM. Expenses must have been incurred while you were still actively employed.

In addition to the benefits offered through the flexible benefits plan, Archdiocese of Louisville employees are eligible for the following benefits.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance and Work-Life Program is available for all employees through our Humana Insurance Plan. Employees do not need to be enrolled in our Humana plan in order to make use of the Employee Assistance Program. For additional information, go to Humana.com/eap or request information from your local bookkeeper.

FAMILY AND MEDICAL LEAVE ACT

The FMLA entitles eligible employees to take up to 12 weeks of job-protected leave in a rolling 12 month period for specified family and medical reasons. To be eligible to request FMLA, the employee must have worked a full year for the Archdiocese of Louisville, and have worked at least 1,250 hours during the twelve months prior to the start of the FMLA leave.

HEALTH INSURANCE FOR EARLY RETIREES

Retiring employees who have reached age 55 and have worked for the Archdiocese of Louisville for a minimum of 10 consecutive years immediately prior to retirement have the option to continue on the medical insurance plan until the qualifying employee becomes eligible for Medicare. Employee must have had health insurance coverage through the Archdiocese of Louisville for at least three years immediately prior to retirement. Contact the Pastoral Center Personnel Office for further information. Employee pays full cost of plan and is billed directly by Humana. Eligible dependents will be provided COBRA information at the time the retiring employee becomes eligible for Medicare.

KENTUCKY TELCO CREDIT UNION

Employees are eligible to participate in Kentucky TELCO Credit Union which offers checking and savings accounts as well as options for obtaining credit cards and consumer loans.

Other Benefits for Archdiocese of Louisville parish, school and division employees:

RETIREMENT

Eligible lay employees may join the Plan on the first day of the month following the date of hire if they are age 21 and meet the eligibility requirements. An assigned ordained diocesan priest will automatically join the Plan on the first day of the month following date of ordination or transfer to the diocese. After becoming a participant, you can make salary deferral contributions to the Plan only through payroll deductions. For complete details, see the ***SUMMARY PLAN DESCRIPTION FOR THE CATHOLIC ARCHDIOCESE EMPLOYEES RETIREMENT PLAN (01/01/2018).***

PERSONAL DAYS

Full-time employees (30 or more hours per week) and regular part-time employees (14 or more hours per week) will be granted two paid days per year for the purpose of personal days. Regular part-time employees (14 or more hours per week) will receive a pro-rated amount of pay for each personal day. Unused personal days may not be accumulated. However, at the end of each school year (or calendar year for 12-month employees) unused personal days may be converted to sick days and added to the employee's accrued sick-day bank. Unused personal days will not be paid at time of termination.

SICK TIME

Regular full-time employees (30 or more hours per week) will receive paid sick time based on the employee earning one sick day per month worked. Regular part-time employees (14 or more hours per week) will earn sick time in proportion to the part-time hours worked. A sick day is earned the last day of each month worked. Sick days can be accrued up to the maximum number determined by archdiocesan policies.

Departing employees who have reached age 55, and have worked for the Archdiocese for a minimum of 10 consecutive years, will receive pay for one-third of their accrued sick days at their daily rate of pay at time of retirement.

SOCIAL SECURITY TAXES (FICA)

Social Security tax (FICA) that is deducted from an employee's pay will be matched by an equal contribution from the employer.

VACATION

Employees who work a full 12-month year at a minimum of 14 hours per week will receive paid vacation. Employees in positions requiring them to work less than 12 months are not eligible to receive paid vacation. Refer to the Archdiocese of Louisville Personnel Policies and Procedures Manual for complete details.

WORKERS' COMPENSATION

All archdiocesan employees are covered by workers' compensation benefits should they be injured on the job. Any job-related accident should be reported to the supervisor immediately and a written report filed. Accidents not causing serious injury should also be reported since complications may arise later. Delayed reports could result in a lack of coverage.

UNEMPLOYMENT COMPENSATION

Employees are not eligible to receive unemployment compensation related to their work with the Archdiocese of Louisville. Per KRS 341.055(19) Services performed in the employ of a church or convention or association of churches or an organization which is operated primarily for religious purposes and which is operated, supervised, controlled, or principally supported by a church or convention or association of churches; is non covered employment and no wages were added.

GENERAL INFORMATION

Plan Employer:	Roman Catholic Bishop of Louisville, a corporation sole, its parishes, agencies or participating related Catholic divisions Pastoral Center 3940 Poplar Level Road Louisville, KY 40213-1463
Employer Identification Number:	61-0447247
Plan Administrator and Agent for Service:	Roman Catholic Bishop Archdiocese of Louisville Pastoral Center 3940 Poplar Level Road Louisville, KY 40213-1463
Contact:	Dr. Brian B. Reynolds, Chancellor (502) 585-3291