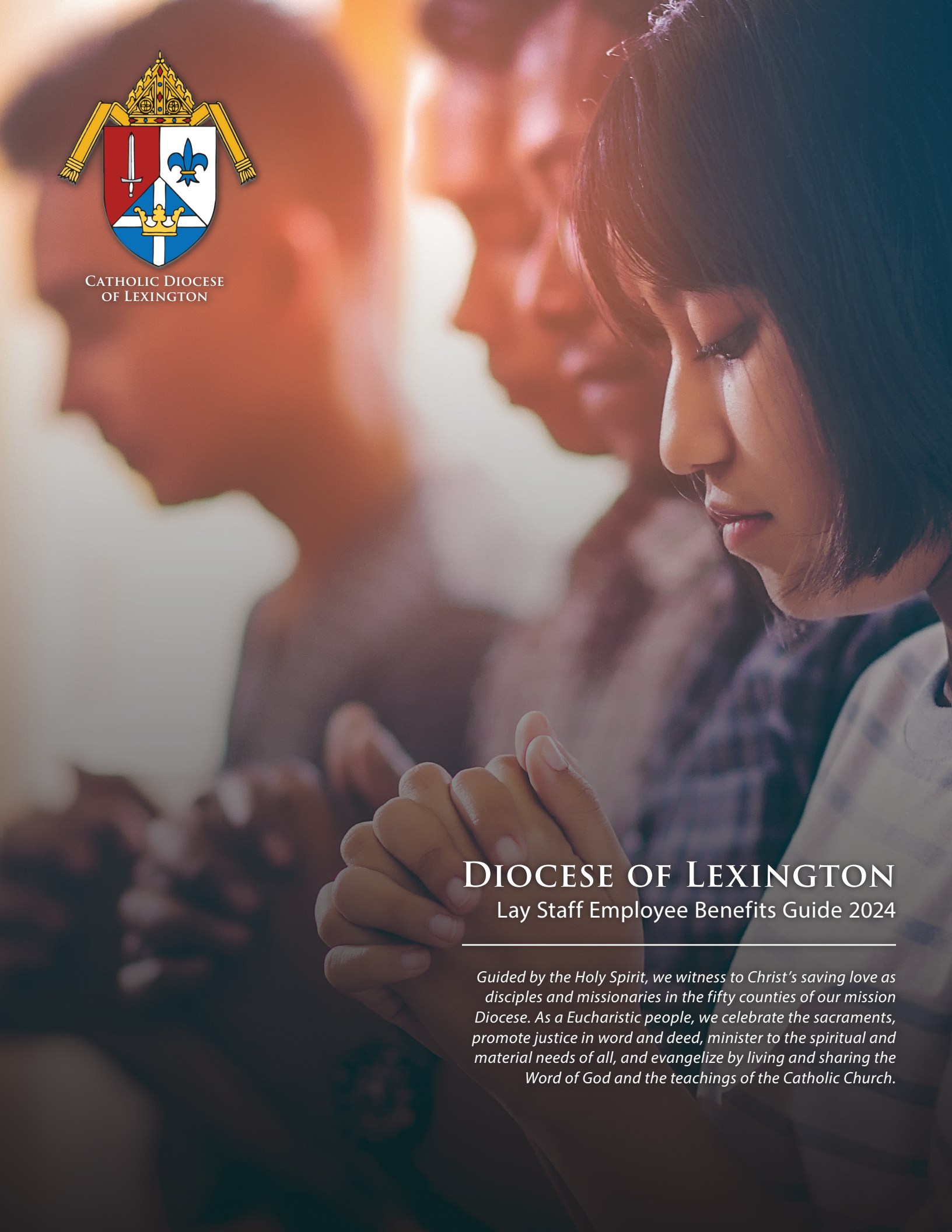


CATHOLIC DIOCESE
OF LEXINGTON

Diocese of Lexington

Lay Staff Employee Benefits Guide 2024

Guided by the Holy Spirit, we witness to Christ's saving love as disciples and missionaries in the fifty counties of our mission Diocese. As a Eucharistic people, we celebrate the sacraments, promote justice in word and deed, minister to the spiritual and material needs of all, and evangelize by living and sharing the Word of God and the teachings of the Catholic Church.

CONTENTS

This enrollment guide highlights the benefit plan choices available to eligible associates and their dependents. This enrollment guide serves as a summary of the benefits described in the official summary plan documents for these plans. It does not interpret, extend or change the plan in any way. The benefits that you receive are based upon the plan's official documents, not this guide or any other written or oral statement. If there is a conflict between this guide and the official plan documents, the official plan documents will govern in all cases. The Diocese of Lexington reserves the right at any time to change or terminate these plans.

EMPLOYEE BENEFITS PACKAGE

The Diocese of Lexington is pleased to offer you a comprehensive, high-quality benefits package to help you live healthier and manage your healthcare costs. We encourage you to make the most of your benefits by reviewing all the offerings available to you, and by using the tools and resources provided to help you make the best coverage decision for you and your family. This brochure is designed to guide you through your benefit choices for the 2024 plan year. Separate information prepared by the provider companies contains more specific details and will be available on the Paycom enrollment site. The contents of this brochure are accurate, but in case of any discrepancy, the written plan document will govern.

Eligibility

- Full-time Lay Staff

- Benefit coverage will begin on the first of the month on or after date of hire.
- Full-time employees scheduled to work at least 37.5 hours per week are eligible for all benefits described in this guide.
- CuraLinc EAP (employee assistance program)

- Part-time Lay Staff

- Benefit coverage will begin on the first of the month on or after date of hire.
- Part-time employees working 20-37 hours per week are eligible for all benefits except the Diocesan paid life coverage and the CuraLinc Employee Assistance Program.

As an employee of the Diocese of Lexington, you can enroll your eligible dependents for coverage.

- *Your eligible dependents include:*
  - Legal spouse
  - Eligible dependent child(ren),* up to the end of the month in which the child(ren) turn age 26, can be enrolled in the Diocese of Lexington's Medical, Dental, Vision, Voluntary Life, and Worksite Benefit plans whether or not they are married, living with you, in school, or financially dependent upon you.

**Eligible children under Internal Revenue Code Section 152 (f) (1) are: sons, daughters, stepchildren, adopted children (including children placed for adoption), and foster children.*

Covering Family Members

If you need to cover a family member (a child or spouse) under your plans, you must do so during the open enrollment period. If a covered spouse or dependent child becomes ineligible for coverage during the year, you will need to remove that individual from your coverage. You can only add a family member to your coverage during your enrollment period or following a qualifying event during the year. Even if you already have "employee + one dependent" or "employee + two or more dependents" coverage, you must make changes to dependents within 30 days of the date of the event or the dependent(s) will not be covered and you cannot enroll/disenroll the dependent(s) untill the next open enrollment period (effective on the first day of the next plan year) unless you have another applicable qualifying event. You have 30 days after the date of the qualifying event to request any needed changes to your coverage elections.

What is a Qualifying Event?

A qualifying event is something in your life that has changed that has made you eligible to change your benefit choices. You must provide notification within 30 calendar days of the date of your qualifying event.

- *Here are the most frequent examples:*
  - Adoption or birth of a child
  - Marriage or divorce
  - Spouse gained or lost health plan coverage through their employer

HOW TO ENROLL: PAYCOM

Welcome to Employee Benefits Enrollment!

During a benefit elections enrollment, you are given the opportunity to update your dependents, beneficiaries, and benefit elections offered through the Diocese. You will complete your benefit enrollment in Paycom, using the same login information you use for payroll. Carefully review the plan information in this benefits guide and all other plan materials that have been provided. The insurance carriers' websites also provide important information and tools that can help you make enrollment decisions.

Consider the needs of any dependents you may have. If you are married, review the coverage currently offered through your spouse's employer to avoid costly duplicate coverage.

1) Go to www.paycom.com or the Paycom app and log in using the same login information you use to access your payroll record

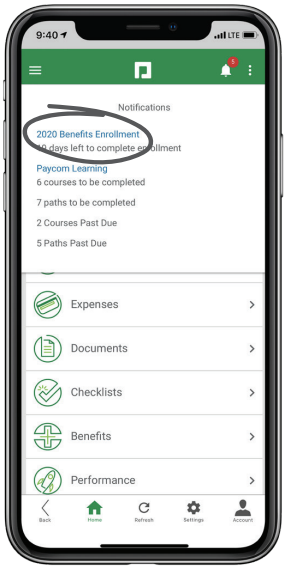
2) From the Notification Center or the Benefits section, click on the current year's Benefit Enrollment;

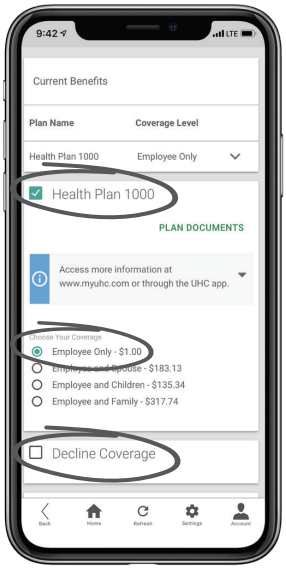
3) Review the initial instructions and click "Start Enrollment";

4) Enter or update your personal information and any dependent or beneficiary information;

5) Move through the benefit option screens, selecting to either enroll or decline each benefit. Make sure you select the coverage level you want for each benefit and the correct dependents are include for coverage;

6) To complete enrollment, click "Finalize," then "Sign and Submit".





GETTING THE MOST FROM YOUR BENEFITS

Understanding how your benefit plans work is an important part of taking control of your health care and costs. Take the time to read through your plan documents to understand what services are covered and how much your health care will cost. For some services you only have to pay a copayment, while for other you must pay your annual deductible first and then the listed coinsurance rate.

To help save time and money:

Stay In-Network

Choose providers that participate in the plan's network to save money. Your cost share is lower with in-network providers and the providers will not balance bill you for amounts disallowed by the insurance. The medical, dental and vision benefit sections of the guide all contain the website addresses where you can find in-network providers.

Practice Prevention

The Diocese of Lexington health plans cover well-adult and well-child annual exams, as well as immunizations, at no cost to you. Getting regular check-ups, screenings and shots is key to maintaining good health and detecting potential issues early when they are easier to treat, or may even be prevented. Talk to your doctor about which screenings are recommended for you and your family.

Register For Online Tools and Programs

Your plan includes a wealth of resources for managing your health including cost calculators, case management, a 24-hour nurse line, access to your claims history and more. Take advantage of these tools by registering on each carrier's website.

Know Where To Go

Getting care from the right place can save you both time and money, such as visiting the emergency room only for true emergencies. For minor medical issues, visit your regular doctor or and urgent care center if s/he isn't available. You can also access board-certified physicians 24/7 via Teladoc for simple ailments such as colds, flu, or allergies with no appointment needed, no driving time, and no waiting room.

HEALTH PLAN: CHRISTIAN BROTHERS SERVICES BCBS PPO

Health Plan Overview

The Health Plan Options chart below provides an overview of each of the health plans offered by the Diocese of Lexington. This overview will help you understand which health plan option best meets the needs of you and your family. In-network providers can be found by using the Find a Doctor tool at www.mycbs.org/ppo-hcsc and searching the Participating Provider Organization [PPO] network.

	PPO	HDHP
PLAN FEATURES	**IN-NETWORK**	**IN-NETWORK**
Calendar Year Deductible • Single • Family	 $500 $1,000	 $3,200 $6,400
Out-of-Pocket Maximum • Single • Family	 $2,000 $3,500	 $3,200 $6,400
Member Coinsurance	90/10%	Covered 100%
Doctor's Office Visits • Primary Care • Specialist	$10 Copay	Deductible + 0%
Routine Preventive Care • Well-child Care to Age 19 • Well-Woman Care • Routine Mammograms • Routine Adult Physical Exams	Covered in Full	Covered in Full
Inpatient Hospital Services	Deductible + 10%	Deductible + 0%
Emergency Room Visit	$200 Copay + 10%	Deductible + 0%
Urgent Care	$50 Copay	Deductible + 0%
Prescription Drug **Retail 30 day** Generic Brand: Preferred Brand: Non-Preferred Brand: **Mail Order 90 day** Generic Brand: Preferred Brand: Non-Preferred Brand: Generic Specialty: Preferred Specialty: Non-Preferred Specialty:	 $10 $25 $40 $25 $60 $100 10% up to a maximum of $150 20% up to a maximum of $150 20% up to a maximum of $250	Deductible + 0%
NOTE: Benefits are reduced for out-of-network providers. Your deductible, coinsurance and out of-pocket limits are higher and the provider may balance bill you for the difference between their billed amount and the amount allowed by the plan.		

DEDUCTIBLE

You pay this amount before your plan starts paying for most covered services. Under the HDHP plan, you'd pay the full charge for most services until you reach $3,200 for yourself or $6,400 for your family.

OUT-OF-POCKET MAXIMUM

This is the most you'll pay for care during a policy period before the plan starts paying 100% for most covered services. In this example, you would not pay more than $3,200 for yourself or $6,200 for your family under the HDHP.

PREVENTIVE CARE AT NO COST

Most preventive care services, including physical exams and mammograms, are covered at no charge and are not subject to the annual deductible.

COINSURANCE

Your covered benefit expenses are paid at a certain "benefit percentage" based on the health plan option you select. If a benefit percentage is less than 100%, you will be responsible for paying the remaining portion of the cost, which is also known as "coinsurance."

Under the HDHP, after you reach your deductible, your plan would pay 100% for the remainder of the policy period. Under the PPO, after reaching your deductible, you would pay 10% of most services until the out-of-pocket maximum is met.

Express Scripts Prescription Drug Plan

A three-tier prescription drug program splits medications into three categories or tiers. The amount you pay will depend on the category of the medication.

Generic Brand: Generally generic drugs that offer the best value compared to other drugs that treat the same conditions. The U.S. Food and Drug Administration (FDA) requires that all drugs be safe and effective and that a generic drug work in the same way as the brand-name drug.

Preferred Brand: These may be preferred brand drugs, based on how well they work and their cost compared to other drugs for the same type of treatment. Some are generic drugs that cost more because they're newer to the market.

Non-Preferred: These are often brand and generic drugs that cost more than drugs on lower tiers that are used to treat the same condition. This may also include specialty drugs that are used to treat serious, long-term health conditions and that may need special handling.

Specialty: Certain specialty pharmacy drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay assistance. For a complete list of non-essential specialty medications, see mycbs.org/health/SaveonSP

To see what tier your medications are on and if any step therapy or prior authorization is required, go to www.mycbs.org/health, log in and on the menu select **Prescription Drug Coverage** or call Express Scripts at 800-718-6601.

Additional Requirements for Some Prescription Drugs

Some drugs have additional requirements that must be met before the plan will cover your prescriptions.

Prior Authorization requires your doctor to submit medical information for review to ensure that certain guidelines are met.

Step Therapy requires that you have tried another recommended drug for your condition first before the prescribed drug is covered.

Specialty Drugs must be obtained through the Express Scripts Specialty Pharmacy. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail order.

Home Delivery Mail Order Pharmacy

With mail order prescriptions, you have the convenience of medications that you take on a regular basis being delivered to your home. You can get up to a 90-day supply instead of the normal 30-day supply and decrease your monthly prescription bill.

EMPLOYEES WORKING 30+ HOURS PER WEEK
PER PAY PERIOD COST (24 CHECKS PER YEAR)

	PPO	HDHP
Employee Only	$0	$0
Employee + 1 Dependent	$363.50	$310.00
Employee + 2 or More Dependents	$374.00	$319.50

EMPLOYEES WORKING 26 - 29 HOURS PER WEEK
PER PAY PERIOD COST (24 CHECKS PER YEAR)

	PPO	HDHP
Employee Only	$107.55	$94.95
Employee + 1 Dependent	$471.05	$404.95
Employee + 2 or More Dependents	$481.55	$414.45

EMPLOYEES WORKING 20 - 25 HOURS PER WEEK
PER PAY PERIOD COST (24 CHECKS PER YEAR)

	PPO	HDHP
Employee Only	$143.40	$126.60
Employee + 1 Dependent	$506.90	$436.60
Employee + 2 or More Dependents	$517.40	$446.10

Christian Brothers Services

Health & Benefits

Livongo Health

Innovative Methods to Managing Diabetes and Hypertension

On average, about 1 in 10 people have diabetes and nearly half of U.S. adults have hypertension, leading to serious health problems.

All participants in the Employee Benefit or Religious Medical Trust, have free access to Livongo by Teladoc Health, offering support in the areas of diabetes prevention, weight management, diabetes and hypertension.

Livongo is a program created to empower all people with chronic conditions, including diabetes and high blood pressure, to live healthier lives and reduce risk for serious health issues. Using advanced technology, personalized recommendations, and real-time communication, the program provides the right information, tools and support—all at no additional cost. All members of the Trusts, diagnosed with prediabetes, diabetes or hypertension, receive free access to Livongo.

Preventing Diabetes Program

The Livongo Healthy Living and Diabetes Prevention Program can help members at risk for type 2 diabetes. The program doesn't cost anything and helps members focus on living a healthier life.

Within the program, participants will have access to a CDC-recognized program that focuses on lifestyle behavior changes to achieve health goals through:

- Effortless data collection: A cellular scale provides seamless weigh-ins and food and activity tracking to understand lifestyle habits.
- Personalized health signals: Lessons provide evidence-based strategies for healthy living and health challenges to drive small changes for big wins!
- Human-centered approach: Coach-led meet ups for support and accountability and 1:1 live coaching from Livongo expert coaches.

Depending on your health goals, you could also receive a blood pressure monitor and/or blood glucose monitor.

CHRISTIAN BROTHERS SERVICES

Livongo®

For more information, call member support at 800.945.4355.

LIVONGO HEALTH

Managing Diabetes

Livongo for Diabetes offers an innovative remote monitoring solution aimed at helping patients with diabetes better manage their blood sugar levels, so they can prevent both short- and long-term complications and reduce their overall health care costs.

Member Benefits

Members who have diabetes will be contacted with information on how to enroll. Those who enroll in the program will receive:

- Livongo Welcome Kit: Livongo In Touch® meter, which tracks strip usage and prompts members with targeted messaging, a lancing device, 150 test strips, 100 lancets and a carrying case.
- Unlimited checking supplies (test strips, lancets and meter). Have test strips and lancets shipped to you whenever you need them.
- Real-time 24/7 interventions by Certified Diabetes Educators for members with dangerous (high and/or low) blood sugar levels.
- Online access: Access your readings, along with graphs and insights, online or on your mobile device.

Livongo Health provides personalized support through the meter and its mobile app, and provides coaches to help participants make better decisions about diabetes management.

Managing Hypertension

Livongo for Hypertension combines advanced technology with personalized coaching to help members identified with hypertension manage their blood pressure.

Member Benefits

Members who have hypertension will be contacted with information on how to enroll. Members who enroll in the Livongo for Hypertension program will receive:

- An automatic monitor connected to a smartphone app that sends data to Livongo.
- Health Summary Reports.
- Convenient automatic reminders to check their blood pressure.
- Around-the-clock access to knowledgeable, caring health professionals whenever and wherever they need them.
- Scheduled care with coaches who provide answers to questions and support for a member's weight loss journey, and give advice on improving overall health through nutrition, stress management and medication.
- Personalized content and tips, as well as nudges, emails and texts. Members who submit a blood pressure reading over 180mmHg also receive feedback on their elevated reading. For participants on high blood pressure medication, the program uses clinical algorithms to ensure they are receiving the maximum medication benefits.

NOTE: It takes less than 10 minutes to register.

EBT members: Register at get.livongo.com/EBT/begin.

RMT members: Register at welcome.livongo.com/RMT/begin.

CHRISTIAN BROTHERS SERVICES

Livongo®

For more information, call member support at 800.945.4355.

PROGRAMS-1/2023

Christian Brothers Services

Health & Benefits

TELADOC

Consult A Doctor 24/7

Where the Doctor is Always In

The Christian Brothers Employee Benefit (EBT) and Religious Medical Trusts (RMT) offer 24/7 access to physicians, 365 days a year through Teladoc for all members who are enrolled with medical coverage.

The telemedicine benefit offers accessible and convenient care, as well as providing patients and physicians a way to communicate, which bypasses the traditional office visit yet provides excellent care through the use of technology. Members can talk with a doctor anytime, anywhere about non-emergent medical conditions via telephone, secure email, video or mobile app.

Telehealth

Teladoc's network of board-certified physicians can discuss symptoms, recommend treatment options, diagnose many common, minor and/or brief illnesses and prescribe medication, when appropriate. Common conditions treated include:

- Allergies
- Eye/Ear Infections
- Sinus Infections
- Stomach Ache/Diarrhea
- Urinary Tract Infections
- Yeast Infections
- Bronchitis
- Cold/Flu
- Headaches
- Rash/Skin Irritation
- Upper Respiratory Infections
- And More …

Mental Health

Talk to licensed psychiatrists, psychologists or therapists to assist in behavioral health needs by phone or video.

- Get confidential counseling seven days a week for conditions like depression, anxiety, stress, marital or family issues.
- Schedule an appointment on one's own time. Visits are secure, discreet, and confidential.
- Choose a therapist or psychiatrist who best fits individual's needs.
- Complete, on average, a visit 18 days faster than at a brick and mortar therapist office.
- Visit with same therapist or psychologist for continuity of care.

Dermatology

Upload images of a skin issue online and get a custom treatment plan within two days for conditions such as eczema, acne, rashes and more.

Primary360

Available beginning January 1, 2023

Consult with a primary care provider of your choice for routine checkups, ongoing wellness needs and referrals.

- Annual checkups
- Ongoing wellness visits
- Manage chronic conditions
- Complex medical needs
- Monitor blood pressure
- General health concerns

Getting Started with Teladoc

1) Set Up your Account in one of three ways:

- Call 800-835-2362 or
- Download the app on Apple App Store or Google Play or
- Log into your account at cbservices.org and click My Telemedicine

2) Provide Medical History

3) Request a Consult

CHRISTIAN BROTHERS SERVICES

Due to the Internal Revenue Service (IRS) requirements of Health Savings Account (HSA) plans, in order to preserve the pre-tax status of the HSA, members must be charged a fair market value for Teladoc services. The fair market value for General Medical visits is $65 for 2023.; Dermatology visits, $85; Nutrition Consultation, $59; Therapist visits, $90; $220 for Initial Psychiatrist Evaluations and $100 for Ongoing Sessions; Primary360 Services, $165 per New Participant, $99 per Primary Care Consultation, and no charge for Annual Wellness Check up.

CURALINC EMPLOYEE ASSISTANCE PROGRAM

This benefit is available to all Full- Time employees working 37.5 hours or more per week.

Emotional wellbeing and work-life balance resources to keep you at your best

supportlinc

Effective Dec. 1, 2023

SupportLinc offers expert guidance to help you and your family address and resolve everyday issues

In-the-moment support
Reach a licensed clinician by phone 24/7/365 for immediate assistance

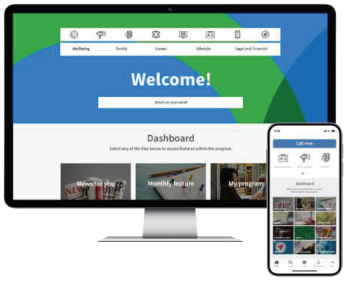
Financial expertise
Consultation and planning with a financial counselor

Legal consultation
By phone or in-person with a local attorney

Short-term counseling
Access up to **five (5) no-cost counseling sessions,** in-person or via video, to resolve stress, depression, anxiety, work-related pressures, relationship issues or substance use

Convenience resources
Referrals for child and elder care, home repair, housing needs, education, pet care and so much more

Confidentiality
Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law



Your web portal and mobile app

- The one-stop shop for program services, information and more
- Discover on-demand training to boost wellbeing and life balance
- Find search engines, financial calculators and career resources
- Explore thousands of articles, tip sheets, self-assessments and videos

Convenient, on-the-go support

- **Textcoach®**
  Personalized coaching with a licensed counselor on mobile or desktop
- **Animo**
  Self-guided resources to improve focus, wellbeing and emotional fitness
- **Virtual Support Connect**
  Moderated group support sessions on an anonymous, chat-based platform

Start with Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator survey. You'll immediately receive personalized guidance to access support and resources.

CHRISTIAN BROTHERS SERVICES

Download the mobile app today!

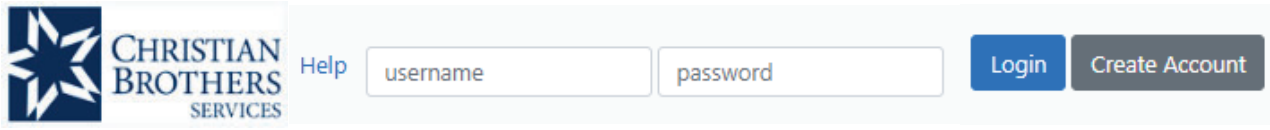
1-888-881-5462

supportlinc.com
group code:
dioceseoflexington

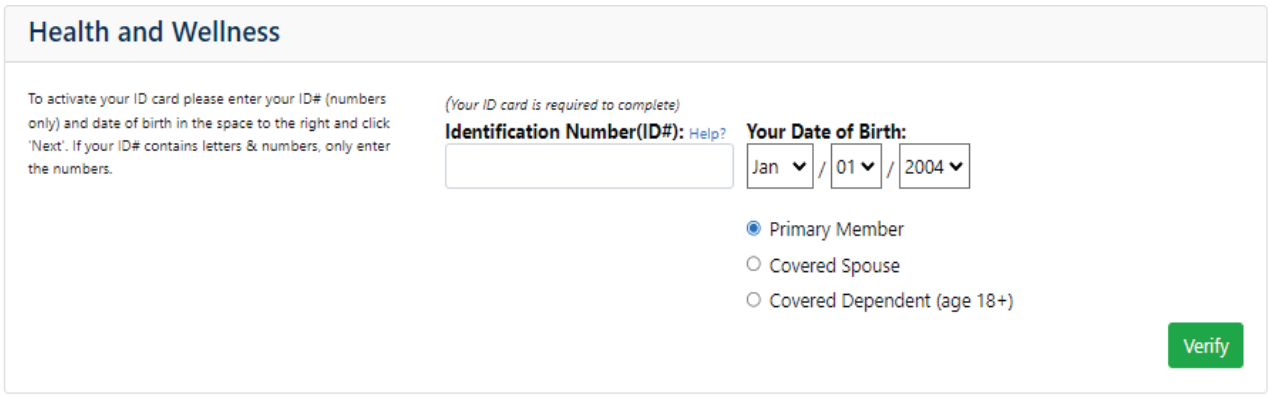
Christian Brothers Services Website Access

Visit mycbs.org/health

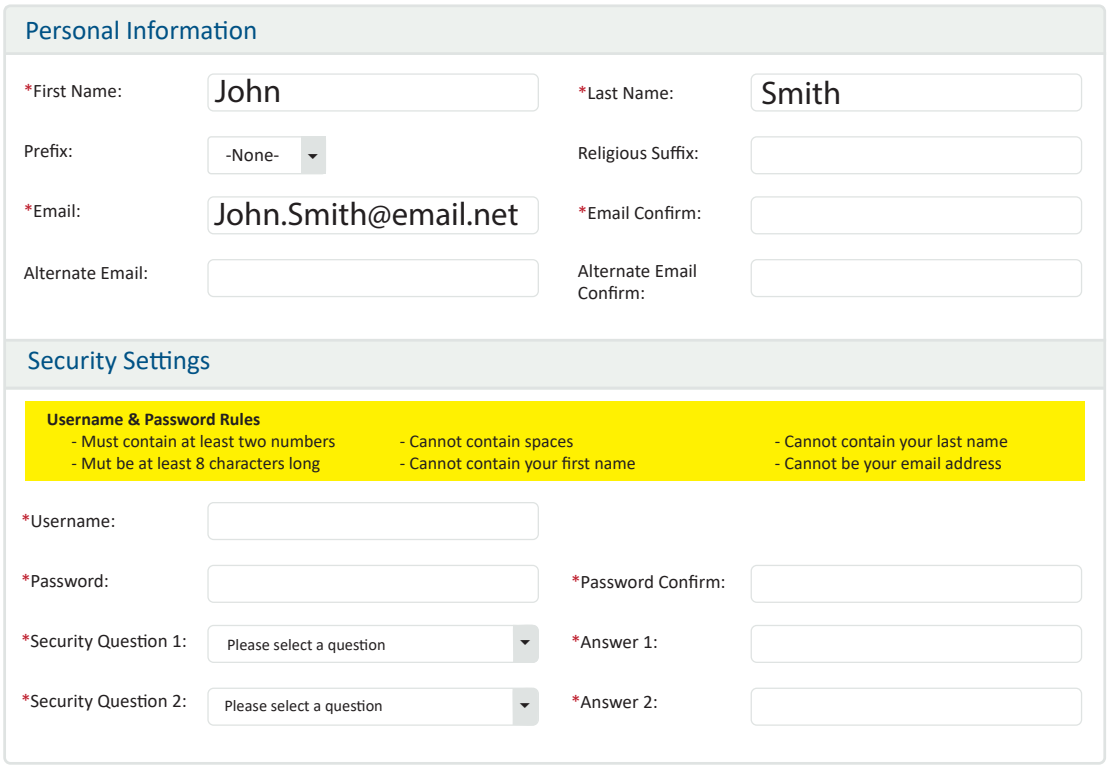
1. In the upper right hand corner of the webpage, click **Create Account**



2. Enter the Identification Number (numbers only 9xxxxxxxx) from your insurance ID card and enter the date of birth of the selected member. Click Verify.



3. Complete the Personal Information and Security Settings. Please make note of the Username & Password Rules. (Some information will be prepopulated)



4 Make your subscription selections, then click **Save Profile**

Subscriptions

- CBS Website News
- Maintaining Your Health Newsletter
- The OutReach Newsletter
- HIPPA Pricacy Policy
- Online Privacy Policy
- Risk Factor
- Opt-out of Emails for Value Added Services

Health and Wellness

Employee Benefit Trust
Religious Medical Trust

To activate your ID card please enter your ID# (numbers only) and date of birth in the space to the right and click 'Next'. If your ID# contains letters & numbers, only enter the numbers.

You are Activated for MyHealth website access!

Our records show your address as:
1234 First Street
Hometown, IL
No phone number on record

If this information is incorrect, click here.

Retirement Planning Services

401k/403b/ERP Account Participant: Activate Retirement

Risk Management Services

Receive emails for Risk Management Seminars: Yes

Save Profile

5 You will receive an email verification request. Please proceed to your email inbox to complete the registration process by clicking the verification link.

** Please note to check your spam folders if you do not see the email verification request in your inbox.*

Email Verification

You will need to click the verification link in the email sent to you at the email address entered in order to continue this process.

Personal Information

CHRISTIAN BROTHERS SERVICES

Thank you for registering with Christian Brothers. Please click on the link below to verify your email address and continue the registartion process.
This link is active 24 hours (Sat-Thur) or until 10:00 pm (Fri.)

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

1

A Tax-advantaged, Interest-bearing account

- Contributions are made pre-tax and funds earn tax-free interest

2

Owned by YOU

- The account belongs to you, so only you decide how to spend it
- It remains yours even if you leave your employer or retire
- Money left in your account carries over from year to year
- Only actual amount deposited is available for reimbursement

3

Used to help pay for both current and/ or future health care expenses

- You can withdraw money tax-free for qualified health expenses and you can use for other expenses (subject to taxes and penalties)
- Or you can watch your money grow to pay for future expenses

HEALTH SAVINGS ACCOUNT

Who is eligible for a Health Savings Account?

To be eligible to open and contribute to an HSA you must:

- Be covered by a High-Deductible Health Plan (HDHP) that meets IRS requirements
- Not be covered by other non-HDHP health insurance
- Not be claimed as a dependent on someone else's tax return

Insurance/Accounts Allowed with HSA	Insurance/Accounts Not Allowed with HSA
Accident Disability Dental Vision Long Term Care Specified Disease or Illness Limited Flexible Spending Account (FSA) VA benefits if due to service related disability	Health Care Flexible Spending Account (FSA) Health Reimbursement Account (HRA) Medical Coverage by Non-HDHP TRICARE or TRICARE For Life Any VA benefits used within previous 3 months (for non-service related conditions) Part A and/or Part B Medicare

How can I use My HSA Funds?

HSA funds can be used for both qualified and non-qualified expenses Funds you withdraw for qualified expenses are tax-free when used to pay for eligible health care expenses for you and your dependents defined by IRS Code Sec. 213(d) such as:

- Deductibles
- Coinsurance
- Prescription Drugs
- Dental Expenses
- Vision Care Expenses (including LASIK & Contact Solution)

A list of these expenses are available on the IRS Website, www.irs.gov in IRS Publication 502, "Medical and Dental Expenses," or can be ordered directly from the IRS at 1-800-TAX-FORM.

Funds you withdraw for non-qualified expenses are included in income and subject to income taxes plus an additional 20% penalty. Additional penalty of 20% applies except when taken after:

- You become eligible for Medicare (age 65) or
- You become disabled or die

Record Keeping

You are responsible for keeping track of how HSA funds are used. You should keep a listing of all the withdrawals that occur from your HSA and the qualified medical expenses they correspond to, in case required to prove to the IRS the distributions were for qualified expenses. Proof could be in the form of:

- Explanation of Benefits (EOB) from Medical, Dental or Vision carrier showing your cost after insurance
- Receipt from pharmacy for prescription drug cost
- Other provider billing showing your payment due amount

You will be required to file a Form 8889 with your annual tax return. The HSA administrator will provide both you and the IRS with Form 1099 and Form 5498—this information will be used to complete your Form 8889.

HEALTH SAVINGS ACCOUNT CONTRIBUTIONS

Contribution Limits

The IRS sets maximum annual contribution limits for Health Savings Accounts. While there is no limit to the savings balance you can accumulate in the account, there is a limit to how much money can be added to the account each year. The contribution maximum includes both employer and employee contributions, so you will need to keep in mind the contribution you will receive from the Diocese of Lexington when you are setting your personal contribution amount. You are not required to contribute any money out of your paycheck to receive the employer contribution.

Coverage Type	2024 Contribution Maximum
Employee	$4,150
Employee + 1 Dependent or Employee + Family	$8,300
Age 55+	Additional $1,000

Employer Contribution

If you elect the HDHP and are eligible for an HSA, the Diocese will make the following contributions into your HSA each pay period:

Coverage Type	Annual Contribution by Diocese	Per Pay Period Contribution
Employee	$500	$20.83
Employee + 1 Dependent or Employee + Family	$1,000	$41.67

FLEXIBLE SPENDING ACCOUNTS

1 Healthcare FSA Compatible with PPO Plan

Set aside money from your paycheck on pre-tax basis to pay for your health expenses after insurance, such as:

- Deductibles, Copays & Coinsurance
- Prescription drugs
- Dental Expenses
- Vison Care Expenses (including LASIK & Contact Lens Solution)
- Annual maximum contribution $3,050*
- Full annual election available after first pay period contribution
- "Use It or Lose It" - any amount contributed must be used on health expenses incurred from 1/1/24-12/31/24. You have until 3/31/25 to file claims for 2024 service dates; any money left in account at that time is forfeited
- Use your Chard Snyder benefit card to pay expenses or you can file a claim for reimbursement to Chard Snyder; substantiation may be required for benefit card charges. Failure to provide documentation will result in card being suspended.

2 Limited FSA Compatible with HDHP Plan

- Set aside money from your paycheck on pre-tax basis to pay for your dental and vision expenses
- Same rules as regular FSA - annual maximum contribution $3,050*, full annual election available after first pay period contribution, "Use It or Lose It".
- Why a Limited FSA since you can use HSA for dental & vision expenses?
    - Help cash flow payment of large dental (including orthodontia) or vision expenses since full election available upfront.
    - If you are contributing annual maximum to HSA to build up account balance, Limited FSA allows you to put money aside for dental/vison expenses without touching HSA savings.

3 Dependent Care FSA

- Set aside money from your paycheck on pre-tax basis to pay dependent care expenses (daycare, after-school activities, summer day camp, elder care).
- Annual maximum contribution $5,000 ($2,500 if married but file taxes separately).
- Money available for reimbursement as deposited after payroll deduction.
- "Use It or Lose It" - any amount contributed must be used on dependent care expenses incurred from 1/1/24-12-31/24. You have until 3/31/2025 to file claims for 2024 service dates; any money left in account at that time is forfeited.

* Contribution limit as of guide print date; IRS expected to announce increases for 2024 to $3,200.

DENTAL PLAN: DELTA DENTAL

Delta Dental Plans

Employees can choose from one of the two dental plans offered through Delta Dental. Both dental plans cover preventive services at 100% including exams, cleanings, and x-rays.

Advantages of Using In-Network Providers

While you can choose any dentist under the PPO Plus Premier plan, there are several advantages to choosing a dentist who participates in the Dental Plan Network including:

- Negotiated discounts
- No balance billing
- No paperwork

If you enroll in the DeltaCare HMO option, there are no out-of-network benefits. Please visit the Delta Dental website at www.deltadentalky.com and search the DeltaCare network to confirm there are available in-network dentists in your area.

DENTAL PLAN FEATURES	DELTA DENTAL PPO PLUS PREMIER	DELTACARE HMO
	In-Network Dentists: Delta PPO & Delta Premier Non-Network Dentists may balance bill	No Out-of-Network benefits
Calendar Year Deductible (Individual/Family)	$50/$150	None
Calendar Year Maximum	$1,000	None
Preventive Services · Exam (every 6 months) · Cleaning (every 6 months) · X-Rays (every 12 months)	Covered in full	Covered in full
Basic Services (ex. Fillings, Root Canal, Oral Surgery)	Deductible + 20%	Member pays fixed copay based on procedure - see benefit summary Plan
Major Services (ex. Crowns, Bridges, Dentures, Implants)	Deductible + 50% 12 month waiting period for new enrollees	
Orthodontic Services	50% - $1,000 lifetime max benefit Children up to age 19 only 12 month waiting period for new enrollees	Member pays $4,100 for 24 month treatment plan

DENTAL PLAN PREMIUMS - Per Pay Period Cost (24 checks per year)		
	PPO Plus Premier	DeltaCare HMO
Employee Only	$13.58	$6.25
Employee + 1 Dependent	$31.52	$11.93
Employee + 2 or More Dependents	$55.08	$18.84

VISION PLAN: ANTHEM

Anthem Vision Plan

Anthem offers benefits through in-network and out-of network providers. By selecting an in-network provider, you will receive higher benefits and pay less out-of-pocket expenses. Benefits include a complete eye examination, as well as prescription lenses and frames. Or, in lieu of glasses, you can choose contact lenses. The plan also provides discounts for laser vision correction surgery. When you utilize an out-of-network provider, you pay more money out of pocket, and must pay for all services at the time services are rendered. You must also submit a claim for reimbursement. A list of private practice and retail optical providers can be found online at www.anthem.com or by phone at 866-723-0515.

VISION PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Frequency · Eye Exam · Prescription Lenses or Contacts · Frames	 12 months 12 months 12 months	 12 months 12 months 12 months
Eye Exams	$10 copay	Reimbursed up to $42
Standard Prescription Lenses · Single Lenses · Bifocal Lenses · Trifocal Lenses	$10 copay	$40 - $60 allowance based on type
Lens Upgrades	Discounted cost (schedule on summary)	No benefits/discounts
Frames	$150 allowance + 20% discount	$45 allowance
Contact Lenses in Lieu of Glasses	$150 allowance Additional 15% discount on conventional lenses; No added discount on disposable lenses	$105 allowance
Contact Lens Fitting Fee	Standard: Member pays up to $55 Premium: 10% discount off retail	No benefits/discounts

VISION PLAN PREMIUMS	
	Employee Cost per Pay
Employee Only	$3.54
Employee + 1 Dependent	$6.20
Employee + 2 or More Dependents	$9.91

LIFE INSURANCE: SUN LIFE

Basic Group Term Life/AD&D Insurance - Full-time Employees

The Diocese of Lexington provides Employer Paid Life Insurance and Accidental Death & Dismemberment Insurance through Sun Life at no cost to you. Beneficiary information must be provided in Paycor. Full-time eligible lay staff receive a life insurance benefit of $25,000. Accidental Death and Dismemberment matches the $25,000 Life benefit and pays in addition to the Life benefit if you die as a result of a covered accident. AD&D benefits also cover the loss of a limb or your sight due to an accident. Life and AD&D benefits will reduce to $16,250 at age 65 and to $12,500 at age 70.

Voluntary Life Insurance

All employees have the option to purchase additional life insurance through Sun Life.

Voluntary Life Insurance Benefits		
Benefit Amount	**Employee Optional Life Age Reduction Schedule**	**Guarantee Issue Amount (at Initial New Hire Enrollment only)**
Increments of $10,000 from $20,000 to a maximum of $500,000	Benefits reduce starting at age 70	$180,000 Employee $50,000 Spouse
Spouse Benefits		
Increments of $5,000 to a maximum of $250,000 (not to exceed 50% of EE benefit)		
Child Benefits		
$5,000 or $10,000 benefit Children under 14 days have $1,000 benefit		
Annual Enrollment Offer		
For 1/1/2024 enrollment, all employees can increase their voluntary benefit by one $10,000 increment, even if they refused coverage previously, up to the Guarantee Issue amount without proof of good health. If you have current coverage on your spouse you can also increase their benefit by one $5,000 increment, up to the Guarantee Issue amount. Late entrant spouses and increases of more than one increment require proof of good health. If you or your spouse are at the Guarantee Issue amount, you must submit proof of good health and be approved once, and then will be allowed annual one increment increases on a guaranteed basis.		

Sample Per Pay Period Cost for Voluntary Life								
	Under 35	35-39	40-44	45-49	50-54	55-59	60-64	65-69
Employee $100,000	$2.80	$3.90	$5.80	$8.80	$14.45	$27.30	$40.10	$64.60
Spouse $50,000	$1.95	$2.90	$3.83	$5.90	$10.20	$19.03	$27.85	$42.85
Child $10,000	$1.00							

DISABILITY: ONEAMERICA AND SUN LIFE

Voluntary Short-Term Disability - OneAmerica

Short-term disability insurance can provide partial income replacement while you are unable to work due to illness or injury. The plan pays 60% of your base weekly earnings after 14 days of disability, with a maximum benefit period of 11 weeks. The max weekly benefit is $1,500. Coverage is offered through OneAmerica and includes a 3/12 pre-existing condition exclusion. A pre-existing condition is a sickness, illness or pregnancy diagnosed or treated in the 3 months prior to your effective date. The policy will not provide a benefit if a pre-existing condition results in a disability that starts during your first 12 months of coverage.

SPECIAL OFFER FOR OPEN ENROLLMENT 1-1-2024:

Employees not previously declined will have guarantee issue for 1-1-24 into the disability program and will be subject to pre-x provisions of the program.

Voluntary STD is always guarantee issue for new hires applying within 30 days of eligibility. Late entrants to the plan will have to provide proof of good health.

Sample Per Pay Period Cost for Voluntary Short-Term Disability				
Salary	Under 40	40-54	55-59	60+
$25,000 Annual Pay	$9.52	$7.07	$10.24	$12.55
$35,000 Annual Pay	$13.33	$9.89	$14.37	$17.57
$45,000 Annual Pay	$17.13	$12.72	$18.43	$22.59
$55,000 Annual Pay	$20.94	$15.55	$22.53	$27.61
$65,000 Annual Pay	$24.75	$18.38	$26.63	$32.63

Voluntary Long-Term Disability - Sun Life

Long-term disability insurance pays 60% of your base monthly earnings (up to a maximum of $5,000 per month) after 90 days of disability. The maximum benefit period is to Social Security Normal Retirement Age (SSNRA). This insurance is offered through Sun Life. This policy contains a 6/12 pre-existing condition limitation. A pre-existing condition means a sickness or injury for which you received in treatment within 6 months prior to your effective date. The policy will not cover any period of disability which is contributed to, caused by, or results from a pre-existing condition for the first 12 months of coverage.

Voluntary LTD is always guarantee issue for new hires applying within 30 days of eligibility. If you previously refused coverage you will have to provide proof of good health to enroll as a late entrant.

Sample Per Pay Period Cost for Voluntary Long-Term Disability								
Salary	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60+
$25,000 Annual Pay	$1.71	$1.81	$2.39	$3.41	$5.68	$9.08	$11.35	$14.53
$35,000 Annual Pay	$2.39	$2.54	$3.34	$4.77	$7.95	$12.72	$15.90	$20.34
$45,000 Annual Pay	$3.08	$3.26	$4.29	$6.13	$10.22	$16.35	$20.44	$26.16
$55,000 Annual Pay	$3.76	$3.99	$5.25	$7.49	$12.49	$19.98	$24.98	$31.97
$65,000 Annual Pay	$4.44	$4.71	$6.20	$8.86	$14.76	$23.62	$29.52	$37.78

WORKSITE BENEFITS: AFLAC

Critical Illness Insurance

Critical Illness Insurance pays a lump-sum benefit if you are diagnosed with a covered illness or condition as listed below. *Features of Critical Illness Insurance include:*

- **Guarantee Issue Limits for all Eligible Employees:**

Critical Illness	GI Limits
Eligible Employees	$30,000
Spouses	$15,000
Coverage amounts over GI limit require proof of health	

- **Family Coverage:** If you elect coverage on yourself, you can also elect coverage on your family.
- **Wellness benefit:** provides a $50 annual benefit if you complete a health screening test. This benefit is designed to encourage you to maintain a healthy lifestyle as the tests can help screen for a wide range of potential illnesses and diseases.

Critical Illness and Conditions

Critical Illness Insurance provides a benefit for illnesses such as:

- Heart attack
- Stroke
- Major organ failure
- Cancer

Critical Illness Coverage Elections & Maximums

- **You:** Increments of $5,000 to a max of $50,000
- **Your spouse:** Increments of $2,500 to a max of $25,000. Spouse coverage limited to 50% of employee election amount; only exception is if coverage is elected for both employee and spouse at minimum benefit of $5,000.
- **Your child(ren):** Automatically covered at no cost for a benefit amount that is 50% of your coverage amount.

Need to talk to an Aflac representative about coverage options?
Scan this code to schedule an appointment.

Accident Insurance

At some point, you may make an unexpected trip to your local emergency room. And that could add a set of unexpected bills into the mix.

- In the event of a covered accident, the accident insurance plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills.
- The plan pays regardless of whether you have any other insurance coverage.
- Coverage is available for employees, as well as their spouses and dependent children.
- Accident Insurance provides a scheduled benefit for initial treatment and follow-up care related to an accidental injury.

Sample of Covered Benefits:

- Initial Injury Treatment: $150 - $2,000
- Fractures & Dislocations: $240 - $8,000
- Hospital Admission: $1,250
- Physical Therapy & Follow-Up Care: $50 per visit

Accident Insurance	Per Pay Cost
Employee	$7.86
Employee + Spouse	$13.03
Employee + Child(ren)	$17.72
Family	$22.90

Hospital Indemnity Insurance

If you or a covered dependent are hospitalized or need surgery, this policy will pay a lump sum benefit that you can use to pay medical bills or help cover living expenses. Benefits of the Hospital Indemnity Insurance include:

- Hospital Admission - $2,000
- Hospital Confinement - $200 per day
- Inpatient Surgery & Anesthesia - $750
- Outpatient Surgery & Anesthesia - $500

Accident Insurance	Per Pay Cost
Employee	$22.98
Employee + Spouse	$45.20
Employee + Child(ren)	$34.45
Family	$56.67

RETIREMENT PLANS: PENSION AND 403(B)

Nyhart - Employee Pension

Who is eligible?

All employees who work 20+ hours per week and are 21 years of age or older are eligible to participate in our diocesan pension plan. This is a defined retirement benefit plan that allows for full vestment at 5 years of participation.

Contribution Rates	
Employee	3.5% of gross pay (post-tax deduction)
Employer	4.75% of gross pay

If you do not already participate, you have an opportunity to enroll during open enrollment. If you elect to withdraw from participation in the pension program prior to the 5 year vestment period, only the employee share of contributions will be reimbursed with any interest accrued. In withdrawing and electing for the contribution payout, if you participated in the pension plan for over 5 years but less than 10, you will not be allowed to rejoin the plan any time in the future. If you participated in the plan for 10+ years, contributions will be retained to help fund your retirement benefit.

The Standard - 403(B) and Roth 403(B)

Who is eligible?

All employees who work 20+ hours per week may elect to contribute to the Traditional 403(B) and/or Roth 403(B).

2023 Elective Deferral Amounts	
Minimum Contribution	1% of income
Maximum Contribution	$22,500* plus Additional $7,500 catch-up contribution if over age 50

Traditional 403(B):

This is a pre-tax contribution plan that allows for investment options directly from your paycheck. These contributions can be set at a flat rate or percentage based, and will directly apply to your own personal 403(B) account. Investing tools provided by The Standard include, but are not limited to: Automatic Investment Rebalancing, Tax Savings Calculator, Guided Portfolios and Investor Profile Quiz.

- **Advantage:** You are taxed less at time of contribution, as the amount deferred is removed from your gross income, which reduces the amount submitted against income tax.
- **Disadvantage:** Upon drawing from the funds in your 403(B) account, income tax will be applied and reduce the payout benefit by a taxed margin, based on the tax bracket you are in at the time of withdrawal.

Roth 403(B):

This is a post-tax contribution plan that allows for investment options directly from your paycheck. These contributions can be set at a flat rate or percentage based, and will directly apply to your own personal Roth 403(B) account. All the aforementioned investment tools are available with any account The Standard manages.

- **Advantage:** Upon drawing from the funds in your Roth 403(B) account, you will be able to enjoy the entirety of the balance without income tax being applied.
- **Disadvantage:** With your contributions being made post tax, your current take-home pay is reduced in a more significant way, as the deferred amount to be withheld is directly subtracted from your net income each check.

* Contribution limit as of guide print date; IRS expected to announce increases for 2024 to $23,000.

Disclosure Notices

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

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

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

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

CALIFORNIA Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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

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

GEORGIA-Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone:678-564-1162, Press 1GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA-Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA-Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366 Hawki
Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

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

KENTUCKY-Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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

MAINE-Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

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

MINNESOTA-Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

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

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

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

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

NEW JERSEY-Medicaid and CHIP
Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

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

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

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

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

PENNSYLVANIA-Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Page/HIPP-Program.aspx
Phone: 1-800-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)
Phone: 1-800-692-7462

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

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

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

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

UTAH-Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

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

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

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

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

WYOMING-Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Disclosure Notices

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS
If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. However, you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

WOMEN'S HEALTH AND CANCER RIGHTS ACT
On October 21, 1998 Congress passed the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include: Reconstruction of the breast upon which the mastectomy has been performed, Surgery/reconstruction of the other breast to produce a symmetrical appearance, Prostheses, and Physical complications during all stages of mastectomy, including lymphedemas. In addition, the plan may not: interfere with a woman's rights under the plan to avoid these requirements, or offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA PRIVACY NOTICE
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information in your company plan (herein referred to as the "Plan") creates or receives about you.

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013.

As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including "genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI"). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI
Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request.

The minimum necessary standard will not apply in the following situations:
- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to HHS;
- Uses or disclosures that are required by law;
- Uses or disclosures that are required for the Plan's compliance with legal regulations; and
- Uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:
For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.
- The PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- The PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request.

Disclosure Notices

Right to Receive Confidential Communications. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.
- The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of you unsecured PHI.

Your Right to File a Complaint. You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information. If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan.

The information in this Benefit Summary is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Benefit Summary was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Benefit Summary and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Benefit Summary, contact the Benefits Department.

MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE NOTICE
IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Your Employer and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current Employer coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Your Employer coverage, be aware that you and your dependents will be able to get this coverage back.

Disclosure Notices

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Your Employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About Your Options Under Medicare Prescription Drug Coverage. More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE
PART A: GENERAL INFORMATION | FORM APPROVED OMB NO. 1210-0149
When key parts of the health care law took effect in 2014, there became 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 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 for coverage starting as early as January 1.

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 Human Resources. 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.

[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.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS
When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Disclosure Notices

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact 1-800-985-3059 beginning on January 1, 2022.

Visit www.cms.gov/nosurprises for more information about your rights under federal law.

Contacts

DIOCESE OF LEXINGTON

1310 West Main Street
Lexington, KY 40508

Greg Hodge, HR Director
(859) 253-1993 ext. 1013
ghodge@cdlex.org

Dwayne Clouse, HR Benefits Manager
(859) 253-1993 ext. 1011
dclouse@cdlex.org

Kathy Massey, Payroll Manager
(859) 253-1993 ext. 1014
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McGRIFF

(800) 753-4440 toll free
(866) 643-2259 fax

Concierge, Customer Service
(844) 923-2370
concierge@mcgriff.com

Tish Harris, Account Manager
(859) 422-3776
tish.harris@mcgriff.com

Christie LeNoue, Account Executive
(859) 422-3890
clenoue@mcgriff.com

Dave Moughamian, Benefit Consultant
(859) 422-3787
dmoughamian@mcgriff.com

Christian Brothers Services (Medical)

Member Services: (800) 807-0400
www.mycbs.org/health

CuraLinc (EAP)

Customer Service: 888-881-5462
www.supportlinc.com

Delta Dental (Dental)

Customer Service: (800) 955-2030
www.deltadentalky.com

Anthem (Vision)

Member Services: (866) 723-0515
www.anthem.com

Chard Snyder (FSA/HSA)

Customer Service: (800) 982-7715
askpenny@chard-snyder.com
www.chard-snyder.com

Sun Life (Life/LTD)

Customer Service: (800) 247-6875
www.sunlife.com

OneAmerica (STD)

Customer Service: (800) 553-5318
www.oneamerica.com

Aflac (Worksite Benefits)

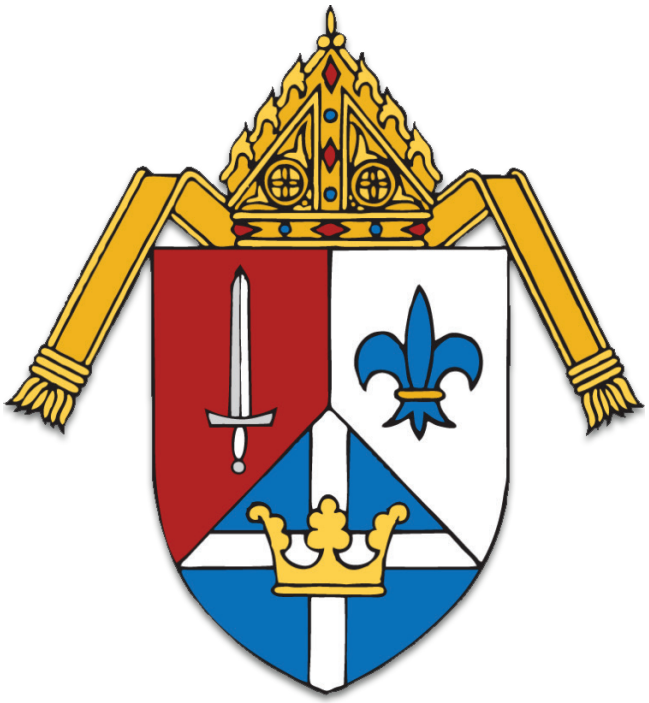
Local Service Contact:
Melanie Ladd (859) 368-0030
melanie_ladd@us.aflac.com
Customer Service (Worksite): (800) 433-3036

Nyhart (Pension Plan)

Customer Service: (800) 428-7106
www.nyhart.com

The Standard (Retirement Plan)

Customer Service: (800) 858-5420
www.standard.com/retirement



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The information in this guide was taken from various summary plan descriptions and benefit information. This summary of benefits is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. Full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail. Carrier contracts are the final benefit determinant. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Benefit Summary, contact HR.