THE ARCHDIOCESE OF KANSAS CITY IN KANSAS

2024 EMPLOYEE BENEFITS GUIDE

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WELCOME

Welcome To Your 2024 Benefits Guide!

This guide is intended to provide a high-level summary of your benefits. To see plan documents and view your benefits online, please visit archkckbenefits.com.

To be eligible to receive these benefits, you must be a full-time employee, working 30 or more hours per week for the school or calendar year. Once eligible, you may also enroll your eligible dependents. Your eligible dependents include your legal spouse of the opposite gender and dependent children (until the end of the calendar year in which they turn 26).

Newly hired employees are required to enroll or waive enrollment in the Archdiocese benefits within 30 days of your date of hire. Coverage in all benefits will begin the first of the month following 30 days from your hire date.

Please see your onsite entity administrator if you have any questions about the enrollment process.

2024 Open Enrollment

Open Enrollment will begin at 12:01am on November 1st and end at 11:59pm on November 14th. Elections you make during Open Enrollment will become effective January 1, 2024. This is an active enrollment.

All employees must go through BSwift and elect or decline benefits before the enrollment deadline.

Qualified Life Events

You may change your benefit elections during the year if you experience a qualifiying life event, including:

- Marriage
- Birth of your child
- Adoption or placement for adoption of your child
- Death of your spouse or dependent child
- Change in employment status of employee, spouse, or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid
- Enrollment in coverage through the Health Insurance Marketplace

Benefit changes outside of open enrollment MUST BE COMPLETED in your Paylocity/BSwift Benefits portal within 30 days of the qualifying life event.

Information in this guide is provided for illustrative purposes only. For more detailed information, please refer to your summary plan description found at **archkckbenefits.com**. *In the case of a discrepancy, the actual plan documents will prevail.*

BENEFITS OVERVIEW

This benefit guide provides a brief overview of your employee benefits program. We encourage you to review this important information about the benefits available to you. It is intended to be a general summary of benefits, and it is not a legal document. Please visit **archkckbenefits.com** for more detailed information regarding the full scope of coverage, limitations, and any exclusions that may apply.

Keep in mind that your out-of-pocket costs will be lower if you receive care from an in-network doctor and facility. To find an in-network doctor, please visit **myhealthtoolkitkc.com**. For more information or to see plan documents, visit **archkckbenefits.com**. Check the list below to select the benefits that best meet your personal needs.

All deductions will be withheld from the first two paychecks each month.

Benefit	Who Pays the Cost
Medical / Pharmacy Coverage	Employer & Employee
Dental Coverage	Employer & Employee
Voluntary Vision Coverage	Employee
Employee Assistance Program	Archdiocese Welfare Benefit Fund & Employer
Basic Life and AD&D Coverage	Employer
Dependent Life Coverage	Employer & Employee
Voluntary Supplemental Life	Employee
Short Term Disability	Archdiocese Welfare Benefit Fund & Employer
Long Term Disability	Employer & Employee
Flexible Spending Account	Employee
Health Savings Account	Employee

EFFECTS OF HEALTHCARE REFORM

Summary of Benefits Coverage

Under the Patient Protection and Affordable Care Act (PPACA or ACA), insurance companies and group health plans must provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This Summary of Benefits and Coverage (SBC) document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
A copy of the SBC can be found on the benefits portal at **archkckbenefits.com**.

Women's Preventive Care Guidelines

In August 2011, the U.S. Department of Health and Human Services (HHS) announced additional preventive care services, developed by the independent Institute of Medicine, to cover women's preventive services without charging a copayment, coinsurance or a deductible. In addition to requiring 100% coverage for well-women visits and various types of screenings, the HHS has included coverage for FDA-approved contraception methods. The Archdiocese Health Plan is not required to comply with these rules, even as a non-grandfathered plan, therefore coverage for contraception continues to be excluded under our plan.

Preventive Services

Our health plan continues to cover routine preventive services for all members. The PPO plan also covers one mammogram and one colonoscopy per calendar year at 100%, regardless if it is a routine or diagnostic service. The high deductible health plan (HDHP) covers only preventive mammograms and colonoscopies at 100%. Covered preventive services may have age and/or gender limitations in line with recommendations of the National Preventive Services Task Force. As these recommendations may change from time to time, please verify with Blue Cross Blue Shield or OptumRx what specific preventive services and types of breast pumps are covered in full.

Certain breast pumps are also covered at 100% for members on both the PPO and HDHP.

MEDICAL

You have the flexibility to seek care from an in-network or out-of-network provider. It is important to note that you receive the maximum benefits from the plan when you seek services from in-network providers.

The Blue Cross Blue Shield network offers the best national access to providers. To find out if your physician is in network, please visit their website at: **myhealthtoolkitkc.com**. You may also direct your questions to the Customer Service number located on the back of your identification card.

Below is a brief summary of the medical plans available to you and your family. For more detailed information, please refer to the Summary of Benefits and Coverage (SBC) provided by Blue Cross Blue Shield.

	PPO BCBS with PCB OR BSP Network	HDHP BCBS with PCB OR BSP Network
Calendar Year Deductible (Individual/Family)	$750 | $1,500	$3,200 | $6,400
Calendar Year Out-of-Pocket Max (Individual/Family)	$6,500 | $13,000	$6,500 | $13,000
Coinsurance	80%	90%
Routine Preventive Care	100% Covered	100% Covered
Physician Office Visit	$25 Copay	Ded + Coinsurance
Urgent Care	$50 Copay	Ded + Coinsurance
Emergency Room	$100, then Ded + Coinsurance	Ded + Coinsurance
Inpatient Hospital Care	Ded + Coinsurance	Ded + Coinsurance
Outpatient Hospital Care	Ded + Coinsurance	Ded + Coinsurance
Chiropractic Care (20 visit limit per year)	$25 Copay + Ded + Coinsurance	Ded + Coinsurance
Lab Services	100%	Ded + Coinsurance

Natural Family Planning - For Members Covered by the Health Plan

This benefit includes office visits and materials (such as the Clear Blue Easy Fertility Monitor and test strips) and is available through programs approved by the archdiocese. The following programs are considered to be approved: Billings Method, Creighton Model, Couple to Couple League, and Marquette Method. The archdiocese will cover 100% of costs up to a maximum of $400 per calendar year for the insured employee or their spouse. The benefit is limited to $400 total per family. Please submit copies of receipts to the archdiocese Human Resources office by January 31 of the following year.

Gianna Family Care - For Members Covered by the Health Plan

The Archdiocese Health Plan provides coverage at Gianna Family Care, which is a membership and faith-based medical practice located in Shawnee, Kansas. Charges from the Gianna Family Care medical practice will be treated as follows:

- Membership and other physician fees will be reimbursed at 90% of billed amount for the PPO plan. The HDHP will be subject to the deductible then covered at 90%.
- Any other fees, such as labs or medications, if billed by Gianna, will be covered as out of network.

A claim form and itemized receipt must be submitted to Blue Cross Blue Shield for reimbursement and can be found on the benefits portal at **archkckbenefits.com**. For more information on this practice, visit: www.giannafamilycare.com.

MEDICAL

BlueCross BlueShield

PPO with PCB Network	Employee per Pay Period	Employer per Pay Period
Employee Only	$98.21	$182.39
Employee + Spouse	$307.51	$571.09
Employee + Child(ren)	$260.82	$484.38
Employee + Family	$338.10	$627.90

Group #71-60342-00

PPO BSP with BSP Network	Employee per Pay Period	Employer per Pay Period
Employee Only	$92.92	$172.58
Employee + Spouse	$289.80	$538.20
Employee + Child(ren)	$244.12	$453.37
Employee + Family	$318.15	$590.85

Group #71-60345-53

High Deductible with PCB Network	Employee per Pay Period	Employer per Pay Period
Employee Only	$50.52	$190.06
Employee + Spouse	$262.43	$487.37
Employee + Child(ren)	$222.18	$412.62
Employee + Family	$286.58	$532.22

Group #71-5954M-00

High Deductible BSP with BSP Network	Employee per Pay Period	Employer per Pay Period
Employee Only	$45.00	$180.00
Employee + Spouse	$245.70	$456.30
Employee + Child(ren)	$207.90	$386.10
Employee + Family	$270.90	$503.10

Group #71-5954M-06

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description found at archkckbenefits.com.

Kansas City

BLUESELECT PLUS NETWORK

When savings is just as important as having quality care close to home.

BlueSelect Plus is a select network of healthcare providers specially designed to provide affordable access to quality care in and around the metro area. With this network, your premiums will be lower based on the discounts Blue Cross and Blue Shield of Kansas City (Blue KC) has negotiated with these providers.

Who should enroll, and what access do I have with the BlueSelect Plus network?

BlueSelect Plus is **best for members who**:

☑ **Live in one of these twelve (12) counties:**

Missouri: Clay, Jackson, Platte, Cass, Clinton, DeKalb, Johnson, Lafayette, Ray, Caldwell
Kansas: Johnson, Wyandotte

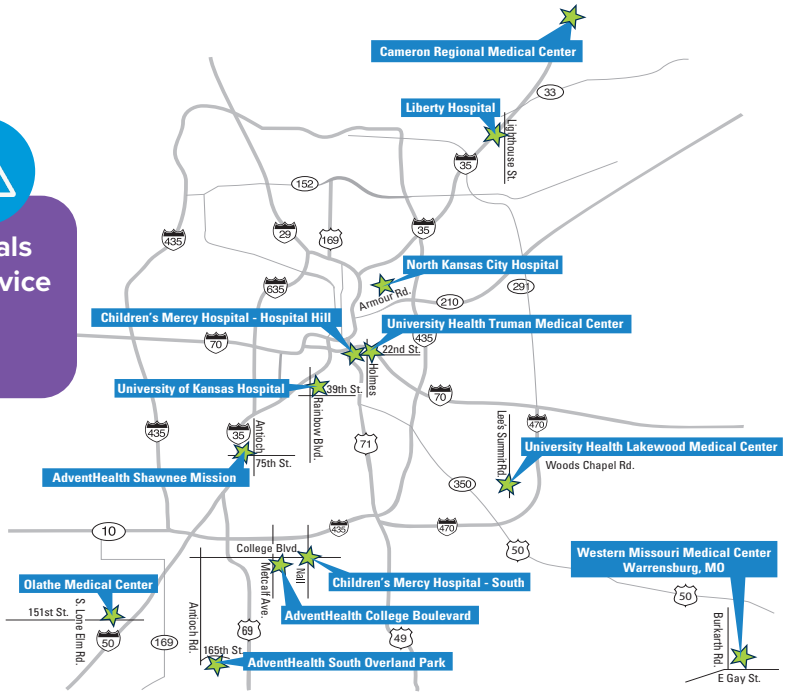
☑ **Seek care from any of the 4,100+ providers and 13 hospitals primarily located in these seven (7) counties:**

Missouri: Clinton, Clay, Jackson, Johnson, Platte
Kansas: Johnson, Wyandotte

Which hospitals are in the network?

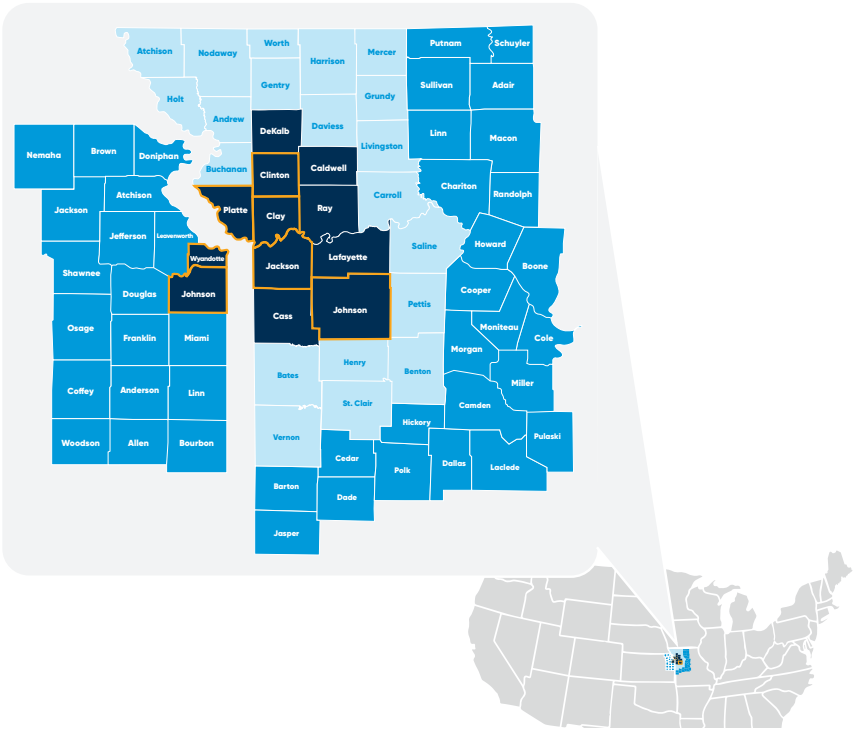
- AdventHealth College Boulevard
- AdventHealth Shawnee Mission
- AdventHealth South Overland Park
- Cameron Regional Medical Center
- Children's Mercy Hospital
- Children's Mercy Hospital - South
- Liberty Hospital
- North Kansas City Hospital
- Olathe Medical Center
- Providence Medical Center
- St. Joseph's Medical Center
- St. Mary's Medical Center
- University Health Truman Medical Center
- University Health Lakewood Medical Center
- University of Kansas Health Hospital
- Western Missouri Medical Center

All other hospitals in Blue KC's service are considered out-of-network.



BlueSelect Plus Network

- Provides in-network coverage in the **dark blue** areas of the map. Costs apply toward your annual deductible.
- Hospitals located in the BlueSelect Plus network are located in the seven counties outlined in **orange** (excludes HCA and St. Luke's). Costs apply toward your annual deductible.



‡Out-of-network benefits are subject to the plan's allowable charge. Out-of-network providers may bill the member for the remaining balance if they are enrolled in a PPO plan. Members with EPO plans receive no out-of-network coverage except for emergency services and will be billed in full.

Questions? Please call Blue KC Customer Service at the number listed on your member ID card.
888-495-9340

PRESCRIPTION DRUGS

OptumRx is the Pharmacy Benefit Manager for our prescription drug benefits. Your plan includes a list of prescription drugs that are preferred by the plan because they help control rising prescription drug costs. This list, sometimes called a formulary, has a wide selection of generic and brand name medications. This information can be accessed after benefits are active January 1, 2024. Members will need to register on OptumRx.com in order to view the Formulary Drug List.

You will want to use a participating retail pharmacy for short term prescriptions (such as antibiotics to treat infections). Be sure to show your OptumRx's prescription benefit card to the pharmacist and pay your retail copayment for each prescription.

Long term medications (those taken for three (3) months or more) may be filled through the OptumRx's Broad 90 day Pharmacy Network. You may fill your long term medications at a local retail pharmacy like Walgreens, Target, Wal-Mart and many grocery stores. OptumRx also offers a mail order pharmacy option through their Home Delivery pharmacy, often called Mail Service Pharmacy. Specialty medications are filled through OptumRx's specialty pharmacy.

Prescription Drugs	PPO Plan BCBS	HDHP BCBS
Calendar Year Deductible (Individual/Family)	Not Applicable	$3,200 / $6,400 Combined with medical benefits
Retail (30 day Supply) Generic Brand Formulary Non-Formulary	 Lesser of $10 or actual cost 25% or minimum of $25 40% or minumum of $40	*After Plan Deductible:* Lesser of $10 or actual cost 25% or minimum of $25 40% or minumum of $40
Mail Order (90 day Supply) Generic Brand Formulary Brand Non-Formulary	 $25 Copay 25% or minimum of $62.50 40% or minimum of $100	*After Plan Deductible:* $25 Copay 25% or minimum of $62.50 40% or minimum of $100
Specialty (30 day Supply) Generic Brand Formulary Brand Non-Formulary	 25% of discounted cost 25% of discounted cost 25% of discounted cost	*After Plan Deductible:* 25% of discounted cost 25% of discounted cost 25% of discounted cost

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to the Optum's Summary Plan Description at **archkckbenefits.com**.

To find a participating retail pharmacy near you, contact OptumRx's Customer Service department at
855-524-0381 or log on to OptumRx.com
Hours of Operation: 24 hours a day, 7 days a week.

MEDICATION MANAGEMENT

tria HEALTH
smarter. medication. management.

Pharmacy Advocate Program

Tria Health is a free and confidential benefit available through your insurance plan with the Archdiocese of Kansas City in Kansas. If you have a chronic condition or take multiple medications, Tria Health's pharmacists are ready to support you in managing your health.

Not only will Tria Health's pharmacists make sure your medications are working as intended and that you're on the right medications, but they can support you by creating a care plan that is specific to your needs and share it with your doctor. Talk to a Tria pharmacist over the phone and receive the personalized care you deserve.

Who Should Participate?

Tria Health's Pharmacy Advocate Program is available for employees and/or dependents on Archdiocese of Kansas City in KS's health insurance. Tria Health is recommended for members who have any of the following conditions:

- Diabetes
- Heart Disease
- High Cholesterol
- High Blood Pressure
- Mental Health
- Asthma/COPD
- Osteoporosis
- Migraines

You can enroll by...

Call
1-888-799-8742

Online
www.triahealth.com/schedule

Active Participants Can Save Money on Their Medications

Active participants will receive discounted copays on select medications used to treat targeted chronic conditions. You are not required to change your medications, pharmacy, or doctor to receive this benefit.

- Free generics
- Reduced cost on select brand medications*

*Chronic pain medications are excluded

Free Diabetes Meter & Testing Supplies

Active participants with diabetes will have access to a FREE blood glucose meter, testing strips, and a digital dashboard designed to help you better understand your diabetes & share readings with your care team. Your dashboard will auto-populate with your data and is available online and through Tria Health's mobile app.

Program	Details
Affordable Med	Saves you time and money by identifying less expensive, effective alternatives for your brand medications
Med Safety Alerts	Prevents the risks associated with taking medications that cause an adverse reaction together
Tria Clinical Alerts	Identifies when taking an additional medication in conjunction with your current treatment can improve your condition
Compliance Alerts	Forget to take your medications? Do side effects cause you to skip your meds? Compliance Alerts help find solutions to help you take your medications as prescribed
Tria Help Desk	Your complete and confidential resource anytime you have a medication-related question. Call us toll free at 1-888-799-TRIA (8742)

TELEHEALTH

MyCatholicDoctor is a nationwide organization that brings a network of faithful medical professionals to you through video appointment (telehealth). We offer rapid access urgent care 24/7/365, as well as appointment-based visits. Appointment based visits will generally have a lower co-pay and include both primary care and specialty care.

We can initiate your medical care virtually, order any necessary labs or imaging, and send prescriptions to any pharmacy of your choice. We practice evidence-based scientific medicine from a Catholic perspective and integrate Catholic spirituality into our care as appropriate to the situation.

To Get Started Visit

https://mycatholicdoctor.com/archkck/

No Password Required

No Special App

When can I use MyCatholicDoctor?

Choose our rapid access urgent care when:

- You need care now
- If you are considering the ER or urgent care center for a non-emergency issue
- You are traveling
- You need care during non-business hours
- PPO co-pay $25, no deductible. HDHP $55 which is applied to the deductible

Smartphone access appointments by video or phone.

Confidential visits available during evenings, weekends, and holidays.

HEALTH SAVINGS ACCOUNT (HSA)

If you elect the High Deductible Health Plan (HDHP), you may elect to open a Health Savings Account (HSA).

Please Note: You cannot contribute to an HSA if: 1) you are covered by a Flexible Spending Account (FSA) even if the FSA is your spouse's, unless it is a Limited Purpose FSA that doesn't cover medical expenses, or 2) are enrolled in Medicare or any other health insurance coverage.

Features of an HSA include:

- HSA funds can be used for qualified medical, dental, and vision expenses.
- You can only use what you contribute; funds will be deposited into your HSA.
- HSA money is yours to keep. Unlike a Flexible Spending Account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow tax deferred.
- HSA is portable. It remains open and funds are available to you even if you leave the employer where you worked when you established or contributed to the HSA.

Triple Tax Advantage with an FSA

The money you contribute to an HSA/FSA is never taxed.

- NOT when it is deducted from your paycheck and deposited to your account
- NOT when you are reimbursed with the funds from the account
- NOT when you file your income tax return at the end of the year.

Annual Contribution Limits	
Individual	**Family**
$4,150	$8,300
If age 55 or older, $5,150	If age 55 or older, $9,300

HSA holders 55 and older can contribute an extra $1,000 per year, increasing the annual contribution limit to $5,150 for individual coverage and $9,300 for family coverage.

FLEXIBLE SPENDING ACCOUNTS (FSA)

You may participate in three different Flexible Spending Accounts (FSAs) administered by Paylocity: a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account and a Limited Purpose Flexible Spending Account. Each account allows you to set aside money to pay for certain expenses on a pre-tax basis.

Triple Tax Advantage with an FSA

The money you contribute to an HSA/FSA is never taxed.

- NOT when it is deducted from your paycheck and deposited to your account
- NOT when you are reimbursed with the funds from the account
- NOT when you file your income tax return at the end of the year.

Account Type	Maximum Annual Contribution	Last Date to Incur Expenses	Last Date to File Claims	What happens to any unused balance at the end of the year?
Health Care FSA* **Medical plan enrollment required*	$3,200*	December 31, 2024	March 31, 2025	You can carry over up to $640 of your unused balance year-to-year**
Dependent Care FSA* **Medical plan enrollment not required*	$5,000 ($2,500 if married and filing separately)	December 31, 2024	March 31, 2025	Any funds left in your account at the end of the year will be forfeited
Limited Purpose FSA* **HDHP Medical plan enrollment required*	$3,200*	December 31, 2024	March 31, 2025	You can carry over up to $640 of your unused balance year-to-year**

***Amounts in excess of $640 will be forfeited.*

DIFFERENCES BETWEEN HSA & FSA

Both HSAs and FSAs allow employees to set aside money for health costs referred to as "qualified expenses" which include deductibles, copayments, coinsurance, prescription medications, dental and vision care and can help save you money and make budgeting for medical costs easier. However, knowing which account to select can be confusing. The information provided here is designed to assist you in making the right decision for you and your family.

	Health Savings Account (HSA)	Flexible Spending Account (FSA)
Eligibility	HDHP enrollment required	Other enrollment options exist*
2024 Contribution Limits	$4,150/$8,300 Over 55: $1,000 catch-up	$3,050
Eligible Medical Expenses	Qualified medical expenses defined under IRC § 213(d) incurred after the HSA is opened, except for amounts distributed to pay health insurance premiums. HSAs can be used to pay premiums for Temporary Continuation of Coverage, Long Term Care, and health insurance for retirees.	Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. e.g. Copays, coinsurance, deductible, prescription drugs, braces, dental and eyecare expenses.
Account Owner	Employee	Employer
Require Proof of Expenses	No; however, the member should be prepared to substantiate to the IRS the expense has been incurred, the amount of the expense and its eligibility	Yes, you need to retain proof of payment. Validation will be required except for debit card swipes for set copays associated with the health or pharmacy benefit.
Changes to Contributions	On an ongoing basis	Only for qualifying events, such as marriage, birth, or during open enrollment.
Disbursement of Funds	Only funds paid in to the account are available for healthcare expenses	The entire annual contribution amount is available at the beginning of the year, even if the account is not fully funded yet.
Portability and Forfeiture	Yes; HSA balance is not forfeited when the member changes employers or health plans	**Option 1**. Upon termination, participation in the Health FSA will cease and no further contributions will be made on your behalf. You have 90 days after the date of termination to submit claims for health care expenses that were incurred prior to the date of termination. **Option 2**. Before your last day of work you can fund the remaining months of contributions to your Health FSA, so all contributions for the year have been made before you leave employment. You will then be allowed to continue to incur health care expenses and submit receipts through the end of the calendar year in which your employment terminates. Submit claims after your employment terminates by contacting Paylocity at batinfo@paylocity.com or 1-800-631-3539
Balance Carry Over (or rollover)	Unused funds are rolled over into the following year and beyond	Up to $610 of unused funds can be carried over to the following year, with the remainder of the unspent balance being forfeited.
Investment Options	Yes, but amount varies by HSA bank	No
Expiration	Never expires or lost	All money in an FSA expires and is lost at the end of the year, up to $610 may be rolled over to the next plan year.

**Other enrollment options exist:*

- *Health Care FSA - enrollment in our PPO plan (this is a change form the current plan year)*
- *Dependent Care FSA - no additional requirements*
- *Limited Purpose FSA - enrollment in HDHP plan*

There is a minimum $200 annual contribution for each

DENTAL

DELTA DENTAL®

Group #51636

The plan covers routine checkups and comprehensive coverage for other types of dental work you might need. Our plan also offers you the flexibility to seek treatment from any provider.

To find a Dentist...

Call
1-800-234-3375

Online
deltadentalks.com

Services	Description	Benefit Amount
Type I Procedures	Exams, cleanings, fluoride treatments (2 per year)	Plan pays **100%** of the Maximum Plan Allowance, This benefit does not apply towards the Annual Maximum
Type II Procedures	Regular fillings (amalgam or composite), extractions, non-surgical root canals	After deductible is met, the plan pays **80%** of the Maximum Plan Allowance
Type III Procedures	Inlays, crowns, dentures, implants	After deductible is met, the plan pays **60%** of the Maximum Plan Allowance
Type IV Procedures	Orthodontia services For adults and children	After deductible is met, the plan pays **50%** of the Maximum Plan Allowance up to a Lifetime Maximum Benefit of **$2,500**
Annual Deductible	Applies to Type II, III, and IV Procedures	**$25** per person
Annual Maximum	Per covered person	**$2,500**

Employee Cost per Pay Period	Employee Share	Employer Share
Employee Only	$8.16	$12.23
Employee + Spouse	$23.29	$34.95
Employee + Child(ren)	$20.09	$30.14
Family	$25.69	$38.53

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VISION

Group #351035

You have a choice between Vision benefits offered through **VSP** and **Eyemed**. The Voluntary Vision program provides comprehensive coverage for all of your routine vision needs. You pay the full cost of coverage through pre-tax payroll deductions.

To find a VSP provider...
Call
1-800-877-7192
Online
vsp.com/eye-doctor

To find a Eyemed provider...
Call
1-866-289-0614
Online
eyemed.com/en.us/provider

Benefit	VSP or Eyemed Network
Eye Exam	$15 Copay
Materials	$20 Copay
Lenses Single Vision Bifocal Trifocal	Covered in Full
Frames	$175 allowance
Contacts Fitting & Evaluation Medically Necessary Elective	 Up to $60 Copay 100% Covered $160 allowance
Frequency Exam Lenses Frames	 12 months 12 months 24 months

The Difference Between Networks

Ameritas will be giving you an option between using the VSP national network or the EyeMed national network.

The VSP network tends to have more individual doctors and providers than big box stores, where EyeMed tends to have more of a larger big box store directory.

Employee Cost per Pay Period	
Employee Only	$4.48
Employee + Spouse	$9.03
Employee + Child(ren)	$10.34
Family	$16.48

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For exact terms and conditions, please refer to your summary plan description at ***archkckbenefits.com****.*

LIFE and AD&D

Sun Life Financial

Group #948064

Basic Life and AD&D

100% Employer Paid

Term Life Insurance and Accidental Death and Dismemberment coverage is provided as a measure of protection to your beneficiaries in the event of your death.

Term Life Insurance

Benefit is paid by employer at a flat $25,000. Benefit reduced 50% at age 70.
If disabled before age 60, coverage will continue for the length of the disability, but not beyond the earlier of age 65, or the date of retirement. If disabled after age 60, but before age 65, coverage may continue for up to one year, but not past the earlier of age 65, or the date of retirement.

Accidental Death and Dismemberment

An additional amount equal to the amount of Life Insurance will be paid to your beneficiary if death is due to an accident. Lesser benefits are payable for specified disabilities resulting from an accident. Limitations and exclusions apply.

Accelerated Death Benefit

If you have a qualifying medical condition that meets certain specifications, you have the right to receive a percentage of the life benefit. Limitations and exclusions apply.

Option to buy additional Dependent Life/Spouse

Spouse: $4,000
Child: $2,000

Voluntary Term Life and AD&D

100% Employee Paid

Voluntary Life Insurance provides employees the opportunity to customize their individual life insurance needs.

Employee

- Coverage is available in $10,000 increments
- Minimum coverage: $10,000
- Maximum coverage: $150,000
- Guarantee issue: $150,000
- Benefits reduce to 50% at age 70

Spouse

- Dependent coverage is only available if the employee is insured for Voluntary Coverage.
- Coverage is available in $5,000 increments (rounded to the next higher $5,000); not to exceed 50% of the employee's elected benefit amount
- Minimum coverage: $5,000
- Maximum coverage: $75,000
- Guarantee issue: $75,000

Child

- Dependent coverage is only available if the employee is insured for Voluntary Coverage.
- Provides coverage for all dependent children up to age 26 in the following amounts: $5,000 or $10,000 (not to exceed 100% of employee amount).

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*For exact terms and conditions, please refer to your summary plan description at **archkckbenefits.com**.*

DISABILITY

Sun Life Financial

Group #948064

Short-Term (STD)

100% Employer Paid

What, Why, and When	Provides income protection in the event you become either totally or partially disabled as indicated by your attending physician.
Waiting Period	7 days
Weekly Benefit	67% of an insured person's weekly earnings
Maximum Benefit	$500 per week
Maximum Benefit Duration	12 Weeks
Maternity Leave	Covers maternity leave. Generally, benefit duration for normal delivery is 6 weeks and 8 weeks for cesarean.

Long-Term (LTD)

50% Employee Paid/50% Employer Paid

What, Why, and When	Provides income protection in the event you become either totally or partially disabled as indicated by the attending physician.
Waiting Period	12 weeks of disability caused by accidental injury or sickness
Monthly Benefit	50% of insured person's monthly earnings
Maximum Benefit	$3,000 per month
Maximum Benefit Duration	To age 67, not less than 48 months

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VOLUNTARY ACCIDENT

Sun Life Financial

Group #948064

Health insurance covers medical expenses, but it doesn't usually cover indirect costs that can arise with a serious or even a not-so-serious injury. You may end up paying out of your own pocket for unexpected expenses like transportation, over-the-counter medication, childcare, and extra help around the house. With accident insurance, the benefits you receive can help take care of these extra expenses.

Coverage Highlights

- Low plan vs High plan (see benefit summary on **https://archkckbenefits.com/** for details)
- Guaranteed Issue coverage
- Covers off the job accidents
- Coverage is portable at the same benefit level and premium amount, as long as premiums are paid to Sun Life Benefits.
- Pays a benefit for hospitalization, emergency treatment, intensive care, fractures, and more.
- Injuries treated within 90 days (180 days for AD&D) from the date of an accident will be paid based on the benefit schedule in the policy.
- Benefit can be used to help pay for out-of-pocket medical costs or everyday expenses.

Low Plan - Per Pay Period Premium	
Employee	$7.72
Employee + Spouse	$12.56
Employee + Children	$14.30
Family	$19.14

High Plan - Per Pay Period Premium	
Employee	$11.00
Employee + Spouse	$18.72
Employee + Children	$21.60
Family	$29.32

VOLUNTARY CRITICAL ILLNESS

Sun Life Financial

Helps protect you in the event that you are diagnosed with a critical illness. Provides a lump-sum benefit to help you cover out-of-pocket expenses. Some examples of a critical illness may include:

- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant

Benefit Description:

- Coverage available in increments of $10,000 from $10,000-$40,000
- Guarantee issue coverage
- Spouse coverage available in increments of $10,000 from $10,000-$40,000 (not to exceed 100% of employee coverage)
- Child coverage available in $5,000 increments from $5,000-$20,000 (not to exceed 50% of employee coverage)
- Benefits are paid directly to you, unless assigned to someone else.
- Coverage supplements existing medical benefits and can help cover the costs of out-of-pocket expenses.
- Continuation of coverage beyond employment with continued premium payments.

Rates are available in the Paylocity Enterprise Benefit portal

This is a brief summary only. Certain restrictions and exclusions apply.
*For exact terms and conditions, please refer to your summary plan description at **archkckbenefits.com**.*

VOLUNTARY HOSPITAL INDEMNITY

Sun Life Financial

Group #948064

Covers out-of-pocket expenses not covered by your medical plan while confined to a hospital. You have the option to purchase hospital indemnity insurance to help with unexpected costs such as child care, deductibles, and lost income.

	Benefits
First day in the hospital (Regular bed)	$1,000
Hospital confinement (Up to 30 days)	$100/day
ICU confinement (Up to 10 days)	$100/day
Extended hospitalization	$100/day

Per Pay Period Rates	
Employee	$8.90
Employee + Spouse	$18.82
Employee + Children	$15.28
Family	$25.20

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For exact terms and conditions, please refer to your summary plan description at ***archkckbenefits.com***.

EMPLOYEE ASSISTANCE PROGRAM

Sun Life Financial

Group #948064

Personal issues, planning for life events, or simply managing daily life can affect your work, health and family, GuidanceResources provides support, resources and information for personal and work-life issues.

Sun Life provides services to assist in a wide range of work/life concerns.

- Family and Caregiving: Caring for children and/or elderly family members
- Workplace: Managing stress and career issues
- Emotional Well-being: Coping with grief and loss, or substance abuse
- Physical Health and Wellness: Handling health challenges of adults or children
- Daily Living: Managing personal finances or legal issues

Program Benefits:

- Confidential Counseling
- Financial Information Resources
- Legal Support and Resources
- Work-Life Solutions
- GuidanceResources Online
- Free Online Will Preparation
- Help for New Parents

The single source for confidential support, expert information and valuable resources, when you need it most. 24 hours a day.
Call: 877.595.5281 TDD: 1-800-697-0353
Online: guidanceresources.com
Web ID: EAPBusiness

WHEN TO USE YOUR EAP

STRESS, GRIEF OR LOSS

RELATIONSHIP AND FAMILY CHALLENGES

LEGAL OR FINANCIAL CHALLENGES

SUBSTANCE DEPENDENCE OR ADDICTION

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description at ***archkckbenefits.com***

NOTICES

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you can designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit **myhealthtoolkitkc.com.**

You do not need prior authorization from your plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit **myhealthtoolkitkc.com.**

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Go to **archkckbenefits.com** for more information.

Newborns' and Mothers' Health Protection Act

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

HIPAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.

NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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

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

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

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

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

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

NOTICES

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

NOTICES

Your Rights and Protections Against Surprise Medical Bills cont.

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

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

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

If you believe you've been wrongly billed, you may contact the entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. Visit https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act#map for information and to view the No Surprises Act Map.

For more information about the impact of the No Surprises Act on consumers, including how to file complaints, please refer to the Centers for Medicaid and Medicaid Services' No Surprises Act Consumer FAQ page.

Visit https://www.cms.gov/nosurprises/policies-and-resources/overview-of-rules-fact-sheets for more information about your rights under federal law.

Visit https://www.ncsl.org/health/surprise-and-balance-billing-state-policy-options for more information about your rights under state law.

To contact state regulators regarding the No Surprises Act, please click here for agency websites.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

CONTACTS

The Archdiocese of Kansas City in Kansas, in partnership with the following vendors, strives to meet your benefit needs. If you have any questions regarding your benefits, please visit:

www.archkckbenefits.com

or contact the corresponding vendor listed below. If you still have questions, please contact your onsite Benefits Administrator.

Benefit	Vendor Name	Customer Service
Health Care Plan	Blue Cross Blue Shield	888-495-9340 MyHealthToolKitKC.com
Prescription Drug Benefits	OptumRx	855-524-0381 OptumRx.com
Medication Management	Tria Health	888-799-8742 triahealth.com
Cancer Care Advocacy	Alere Oncology Management	855-814-5077
Telemedicine	MyCatholicDoctor	888-822-8436 https://mycatholicdoctor.as.me/Kathleen-Berchelmann-MD
Dental Plan	Delta Dental of Kansas	800-234-3375 / 316-264-4511 deltadentalks.com
Vision Plan	VSP Eyemed	800-877-7195 vsp.com 844-225-3107 eyemed.com
Life and AD&D	Sun Life Financial	877-431-7379 usebglifeclaimsinbox@sunlife.com
Disability STD/LTD	Sun Life Financial	877-932-7287
Voluntary Tem Life and AD&D, Accident and Critical Illness Insurance	Sun Life Financial	888-551-2084
Voluntary Hospital Indemnity	Sun Life Financial	866-376-9480
Flexible Spending Accounts (FSA)	Paylocity	800-520-2687 batinfo@paylocity.com
Health Savings Accounts (HSA)	Paylocity	800-631-3539 batinfo@paylocity.com
Employee Assistance Program (EAP)	Sun Life Financial	877-595-5281 guidanceresources.com

THE ARCHDIOCESE OF KANSAS CITY IN KANSAS

To see plan documents and view your benefits online, please visit **archkckbenefits.com**