



CATHOLIC DIOCESE
OF LEXINGTON

DIOCESE OF LEXINGTON

Lay Staff Employee Benefits Guide 2026

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.

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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 2026 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 employer life and CuraLinc EAP

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) until 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

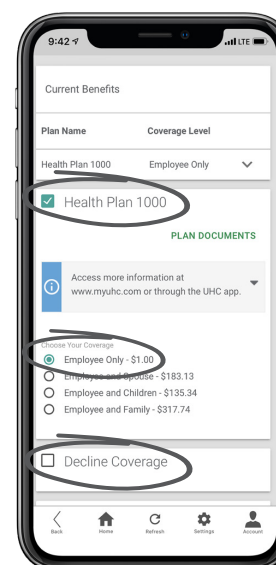
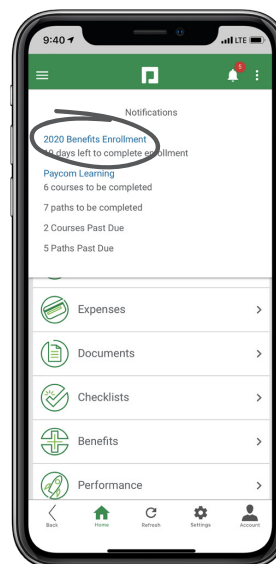
HOW TO ENROLL: PAYCOM

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 an urgent care center if she/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: RETA BLUE SHIELD MEDICAL PLAN

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.blueshieldca.com and searching the Participating Provider Organization [PPO] network. To look up a provider before your enrollment is effective, you can visit the national BCBS Association website at bcbs.com and use the Find a Doctor search tool for the plan type of BlueCard PPO/EPO.

PLAN FEATURES	PPO		EPO		HDHP	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible • Single • Family	\$500 \$1,000		\$1,500 \$3,000	N/A N/A	\$3,000 - only applies to EE Only coverage *\$3,300 (per person) \$6,000 (family maximum)	
Out-of-Pocket Maximum • Single • Family	\$2,000 \$4,000	\$4,000 \$8,000	\$6,000 \$12,000	N/A N/A	\$7,000 \$14,000	
Member Coinsurance	90%/10%	70%/30%	80%/20%	N/A	80%/20%	60%/40%
Doctor's Office Visits • Primary Care • Specialist	\$20 Copay \$35 Copay	Ded + 30% Ded + 30%	\$25 Copay \$40 Copay	Not Covered	Ded + 20% Ded + 20%	Ded + 40% Ded + 40%
Routine Preventive Care • Well-child Care to Age 19 • Well-Woman Care • Routine Mammograms • Routine Adult Physical Exams	Covered in Full	Ded + 30%	Covered in Full	Not Covered	Covered in Full	Ded + 40%
Urgent Care	\$50 Copay		\$75 Copay		Ded + 20%	Ded + 40%
Emergency Care • Facility • Physician	\$100 Copay + 10% 10%, no Ded		\$200 Copay + 20% 20%, no Ded		Ded + 20% Ded + 20%	
Ambulatory Surgery Center	Covered in Full	Ded + 30%	Covered in Full	Not Covered	Ded + 0%	Ded + 40%
Outpatient Hospital Services	Ded + 10%	Ded + 30%	Ded + 20%	Not Covered	Ded + 20%	Ded + 40%
Physician/Surgeon Fees	Ded + 10%	Ded + 30%	Ded + 20%	Not Covered	Ded + 20%	Ded + 40%
Inpatient Hospital Services	Ded + 10%	Ded + 30%	Ded + 20%	Not Covered	Ded + 20%	Ded + 40%
Prescription Drugs Retail 30 day Generic Brand: Preferred Brand: Non-Preferred Brand:	\$10 Copay \$20 Copay \$40 Copay	Not Covered	\$10 Copay \$30 Copay \$50 Copay	Not Covered	Ded, then \$10 Copay Ded, then \$20 Copay Ded, then \$40 Copay	Not Covered
Mail Order 90 day Generic Brand: Preferred Brand: Non-Preferred Brand:	\$20 Copay \$40 Copay \$80 Copay	Not Covered	\$20 Copay \$60 Copay \$100 Copay	Not Covered	Ded, then \$20 Copay Ded, then \$40 Copay Ded, then \$80 Copay	Not Covered
Specialty 30 Day Supply	\$30 Copay	Not Covered	\$50 Copay	Not Covered	Ded, then \$40 Copay	Not Covered

***NOTE:** Per Person deductible under Family coverage will increase by \$100 to \$3,400 effective 7/1/26 due to IRS minimum requirements.

CVS CAREMARK PHARMACY PLAN

CVS 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.

To see what tier your medications are on and if any step therapy or prior authorization is required, go to Caremark.com, log in and on the menu select check drug cost. You must sign in or register. For specialty, contact PrudentRX at 800-578-4403 to enroll and save on your copay for PrudentRX eligible drugs.

If you want to look up current medications before you are enrolled, please click the applicable link on the Rx summary for the medical plan that you are enrolling in, under the Documents section in Paycom.

All plans include coverage in full with no deductible or copay for preventive medications under the Affordable Care Act. Includes tobacco Cessation drugs, and generic to moderate intensity statins (medications for high cholesterol)

The HDHP also includes an expanded Preventive Drug List. Medications on this list are not subject to your deductible and are covered in full. This includes many drugs to treat high blood pressure, diabetes, Asthma and more.

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 CVS 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	EPO	HDHP
Employee Only	\$0.00	\$0.00	\$0.00
Employee + 1 Dependent	\$457.71	\$402.78	\$390.37
Employee + 2 or More Dependents	\$470.85	\$414.35	\$402.41

EMPLOYEES WORKING 26 - 29 HOURS PER WEEK

PER PAY PERIOD COST (24 CHECKS PER YEAR)

	PPO	EPO	HDHP
Employee Only	\$135.56	\$119.59	\$106.29
Employee + 1 Dependent	\$593.22	\$522.03	\$509.94
Employee + 2 or More Dependents	\$606.36	\$533.59	\$521.99

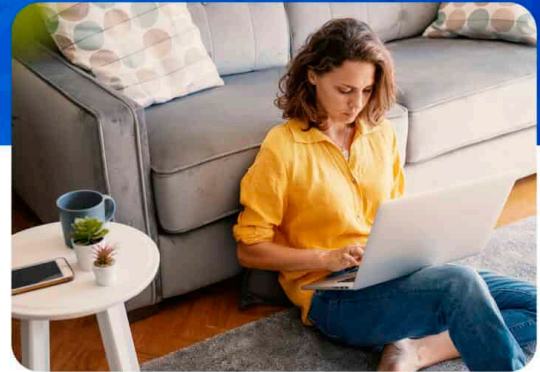
EMPLOYEES WORKING 20 - 25 HOURS PER WEEK

PER PAY PERIOD COST (24 CHECKS PER YEAR)

	PPO	EPO	HDHP
Employee Only	\$180.74	\$159.45	\$141.72
Employee + 1 Dependent	\$638.39	\$561.78	\$549.80
Employee + 2 or More Dependents	\$651.53	\$573.34	\$561.84

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

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 when you call for assistance.



Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.



Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.



Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.



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

- Create a personal profile to quickly access support from a licensed clinician
- Complete the short Mental Health Navigator assessment and instantly receive personalized guidance to access care and support
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos



Explore Mindstream™

A fitness studio for your mind with on-demand sessions to help you strengthen your life skills and emotional health. Engage with sessions anytime and anywhere.



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 <u>Allowed</u> with HSA	Insurance/Accounts <u>Not Allowed</u> with HSA
Accident Disability Dental Vision Long Term Care Specified Disease or Illness <u>Limited</u> 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	2026 Contribution Maximum
Employee	\$4,400
Employee + 1 Dependent or Employee + Family	\$8,750
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

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
- Vision Care Expenses (including LASIK & Contact Lens Solution)
- Annual maximum contribution \$3,400
- 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 1/1/26-12/31/26. You have until 3/31/27 to file claims for 2026 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.

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 \$3,400, 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/vision expenses without touching HSA savings.

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 \$7,500 (\$3,750 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 1/1/26-12-31/26. You have until 3/31/2027 to file claims for 2026 service dates; any money left in account at that time is forfeited.

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 + PREMIER LOW PLAN	DELTA DENTAL PPO + PREMIER HIGH PLAN	DELTACARE HMO
	In-Network Dentists: Delta PPO & Delta Premier Non-Network Dentists may balance bill	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	\$50/\$150	None
Calendar Year Maximum	\$1,500	\$2,000	None
Preventive Services • Exam (every 6 months) • Cleaning (every 6 months) • X-Rays (every 12 months)	Covered in full	Covered in full	Covered in full
Basic Services (ex. Fillings, Root Canal, Oral Surgery)	Deductible + 20%	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	Deductible + 20% 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	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 + Premier Low Plan	PPO + Premier High Plan	DeltaCare HMO
Employee Only	\$13.58	\$17.83	\$6.25
Employee + 1 Dependent	\$31.52	\$41.39	\$11.93
Employee + 2 or More Dependents	\$55.08	\$72.32	\$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 <ul style="list-style-type: none"> · 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 <ul style="list-style-type: none"> · 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 1/1/2025 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+
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.

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 STD is Guarantee Issue for 1/1/25				
Salary	Under 40	40-54	55-64	65+
\$25,000 Annual Pay	\$9.52	\$7.07	\$10.24	\$12.55
\$35,000 Annual Pay	\$13.33	\$9.89	\$14.34	\$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	\$1.58	\$1.68	\$2.21	\$3.16	\$5.27	\$8.43	\$10.53	\$13.48
\$35,000 Annual Pay	\$2.22	\$2.35	\$3.09	\$4.42	\$7.38	\$11.80	\$14.74	\$18.87
\$45,000 Annual Pay	\$2.85	\$3.02	\$3.98	\$5.68	\$9.49	\$15.17	\$18.96	\$26.16
\$55,000 Annual Pay	\$3.48	\$3.69	\$4.86	\$6.94	\$11.60	\$18.54	\$24.98	\$29.65
\$65,000 Annual Pay	\$4.12	\$4.36	\$5.74	\$8.21	\$13.70	\$21.91	\$27.38	\$35.05

WORKSITE BENEFITS: AFLAC

(IMPORTANT- These are fixed indemnity policies, NOT health insurance)

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
- Major organ failure
- Stroke
- 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.
- **Annual Enrollment Offer:** Current enrollees & Late entrants can increase self and spouse by one \$5,000 increment.



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).

2025 Elective Deferral Amounts	
Minimum Contribution	1% of income
Maximum Contribution	\$23,500* 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 2026 to \$24,500 with \$8,000 catch-up.

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

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

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

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

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

<p>ALABAMA – Medicaid</p> <p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p>KENTUCKY – Medicaid</p> <p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kyconnect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>
<p>ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>LOUISIANA – Medicaid</p> <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p>OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
<p>ALASKA – Medicaid</p> <p>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</p>	<p>MAINE – Medicaid</p> <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>OREGON – Medicaid and CHIP</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
<p>CALIFORNIA – Medicaid</p> <p>Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov</p>	<p>MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>PENNSYLVANIA – Medicaid and CHIP</p> <p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>
<p>COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>	<p>MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov</p>	<p>RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
<p>FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>	<p>MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspreassistance@accenture.com</p>	<p>SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>
<p>GEORGIA – Medicaid</p> <p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>SOUTH DAKOTA – Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p>INDIANA – Medicaid</p> <p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>	<p>MONTANA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>	<p>TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>
<p>IOWA – Medicaid and CHIP (Hawki)</p> <p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (Iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>	<p>UTAH – Medicaid and CHIP</p> <p>Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/</p>
<p>KANSAS – Medicaid</p> <p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>	<p>NEW HAMPSHIRE – Medicaid</p> <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>	<p>VERMONT – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>
	<p>NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>VIRGINIA – Medicaid and CHIP</p> <p>Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p>
	<p>NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>	<p>WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>
	<p>NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>	<p>WEST VIRGINIA – Medicaid and CHIP</p> <p>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)</p>
		<p>WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>
		<p>WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

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

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

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

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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 NOTICES

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.

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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

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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.

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 to 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.

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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.

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).

When Can You Join A Medicare Drug Plan? You can join a Medicare drug plan when you become eligible for Medicare and each year from October 15 to December 7. However, if you decide to drop your current coverage with Your Employer, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Your Employer.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? Since the coverage under Your Employer, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base benefit 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 benefit premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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. [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] 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.

For More Information About This Notice Or Your Current Prescription Drug Coverage. Contact the Your Employer Benefit Department. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Your Employer changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Looking for comprehensive health insurance?

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

Questions about this policy?

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

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HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

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

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.¹²

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

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace? You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact 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](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

CONTACTS

DIOCESE OF LEXINGTON

1310 West Main Street
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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
kmassey@cdlex.org

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

RETA (Medical)

Member Services: 888-772-1076
www.blueshieldca.com

CVS Caremark Pharmacy

Customer Service: 844-214-6463
www.cvshealth.com

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)

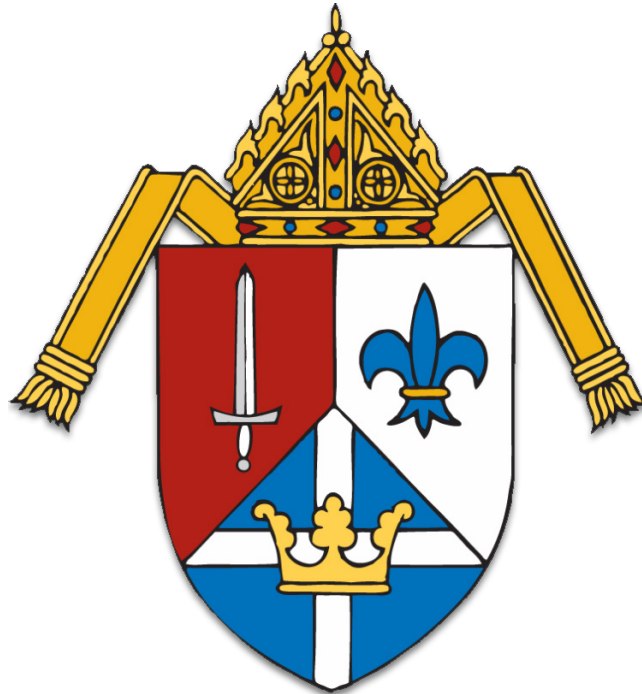
Local Service Contact:

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



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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.