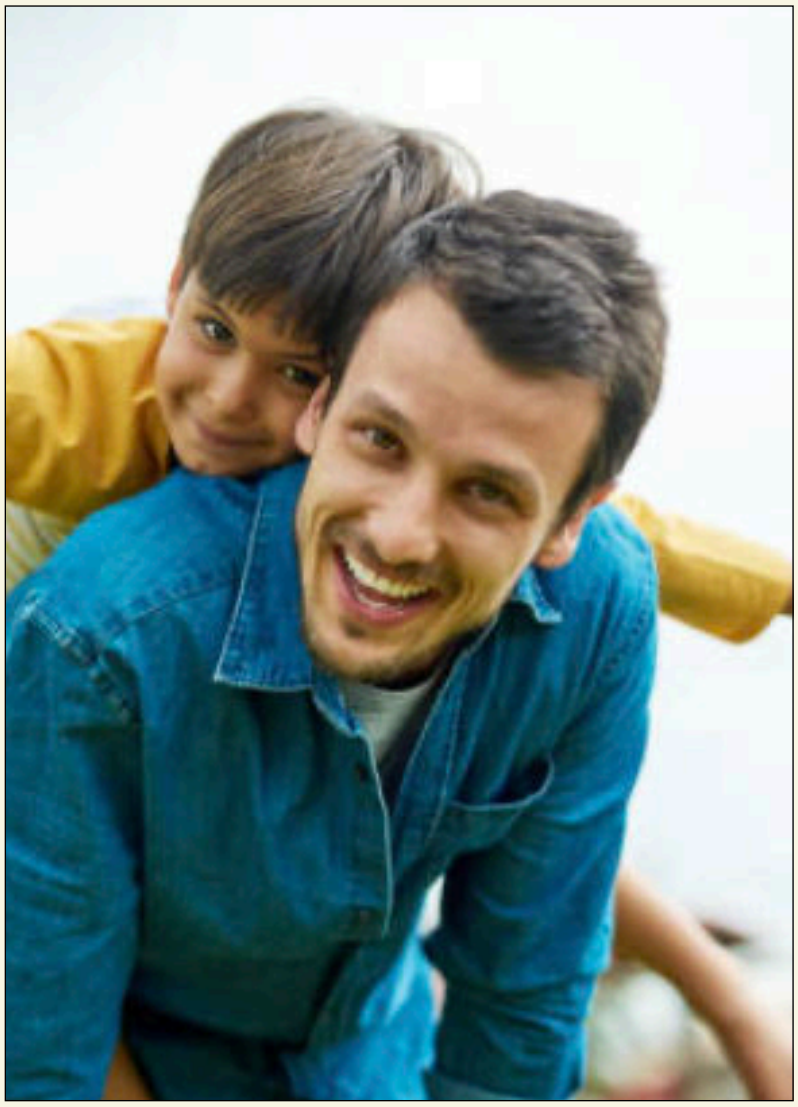
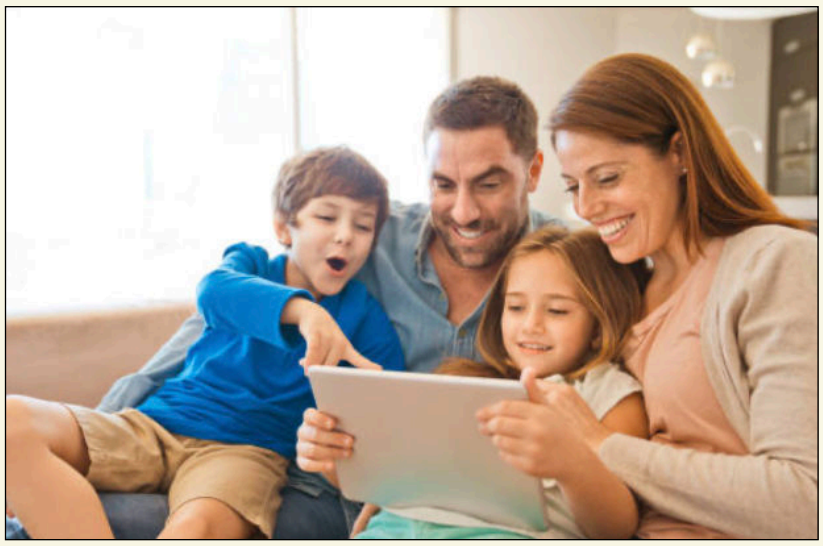
Diocese of
OWENSBORO

2023/2024 Employee Benefits Guide

Medical | Dental | Vision | Life | Disability | Supplemental | Retirement

Your guide to Employee Benefits provided to you and your family as a Full-Time Employee at Diocese of Owensboro





2023/2024 Employee Benefits Guide

Diocese of OWENSBORO

Diocese of Owensboro offers a comprehensive benefits package, designed to meet the needs of Employees and their eligible family members. This guide has been created to help you become familiar with the various benefit options available, as well as how to enroll. The following summaries are designed to help you understand your benefit coverages; they are not intended to be a complete reference tool in regards to Plan coverage. If the benefit guide differs from the Summary Plan Description/Plan Documents, the Summary Plan Description/Plan Documents supersede the guide.

Benefit Eligibility

When are Employees eligible to enroll?

All benefits are effective on the first day of the month following the active date of hire. In order to complete timely issuance of insurance cards, Employees will have 31 days to complete Benefit Enrollment once he/she begins employment.

Benefit Eligibility

The Diocese offers full-time employees working 20 hours or more per week the following benefits: Medical / Rx / Dental, Basic Term Life Insurance, Long Term Disability, Accidental Death and Dismemberment (AD&D), Retirement Benefits, Voluntary Life, Voluntary Vision, Voluntary Dental, Short-Term Disability Insurance, Flexible Spending Account (FSA), Cancer, Accident, Critical Care Insurance and a 403(B) Retirement Savings Plan.

A full-time employee is eligible for Medical / Rx / Dental coverage, Long Term Disability, Life Insurance, AD&D, Voluntary Life, Short-Term Disability, Voluntary vision benefits, FSA , Cancer, Accident and Critical Care Insurance on the first day of the month following the date of hire. Full-time employees are eligible for all retirement benefits on the first day worked with the Diocese.

New Employee - Open Enrollment

As a new employee working for the Diocese of Owensboro, your open enrollment period is the first 31 days of your employment. Although you have 31 days to submit your paperwork to your parish or employer, it is best to submit your enrollment form prior to the date of coverage to ensure there are no problems with your coverage. During the open enrollment period you may enroll in Medical / Rx / Dental, FSA, Voluntary Life, Voluntary Short-Term Disability, Voluntary Vision, Voluntary Dental, Cancer, Accident and Critical Care. You must enroll during the first 31 days of your employment to receive these benefits. If you chose not to enroll during the first 31 days you must wait until next Diocesan Open Enrollment Period or unless you have a “Qualifying Event” which allows you to enroll as a Special Enrollee.

When can I change my elections/coverage?

Changes to your benefit elections can be made throughout the year if preceded by a Qualifying Event. The following events “qualify” for a change in coverage:

- Marriage
- Divorce or Legal Seperation
- Loss of Health Care Coverage
- Birth or Placement for adoption of a child
- Death in the Family
- Ineligibility of a dependent
- Termination/Status change of employment of you or your spouse
- A court order
- Entitlement to Medicare or Medicaid
- Open enrollment on the Insurance Market Exchange

Preventive Care Covered at 100%

Take advantage of your preventive care benefits - routine physical exams, mammograms, prostate screening, annual PAP tests, and immunizations for your children, blood pressure and cholesterol readings are covered at 100% by the plan.

Medical Benefits

Anthem

Diocese of Owensboro is pleased to offer you and your family two plan options. The medical benefit plan is administered by Anthem Blue Cross Blue Shield. The prescription drug benefit is administered by TrueScripts. Below is a brief benefits summary, for more plan detail, please refer to the Summary Benefit of Coverage.

	Low Deductible Option		High Deductible Option	
Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible	$1,000 - Single $3,000 - Family	$2,000 - Single $4,000 - Family	$3,500 - Single $7,000 - Family	$7,000 - Single $14,000 - Family
Out-of-Pocket Maximum	$3,250 - Single $9,750 - Family	$6,600 - Single $19,500 - Family	$6,500 - Single $13,000 - Family	$13,000 - Single $26,000 - Family
Coinsurance	80% - Plan 20% - Member	60% - Plan 40% - Member	70% - Plan 30% - Member	50% - Plan 50% - Member
Emergency Room	20% Coinsurance	20% Coinsurance	30% Coinsurance After Deductible	30% Coinsurance After Deductible
Urgent Care & Retail Health Clinics	$20 Copay	40% Coinsurance After Deductible	30% Coinsurance After Deductible	50% Coinsurance After Deductible
Imaging *(CT, PET, MRI)*	20% Coinsurance After Deductible	40% Coinsurance After Deductible	30% Coinsurance After Deductible	50% Coinsurance After Deductible
Office Visit (PCP / Specialist)	$20 / $20 Copay	40% Coinsurance After Deductible	30% Coinsurance After Deductible	50% Coinsurance After Deductible
Preventive Services	Covered at 100%	40% Coinsurance After Deductible	Covered at 100%	50% Coinsurance After Deductible
TrueScripts	**Your Pharmacy Benefit Manager (PBM), TrueScripts, offers various programs to assist Employees and their eligible dependents when it comes to their prescription medication needs. Below is a summary of the various programs TrueScripts offers. For details regarding available programs please contact TrueScripts or a member of HR.**			
Retail 30-Day Co-Pays: Tier 1 Generic Tier 2 Preferred Tier 3 Non-Preferred	$15 Copay $25 Copay $45 Copay		$15 Copay $30 Copay $55 Copay	
Retail 90-Day Co-Pays: Tier 1 Generic Tier 2 Preferred Tier 3 Non-Preferred	$30 Copay $50 Copay $90 Copay		$30 Copay $60 Copay $110 Copay	
Rx Manage International Rx Program	Rx Manage offers an individual, voluntary, international prescription drug program that allows participants to receive eligible brand-name medications for $0 Co-pay. **Visit www.rxmanage.com for details and enrollment.**			
Monthly Premium Contributions	**Low Deductible Option**		**High Deductible Option**	
Employee **Family**	$350.00 $950.00		$103.00 $600.00	

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Diocese of OWENSBORO

Flexible Spending Account (FSA)

Anthem

Flexible Spending Account (FSA) - An account that allows you to save tax-free dollars for qualified medical expenses that are not reimbursed. FSA dollars can be used to pay for out-of-pocket medical expenses incurred during the plan year. Medical expenses covered under this account include insurance co-pays and deductibles, prescription drugs, diabetic supplies, eyeglasses, podiatry services, dental services, and more. You determine how much you want to contribute to the FSA at the beginning of the plan year. The plan year runs from January through December.

The maximum contribution allowed is $208.33 per Month or $2,500 annually with $610 max rollover. Any amount above the max rollover limit will be forfeited. Employees who leave employment with the Diocese, may submit FSA claims 90 days after termination for eligible expenses occurring prior to termination.

Dental Benefits

Anthem PARAMOUNT DENTAL

Owensboro Diocese offers two dental plans: Anthem Dental and Paramount Dental. If you are covered under the medical plan then you will automatically be enrolled into the Anthem Dental Plan at no extra cost out of your paycheck. If you are not covered on the medical plan and would like to enroll in a dental plan you have the option of choosing Paramount Dental on a voluntary basis. You can still enroll in Paramount Dental even if you are covered under the Anthem Dental plan as well. Below is a summary of both dental plan options.

Anthem — Provided with Medical Coverage

Benefits	Coverage
Deductible	$50 - Single $150 - Family
Annual Benefit	$1,000 per member
Preventive Services *(Includes 2 cleanings per year)*	100% paid by plan
Basic Services	80% plan / 20% member
Major Services	50% plan / 50% member
Orthodontics	50% plan / 50% member
Orthodontic Lifetime Benefit	$2,000

PARAMOUNT DENTAL — Additional Voluntary Coverage

Benefits	Coverage
Deductible	No Deductible
Annual Benefit	$1,000 per member
Preventive Services *(Includes 2 cleanings per year)*	100% paid by plan
Basic Services	80% plan / 20% member
Major Services	50% plan / 50% member
Orthodontics	50% plan / 50% member
Orthodontic Lifetime Benefit	$2,000

Tiers of Coverage	Monthly Premium Contributions
Employee Only	$28.24
Employee + Spouse	$59.31
Employee + Child(ren)	$74.07
Family	$104.23

Vision Benefits

PARAMOUNT DENTAL

Vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. *For more plan detail refer to the benefit summary.*

Benefits	In-Network Coverage
Annual Exam *(12 months)*	$10 Copay
Contact Lenses *(12 months)*	$150 Allowance 15% off amount over allowance
Contact Lense Fitting and Exam	$40 Co-Pay
Lenses *(12 months)*	$25 Co-Pay
Frames *(24 months)*	$150 Allowance 20% off amount over allowance

Tiers of Coverage	Premium Contributions
Employee Only	$6.49
Employee + Spouse	$12.97
Employee + Child(ren)	$13.61
Family	$18.93

* Dependent Age Limit: To the end of the month which the child turns 26

Life Insurance

Mutual of Omaha

Group Life Insurance

Life insurance can help provide for your loved ones if something were to happen to you. Diocese of Owensboro provides all Full-Time Employees with 150% of an Employees annual salary. For example $10,000 annual salary, the benefit would be $15,000. The principal sum is reduced by 35% at age 65 and reduced by 50% at age 70.

Voluntary Life Insurance

In addition to the life insurance provided through Diocese of Owensboro, some Employees may want to purchase additional coverage. The schedule below outlines the voluntary coverage amounts available:

Voluntary Life	Employee	Spouse	Children
Coverage Amount	Up to 5 times salary not to exceed $500,000	Up to 100% of Employee's coverage amount not to exceed $500,000	Increments of $2,000 not to exceed $10,000
Guarantee-Issue Amount	Up to $180,000	Up to $25,000	Up to $10,000
Coverage Increments	$10,000	$5,000	$2,000

Disability Insurance

Mutual of Omaha

The financial consequences of not being able to work due to a disabling accident or sickness can be devastating. Diocese of Owensboro certainly recognizes the risk and provides a voluntary short term disability for Employees. Long term disability is provided at no cost to all eligible Employees. *For more plan detail refer to the benefit summary.*

Voluntary Short Term Disability

Benefits	Coverage
Eligibility	Active Employee working a minimum of 20 hours per week
Elimination Period	14 Days
Benefit Percentage	60% ($1,000 Weekly Maximum)
Benefit Duration	Up to 11 Weeks

Employer Paid Long Term Disability

Benefits	Coverage
Eligibility	Active Employee working a minimum of 20 hours per week
Elimination Period	90 Days
Benefit Percentage	Up to 60% ($5,000 Maximum)
Benefit Duration	Less than age 62: SSNRA Age 62: 60 Months

Retirement

Christian Brothers Services

Defined Benefit Retirement Plan

Employer Contribution - The Employer contributes 8.39% of an employee's gross pay to the Christian Brothers Retirement. Benefit ceases on the effective date in which the employee is no longer employed with the Diocese.

Vesting - The vesting period is 4 years and 9 months.

Statements - Annually in the Fall, employees will receive a copy of their statement of retirement benefits.

403(b) Pre-Tax Savings Plan

Employee Contribution - The Employee can save up to the IRS imposed 403 (B) limits. The limit for 2024 is $23,000. Anyone over the age of 50 can make a catch-up contribution of $7,500 in 2024.

Employees are eligible on the first day hired and can enroll in the plan on 01/01, 04/01, 07/01 and 10/01. Money is invested with Fidelity and employees direct their investments.

Employee Assistance Program (EAP)

Mutual of Omaha

Full-Time Employees that work 20 hours or more per week have access to an Employee Assistance Program (EAP) thru Mutual of Omaha. The program provides three calls per year (per household) with our in-house Master's level EAP professional, who will provide community resources. Services are available to both employees and eligible dependents. 24/7/365 access @ 800-316-2796.

Supplemental Insurance

Colonial Life

Owensboro Diocese offers voluntary worksite benefits through Colonial. These benefits provide you with supplemental income due to unforeseen circumstances related to an out of pocket medical expense whether expected or unexpected. **Meet with Colonial Benefits Counselor for rates and additional benefit information.**

Cancer — Cancer insurance pays benefits to help pay for some of the direct medical and indirect non-medical costs related to cancer diagnosis and treatment. Most plans offer options to help you protect your spouse or children, as well.

Critical Illness — Critical illness insurance offers you a lump-sum benefit when you are initially diagnosed with a serious condition. Most plans offer family options to help protect your spouse or children, as well.

Accident — When an unexpected injury happens, accident insurance can help offset costs that are not covered by your medical plan.

Helpful Contact Information

Houchens Insurance Group	**Houchens Insurance Group Customer Service** Leslie Dukate, Account Manager 270-793-0367 ldukate@higusa.com
Anthem	**Anthem BCBS Customer Service** (Medical / Dental) Medical - 833-578-4443; Dental - 844-729-1565 www.anthem.com
Anthem	**Anthem BCBS Customer Service** (FSA) www.anthem.com
TrueScripts	**TrueScripts Customer Service** (Pharmacy Coverage) 844-257-1955; www.truescripts.com
RxManage	**Rx Manage International Pharmacy Customer Service** (International Pharmacy) 800-883-8841; www.rxmanage.com
Paramount Dental	**Paramount Dental Customer Service** (Dental) 800-727-1444; www.insuringsmiles.com
Paramount Dental	**Paramount Vision Customer Service** (Vision) 800-727-1444; www.eyemed.com
Mutual of Omaha	**Mutual of Omaha Customer Service** (Life & Disability) 800-228-7104; www.mutualofomaha.com EAP - 800-316-2796; www.mutualofomaha.com/EAP
Colonial Life	**Colonial Life Customer Service** (Supplemental) 866-215-2413; www.coloniallife.com

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: ROMAN CATHOLIC DIOCESE OF OWENSBORO: Anthem Blue Access PPO Low Deductible Plan Your Network: Blue Access

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works.*	$1,000 person / $3,000 family	$2,000 person / $4,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$3,250 person / $9,750family	$6,500 person / $19,500 family
Preventive care/screening/immunization	No charge	40% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Specialist Care Visit	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-Natal Care *In-Network preventative prenatal services are covered at 100%. All office visits copayments count toward the same visit limit.*	$20 copay per pregnancy for the 1st visit deductible does not apply then 10% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Live Health On-line Visit	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	20% coinsurance after deductible is met	30% coinsurance after deductible is met
Chemo/Radiation Therapy	$20 copay per visit deductible does not apply	30% coinsurance after deductible is met
Dialysis/Hemodialysis	$20 copay per visit deductible does not apply	30% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office *Office cost share applies only when Freestanding/ Reference Labs are not used*	No charge	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab	No charge	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
X-Ray:		
Office	No charge	40% coinsurance after deductible is met
Freestanding Lab/Reference Lab *Office Cost Share applies only when Freestanding/ Reference Labs are not used*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Radiology Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting) *When Allergy injections are billed separately by network providers, the member is responsible for a $5 copay. When billed as part of an office visit, there is no additional cost to the member for the injection.*	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Urgent care(Facility Setting)		
Urgent Care: Facility fees	No Charge	40% coinsurance after deductible is met
Urgent Care: Doctor and other services	No Charge	40% coinsurance after deductible is met
Emergency Room Facility Services *Copay waived if admitted.*	20% coinsurance deductible does not apply	Covered as In-Network
Emergency Room Doctor and Other Services	20% coinsurance deductible does not apply	Covered as In-Network
Ambulance (Air, Ground, and Water) *Medically Necessary*	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Facility visit:		
Facility Fees	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor Services	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Freestanding Surgical Center	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs is limited to 60 days combined per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	40% coinsurance after deductible is met
Doctor and other services	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met
Outpatient Hospital *Limit is combined for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across*	No Charge	40% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Pulmonary rehabilitation		
Office *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	$20 copay per visit deductible does not apply	40% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Hospice	No charge	No charge
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to both the individual deductible and individual out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- Dependent age: to end of the year in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, geriatrics, or any other Network provider as allowed by the plan.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips are paid the same as any other drug.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- All medical deductibles and coinsurance apply toward the out-of-pocket maximum (excluding Non-Network Human Organ and Tissue Transplant (HOTT) Services).
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, geriatrics, or any other Network provider as allowed by the plan.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

Your summary of benefits

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4443

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على 578-4443 (833) .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4443:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4443。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4443 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4443.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 578-4443.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 578-4443.

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It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Your summary of benefits

Anthem® BlueCross and BlueShield

Your Plan: ROMAN CATHOLIC DIOCESE OF OWENSBORO: Anthem Blue Access PPO High Deductible Plan Your Network: Blue Access

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works.*	$3,500 person / $7,000 family	$7,000 person / $14,000 family
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$6,500 person / $13,000 family	$13,000 person / $26,000 family
Preventive care/screening/immunization	No charge	50% coinsurance after deductible is met
Doctor Home and Office Services		
Primary Care Visit to treat an injury or illness	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Specialist Care Visit	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Prenatal and Post-Natal Care	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Other Practitioner Visits:		
Retail Health Clinic	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Live Health On-line Visit	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Manipulation Therapy *Coverage is limited to 12 visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met	40% coinsurance after deductible is met
Other Services in an Office:		
Allergy Testing	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prescription Drugs *For the drugs itself dispensed in the office through infusion/injection.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Diagnostic Services		
Lab:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Lab/Reference Lab	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray:		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Advanced Diagnostic Imaging (for example, MRI/PET/CAT scans):		
Office	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Radiology Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Urgent Care (Office Setting)	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Urgent care(Facility Setting)		
Urgent Care: Facility fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Urgent Care: Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Emergency Room Facility Services	30% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services	30% coinsurance after deductible is met	Covered as In-Network
Ambulance (Air, Ground, and Water) *Medically Necessary*	30% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor Office Visit	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Facility visit:		
Facility Fees	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor Services	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Surgery		
Facility Fees:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Doctor and Other Services:		
Hospital	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Freestanding Surgical Center	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospital Stay (all inpatient stays including Maternity, Mental / Behavioral Health, and Substance Abuse)		
Facility fees (for example, room & board) *Coverage for Inpatient Rehabilitation is limited to 60 days per benefit period. Limit is combined In-Network and Non-Network.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Human Organ and Tissue Transplants *Acquisition and transplant procedures, collection and storage. Kidney and Cornea are treated the same as any other illness and subject to the medical benefits.*	No charge	50% coinsurance after deductible is met
Doctor and other services	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Recovery & Rehabilitation		
Home Health Care *Coverage is limited to 90 visits per benefit period. Limit is combined In-Network and Non-Network.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage for rehabilitative and habilitative services. Coverage for Occupational Therapy is limited to 20 visits per benefit period, Physical Therapy is limited to 20 visits per benefit period and Speech Therapy is limited to 20 visits per benefit period. Limit is combined for In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation		
Office *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Outpatient Hospital *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Pulmonary rehabilitation		
Office *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital *Coverage is limited to unlimited visits per benefit period. Limit is combined In-Network and Non-Network. Limit is combined across professional visits and outpatient facilities.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (in a facility) *Coverage is limited to 90 days per benefit period. Limit is combined In-Network and Non-Network.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Hospice	No charge	No charge
Durable Medical Equipment	30% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices *Coverage for wigs needed after cancer treatment is limited to 1 item per benefit period. Limit is combined In-Network and Non-Network.*	30% coinsurance after deductible is met	50% coinsurance after deductible is met

Your summary of benefits

Notes:

- The family deductible and out-of-pocket maximum are non-embedded meaning the cost shares of all family members apply to one shared family deductible and one shared family out-of-pocket maximum. The individual deductible and individual out-of-pocket maximum only apply to individuals enrolled under single coverage.
- Network and Non-network copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.
- Dependent age: to end of the year in which the child attains age 26.
- No charge means no deductible/copayment/coinsurance up to the maximum allowable amount. 0% means no coinsurance up to the maximum allowable amount. However, when choosing a Non-network provider, the member is responsible for any balance due after the plan payment.
- Certain diabetic and asthmatic supplies are available at Network pharmacies, diabetic test strips are paid the same as any other drug.
- Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.
- Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits are covered.
- Members are encouraged to always obtain prior approval when using non-network providers. Precertification will help the member know if the services are considered not medically necessary.
- Hospital stay for Maternity Coverage will not be limited to less than 48 hours for a vaginal delivery or 96 hours for a caesarean section.
- If office visit is a coinsurance, the coinsurance also applies to allergy injections.
- PCP is a Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, geriatrics, or any other Network provider as allowed by the plan.
- If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an office visit or outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician office visit.

Your summary of benefits

Questions: (833) 578-4443 or visit us at www.anthem.com

KY/LG/ROMAN CATHOLIC DIOCESE OF OWENSBORO: Blue Access PPO Core Plan/3PUP/09-01-2023

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (833) 578-4443

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 578-4443 .

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 578-4443:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 578-4443。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 578-4443 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 578-4443.

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Welcome, Catholic Diocese of Owensboro, to TrueScripts!

As your prescription benefit management company, we work with you and Catholic Diocese of Owensboro as a team to achieve the best possible value from your prescription benefit plan. We strive to provide cost-effective solutions without interfering with the quality of your healthcare. Here are some key points to keep in mind effective 9/1/2023**:**

1. You will be receiving ***new insurance ID cards*** from Anthem with the TrueScripts pharmacy billing information. It is imperative that you present this card to your pharmacy when filling prescriptions on or after 9/1/2023; this includes refills. We also suggest telling the pharmacy staff you have switched to TrueScripts – this will minimize any confusion and delays in filling your prescription.

2. ***90-day supply prescriptions*** can conveniently be filled at any retail pharmacy or filled through our mail order provider listed on the attached form. A new prescription will be needed from your healthcare provider for 90-day fills at the pharmacy or mail order. Since your provider should be able to call this into your pharmacy of choice, an office visit typically will not be required.

3. If you have a ***Prior Authorization*** in place for a medication or taking a ***Specialty Medication,*** please contact our Member Care staff prior to 9/1/2023 to prevent disruption at the pharmacy. If you are not sure if a prior authorization is in place for any of your current medications, please contact us and we will verify if one is required.

4. The TrueScripts Member Portal gives you 24/7 access to your plan information, claims history, and other tools and resources that will help you save money and get the most out of your prescription benefits. To register please visit memberportal.truescripts.com.

Our friendly Member Care staff is available to address any concerns discreetly and with a professional attitude. Please contact us toll free Monday-Friday 8:00 a.m. – 6:00 p.m. EST at (844) 257-1955 with any questions. Again, welcome to TrueScripts. We look forward to a long and successful partnership with you!

Your Account Management Team,

Lisa Walker	*Autumn Strawn*	*Lauren Gaines*
Lisa M. Walker Director of Account Management	Autumn Strawn Account Executive	Lauren Gaines Account Manager

In case you need to fill a prescription and have not received your new ID card from Anthem, please contact TrueScripts Member Care at (844) 257-1955 or your pharmacy can contact the pharmacy help desk at (855) 326-2159.

International Sourcing

Brand-name medications are overly expensive in the US. Fortunately, arrangements such as international sourcing through companies like RxManage allow members to order eligible medications from outside the US at a much lower cost.

About RxManage and International Sourcing:

RxManage sources medications from licensed pharmacies in Canada, United Kingdom, New Zealand, and Australia. These countries are classed as Tier One countries (designated by the US Congress) for pharmaceutical supply. All prescription drugs are from Good Manufacturing Practices-certified manufacturing plants.

Medications are brand name medications in original sealed manufacturer's packaging. The medication you receive through this program will be exactly the same as what you currently take.

How much will I pay?

RxManage offers a $0 copay on over 250 brand name medications. You will receive a 90-day supply of medication mailed directly to your home.

How do I get started?

Ordering is easy! You can place your first order online at rxmanage.com, or by phone at 1-800-883-8841. The RxManage call center is open 9am - 9pm Monday to Friday (EST) and 9am - 4pm Saturday and Sunday to answer simple questions or take your orders.
Alternatively, you can get started by emailing inquiries@rxmanage.com.

Important Note: Have a 30-day supply on hand before placing your first order for each medication. You will receive your first order 10-15 working days after the order has shipped.

SUMMARY OF BENEFITS

The Summary of Benefits is a summary of the Deductibles, Coinsurance and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section of this Certificate for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate including any attachments or riders.

Coverage Year	Calendar Year - A 12-month period starting January 1
Dependent Age Limit	To the end of the calendar year in which the child attains age 26.
Benefit Waiting Period	There are no benefit waiting periods.

DENTAL BENEFIT MAXIMUMS

Dental Benefit Maximums (combined for Participating and Non-Participating Dentists)

Coverage Year Maximum. Your combined benefits, excluding orthodontics, are subject to the Coverage Year Maximum. We will not pay any benefit in excess of that amount during a Coverage Year.

Coverage Year Maximum $1000.00 per Member

Orthodontic Services Lifetime Maximum. Your orthodontic benefits are subject to the Orthodontic Services Lifetime Maximum. We will not pay any orthodontic benefits in excess of that amount during a Member's lifetime.

Orthodontic Services Lifetime Maximum $2000.00 per Member

Accidental Dental Injury Benefit. No member coinsurance, and/or deductible, or waiting period will apply to services received as a result of an Accident. Accidental Dental Injury benefits are subject to the Coverage Year Maximum. An Accident is defined as an injury that results in physical damage or injury to sound natural teeth and/or the supporting hard and soft tissues as a result of extraoral blunt forces and not due to chewing or biting forces. Sound natural teeth are those that were in good repair prior to the accident and were stable, in functional occlusion, free from decay, fracture and advanced periodontal disease at the time of the accident. The initial claim for the Accident and all claims related to the Accident must be submitted within 12 months following the date of the Accident.

DEDUCTIBLES

Deductible (combined for Participating and Non-Participating Dentist)

Participating Dentist	
Per Member	$ 50.00
Per Family	$150.00
Non-Participating Dentist	
Per Member	$ 50.00
Per Family	$150.00

Exception: The Deductible does not apply to Diagnostic and Preventive Services and Orthodontic Services.

Deductible. You are responsible for satisfying the Deductible before We pay for benefits. If 3 family Members satisfy their individual Deductible, the family Deductible will be met. Only charges that are considered a Maximum Allowed Amount will apply toward satisfaction of the Deductibles. For the Participating Dentist Deductible, only the Maximum Allowed Amount for the services of a Participating Dentist will be applied. For the Non-Participating Dentist Deductible, only the Maximum Allowed Amount for the services of a Non-Participating Dentist will be applied.

Dental Covered Services

After you have satisfied the Deductible, We will pay benefits for Covered Services at the percentage or applicable amount up to the Maximum Allowed Amount for each completed Dental Service. The Maximum Allowed Amount payable for each Dental Procedure is determined by Anthem, and there may be different levels of reimbursement for the Maximum Allowed Amount depending upon whether you elect to receive services from a Participating or a Non-Participating Dentist.

	Participating Dentist	Non-Participating Dentist
Diagnostic and Preventive Services*	100%	100%
Basic Restorative Services	80%	80%
Endodontic Services	80%	80%
Periodontal Services	80%	80%
Oral Surgery Services	80%	80%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Orthodontic Services*	50%	50%

*(Not subject to the Deductible)

PARAMOUNT DENTAL

Affiliate of ProMedica

Product Summary Guide for Roman Catholic Diocese of Owensboro

100/80/50 (DHO 7)

Your rates:

Employee Only:	$28.24
Employee + Spouse:	$59.31
Employee + Child(ren):	$74.07
Employee + Family:	$104.23

Plan Annual Maximum Benefit:	**$1,000**	
Diagnostic & Preventive	**In Network**	**Out of Network***
Exams – periodic, limited, comprehensive	Covered at 100%	Covered at 100%
Radiographs – full mouth series, panoramic, bitewings	Covered at 100%	Covered at 100%
Fluoride	Covered at 100%	Covered at 100%
Routine teeth cleaning	Covered at 100%	Covered at 100%
Sealants	Covered at 100%	Covered at 100%
Restorative & Prosthodontics		
Fillings - silver or white (anterior and posterior teeth)	Covered at 80%	Covered at 80%
Protective restorations	Covered at 80%	Covered at 80%
Core build ups	Covered at 50%	Covered at 50%
Crowns – porcelain, ceramic, stainless steel	Covered at 50%	Covered at 50%
Removable dentures	Covered at 50%	Covered at 50%
Endodontics & Periodontics		
Root canal therapy – anterior, posterior	Covered at 80%	Covered at 80%
Root canal therapy – retreatment	Covered at 80%	Covered at 80%
Scaling and root planing	Covered at 80%	Covered at 80%
Full mouth debridement	Covered at 80%	Covered at 80%
Periodontal maintenance	Covered at 80%	Covered at 80%
Oral Surgery		
Simple extractions	Covered at 80%	Covered at 80%
Impactions	Covered at 80%	Covered at 80%
Surgical extractions	Covered at 80%	Covered at 80%
Miscellaneous		
Emergency palliative treatment	Covered at 100%	Covered at 100%
Anesthesia – general and IV sedation	Covered at 80%	Covered at 80%
Athletic mouthguards	Covered at 50%	Covered at 50%
Deductible (Not applicable on Diagnostic & Preventive):	**None**	**None**
Lifetime Orthodontic Benefit (Child Only):	**$2,000**	

Procedures listed herein are payable up to the lifetime maximum benefit, not to exceed the maximum monthly installment. To receive maximum benefit, the patient must be in active orthodontic treatment a minimum of two years while covered by the Plan. Once an individual has exhausted his/her lifetime maximum benefit under any Plan, additional charges will be excluded.

Limited Orthodontic Treatment

Interceptive Orthodontic Treatment

Comprehensive Orthodontic Treatment

Treatment to Control Harmful Habits

*In-network dentists have agreed to accept discounts on covered dental services which allows for your benefit dollars to go further. Whereas out-of-network dentists are under no obligation to accept contracted fees. If there is a difference between the allowed reimbursement and the amount the dentist charges for the service, you are responsible for this difference. Therefore, your coinsurance may vary from the figures outlined above.

Your Employer will sponsor your plan and select your individual annual maximum dollar level, of which the benefit accumulation period is the Plan year. Your employer will also collect your portion of the premiums via payroll deduction and define eligibility requirements. You may not add, drop or change coverage during each contract period unless a qualifying event occurs. If a statement in this summary conflicts with a statement in the Certificate, the terms of the Certificate will control. All plans are issued subject to certain exclusions, limitations and restrictions such as frequency and age limitations. These exclusions, limitations and restrictions, and a listing of all covered services by ADA code, are described in your Certificate, which is available on our website or by calling 800-727-1444.

To find a dentist visit: InsuringSmiles.com/FindADentist

Explore a new vision with us

Thanks for giving EyeMed the opportunity to provide a vision benefits quote. As America's fastest growing vision benefits company,[1] we're looking forward to providing you with the results other groups have already seen - with us, more employees enroll, more employees visit in-network providers and more employees use their benefits.[3]

THE VISION NETWORK EMPLOYEES WANT

98% of members choose an in-network provider[2]

America's largest vision network[5]

The right mix of providers to match consumer preferences

Favorite national retail chains like LensCrafters, Pearle Vision and Target Optical, plus a wide selection of regional retailers, such as America's Best, Shopko, MyEyeDr. and more

Several in-network options for buying online:

- Glasses.com
- ContactsDirect.com
- LensCrafters.com
- TargetOptical.com
- Ray-Ban.com

Eye care and eyewear directly to you at your facility with our Pop-Up Clinics*

BENEFITS THAT REDEFINE EXPECTATIONS

96% of members are satisfied with their benefits[4]

The flexibility to **design a benefits package that fits your employees**

The **freedom to choose any ophthalmic frame, lens or contact lens** without frame towers, formularies or restrictions

Up to $50 savings on non-prescription sunglasses at Sunglass Hut

Members-only savings on eyewear, LASIK, hearing aids and more on our Member Web

Emergency eyewear, access to providers and 24/7 support for vision care problems outside the U.S.

ABOVE ALL ELSE, WE MAKE BENEFITS EASY

100% of clients say we're easy to work with[4]

Open enrollment and communication support to make sure employees understand their benefits

Welcome Kit with ID cards for all enrolled employees

User-friendly resources like our Enhanced Provider Search, EyeMed Members App, new customized text alerts and cost transparency tools

Award-winning service available 7 days a week, with hours aligned to provider office hours

100% implementation satisfaction for the past 11 years[4]

[1] Internal analysis of EyeMed membership data compared to data from leading vision benefit companies, as reported in publicly available information. [2] EyeMed internal book of business data, 2018 [3] EyeMed analysis of new business that transferred over from a prior benefits company, 2017. [4] EyeMed external satisfaction surveys, conducted by Walker and Convergys, 2018. [5] Based on the EyeMed Insight network, October 2018.

*Not available for all groups or all group sizes.

Offer more of what's best–
Contact your EyeMed rep or visit **starthere.eyemed.com**

S-1903-CB-428

Health Resources, Inc.

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option EE Paid 150/150 PK

Exam & Materials

Insight Network

Fully Insured

Employee Paid

Funded Benefits

Frequency

Examination
Once every plan year

Lenses (in lieu of contacts)
Once every plan year

Contacts (in lieu of lenses)
Once every plan year

Frame
Once every other plan year

Vision Care Services	Member Cost In-Network	Out of Network Member Reimbursement
Exam		
With Dilation as Necessary	$10 copay	Up to $40
Frames		
Any available frame at provider location	$0 copay; $150 allowance, 20% off balance over allowance	Up to $105
Contact Lenses		
(Contact Lens allowance includes materials only)		
Conventional	$0 copay; 15% off balance over $150 allowance	Up to $105
Disposable	$0 copay; plus balance over $150 allowance	Up to $105
Medically Necessary	$0 copay; Paid-In-Full	Up to $210
Standard Plastic Lenses		
Single	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Standard Progressive	$80 copay	Up to $50
Premium Progressive Tier 1	$110 copay	Up to $50
Premium Progressive Tier 2	$120 copay	Up to $50
Premium Progressive Tier 3	$135 copay	Up to $50
Premium Progressive Tier 4	$200 copay	Up to $50
Covered Lens Options		
Anti Reflective Coating - Standard	$45 copay	Up to $5
Anti Reflective Coating - Premium Tier 1	$57 copay	Up to $5
Anti Reflective Coating - Premium Tier 2	$68 copay	Up to $5
Anti Reflective Coating - Premium Tier 3	$85 copay	Up to $5
Polycarbonate - Standard - under 19	$0 copay	Up to $5

Monthly Rates	
Subscriber	$6.49
Subscriber + Spouse	$12.97
Subscriber + Child(ren)	$13.61
Subscriber + Family	$18.93

All plans are based on a -month contract term and 48-month rate guarantee.
Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies.
EyeMed Vision Care reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers.

Plan Details

Quote for group situated in the State of IN and will be valid until the 01/01/2020 implementation date. Date Quoted 04/17/2019. Benefit allowances provide no remaining balance for future use within the same benefit frequency. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Percentage discounts are not part of the insurance benefit. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. Fidelity Security Life Policy number VC-19/VC-20, form number M-9083.

Plan Exclusions

No benefits will be paid for services or materials connected with or changes arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing. Aniseikonic lenses. Medical and/or surgical treatment of the eye, eyes or supporting structures. Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment. Safety eyewear. Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof. Plano (non-prescription) lenses. Non-prescription sunglasses. Two pair of glasses in lieu of bifocals. Services or materials provided by any other group benefit plan providing vision care. Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and services rendered to the Insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Health Resources, Inc.

Saving our members some extra green

We're committed to keeping money in our members' pockets.
That's why we offer our members additional discounts above the proposed plan benefits.

$avings for Members

40% off

additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

20% off

any item not covered by the plan, including non-prescription sunglasses

Lasik

Lasik or PRK from US Laser Network
15% off retail price or 5% off promotional price

Hearing Care

Amplifon Hearing Health Care Network
40% off hearing exams and a low price guarantee on discounted hearing aids

Additional Discounts

Vision Care Services	Member Cost In-Network
Discounted Exam Services	
Retinal Imaging	Up to $39
Contact Lens Fit and Follow-up	
(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)	
Fit and follow-up - Standard	$40
Fit and follow-up - Premium	10% off retail price
Discounted Lens Options	
Polycarbonate - Standard	$40
Scratch Coating - Standard Plastic	$15
Photochromic Plastic	$75
Tint - Solid or Gradient	$15
UV Treatment	$15
Other Add-on Services and Materials	20% off retail price

Discount Details
Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses.
Plan discounts cannot be combined with any other discounts or promotional offers.
In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.
Discounts on vision materials may not be applicable to certain manufacturers' products
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.
Service and amounts listed above are subject to change at any time

Summary of Benefits

Critical Illness $10,000 Plan

With Skin Cancer benefit

Anthem

Critical Illness coverage provides the added layer of security you want and need when illness occurs— a lump-sum cash benefit to help pay for unexpected costs. You decide how to use the benefits to best support recovery for yourself or a family member. Use your critical illness coverage to help pay for out-of-pocket medical costs, such as for prescriptions, hospital bills, X-rays or daily expenses like rent, food or transportation.

Key features:

- Cash benefit is paid directly to you in a lump-sum, tax-free payment.
- $50 payment towards health screenings, such as a lipid panel or fasting glucose test. .
- You can take your coverage with you even if you leave your employer.[1]

Convenience

We are here to help. To file a claim, start with the claim form provided by your employer. Follow the instructions on the form to submit and contact the phone number listed on that form with any questions about your benefits or about how to file a claim.

Note: Critical Illness benefits for covered spouse and dependents are 50% of the amount shown below, except for Health Screening, which is $50 for any covered member, and Skin Cancer, which is $250 for any covered member.

	Benefit	Amount
Cancer	Invasive cancer	$10,000
	Non-invasive cancer	$2,500
	Benign brain tumor	$10,000
Vascular	Heart transplant	$10,000
	Heart attack (myocardial infarction)	$10,000
	Stroke	$10,000
	Coronary artery by-pass surgery	$2,500
Other Specified Illness	Coma	$10,000
	Paralysis	$10,000
	Major organ transplant	$10,000
	End-stage renal disease	$10,000
	Loss of hearing	$10,000
	Loss of speech	$10,000
	Loss of vision	$10,000
Neurological	Advanced Parkinson's disease	$10,000
	Advanced Alzheimer's disease	$10,000
	Amyotrophic Lateral sclerosis	$10,000
	Advanced Multiple Sclerosis	$10,000
		5
	Health screening benefit: per member, per calendar year	$50
	Skin Cancer benefit, per member, once per lifetime	$250
Recurrence benefits	Recurrence waiting period	12 months
	Invasive cancer	50% of previously covered benefit
	Benign brain tumor	50% of previously covered benefit
	Heart transplant	50% of previously covered benefit
	Heart attack (myocardial infarction)	50% of previously covered benefit
	Stroke	50% of previously covered benefit
	Coma	50% of previously covered benefit
	Major organ transplant	50% of previously covered benefit
Other Key Features	Additional occurrence of multiple conditions	Covered with 30-day separation period if both conditions are vascular or both are cancer. Otherwise, covered with no separation period.
	Lifetime benefit maximum — employee	$250,000
	Lifetime benefit maximum — spouse & children	$125,000

United of Omaha Life Insurance Company
A Mutual of Omaha Company

Term Life Insurance

FOR EMPLOYEES OF ROMAN CATHOLIC DIOCESE OF OWENSBORO

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Life Insurance Benefit Amount	For You: An amount equal to 1.5 times your annual salary, but in no event less than $0 or more than $150,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	75% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $112,500.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag - Coma - Repatriation - Common Carrier - Paralysis
Portability	Allows you to continue this insurance program should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
Conversion	If your employment or class membership ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Employee Assistance Program (EAP)	Mutual of Omaha's team of master's level EAP professionals are available 24/7/365 to provide you and your loved ones resources for assistance with personal and workplace issues. Access to EAP services is obtained by calling 1-800-316-2796 or by using an online submission form for employee convenience at www.mutualofomaha.com/eap. Online are valuable resources and links for additional assistance, including current events, family and relationships, emotional well-being, financial wellness, substance abuse and addiction, legal assistance and work and career.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability).

Guarantee Issue is available to new hires only. For new hires, coverage amounts over the Guarantee Issue Amount will require a health application/evidence of insurability. For late entrants, all coverage amounts will require a health application/evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 50%
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Term Life Insurance

FOR EMPLOYEES OF ROMAN CATHOLIC DIOCESE OF OWENSBORO

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or child(ren) to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

COVERAGE GUIDELINES			
	Minimum	**Guarantee Issue**	**Maximum**
For You	$10,000	5 times annual salary, up to $180,000	$500,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $25,000	100% of employee's benefit, in increments of $5,000, up to $250,000
Child(ren)	$2,000 Six months and older is the amount elected 14 days to less than six months is $1,000 Less than 14 days is $1,000	$10,000	100% of employee's benefit, in increments of $2,000, up to $10,000

Subject to any reductions shown below. Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

BENEFITS	
Life Insurance Benefit Amount	Within the coverage guidelines defined above, you select the amount of life insurance coverage you want. This plan includes the option to select coverage for your spouse and dependent child(ren). Child(ren) include those 14 days old up to age 26. In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
FEATURES	
Living Care/ Accelerated Death Benefit	75% of the amount of the life insurance benefit is available to you and your spouse if terminally ill, not to exceed $375,000.
Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you have the ability to increase your coverage at your next enrollment by up to $20,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).
Portability	Allows you to continue this insurance program for yourself and your dependents should you leave your employer for any reason, without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.

Conversion	If your employment or class membership ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 50%

Spouse coverage terminates when you reach age 75.

Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

Please contact your employer if you have questions prior to enrolling.

Voluntary Term Life Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Life section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want. For example, if you want $150,000 in coverage, you obtain your premium amount by multiplying the rate for $50,000 times 3.

EMPLOYEE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 24	$0.23	$0.46	$0.69	$0.92	$1.15	$1.38	$1.61	$1.84	$2.07	$2.30
25 - 29	$0.27	$0.54	$0.81	$1.08	$1.35	$1.62	$1.89	$2.16	$2.43	$2.70
30 - 34	$0.37	$0.74	$1.11	$1.48	$1.85	$2.22	$2.59	$2.96	$3.33	$3.70
35 - 39	$0.57	$1.14	$1.71	$2.28	$2.85	$3.42	$3.99	$4.56	$5.13	$5.70
40 - 44	$0.84	$1.68	$2.52	$3.36	$4.20	$5.04	$5.88	$6.72	$7.56	$8.40
45 - 49	$1.34	$2.68	$4.02	$5.36	$6.70	$8.04	$9.38	$10.72	$12.06	$13.40
50 - 54	$2.08	$4.16	$6.24	$8.32	$10.40	$12.48	$14.56	$16.64	$18.72	$20.80
55 - 59	$3.14	$6.28	$9.42	$12.56	$15.70	$18.84	$21.98	$25.12	$28.26	$31.40
60 - 64	$4.69	$9.38	$14.07	$18.76	$23.45	$28.14	$32.83	$37.52	$42.21	$46.90
65 - 69	$7.90	$15.80	$23.70	$31.60	$39.50	$47.40	$55.30	$63.20	$71.10	$79.00
70 - 74	$14.04	$28.08	$42.12	$56.16	$70.20	$84.24	$98.28	$112.32	$126.36	$140.40
75+	$20.58	$41.16	$61.74	$82.32	$102.90	$123.48	$144.06	$164.64	$185.22	$205.80

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse and/or child(ren) coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

SPOUSE PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 24	$0.25	$0.50	$0.75	$1.00	$1.25	$1.50	$1.75	$2.00	$2.25	$2.50
25 - 29	$0.30	$0.60	$0.90	$1.20	$1.50	$1.80	$2.10	$2.40	$2.70	$3.00
30 - 34	$0.40	$0.80	$1.20	$1.60	$2.00	$2.40	$2.80	$3.20	$3.60	$4.00
35 - 39	$0.46	$0.92	$1.38	$1.84	$2.30	$2.76	$3.22	$3.68	$4.14	$4.60
40 - 44	$0.64	$1.28	$1.92	$2.56	$3.20	$3.84	$4.48	$5.12	$5.76	$6.40
45 - 49	$1.00	$2.00	$3.00	$4.00	$5.00	$6.00	$7.00	$8.00	$9.00	$10.00
50 - 54	$1.58	$3.16	$4.74	$6.32	$7.90	$9.48	$11.06	$12.64	$14.22	$15.80
55 - 59	$2.46	$4.92	$7.38	$9.84	$12.30	$14.76	$17.22	$19.68	$22.14	$24.60
60 - 64	$4.33	$8.66	$12.99	$17.32	$21.65	$25.98	$30.31	$34.64	$38.97	$43.30
65 - 69	$7.66	$15.32	$22.98	$30.64	$38.30	$45.96	$53.62	$61.28	$68.94	$76.60
70 - 74	$13.57	$27.14	$40.71	$54.28	$67.85	$81.42	$94.99	$108.56	$122.13	$135.70

ALL CHILDREN PREMIUM TABLE (12 PAYROLL DEDUCTIONS PER YEAR)*

$2,000	$4,000	$6,000	$8,000	$10,000
$0.51	$1.02	$1.53	$2.04	$2.55

*Regardless of how many children you have, they are included in the "All Children" premium amounts listed in the table above.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital/care facility) and any child(ren) must be under age 26.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability).

Guarantee Issue is available to new hires only. For new hires, coverage amounts over the Guarantee Issue Amount will require a health application/evidence of insurability. For late entrants, all coverage amounts will require a health application/evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you or your insured spouse may have the right to continue this insurance under the Portability or Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 50%
- Spouse coverage terminates when you reach age 75.
- Life insurance benefits will not be paid if the insured's death is the result of suicide within two years from the date coverage begins. If this occurs, the sum of the premiums paid will be returned to the beneficiary. The same applies for any future increases in coverage under this plan.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

Voluntary Short-Term Disability Insurance

FOR EMPLOYEES OF ROMAN CATHOLIC DIOCESE OF OWENSBORO

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by you.
BENEFITS	
Elimination Period	If you become disabled, there is an elimination period before benefits are payable. Your benefits begin: • On the 15th day of your disabling injury. • On the 15th day of your disabling illness.
Weekly Benefit	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources. The premium for your short-term disability coverage is waived while you are receiving benefits.
Maximum Benefit Period	Up to 11 weeks
Maximum Weekly Benefit	$1,000
Minimum Weekly Benefit	$25
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits, which will help supplement your income until you are able to return to work full-time.
DEFINITIONS	
Definition of Disability	Disability and disabled mean that because of an injury or illness, a significant change in your mental or functional abilities has occurred, for which you are prevented from performing at least one of the material duties of your regular job and are unable to generate current earnings which exceed 99% of your weekly earnings from your regular job. You can be totally or partially disabled during the elimination period.
Definition of Weekly Earnings	Weekly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 52. Weekly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per week during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, weekly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 10%.
Reasonable Accommodation	Provides a benefit to the employer to assist in covering costs incurred to make workplace modifications for you to return to work.

SERVICES	
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

VOLUNTARY SHORT-TERM DISABILITY PREMIUM CALCULATION

Use the rates in the Age/Premium Factor Table to calculate your premium for voluntary short-term disability coverage in the worksheet below, using the example as a guide.

MONTHLY PREMIUM CALCULATION		EXAMPLE *(42-year-old employee earning $40,000 a year)*
List your weekly earnings (Maximum is $1,666.67)	$_____	$ *769.23*
Multiply by the premium factor	_____	*0.0385800*
Your Estimated Monthly Premium**	$_____	$ *29.68*

**This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

AGE	PREMIUM FACTOR
< 25	0.0487200
25 - 29	0.0642000
30 - 34	0.0587400
35 - 39	0.0442800
40 - 44	0.0385800
45 - 49	0.0395400
50 - 54	0.0450000
55 - 59	0.0567600
60 - 64	0.0679800
65+	0.0822000

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

No, your STD insurance only provides benefits for off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/6 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 6 months of coverage, would not be covered.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results from elective or cosmetic surgery or procedure, or resulting complications, unless such surgery or procedure is medically necessary for the appropriate diagnosis and treatment of your injury or illness
  - Arises out of or in the course of employment with the policyholder for benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, or attempted suicide
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a failed drug test
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

United of Omaha Life Insurance Company
A Mutual of Omaha Company

Long-Term Disability Insurance

FOR EMPLOYEES OF ROMAN CATHOLIC DIOCESE OF OWENSBORO

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 20 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
BENEFITS	
Elimination Period	Your benefits begin on the later of 90 calendar days after the onset of your disabling injury or illness or the date your short-term disability ends.
Monthly Benefit	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources. The premium for your long-term disability coverage is waived while you are receiving benefits.
Maximum Monthly Benefit	$5,000
Minimum Monthly Benefit	$100
Maximum Benefit Period	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Partial Disability Benefits	If you become disabled and can work part-time (but not full-time), you may be eligible for partial disability benefits. Additional benefits for child care expenses for eligible dependent children are also available while receiving partial disability benefits.
DEFINITIONS	
Own Occupation	2 Years
Own Occupation Earnings Test	99%
Definition of Monthly Earnings	Monthly earnings for salaried employees is the gross annual salary in effect immediately prior to the date disability begins, divided by 12. Monthly earnings for hourly employees is the hourly rate of pay multiplied by the average number of hours worked per month during the 6 month period immediately prior to the date disability begins. If employed for part of the prior 6 month period, monthly earnings is the hourly rate of pay multiplied by the average number of hours worked.
FEATURES	
Vocational Rehabilitation Benefit	If you become disabled and participate in the vocational rehabilitation program, you will be eligible for a monthly benefit increase of 10%.
Survivor Benefit	If you pass away while receiving disability benefits, a lump sum equal to 3 times your monthly benefit will be paid to your eligible survivor.
Reasonable Accommodation	Provides a benefit to the employer to assist in covering costs incurred to make workplace modifications for you to return to work.

SERVICES	
Employee Assistance Program (EAP)	Mutual of Omaha's team of master's level EAP professionals are available 24/7/365 to provide you and your loved ones resources for assistance with personal and workplace issues. Access to EAP services is obtained by calling 1-800-316-2796 or by using an online submission form for employee convenience at www.mutualofomaha.com/eap. Online are valuable resources and links for additional assistance, including current events, family and relationships, emotional well-being, financial wellness, substance abuse and addiction, legal assistance and work and career.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 20 hours per week.

How long will my benefits be paid?

Benefits begin after the end of the elimination period and can be payable up to the maximum benefit period as long as you remain disabled.

Will my benefits be reduced by other sources of income?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, other group disability plans, paid family leave, salary continuance/sick leave, settlements on payments received and no-fault benefits.

Does this plan cover me if I become disabled due to an injury at work?

Yes, your LTD insurance provides benefits for both on-the-job and off-the-job coverage for disabilities due to injury or sickness.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Disabilities related to alcohol and drug abuse are only payable for up to 24 months while insured under the policy.
- Disabilities related to mental disorders are only payable for up to 24 months while insured under the policy.
- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/6/12 which means any condition that you receive medical attention for in the 3 months of coverage, would not be covered. The condition would be covered if there is a 6 month treatment free period within the first 12 months of coverage.
- Benefits are not payable for any disability or loss that:
  - Results from an act of declared or undeclared war or armed aggression
  - Results from participation in a riot or commission of or attempt to commit a felony
  - Results from elective or cosmetic surgery or procedure, or resulting complications, unless such surgery or procedure is medically necessary for the appropriate diagnosis and treatment of your injury or illness
  - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, or attempted suicide
  - Results from alcohol and drug abuse and/or substance abuse, except as noted above
  - Results from a mental disorder, except as noted above
  - Is caused by alcohol and drug abuse and/or substance abuse, while not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction
  - Occurs while incarcerated or imprisoned for any period exceeding 31 days
  - Is solely a result of a failed drug test
  - Is solely a result of a loss of a professional license, occupation license or certification

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

Roman Catholic Diocese of Owensboro

Offers

COLONIAL LIFE & ACCIDENT VOLUNTARY BENEFITS

Rates illustrated for Monthly pay periods

Full Time Assistance with Claims! Call 866-215-2413 and speak to a real person!!!

Grp ACCIDENT PLAN 4000 Preferred: Guarantee Issue – no health questions!

Provides benefits to help with your out of pocket expenses when faced with medical bills related to covered accidents on and off the job such as cuts, broken bones, dislocations and burns. It is great for kids in sports or adults with active lifestyles. A **$50** annual screening benefit is also paid for tests such as mammograms, pap smears, cholesterol and blood sugar. See brochure for details! brochure 101862-KY -- wellness brochure 101865-KY

Employee	Employee + Spouse	Employee + Children	Family
$ 14.83	$ 24.08	$25.89	$ 35.14

CANCER ASSIST: Offers protection for your financial security and quality of life if you experience the battle of cancer. This plan provides benefits for expenses not covered by most major medical plans. Experimental treatments, stem cell transplant, transportation expenses, hotel expenses and family care expenses are a few of those not covered by most major medical plans. The plan also provides a **$100** wellness benefit for each covered family member to have one screening per year. The screenings can be either pap smear, psa, mammogram etc. Refer to the brochure for details on eligible screenings.

Base Plan Prices Shown:

	Single	Employee + Spouse	Employee + Children	Family
Level 1 Brochure 101482	$**18.10/**month	$**28.60/**month	$**18.25/**month	$**28.75/**month
Level 2 Brochure 101483	$**21.65/**month	$**33.85/**month	$**21.95/**month	$**34.15/**month
Level 3 Brochure 101484	$**26.65/**month	$**44.40/**month	$**27.10/**month	$**44.85/**month
Level 4 Brochure 101485	$**35.60/**month	$**59.40/**month	$**36.20/**month	$**60.00/**month

Optional Riders not included; ask your representative for details. Wellness brochure101486 - Specified Disease brochure 101547 - $1,000 Initial Diagnosis brochure 78443 Progressive Payment brochure 78453

Diocese of Owensboro

Offers

COLONIAL LIFE & ACCIDENT VOLUNTARY BENEFITS

<u>Group CRITICAL Care 6000 Plan 1 with Progressive Diseases benefit!</u> Guarantee Issue for initial enrollment up to $35,000– health questions waived!

This plan provides a lump sum, tax-free benefit of **up to $75,000** for financial peace of mind if you or a covered dependent have a diagnosis of heart attack, stroke, major organ failure, coma, blindness, occupational infectious HIV/Hepatitis B, C, or D, permanent paralysis due to covered accident or end stage renal failure. A **$50** annual screening benefit is also paid for tests such as mammograms, pap smears, cholesterol and blood sugar along with additional benefits for progressive diseases! See brochure for details! brochure 385403EX -- wellness brochure 387307 -- Progressive Disease option brochure 387594

Note: Spouse and child coverage is 50% of employee coverage.

Non-Tob	$10,000	Employee	Emp+Spse	Emp+Chldn	Fam
Issue	17-24	$4.22	$6.40	$4.22	$6.40
Age	25-29	$4.92	$7.40	$4.92	$7.40
	30-34	$6.12	$9.20	$6.12	$9.20
	35-39	$8.22	$12.20	$8.22	$12.20
	40-44	$10.42	$15.60	$10.42	$15.60
	45-49	$13.52	$20.70	$13.52	$20.70
	50-54	$17.12	$26.50	$17.12	$26.50
	55-59	$20.82	$32.10	$20.82	$32.10
	60-64	$26.12	$40.40	$26.12	$40.40
	65-69	$28.32	$43.70	$28.32	$43.70
	70-74	$33.72	$52.10	$33.72	$52.10

Tobacco	$10,000	Employee	Emp+Spse	Emp+Chldn	Fam
Issue	17-24	$5.42	$8.10	$5.42	$8.10
Age	25-29	$6.72	$10.00	$6.72	$10.00
	30-34	$8.92	$13.20	$8.92	$13.20
	35-39	$12.52	$18.70	$12.52	$18.70
	40-44	$16.52	$24.70	$16.52	$24.70
	45-49	$22.22	$33.90	$22.22	$33.90
	50-54	$28.62	$44.30	$28.62	$44.30
	55-59	$35.22	$54.50	$35.22	$54.50
	60-64	$44.92	$69.30	$44.92	$69.30
	65-69	$48.72	$75.20	$48.72	$75.20
	70-74	$58.52	$90.40	$58.52	$90.40

Non-Tob	$20,000	Employee	Emp+Spse	Emp+Chldn	Fam
	17-24	$6.12	$9.20	$6.12	$9.20
	25-29	$7.52	$11.20	$7.52	$11.20
	30-34	$9.92	$14.80	$9.92	$14.80
	35-39	$14.12	$20.80	$14.12	$20.80
	40-44	$18.52	$27.60	$18.52	$27.60
	45-49	$24.72	$37.80	$24.72	$37.80
	50-54	$31.92	$49.40	$31.92	$49.40
	55-59	$39.32	$60.60	$39.32	$60.60
	60-64	$49.92	$77.20	$49.92	$77.20
	65-69	$54.32	$83.80	$54.32	$83.80
	70-74	$65.12	$100.60	$65.12	$100.60

Tobacco	$20,000	Employee	Emp+Spse	Emp+Chldn	Fam
	17-24	$8.52	$12.60	$8.52	$12.60
	25-29	$11.12	$16.40	$11.12	$16.40
	30-34	$15.52	$22.80	$15.52	$22.80
	35-39	$22.72	$33.80	$22.72	$33.80
	40-44	$30.72	$45.80	$30.72	$45.80
	45-49	$42.12	$64.20	$42.12	$64.20
	50-54	$54.92	$85.00	$54.92	$85.00
	55-59	$68.12	$105.40	$68.12	$105.40
	60-64	$87.52	$135.00	$87.52	$135.00
	65-69	$95.12	$146.80	$95.12	$146.80
	70-74	$114.72	$177.20	$114.72	$177.20

Roman Catholic Diocese of Owensboro

Offers

COLONIAL LIFE & ACCIDENT VOLUNTARY BENEFITS

Rates illustrated for 24 pay periods

Full Time Assistance with Claims! Call 866-215-2413 and speak to a real person!!!

Grp ACCIDENT PLAN 4000 Preferred: Guarantee Issue – no health questions!

Provides benefits to help with your out of pocket expenses when faced with medical bills related to covered accidents on and off the job such as cuts, broken bones, dislocations and burns. It is great for kids in sports or adults with active lifestyles. A **$50** annual screening benefit is also paid for tests such as mammograms, pap smears, cholesterol and blood sugar. See brochure for details! brochure 101862-KY -- wellness brochure 101865-KY

Employee	Employee + Spouse	Employee + Children	Family
$ 7.42	$ 12.04	$12.95	$ 17.57

CANCER ASSIST: Offers protection for your financial security and quality of life if you experience the battle of cancer. This plan provides benefits for expenses not covered by most major medical plans. Experimental treatments, stem cell transplant, transportation expenses, hotel expenses and family care expenses are a few of those not covered by most major medical plans. The plan also provides a **$100** wellness benefit for each covered family member to have one screening per year. The screenings can be either pap smear, psa, mammogram etc. Refer to the brochure for details on eligible screenings.

Base Plan Prices Shown:	Employee	Employee/Spouse	Employee/Children	Family
Level 1 Brochure 101482	$ 9.05/paycheck	$14.30/paycheck	$ 9.13/paycheck	$14.38/paycheck
Level 2 Brochure 101483	$10.83/paycheck	$16.93/paycheck	$10.98/paycheck	$17.08/paycheck
Level 3 Brochure 101484	$13.33/paycheck	$22.20/paycheck	$13.55/paycheck	$22.43/paycheck
Level 4 Brochure 101485	$17.80/paycheck	$29.70/paycheck	$18.10/paycheck	$30.00/paycheck

*Optional benefits also available; ask your representative for details.

Wellness brochure101486 - Specified Disease brochure 101547 - $1,000 Initial Diagnosis brochure 78443 Progressive Payment brochure 78453

Diocese of Owensboro

Offers

COLONIAL LIFE & ACCIDENT VOLUNTARY BENEFITS

<u>Group CRITICAL Care 6000 Plan 1 with Progressive Diseases benefit!</u> Guarantee Issue for initial enrollment up to $35,000– health questions waived!

This plan provides a lump sum, tax-free benefit of **up to $75,000** for financial peace of mind if you or a covered dependent have a diagnosis of heart attack, stroke, major organ failure, coma, blindness, occupational infectious HIV/Hepatitis B, C, or D, permanent paralysis due to covered accident or end stage renal failure. A **$50** annual screening benefit is also paid for tests such as mammograms, pap smears, cholesterol and blood sugar along with additional benefits for progressive diseases! See brochure for details! brochure 385403EX -- wellness brochure 387307 -- Progressive Disease option brochure 387594

Note: Spouse and child coverage is 50% of employee coverage.

Non-Tob	$10,000	Employee	Emp+Spse	Emp+Childn	Fam	Tobacco	$10,000	Employee	Emp+Spse	Emp+Chldn	Fam
Issue	17-24	$2.11	$3.20	$2.11	$3.20	Issue	17-24	$2.71	$4.05	$2.71	$4.05
Age	25-29	$2.46	$3.70	$2.46	$3.70	Age	25-29	$3.36	$5.00	$3.36	$5.00
	30-34	$3.06	$4.60	$3.06	$4.60		30-34	$4.46	$6.60	$4.46	$6.60
	35-39	$4.11	$6.10	$4.11	$6.10		35-39	$6.26	$9.35	$6.26	$9.35
	40-44	$5.21	$7.80	$5.21	$7.80		40-44	$8.26	$12.35	$8.26	$12.35
	45-49	$6.76	$10.35	$6.76	$10.35		45-49	$11.11	$16.95	$11.11	$16.95
	50-54	$8.56	$13.25	$8.56	$13.25		50-54	$14.31	$22.15	$14.31	$22.15
	55-59	$10.41	$16.05	$10.41	$16.05		55-59	$17.61	$27.25	$17.61	$27.25
	60-64	$13.06	$20.20	$13.06	$20.20		60-64	$22.46	$34.65	$22.46	$34.65
	65-69	$14.16	$21.85	$14.16	$21.85		65-69	$24.36	$37.60	$24.36	$37.60
	70-74	$16.86	$26.05	$16.86	$26.05		70-74	$29.26	$45.20	$29.26	$45.20
Non-Tob	$20,000	Employee	Emp+Spse	Emp+Childn	Fam	Tobacco	$20,000	Employee	Emp+Spse	Emp+Chldn	Fam
	17-24	$3.06	$4.60	$3.06	$4.60		17-24	$4.26	$6.30	$4.26	$6.30
	25-29	$3.76	$5.60	$3.76	$5.60		25-29	$5.56	$8.20	$5.56	$8.20
	30-34	$4.96	$7.40	$4.96	$7.40		30-34	$7.76	$11.40	$7.76	$11.40
	35-39	$7.06	$10.40	$7.06	$10.40		35-39	$11.36	$16.90	$11.36	$16.90
	40-44	$9.26	$13.80	$9.26	$13.80		40-44	$15.36	$22.90	$15.36	$22.90
	45-49	$12.36	$18.90	$12.36	$18.90		45-49	$21.06	$32.10	$21.06	$32.10
	50-54	$15.96	$24.70	$15.96	$24.70		50-54	$27.46	$42.50	$27.46	$42.50
	55-59	$19.66	$30.30	$19.66	$30.30		55-59	$34.06	$52.70	$34.06	$52.70
	60-64	$24.96	$38.60	$24.96	$38.60		60-64	$43.76	$67.50	$43.76	$67.50
	65-69	$27.16	$41.90	$27.16	$41.90		65-69	$47.56	$73.40	$47.56	$73.40
	70-74	$32.56	$50.30	$32.56	$50.30		70-74	$57.36	$88.60	$57.36	$88.60

FAQ's

What happens in EN when we hire/term a new employee? Is there a new process? Continue the current process.

Do I need to contact someone from Colonial when I hire or term someone? Or do I still need to use EN? Continue to use EN. We will be notified through email that a new hire or term has been entered. The enrollment team will reach out to new hires by phone/text/email and terminations will be processed.

Will I print a report from EN with a summary of the benefits on 09/01 and going forward. Yes, you will print an enrollment summary.

Who do I send info to when I have a qualifying event or not sure if I have a qualifying event? In the past they have notified BAS and Mary Hall. Continue the same process. Continue the same process, we will be notified of the change and process accordingly.

Will BAS still do our monthly billing? Yes

What if someone has a change within 30 days of open enrollment, who do they contact? How will I know what the new deductions are if they change?

- If there is a change to a Colonial policy, please reach out to your benefits counselor or directly to Colonial at 833-703-1967. Colonial will give you the new deductions.

- If there is a change to the Core benefits (Medical, Dental, Vision, Life, Disability please reach out to your dedicated Account Manager, Leslie Dukate at (270) 793-0367 Ext. 4620 or ldukate@higusa.com. Employee Navigator will have the new deductions.

Will we get new Anthem cards? Will we get new RX cards? New Anthem ID cards will be issued with TrueScripts listed on it. There will only be one card effective 9/1.

How will employees know if their current meds will be covered? Please contact TrueScripts at the Member Care Line (812) 257-1955.

- RxGroup #99995847

How will current prescriptions be processed? Current prescription will be grandfathered over to TrueScripts. When you go to the pharmacy to refill your medication there may be an initial rejection. TrueScripts will be monitoring this and will reach out to the pharmacy to correct. They will also reach out to the members.

- If you have a **Prior Authorization** in place for a medication or taking a **Specialty Medication**, please contact our Member Care staff prior to 9/1/2023 to prevent disruption at the pharmacy. If you are not sure if a prior authorization is in place for any of your current medications, please contact us and we will verify if one is required.

- **90-day supply prescriptions** can still conveniently be filled at any retail pharmacy. In addition, you may continue to use your current pharmacy! Any retail pharmacy can be utilized and is in network.

Since we are no longer a grandfathered plan, what does mean? All preventative services will be covered at 100% effective 9/1/23

What happens to my current critical care plan, vision plan, life plans and short-term disability plan now that we are changing? What if an employee is currently on leave under STD?

- You may keep your current Anthem Critical Illness (CI) plan. All new CI plans will be with Colonial Life.

- You will need to meet with a benefits counselor to elect the new coverages (Medical, Dental, Vision, Life, STD. LTD) and to confirm beneficiary information.

- All the current Life and disability plans will be transferred to Mutual of Omaha. If you are on STD leave with Unum, that benefit will continue with Unum until the plan provisions are met. When you return to active work, your plan will become effective with Mutual of Omaha.

How does the change in deductible affect me and my dependents? All deductible changes will become effective 1/1/24.

- Elect low health plan on 09/01/2023 – deductible is the same as the current 2022/2023 low deductible plan amount ($700) from 09/01-12/31. Employees will start with the new low plan deductible ($1000) on 01/01/2024.

- Elect high health plan on 09/01/2023 – deductible is the same as the current 2022/2023 high deductible plan amount ($2500) from 09/01-12/31. Employees will start with the new high plan deductible ($3500) on 01/01/2024.

- Current employees - Any prior deductible amounts met from 01/01-08/31 is applied to their deductible at 09/01/2023.

Does the new voluntary dental plan with Paramount cover implants and dentures? Yes. Both are considered a major service and covered at 50% up to the annual plan max of $1,000.