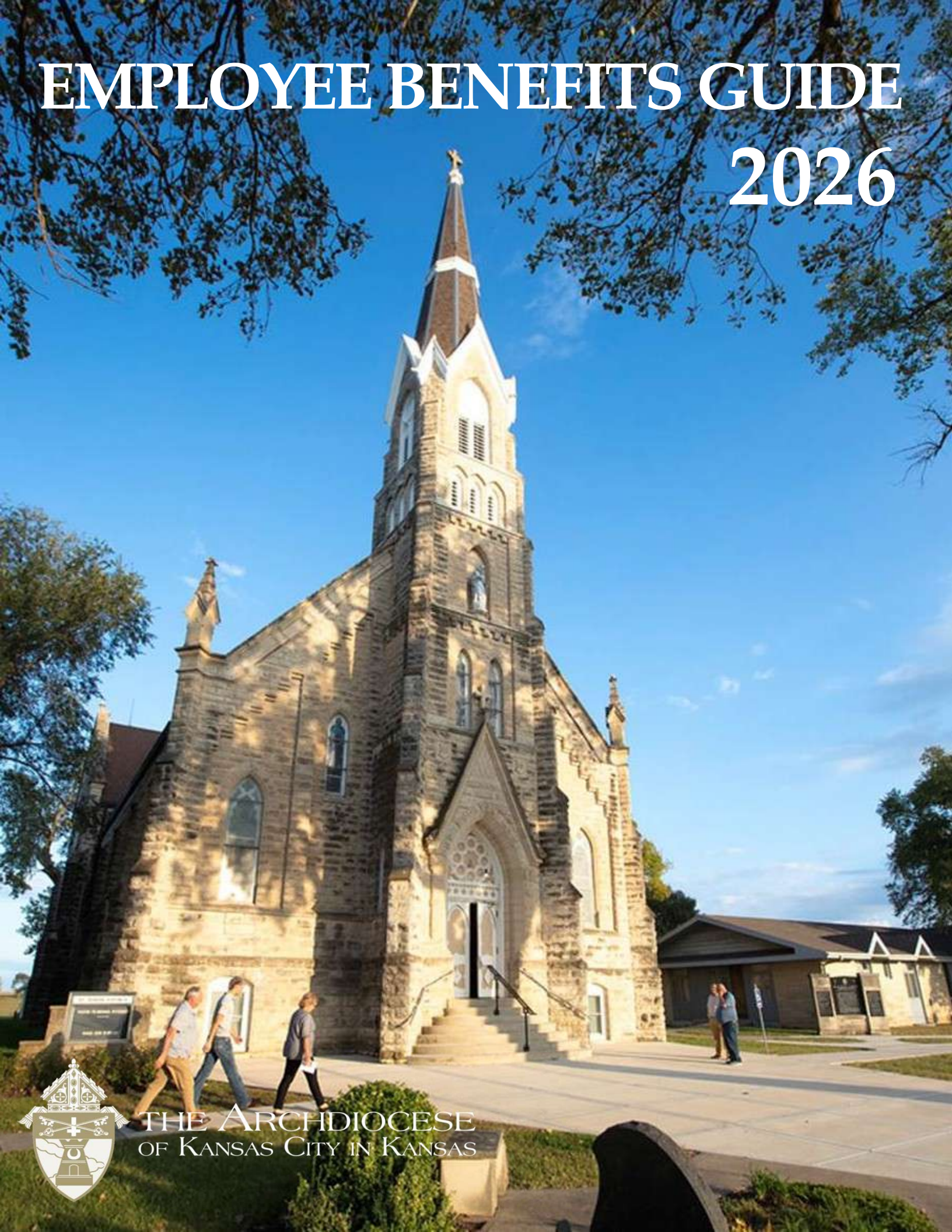
EMPLOYEE BENEFITS GUIDE 2026



THE ARCHDIOCESE
OF KANSAS CITY IN KANSAS

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WELCOME

This guide is intended to provide a high-level summary of your benefits plan.

Eligibility	Full-time employees working 30+ hours/week, eligible legal spouse of the opposite sex and dependent children (until the end of the calendar year in which they turn 26).
Plan Year	Calendar year, January 1- December 31
New Employees	New hires are required to enroll or waive enrollment within 30 days of hire. Coverage begins the first day of the month after 30 days of employment.
Open Enrollment	There is a 2-week window for Open Enrollment that begins around November 1 every year. Elections you make during Open Enrollment will become effective January 1 and will remain effective through December 31. All employees must go through Paylocity and select or waive benefits before the enrollment deadline. Please remember to SUBMIT when you are all finished.
Qualifying Life Events	A qualifying life event (QLE) is a life event that permits certain benefit changes outside of open enrollment. See pages 4 and 5 for more information.
Contact Person	Contact your **onsite** benefits administrator with any questions about the benefits plan.



QUALIFYING LIFE EVENTS (QLE)

Qualified Life Events must be completed WITHIN 30 DAYS following the date of the event.

There are 4 basic types of qualifying life events.
(The following are examples, not a full list.)

Loss of Health Coverage	• Losing existing health coverage, including job-based, individual, and student plans • Losing eligibility for Medicare, Medicaid, or CHIP • Turning 26 and losing coverage through a parent's plan
Changes in household	• Getting married or divorced • Having a baby or adopting a child • Death in the family
Changes in residence	• Moving to a different ZIP code or county • A student moving to or from the place they attend school • A seasonal worker moving to or from the place they both live and work • Moving to or from a shelter or other transitional housing
Other qualifying events	• Changes in your income that affect the coverage you qualify for • Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder • Becoming a U.S. citizen • Leaving incarceration (jail or prison) • AmeriCorps members starting or ending their service

***See page 5 for more information**

Qualifying Life Events are Employee driven. You must start the process.

Employee Actions:

1. Login to Paylocity.
2. Navigate to & open BSwift Benefits.
3. Select the appropriate Life Event.
4. Upload required Documentation, if applicable.
5. Submit.

After submission, Arch KCK Human Resources will review your request for either approval or denial.

QUALIFYING LIFE EVENTS (QLE)

Use this quick guide to determine which benefit changes are permitted after a qualifying event

🔹 **Global Rules (Applies to ALL QLEs)**

✅ Allowed Actions
- Changes must directly relate to the qualifying event
- Updating coverage tier (e.g., employee → family) occurs when applicable

🚫 Not Allowed Actions
- Changing plans (e.g., Advantage or Premier)
- Changes to any other benefits (e.g., FSA, DCFSA, Life Insurance)
- Unrelated additions, removals, or coverage changes outside the qualifying life event

QLE	✓ Allowed	🚫 Prohibited
Marriage of employee	Employee drops coverage. Add spouse/dependents; enroll medical, dental, vision	Drop unrelated dependents
Divorce/legal separation of employee	Drop former spouse	Keep ex-spouse as active dependent; drop children unless they also lose eligibility
Birth/adoption/placement	Add self, spouse, child; enroll medical, dental, vision	Drop existing covered dependents unrelated to the event
Death of spouse/dependent	Drop deceased dependent	Add/drop or make changes to coverage for unrelated dependents or switch plans unrelated to the loss
Employee/spouse/ dependent gains/loses other coverage	Add/drop self or that dependent; enroll medical, dental, vision	Add/drop coverage for other family members not affected
Court order/QMCSO	Add required child/dependent; enroll in medical, dental, vision	Drop court-ordered coverage while order is in effect
Medicare/Medicaid/CHIP eligibility change	Add/drop affected person consistent with entitlement or loss; enroll medical, dental, vision	Add/drop coverage for unaffected dependents

Finding a health care provider

With a growing nationwide PPO network* with more than 1.5 million providers and over 6,400 facilities,** Cigna HealthcareSM offers you a range of quality choices to help you stay healthy.

Three ways to find what you need

There are three ways to find a network provider:

- If you're already enrolled, visit **myCigna.com** and log in using your user ID and password.
- Visit Cigna.com and click **"Find a Doctor, Dentist or Facility."** Be sure to select PPO***
- Call **Sage or CNN** during business hours.

Features on myCigna.com allow you to:

- Narrow your results by distance, specialty and more.
- Email a copy of your search results.
- Find doctors in 21 different medical specialties who meet certain quality and cost-efficiency measures and have been awarded the Cigna Care Designation.
- Estimate procedure costs based on Cigna Healthcare historical data.

A good way to avoid unexpected medical bills is to know how your plan works. Certain choices you make can affect what you'll pay out of pocket.

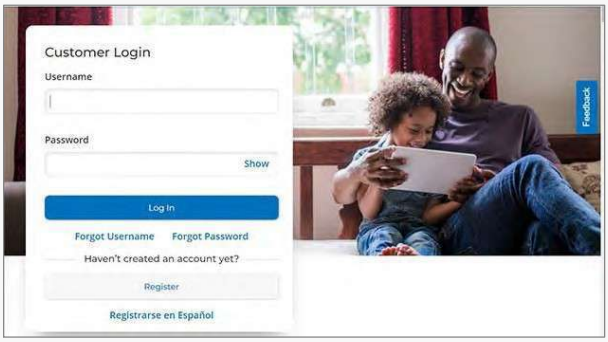
In-network vs. out: what's the difference?

To help you save money, your health plan provides access to a network of providers. These include:

- Doctors
- Hospitals
- Labs
- Radiology centers
- Surgical centers

Option 1

Log in to myCigna.com



1. Visit Cigna.com and click on "Find a Doctor, Dentist or Facility" (upper right).
2. Choose "Employer or School."
3. Enter the geographic location you want to search and select the search type.
4. Log In or Register for myCigna.com, or "Continue as guest."
5. Fill in the "I Live in" field and choose "Continue."
6. Select the PPO option that appears on your screen.***

Option 2

Call Sage or CNN during business hours.
Sage: 855-929-5956
CNN: 913-600-7150 or 913-600-7130

cigna healthcare

MEDICAL

	Premier Plan In-Network	Direct Primary Care (DPC) & Nurse Navigation	Advantage Plan In-Network
Calendar Year Deductible (Individual/Family)	$1,000| $2,000	**$0 Deductible & $0 Coinsurance Options Available with Both Plans**	$3,500 | $7,000
Calendar Year Out-of-Pocket Max (Individual/Family)	$6,500 | $13,000		$6,500 | $13,000
Coinsurance	20%		10%
Routine Preventative Care	100% Covered		100% covered
Physician Office Visit	$25 Copay	**$0 with Direct Primary Care**	$40 Copay
Specialist Office Visit	$35 Copay	***Copay as Listed***	$50 Copay
Rehabilitation (PT, OT, ST)	$25 Copay	***Copay as Listed***	$40 Copay
Chiropractic Care (20 visit limit per year)	$25 Copay	***Copay as Listed***	$40 Copay
Urgent Care	$100 Copay	**$0 with Direct Primary Care or MyCatholicDoctor.com**	$125 Copay
Emergency Room	$450 Copay, then Ded + Coinsurance (ded & coins waived if admitted)	***Copay as Listed, then Ded + Coinsurance (ded & coins waived if admitted)***	$550 Copay, then Ded + Coinsurance (ded & coins waived if admitted)
Maternity	Ded + Coinsurance	**Pay Deductible only with Nurse Navigation** ****member must be engaged with CNN by week 12 of their pregnancy****	Ded + Coinsurance
Inpatient Hospital Care	Ded + Coinsurance	**$0 with Nurse Navigation**	Ded + Coinsurance
Outpatient Hospital Care	Ded + Coinsurance	**$0 with Nurse Navigation**	Ded + Coinsurance
Mental Health	$25 Copay	***Copay as Listed***	$40 Copay
Labs	Ded + Coinsurance	**$0 at in-network independent lab**	Ded + Coinsurance
Imaging	Ded + Coinsurance	**$0 with Nurse Navigation**	Ded + Coinsurance

	Premier Plan Employee Cost Per Pay Period	Tier	Advantage Plan Employee Cost Per Pay Period
Employee Share	$87.00	**Employee Only**	$49.20
	$270.90	**Employee + Spouse**	$229.50
	$228.30	**Employee + Child(ren)**	$194.10
	$297.30	**Employee + Family**	$253.20
Employer Share	$203.00	**Employee Only**	$196.80
	$632.10	**Employee + Spouse**	$535.50
	$532.70	**Employee + Child(ren)**	$452.90
	$693.70	**Employee + Family**	$590.80

Natural Family Planning - For Members Covered by the Medical Plan

This benefit includes education and counseling visits (in-person or virtual) to learn Natural Family Planning, office visits, and testing materials, at no cost to you through MyCatholicDoctor.com.

Any medically necessary addional c are (such as labs, ultrasounds, surgery, etc) ordered by a MyCatholicDoctor.com provider will also be available at no cost to you, provided that such care is facilitated through your Nurse Navigator.

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.

Please Note: Some items such as the Oura ring, or electives such as a charting application, are not reimbursable

Counseling Services

Individual, marriage and family counseling services are available at no cost if obtained from **MyCatholicDoctor.com/archkck**. See page 10 for more information.

Gianna Family Care

Direct Primary Care services for adults only: covered with KerixHealth affiliation at NO COST to members

Fertility/Hormonal Care services: $60/month Covered with KerixHealth Affiliation
$80/month billed to patient & reimbursable at the out-of-network benefit level by submitting a claim to Sage (12 month lifetime maximum)

Prenatal/Obstetric Care: $60/month Covered with Nextera Affiliation
$80/month billed to patient & reimbursable at the out-of-network benefit level by subming a claim to Sage

Additional Services (Newborn Hospitalization Care, Delivery Fees, Circumcision): Billed to patient & reimbursable at the out-of-network benefit level by subming a claim to Sage.

Reimbursements will be submitted as out-of-network claims and will be processed the same way as the rest of your out-of-network benefit, meaning that, after you have satisfied your out-of-network deductible, you will be reimbursed at 60% on both the Premier and Advantage plans.
Timely Filing: Complete reimbursement requests must be received by the TPA within 180 days of the last day of the month for which the monthly fee applies. Requests received after 180 days will be denied.
Reimbursement instructions can be found on page 21 of this benefit guide.

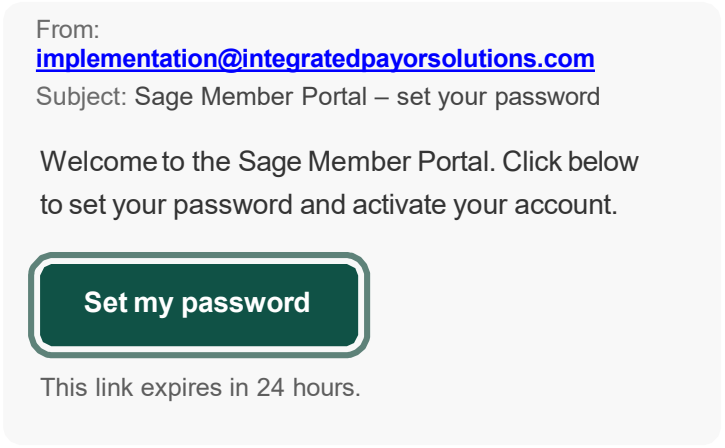
MEMBER PORTAL GUIDE:
Getting into your Sage portal

Set your password, find your username and log in. Portal address: sagetpa.my.site.com/members

1 Set your password

You'll receive an email with a link to set your password.

- It comes from **implementation@integratedpayorsolutions.com**. Check your junk and spam folders.
- **The link expires after 24 hours.** Set your password as soon as it arrives.
- It is sent to the email address you entered in Paylocity.



2 Know your username

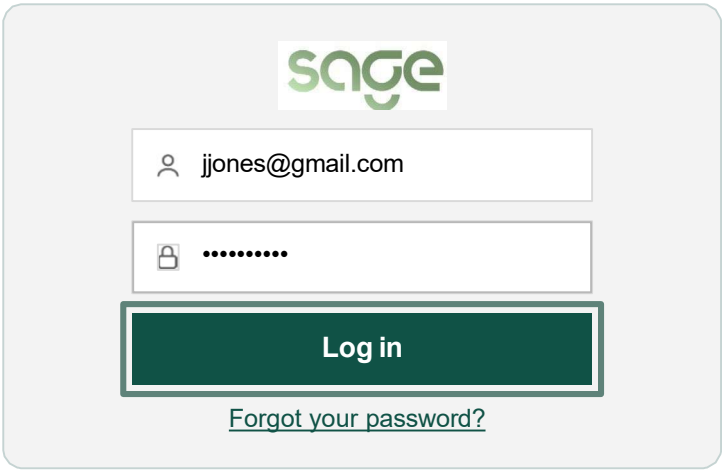
The employee's username is the **email address on file**. Each family member's username is that same email plus the **last two digits of their member ID**.

EMPLOYEE	SPOUSE	CHILD 1	CHILD 2
Email on file	ID ends in **02**	ID ends in **03**	ID ends in **04**
jjones@gmail.com	**jjones@gmail.com02**	**jjones@gmail.com03**	**jjones@gmail.com04**

Each login shows only that person's own claims, as HIPAA privacy rules require. See page 2 for details.

3 Log in

- Enter your username from step 2.
- Enter the password you set, then click **Log in**.
- Forgot your password or your link expired? Email **archkckbenefits@sagetpa.com** and we'll send a new link.

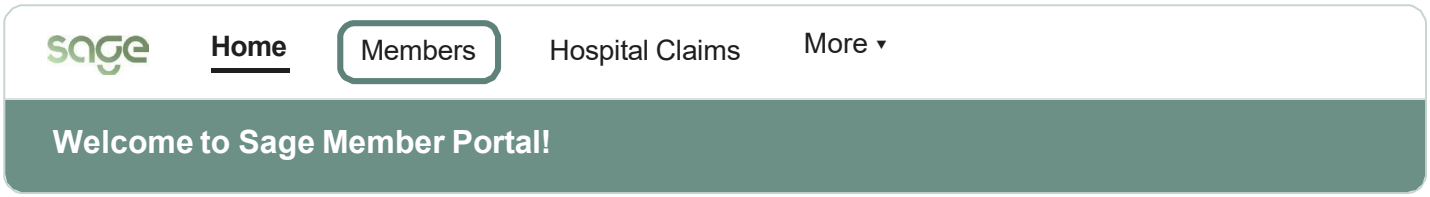


Screens shown are examples

Questions or need a password reset?
Email **archkckbenefits@sagetpa.com**

MEMBER PORTAL GUIDE:

Getting around: use the menu at the top

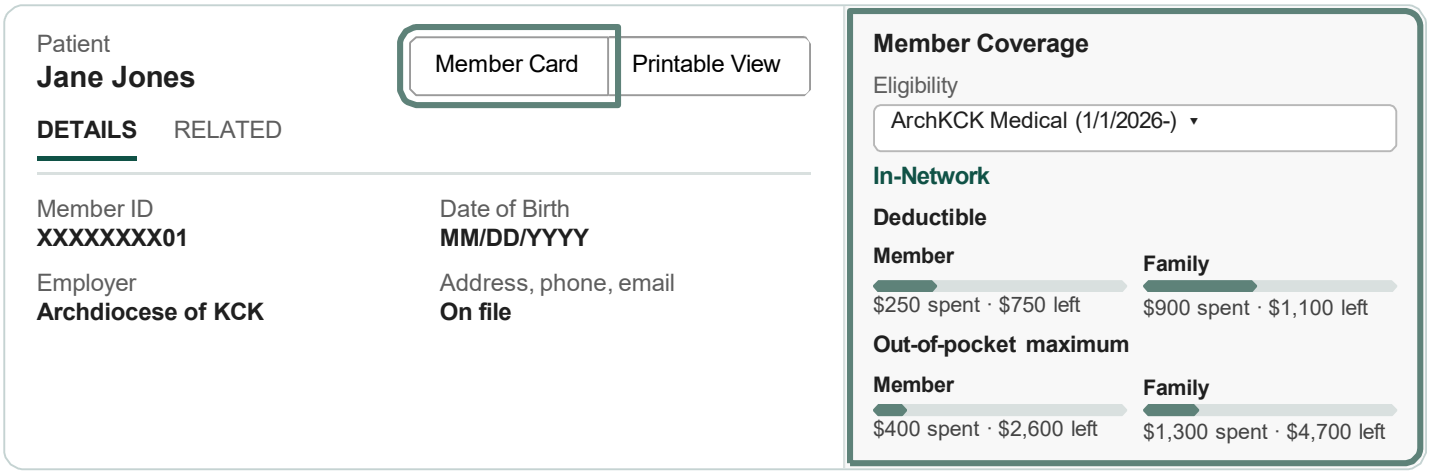


Members
Your ID card and benefits used

Hospital Claims
Hospital and facility claims

More
Physician, office and lab claims

Your member page



Get your ID card

1. Click **Members** in the top menu.
2. Click **your name** in the Patient Name column.
3. Click **Member Card**, then download or print it.

See your deductible and out-of-pocket

1. Open your member page (steps 1–2 at left).
2. Look at **Member Coverage** on the right.
3. See **Member** and **Family** totals, in network and out of network.

Your login shows only your own claims

Each person on the plan has their own login. The employee cannot see a spouse's or child's claims, and a spouse or child cannot see the employee's claims. To view a family member's claims, log in with that person's username. **Family deductible and out-of-pocket totals show in every login.**

Questions or need a password reset?
Email **archkckbenefits@sagetpa.com**

MEMBER PORTAL GUIDE:
Viewing claims and EOBs

Your claims list

Professional Claims (CMS-1500)
All Processed Claims ▾

Printable View

Claim number	Status	Service date	Total charge	You owe	Plan paid
PC-000100001	Accepted (T)	1/13/2026	$310.00	$0.00	$135.00
PC-000100002	Accepted (T)	1/30/2026	$220.00	$35.00	$130.00
PC-000100003	Accepted (T)	2/12/2026	$150.00	$0.00	$123.00

- **Get there:** click **Hospital Claims** in the top menu, or **More** ▾ for physician, office and lab claims. You'll see only your own claims.
- **Printable View** prints the whole list.
- **Click a claim number** to open that claim's details.
- See what was charged, **what you owe** and **what the plan paid** on each claim.

View and print your Explanation of Benefits (EOB)

Professional Claim (CMS-1500)
PC-000100001

Total Charge **$310.00** Status **Accepted (T)**

DETAILS RELATED **EOB**

Provider
Example Medical Group

EOB

Explanation Of Benefits

THIS IS NOT A BILL
Claim number, dates of service, provider, and how the claim was paid.

1. Open **Hospital Claims**, or **More** ▾ for physician, office and lab claims.
2. Click the **claim number** you want.
3. Click the **EOB** tab.
4. Click the **print** icon to print it, or the **download** icon to save a PDF.

An EOB is not a bill

It shows how your claim was processed. If you owe anything, your provider will bill you directly. Compare the EOB with any bill you receive before you pay.

Questions about the portal or a claim, or need a new password link?
Email archkckbenefits@sagetpa.com

Screens and amounts shown are examples

TELEHEALTH

MyCatholicDoctor

MyCatholicDoctor is a nationwide organization that brings a network of faithful medical professionals to you through video appointment (telehealth), at NO COST to you. We offer rapid access urgent care 24/7/365, as well as appointment-based visits. Appointment-based visits will have NO COPAY 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.

$0 for all members

to get started, scan the QR code or 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

Smartphone access appointments by video or phone. Confidential visits available during evenings, weekends, and holidays.

Services Offered in Kansas & Missouri:

- Virtual Primary Care
- Pediatric Care
- Women's Health & Fertility
- Men's Health
- Mental Health
- Functional Medicine
- Care for the Aging
- Covid Care
- Dermatology
- Addiction Care
- Adolescent Medicine
- Cognitive Impairment & Dementia Services (KS only)
- Endocrinology
- Genetic Counseling
- Lifestyle Medicine (KS only)
- Lactation Consultation
- Miscarriage and Infant Loss Support
- Natural Family Planning
- PCOS Care
- Palliative Care & End-of-Life Care
- Pediatric & Adolescent Gastroentology (KS only)
- Physical Therapy, including pelvic floor PT
- Podiatry (KS only)
- Sleep Medicine
- Vaccine and Medication Consultation
- Vestibular & Balance Physical Therapy
- Wellness Clinicians
- Wound Care

In an emergency, always call 911.

PRESCRIPTION DRUGS

OptumRx

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 a e active January 1, 2026. 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.

Your spend on prescription drugs counts for your maximum out-of-pocket.

Prescription Drugs	Premier Plan	Advantage Plan
Tier 1 Retail (30-day Supply) Tier 1 Mail Order (90-day Supply)	Lesser of $5 or actual cost Lesser of $15 or actual cost	Lesser of $5 or actual cost Lesser of $15 or actual cost
Tier 2 Retail (30-day Supply) Tier 2 Mail Order (90-day Supply)	25% of cost up to $50 25% of cost up to $50	25% of cost up to $75 25% of cost up to $75
Tier 3 Retail (30-day Supply) Tier 3 Mail Order (90-day Supply	40% of cost 40% of cost	40% of cost 40% of cost
Specialty Drugs	25% of cost up to $300	25% of cost up to $350

Pharmacy at your fingertips

The Optum Rx website and app are fast, easy and secure ways to get the information you need to make the most of your pharmacy benefit. Register for an online account and you can:

- Check drug prices
- Place a home delivery order
- Track home delivery order status
- Access and print your ID card

- Find a network pharmacy
- Sign up for automatic refills
- View claims and benefit information

Download the Optum Rx mobile app

Take the same **OptumRx.com** tools with you on the go by downloading the app. Manage your medication any time, anywhere.

Download on the App Store

GET IT ON Google Play

Register now

To set up your online account:

1. Go to **OptumRx.com** or scan the QR code below
2. Select Register on the home page
3. Enter the information from your member ID card
4. Create a username and password
5. Complete your profile

If you already have an account, sign in using your username and password.

Scan here to go to **OptumRx.com**

Save time and manage your medication using these Optum Rx digital tools

Home delivery

- Transfer your prescriptions to Optum® Home Delivery and get a 90-day supply delivered to your home.
- Manage home delivery medication renewals, track delivery status and view your medications filled at a network pharmacy.
- See how you may save on your medications.

More features and tools

- Price a drug and compare costs from different pharmacies or find lower-cost alternatives.
- View your prescription drug list/formulary to see covered drugs.
- Use the Pharmacy locator tool to find the closest network pharmacy.
- View claims and benefit information like your deductible, out-of-pocket costs and claims history.
- Submit and track a prior authorization request.

Tell us how you want to hear from us

- Sign up for paperless communications.
- Opt in for personalized emails.
- Set up text message pharmacy notifications and medication reminders.

CONCIERGE NURSE NAVIGATORS

Nurse Navigation Available to All Enrolled Members of the Medical Plan

CONCIERGE NAVIGATION - Let's find the highest-qualitydoctors for YOU!

- Choosing facilities that deliver proven high-quality care
- Choosing doctors and facilities that gladly accept your health plan
- Help maximizing your benefits and reducing your out of pocket
- Understanding your diagnosis and treatment options
- When is a second opinion appropriate?

Call BEFORE you schedule care.

ELIMINATE YOUR DEDUCTIBLE & COINSURANCE

WHY SEEK QUALITY FIRST?

- **Less Misdiagnosis**
- **Lower Infection Rates**
- **Fewer Complications**
- **Lower chance of returning to hospital after being discharged.**
- **Reduced patient harm and death**
- **Less Cost**
- **Right Care, Right Time, Right Place.**

What qualifies for *WAIVED DEDUCTIBLE & COINSURANCE* under the Concierge Nurse Navigator program?

- **Imaging** – CT Scan, MRI, Ultrasound, Echocardiogram, etc.
- **Scheduled Inpatient/Outpatient Surgeries** – Hip Replacement, Heart Bypass Surgery, Knee Replacement, etc.
- **Scheduled Outpatient Procedures** – Colonoscopy, Heart Catheterization, etc.
- **Second Opinions** – with a highly qualified physician or Center of Excellence (i.e. cancer diagnosis or treatment, spine surgery or fusion, complex surgeries)

Contact your local Concierge Nurse Navigators

for assistance navigating the complex healthcare system.

CONCIERGE NURSE NAVIGATORS



Jill Stean, RN
913-600-7150 voice/text (HIPAA secure)
Jill@mynursenavigators.com



Jessica Zulauf, RN
913-600-7130 voice/text (HIPAA secure)
Jessica@mynursenavigators.com

In an emergency,always call 9-1-1.

MEDICAL SUPPLIES

CONCIERGE NURSE NAVIGATORS

Medical Products & Services

ConnectDME



ConnectDME is the leading provider of supplies direct to home. We are committed to caring and providing you solutions that make it easy to choose and receive the products needed to live your best life. We help keep life simple: from product awareness and order status, to insurance coverage details, we are advocates through the complexities of healthcare. For over 90 years, customers have trusted us to get supplies easily, urgently, and accurately.

- CPAPs, BiPAPs
- CPAP Supplies
- Nebulizers
- Joint & Back Braces
- Boot Walkers
- Knee-Wheelers
- Catheters
- Sleep Study
- Bone Stimulators
- TENS Units
- Cold/Heat Therapy
- Breast Pumps
- Compression Therapy

ZERO COPAY 100% BENEFIT

FREE Shipping & handling and Next-day shipping
FREE In-home setup and training

NO COST to you or your family
Contact your Nurse Navigators at
913-600-7150 913-600-7130

Diabetic Supplies

Diathrive
Confidence delivered.



Diathrive opened in 1928 as a small corner pharmacy in Ohio and has grown to become a leading nationwide provider of medical supplies. Our decades of experience enable us to offer you the largest selection of products and brands, comprehensive insurance coverage and hassle-free ordering.

QUALITY DIABETES TESTING SUPPLIES

Supplies delivered straight to your door at NO COST to you.

- FDA-approved
- Accurate and reliable
- Delivered every 3 months

BEHAVIORAL HEALTH

CONCIERGE NURSE NAVIGATORS®

ViCARE® *A Behavioral Health Solution*

ViCare® is a program to enable lifestyle change and sustainably treat serious anxiety, depression, and stress.

No pre-authorization needed. No co-pay or deductible

ViCare® is frictionless, members do not need pre-approval, and there are no co-pays or deductibles*.

We use real therapists that we call ViCare® Guides to form relationships with those enrolled in our programs.

Your ViCare® Guide works with you to create a care plan and schedules regular appointments to track progress.

Find out how ViCare® can help you!
Contact your dedicated Nurse Navigators:



Jill Stean, RN
913-600-7150 voice/text (HIPAA secure)
Jill@mynursenavigators.com



Jessica Zulauf, RN
913-600-7130 voice/text (HIPAA secure)
Jessica@mynursenavigators.com

CONCIERGE NURSE NAVIGATORS®

DIRECT PRIMARY CARE

You will love this new health benefit.

You now have the benefit of personalized, ongoing care from a primary care doctor without leaving the comfort of home!

Local doctor, $0 copays, $0 deductibles, Unlimited Visits

All NEW value-based Primary Care program means
more time with your doctor for a Better YOU!

Use Direct Primary Care for:

Prevention & Wellness
Check in on your current health and make a personalized plan to stay healthy and strong.

Mental Health Services
Help for depression, anxiety and more

Disease Management
Support managing asthma, diabetes, hypertension, obesity, high cholesterol, smoking, COPD and more.

Urgent Care Issues
Talk to your doctor in minutes for sinus infection, UTI, cold, flu rash, headache and more.

Referrals, Tests and More
Our doctors can:

- Order labs, tests and screenings
- Provide sick notes and documentation
- Work with your Nurse Navigator for referrals to High-Quality specialists



Care on your time.

- direct access to your doctor
- text/consult your doctor directly
- convenient video/image consults
- schedule appointments directly via app



No Copays, No Hassles

This care & service is available 24/7/365 with a concierge physician who works for YOU. Primary care, disease management and urgent issues for adults.

As published by the *International Journal of Health Sciences, "*Primary Care is by far the most significant variable related to better health status, correlating with lower mortality, fewer deaths from cancer and heart disease, as well as a host of other beneficial outcomes"

In an emergency, always call 911.

DIRECT PRIMARY HEALTH

NEXTERA HEALTHCARE
a KerixHealth company

Primary Care Redefined

Affordable
Accessible
Exceptional



Embracingthe Direct PrimaryCare Model

Your KerixHealth Primary Care membership offers you and your adult family members a convenient and cost-effective solution. Direct primary care eliminates insurance hassles by providing unlimited access to your doctor, extended appointment times, and a focus on pro-active care, delivering enhanced value from your primary care coverage.

What KerixHealth Offers You:

$0 Primary Care/ Urgent Needs

With KerixHealth, enjoy quick access to comprehensive primary care services like check-ups, physicals, urgent needs, and chronic disease management, for example asthma and mental health care. Our direct primary care membership provides convenient, no cost access to personalized healthcare, ensuring you receive the best and time appropriate care for your health needs.

$0 After Hours, Holidays and Weekends Care

At KerixHealth, your well-being is our priority, even after regular office hours. Our after-hours urgent care service allows you to connect with a doctor on call for immediate assistance, ensuring you receive timely and expert care whenever you need it most.

Secure App

Experience seamless healthcare with Nextera Healthcare's HIPAA secure app. Accessible 24/7, our app allows you to request appointments, seek after-hours help, stay connected to your care team and communicate directly with your physician. Enjoy peace of mind with healthcare that's always within reach.

Our Services:

- Acute care and chronic disease management
- Allergy management
- Dermatology
- Mental health Management
- Sleep assessment and support
- Stress management
- Sprains, lacerations and broken bones
- Weight management and health risk assessment
- Women's and Men's Health

In addition to the services above, KerixHealth membership offers patients:

- After-hours care for more urgent medical needs (non-life threatening emergencies)
- Remote or virtual access to physicians via email or phone if you are busy or traveling
- Deeply discounted imaging and laboratory services
- Same Day/ Next Day appointments
- No Copays or Deductibles

Ready to Use Your KerixHealth Membership? Call us today at 303-501-2600 for your first appointment

Locations Near You www.kerixhealth.com care@kerixhealth.com

FLEXIBLE SPENDING ACCOUNTS (FSA)

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

Please note: You must be enrolled in the medical plan to participate in a Health Care FSA account.

Triple Tax Advantage with an FSA

The money you contribute to an 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 ClaimFiles	What happens to any unused balance at the end of the year?
Health Care FSA* *Medical plan enrollment required	$3,400*	December 31, 2026	March 31, 2027	You can carry over up to $680 of your unused balance year-to-year, and the remaining funds left in your account at the end of the year will be FORFEITED.
Dependent Care FSA*	$7,500 ($3,750 if married and filing separately)	December 31, 2026	March 31, 2027	Any funds left in your account at the end of the year will be FORFEITED.



MEDICAL FLEXIBLE SPENDING ACCOUNTS (FSA)

Health Care FSAs allow employees to set aside money for health costs referred to as “qualified expense" which include deductibles, copayments, coinsurance, prescription medications, dental and vision care and can help save you money and make budgeting for medical costs easier.

	Health Care Flexible Spending Account Information (FSA)
Eligibility	You must be an employee enrolled in a medical plan.
2026 Contribution Limits	$3,400
Eligible Medical Expenses	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	Employer
Require Proof of Expenses	Yes, you need to retain proof of payment. Validation will be required except for debit card swipes for set copays associated with the medical or pharmacy benefit
Changes to Contributions	Only during open enrollment.
Disbursement of Funds	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	Upon termination, participation in the Health Care 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. Submit claims after your employment terminates by contacting Paylocity at batinfo@paylocity.com or 1-800-631-3539
Balance Carry Over (or rollover)	Up to $680 of unused funds can be carried over to the following year, with the remainder of the unspent balance being forfeited.
Investment Options	No
Expiration	All money in a Health Care FSA expires and is lost at the end of the year; up to $680 may be rolled over to the next plan year.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS (DCFSA)

A Dependent Care FSA (DCFSA) is a pre-tax benefit account used to pay for eligible dependent care services, such as preschool, summer day camp, before or after school programs, and child daycare. It's a smart, simple way to save money while taking care of your loved ones so that you can continue to work.

These funds may only be used for dependents aged 13 years or younger.

	Dependent Care Flexible Spending Account Information (DCFSA)
Eligibility	To be eligible for a Dependent Care Flexible Spending Account (DCFSA), you must: Have a dependent: You must have a dependent who is under 13 years old or who is mentally or physically unable to care for themselves. Claim the dependent: You must claim the dependent on your federal tax return. Pay for care: You must pay for the dependent's care so that you can work, look for work, or go to school full-time.
2026 Contribution Limits	$7,500
Eligible Medical Expenses	Childcare, such as daycare, babysitting, and preschool, Before- and after-school programs, Summer day camps (not overnight camps) Application fees and registration fees for qualifying programs, Transportation to and from eligible dependent care services, Payroll taxes related to eligible dependent care
Account Owner	Employer
Require Proof of Expenses	Yes, you need to retain proof of payment. Validation will be required except for debit card swipes for set copays associated with the medical or pharmacy benefit.
Changes to Contributions	Only during open enrollment.
Disbursement of Funds	DCFSA funds are available through payroll deductions, and you can use them to pay for eligible dependent care expenses.
Portability and Forfeiture	If the Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. Any balance remaining in the Participant's Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited. Submit claims after your employment terminates by contacting Paylocity at batinfo@paylocity.com or 1-800-631-3539
Balance Carry Over (or rollover)	No carry over or rollover.
Investment Options	No
Expiration	All money in a DCFSA expires and is lost at the end of the year.

HOW TO FILE AN OUT-OF-NETWORK MEDICAL CLAIM

Same Day Reimbursements Made Simple. Sage offers same-day reimbursements for eligible medical expenses when requested via Venmo or Zelle, based on your benefit coverage.

1

Get an itemized receipt (or superbill)

Your documentation must include:

- Patient name + one identifier (DOB, address, or phone)
- Date of service + procedure codes (CPT)
- Charges + proof of payment
- Provider name + one identifier

2

Choose Payment Method

We can send your reimbursement the same day via Venmo or Zelle.

You must include your username or handle for same day reimbursements

If those apps are not an option, we'll issue a paper check (please allow up to 30 calendar days for processing)

3

Send an Email

To:	archkckbenefits@SageTPA.com
Subject:	Reimbursement Request for First Name Last Name

The email must include:

- First Name & Last Name
- Provider
- Date of Service
- Total payment made
- Chosen Payment Method: Venmo, Zelle, or Paper Check -*Venmo or Zelle username (if applicable)*
- Itemized Receipt or Superbill

4

We verify and process your request and confirm once complete.

Note: Processing begins only after all required information is received and is subject to plan coverage and review. Complete reimbursement documentation **must** be received within 180 days of the date of service. Requests received after the 180 day deadline will be denied.

Questions? Reach out to: archkckbenefits@SageTPA.com

HOW TO FILE OUT-OF-NETWORK CLAIMS

Prescription:

1. Login in at: www.optumrx.com
2. Select member
3. Enter prescription details
4. Upload receipt
5. Confirm & submit

Flexible Spending Account:

1. Login in at: https://access.paylocity.com/
2. Go to Spending Accounts / Benefits
3. Select File a Claim
4. Enter details + upload receipt/EOB
5. Add to Claims Basket → Submit

*__Docs must show__ patient name, provider name/address, date of service, amount charged.

Life/AD&D, Accident, Disability, Critical Illness, Hospital Indemnity:

1. Login in: www.mutualofomaha.com/my-benefits
2. Select "Submit Claim"
3. Complete the required form(s) & submit required documents
4. Confirm & submit the form(s)

Forms may also be downloaded and faxed to the following:

Fax:
ATTN: Claims
402-997-1869

Mailing Address:
Mutual of Omaha (ATTN: Claims)
3300 Mutual of Omaha Plaza,
Omaha, NE 68175

HOW TO FILE OUT-OF-NETWORK CLAIMS

Vision (VSP)

1. Log in: vsp.com
2. Go to *My Benefits*
3. Submit a Claim
4. Complete form + upload receipt
5. Submit

*Receipt must include: provider name, patient name, date of service, services received + cost.

Dental:

1. Log in: deltadentalins.com
2. Claims & Visits → How to File a Claim
3. Download claim form
4. Complete + sign (**dentist must also sign**)
5. Mail originals (keep copies)
6. Required statement/receipt must include:

- Dentist name, address, phone
- Dates of service
- Procedure codes + fees
- Affected teeth + total cost
- NPI, TIN, license number, specialty code

Mail: Delta Dental of California PO Box 997330, Sacramento, CA 95899-7330

Gianna Family Care:

1. Email: archkckbenefits@SageTpa.com
2. Include:

- Receipt/superbill (patient identifier, CPT codes, charges/payment, provider identifier)
- Provider name
- Date of service
- Total paid
- Payment method (Venmo/Zelle/Check) + username if needed

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 oes not apply towards the Annual Maximum
Type II Procedures	Regular fillings (amalgam or composite), extractions, nonsurgical root canals	After the deductible is met, the plan pays 80% of the Maximum Plan Allowance
Type III Procedures	Inlays, crowns, dentures, implants	After the deductible is met, the plan pays 60% of the Maximum Plan Allowance
Type IV Procedures	Orthodontia services For adults and children	After the 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	$8.99	$13.50
Employee + Spouse	$25.69	$38.53
Employee + Child(ren)	$22.15	$33.24
Employee + Family	$28.32	$42.49

VISION

Group #351035

Vision benefits offered through VSP. 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 1-800-877-7195

Benefit	VSP 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

** Progressive lenses are covered to provider's contracted fee for lined Bifocal Lenses. Members are responsible for the difference between the base lens and the progressive lens charge.

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

LIFE AND AD&D

Group #: G000CV3Y

100% Employer Paid

Basic Life and AD&D

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 employerat a flat $25,000. Benefit is 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

GUARANTEED ISSUE LIFE

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

100% Employee Paid

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 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	$150,000	$150,000, in increments of $10,000
Spouse	$5,000	100% of employee's benefit, up to $75,000	100% of employee's benefit, in increments of $5,000, up to $75,000
Child(ren)	$5,000	100% of employee's benefit	100% of employee's benefit, in increments of $5,000, up to $10,000

Who is eligible for this insurance?
You must be actively working (performing all normal duties of your job) at least 30 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). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

GUARANTEED ISSUE LIFE

Voluntary Term Life Insurance

100% Employee Paid

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

Scan the QR code for a customized presentation to explain your *Guaranteed Issue Election option with no benefit waiting periods*

- Guarantee Issue amount for Employee- $10,000 increments, up to $150,000
- Guarantee Issue amount for Spouse- 100% of employee's benefit, up to $75,000
- Guarantee Issue amount for Child(ren) under 26- increments of $5,000 per child, $10,000 maximum benefit
- No medical exam
- Policy issue is guaranteed
- Rate Guarantee = 3 Years (01/01/2029)

COST SUMMARY*

Voluntary Term Life

Age Band	Employee & Spouse Rate per $1,000	All Children Rate per $1,000
<25	$0.06	$0.10
25 - 29	$0.06	
30 - 34	$0.08	
35 - 39	$0.10	
40 - 44	$0.14	
45 - 49	$0.23	
50 - 54	$0.36	
55 - 59	$0.56	
60 - 64	$0.71	
65 - 69	$1.27	
70 - 74	$2.10	
75 - 79	$3.70	
80 - 84	$3.70	
85 - 89	$3.70	
90 - 100	$3.70	

* This plan is rated using the same rates for the employee and spouse. Employee and spouse rates are calculated based on the employee's current age as of the effective date of the plan. Employee and spouse rates are adjusted once each year on the plan anniversary date for employees advancing to the next age band. Spouse coverage terminates when the employee attains age 70 (regardless of the spouse's actual age).

Questions?
Please contact your dedicated Benefits Educator, Pam Eisenberg at
Pamela.Eisenberg@Mutualofomaha.com
617-716-9920

DISABILITY

Group #: G000CV3Y

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
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



VOLUNTARY ACCIDENT

Group #: G000CV3Y

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 Mutual of Omaha.*
  - *Pays a benefit for 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	4.32
Employee Spouse	7.04
Employee Child(ren)	8.00
Family	10.72

High Plan - Per Pay Period Premium	
Employee	6.16
Employee Spouse	10.49
Employee Child(ren)	12.10
Family	16.42

VOLUNTARY CRITICAL ILLNESS

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 portal

VOLUNTARY HOSPITAL INDEMNITY

Group #: G000CV3Y

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 childcare, 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	$7.12
Employee + Spouse	$15.05
Employee + Children	$12.23
Family	$20.15



EMPLOYEE ASSISTANCE PROGRAM

Mutual of Omaha

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Enhanced EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Three sessions per year (per household) conducted by face-to-face* counseling or telehealth (text, chat, phone or video) via a secure, HIPAA compliant portal

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Continued on next page.

WHEN TO USE YOUR EAP



STRESS, GRIEF OR LOSS

RELATIONSHIP AND FAMILY CHALLENGES

LEGAL OR FINANCIAL CHALLENGES

SUBSTANCE DEPENDENCE OR ADDICTION

Enhanced EAP Services *(continued)*

Features	Value to Company and Employees
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers for face-to-face counseling • National network of more than 30,000 licensed clinical providers for telehealth counseling • Network continually expanding to meet customer needs
Access	•Flexibility to meet individual client/member needs • 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources — legal libraries, tools and forms — available on EAP website • A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health • A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney
Employee Family Work/Life Services	• Child care resources and referrals • Elder care resources and referrals
Online Services	• An inclusive website with resources and links for additional assistance, including: • Current events and resources • Substance abuse and addiction • Family and relationships • Legal assistance • Work and career • Emotional well-being • Physical well-being • Financial wellness • Full Time • Bilingual article library • All materials available in English and Spanish
Employee	employees and their immediate family members; including the employee, spouse and
Communication **Eligibility**	dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

TRAVEL ASSISTANCE

Take comfort in knowing that Travel Assistance* travels with you worldwide, offering access to a network of professionals who can help you with local medical referrals or provide other emergency assistance services in foreign locations.

Enjoy Your Trip

We'll Be There If You Need Us — 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Pre-trip Assistance**

Minimize travel hassles by calling us pre-departure for:

- Information regarding passport, visa or other required documentation for foreign travel
- Travel, health advisories and inoculation requirements
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations
- Translation and Interpreter Services for emergency situations while traveling internationally

Emergency Travel Support Services

- Telephonic translation and interpreter services — 24/7 access to telephone translation services
- Locating legal services — referrals for local attorney or consular offices and help maintain business and family communications until legal counsel is retained (includes coordination of financial assistance for bonds/bail)
- Baggage — assistance with lost, stolen or delayed baggage while traveling on a common carrier
- Emergency payment and cash — assistance with advance of funds for medical expenses or other travel emergencies by coordinating with your credit card company, bank, employer, or other sources of credit; includes arrangements for emergency cash from a friend, family member, business or credit card
- Emergency messages — assistance with recording and retrieving messages between you, your family and/or business associates at any time
- Document replacement — coordination of credit card, airline ticket or other documentation replacement
- Vehicle return — if evacuation or repatriation is necessary, return your unattended vehicle to the car rental company

613210 *Brought to you by Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. Services provided by AXA Assistance USA (AXA)
**Available at any time, not subject to 100 mile travel radius



Worldwide Travel Assistance

Services available for business and personal travel.

For inquiries within the U.S. call toll free:
1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658



Worldwide Travel Assistance

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1-800-856-9947

Outside the U.S. call collect:
(312) 935-3658

TRAVEL ASSISTANCE

Medical Assistance

- Locating medical providers and referrals
- Communication on your medical status with family, physicians, employer, travel company and consulate
- Emergency evacuation if adequate medical facilities are not available, including payment of covered expenses
- Transportation home for further treatment – in the event of death, assist in the return of mortal remains
- Transportation arrangements for the visit of a family member or friend if your hospitalization is more than seven calendar days
- Return home for dependent children if your hospitalization is more than seven calendar days
- Assistance with lodging arrangements if convalescence is needed prior to, or after, medical treatment
- Coordination with your health insurance carrier during a medical emergency
- Assistance obtaining prescription drugs or other necessary personal medical items

Identity Theft

Your Travel Assistance benefit automatically includes Identity Theft Assistance, coordinated at no additional cost. Whether at home or traveling, this benefit provides education, prevention and recovery information to help you protect your identity.

Education and Prevention

- Comprehensive ID theft assistance guide
- Tips to defend against ID theft

Recovery Information

- Information regarding the steps to recover from credit card and check fraud
- Guidelines if your Social Security number is compromised
- Instructions for lost or stolen passport
- Contact list for financial institutions, credit bureaus and check companies

Assistance

If you need help with an ID theft issue, case managers are available 24 hours a day, seven days a week and can be reached by calling the same toll-free number used to contact AXA: 800-856-9947.

Travel Assistance Plan Limitations

AXA will not pay emergency evacuation, medically necessary repatriation, repatriation of remains or other expenses incurred while traveling within 100 miles of participant's place of residence, or for any one of the following reasons:

- A single trip lasts more than 120 days in length
- Traveling against the advice of a physician
- Traveling for medical treatment
- Pregnancy and childbirth (exception: complications of pregnancy)

There is a maximum benefit amount per person associated with emergency evacuation, medical repatriation and/or return of mortal remains.

All additional costs would be the responsibility of the member. This includes medical costs which are the responsibility of the person receiving medical services. Services must be authorized and arranged by AXA Assistance USA, Inc. designated personnel to be eligible for this program. No reimbursement claims for out-of-pocket expenses will be accepted.

Travel assistance services are independently offered and administered by AXA Assistance USA, Inc. (AXA). Insurance benefits provided as part of Travel Assistance underwritten by a third party. AXA is not affiliated in any way with Mutual of Omaha companies. Each company is responsible for its own financial and contractual obligations. There may be times when circumstances beyond AXA Assistance USA's control hinder its endeavors to provide services. AXA Assistance USA will make all reasonable efforts to help you resolve the emergency situation. Both companies are responsible for their own contractual and financial obligations. Additional limitations may apply. Please contact AXA for specifics.

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA.

Carry this card with you when you travel

Brought to you by Mutual of Omaha.
Services provided by AXA Assistance USA.

SAMARITAN FUND

samaritan fund program

THE ARCHDIOCESE OF KANSAS CITY IN KANSAS

Giving the Peace of Mind to Heal

The Samaritan Fund Program sources funds from Samaritan Sponsors to pay for all medical expenses for individuals with serious medical conditions with high-cost treatments.

"You are our guardian angel.... We are now not on edge, not stressed. Now we can focus on medical care and actually enjoy time with our daughter instead of stressing about the financial piece... Thank you, Thank you, Thank you"

- PARTICIPANT

SCAN TO APPLY



866-764-9290 | samaritanfundprogram.com
service@samaritanfundprogram.com

HOW IT WORKS

- If you have a serious medical condition with high-cost treatment, electronically submit a confidential Medical Insurance Release form.
- A Samaritan Fund Program Representative reaches out to explain the program, answer questions, and gather your information.
- If approved a personalized Samaritan Fund Program offer is issued.
- If you wish to accept you will sign and submit your offer letter.
- Your account is set up, and we issue your debit card for medical expenses.
- Enjoy the Peace of Mind to Heal and submit your feedback on your Samaritan Fund Program experience.

MEDICARE

Qualifications:

- Age 65 and older
- Under age 65 with certain disabilities
- Any age with End-Stage Renal Disease

The Four Parts of Medicare



Part A
Hospital Insurance

- Inpatient care in a hospital
- Inpatient care in a skilled nursing facility
- Hospice care
- Home Healthcare



Part B
Medical Insurance

- Doctors' services – Primary and Specialists • Outpatient Medical & Surgical services, supplies • Clinical lab tests & diagnostic tests • Durable medical equipment • Preventive Services • Expensive Drugs –Cancer/ Rheumatoid Drips



Part C
Medicare Advantage Plans • Covers All Benefits/ Services of Parts A&B • Includes Part D Prescription Drub Coverage at No Premium • Plans Provided by health Insurance Companies • Plans have Copays & Coinsurance up to a Max. Annual Limit • Includes Dental, Vision, Hearing,



Part D
Medicare Prescription Drug Coverage

- Covers prescription medication
- All plans have a monthly premium that varies by plan
- All plans have a set 6 tier drug formulary
- You pay Copays or coinsurance on your prescriptions
- Some plans have a deductible of up to $505 in 2023

When to enroll?

- Part A – 65th birthday. The IEP (Initial Enrollment Period) is a total of 7-month period when you are aging to 65. It includes the 3 months before 65, the month you turn 65 and the 3 months after age 65.
- Part B – Retire from active ministry. The SEP (Special Enrollment Period) is 60 days prior to the effective day after group coverage ends.
- Part C and D – not applicable to priests

How to enroll?

- Call 1-800-(Medicare) 633-4227
- www.ssa.gov via "MySocialSecurity" account
- If you have Part A but not Part B, Complete from 40 B

Contact our local Medicare advisors at no cost to you:

Jennings Insurance Group Kansas City Location: 816-472-0676

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.

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 or 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.html
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 Securit 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 medical 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.

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 medical plan will pay out-of-network providers and facilities directly.
- Your medical 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.

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 meetyour 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
Plan Administrator	Sage TPA	855-929-5956
Network	Cigna PPO Network	Cigna.com
Prescription Drug Benefits	OptumRx	855-524-0381 OptumRx.com
Direct Primary Care	KerixHealth	303-501-2600 care@kerixhealth.com
Nurse Navigation	Concierge Nurse Navigators	913-600-7150 913-600-7130
Telehealth	MyCatholicDoctor	888-822-8436 https://mycatholicdoctor.com/archkck
Dental Plan	Delta Dental of Kansas	800-234-3375 / 316-264-4511 deltadentalks.com
Vision Plan	VSP	800-877-7195 vsp.com
Life and AD&D	Mutual of Omaha	800-228-7104
Disability STD/LTD	Mutual of Omaha	800-228-7104
Voluntary Tem Life and AD&D, Accident and Critical Illness Insurance	Mutual of Omaha	800-228-7104
Voluntary Hospital Indemnity	Mutual of Omaha	800-228-7104
Flexible Spending Accounts (FSA)	Paylocity	800-520-2687 batinfo@paylocity.com
Employee Assistance Program (EAP)	Mutual of Omaha	800-316-2796 mutualofomaha.com/eap
Behavioral Health	ViCare	913-600-7150 913-600-7130
Samaritan Fund Program	Samaritan Fund	866-764-9290
Medicare	Jennings Group	816-472-0676

THE ARCHDIOCESE OF KANSAS CITY IN KANSAS

To view your benefits online, please visit
archkckbenefits.com

