EMPLOYEE BENEFITS GUIDE 2027



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 an average of 30 hours per 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 6 and 7 for more information.
Contact Person	Contact your **onsite** benefits administrator with any questions about the benefits plan.



YOUR HEALTH PLAN IS SELF-FUNDED

The Archdiocese pays member health claims directly, rather than purchasing a fully insured medical policy. That means every thoughtful health care choice helps protect both your household budget and the long-term value of the plan.

A SHARED RESPONSIBILITY

The goal is not to avoid care—it is to get the right care, in the right setting, at the right time. Preventive care, informed decisions, and the Archdiocese's care-navigation resources can improve outcomes while helping control unnecessary costs.

WAYS TO BE A GOOD STEWARD OF THE PLAN

1. Stay current with preventive care and discuss healthy habits with your provider.
2. Start with primary care, Direct Primary Care, or MyCatholicDoctor for non-emergency needs.
3. Use in-network providers and facilities whenever possible.
4. Call a Concierge Nurse Navigator before scheduling eligible imaging, surgery, or other planned care.
5. Take medications as directed and compare covered pharmacy options when a lower-cost alternative may be available.
6. Choose urgent care instead of the emergency room when the situation is not life-threatening.
7. Ask questions when a diagnosis, treatment, bill, or benefit is unclear.
8. Review your Explanation of Benefits and report anything that does not look right.

WHEN YOU NEED HELP

Your Concierge Nurse Navigators can help explain available resources, where to receive care and potential out-of-pocket savings if their guidance is followed. For questions about claims, eligibility and coverage, contact Sage TPA. Reaching out **before** care is scheduled can help you make the most of the benefits available to you.

CARE OPTIONS

Understanding your options can save time and money. If an illness or injury is life-threatening—or you are unsure whether it is an emergency—call 9-1-1 or go to the nearest emergency room. For non-life-threatening needs, use the chart below to help choose the most appropriate care option.

CALL 9-1-1 FOR CHEST PAIN, TROUBLE BREATHING, SEIZURES, STROKE SIGNS, SEVERE INJURY, OR LOSS OF CONSCIOUSNESS.

CARE OPTION	COMMON REASONS TO USE IT	GOOD NEXT STEP
EMERGENCY ROOM For serious or life-threatening conditions	Chest pain; stroke symptoms; seizures; severe bleeding; major burns; serious head injury; major or visibly displaced fractures.	**Call 9-1-1 when appropriate. ER cost sharing applies; see the 2027 Medical Plan Benefits.**
PRIMARY CARE / DPC Best starting point for routine and ongoing care	Wellness exams; preventive screenings; medication follow-up; chronic-condition care; minor illness; non-urgent rashes, strains, or infections.	**Use your regular provider or Direct Primary Care when available.**
VIRTUAL CARE Convenient care from home or while traveling	Cold, cough, allergies, flu, sore throat, sinus problems, headaches, minor skin concerns, stress, and other non-emergency needs.	**Use MyCatholicDoctor for 24/7 urgent care or scheduled care.**
URGENT CARE Prompt in-person care, including retail clinics	Sprains and strains; minor burns or cuts; insect bites; pink eye; strep symptoms; flu symptoms; minor fractures; vaccinations.	**If enrolled in DPC, contact your DPC first unless the situation can not wait. Confirm network status.**

PLANNING IMAGING, SURGERY, OR OTHER SCHEDULED CARE?

Call a Concierge Nurse Navigator before you schedule. A navigator can help identify high-quality options and explain when special plan benefits may apply.

*Costs vary by plan and place of service. Refer to the 2027 Medical Plan Benefits.

QUALIFIED 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
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

*For more information regarding Qualifying Life Events, please see page 7

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

Employee Actions:

1. Login to Paylocity at https://access.paylocity.com/
2. Navigate to and open BSwift Benefits.
3. Select the appropriate Life Event.
4. Upload all required supporting documentation for your QLE. Requests cannot be reviewed until all required documentation is received. Missing documentation will delay processing.
5. Review your request and documentation, then select Submit.

After submission, Arch KCK Human Resources will review the completed request and supporting documentation for approval or denial.

QUALIFIED 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

- Updating coverage tier (e.g., employee → family) occurs when applicable
- Enroll in or disenroll from available benefits
- Add or remove eligible dependents

🚫 Not Allowed Actions

- Changing medical plan or network options (e.g., Cigna to Centrus)
- Enrollment of anyone ineligible under the Archdiocese Benefit Plan

QLE	✓ Allowed	🚫 Prohibited
Marriage of employee	Employee drops coverage. Add eligible spouse/dependents	Add an ineligible person. Drop coverage unless joining the spouse's plan. Drop unrelated dependents.
Divorce/legal separation of employee	Drop former spouse. Enroll anyone losing other coverage.	Keep ex-spouse as active dependent; drop children unless they also lose eligibility
Birth/adoption/placement	Add self, spouse, child	Drop existing covered dependents unrelated to the event. Add ineligible dependent
Death of spouse/ dependent	Drop deceased dependent. Enroll eligible dependents losing other coverage.	Add/drop or make unrelated benefit or plan changes
Employee/spouse/ dependent gains/loses other coverage	Add/drop self or that dependent; enroll or waive coverage	Add/drop coverage for other family members not affected. Use voluntary cancellation or nonpayment as a QLE
Court order/QMCSO	Add/remove child/dependent as required	Drop court-ordered coverage while order is in effect
Medicare/ Medicaid/ CHIP eligibility change	Add/drop affected person consistent with entitlement or loss.	Add/drop coverage for unaffected dependents
Employment status/hours/Leave	Add/drop affected person when eligibility changes. Enroll or waive coverage when permitted	Make changes when the employment does not affect eligibility or coverage
Residence change	Switch ArchKCK benefit plans if the move affects access to the current plan's service area	Change plans when the move does not affect network access or available coverage

MEDICAL

BENEFIT CATEGORY	CENTRUS PLAN	CIGNA PLAN	ZERO COST OPTIONS
	REGIONAL PPO NETWORK	NATIONAL PPO NETWORK	Direct Primary Care + Nurse Navigators
In-Network Deductible (Individual/Family)	$1,750 | $3,500	$3,500 | $7,000	Zero Cost with Nurse Navigation
Out-of-Network Deductible (Individual/Family)	$3,000 | $6,000	$7,000 | $14,000	
In-Network Out-of-Pocket Max (Individual/Family)	$6,500 | $13,000	$6,500 | $13,000	Zero Cost with Nurse Navigation
Out-of-Network Out-of-Pocket Max (Individual/Family)	$13,000 | $26,000	$13,000 | $26,000	
Coinsurance	20% coinsurance	20% coinsurance	Zero Cost with Nurse Navigation
Routine Preventive Care	100% Covered	100% Covered	Zero Cost with Direct Primary Care
Physician Office Visit	$40 Copay	$40 Copay	Zero Cost with Direct Primary Care
Specialist Office Visit	$50 Copay	$50 Copay	Zero Cost with Direct Primary Care
Urgent Care Visit	$125 Copay	$125 Copay	Zero Cost with Direct Primary Care
Emergency Room	$450 copay + deduct + coinsurance (copay waived if admitted)	$550 copay + deduct + coinsurance (copay waived if admitted)	N/A
Inpatient Hospital Care	Deductible + Coinsurance	Deductible + Coinsurance	Zero Cost with Nurse Navigation
Outpatient Services/Procedures	Deductible + Coinsurance	Deductible + Coinsurance	Zero Cost with Nurse Navigation
Advanced Imaging (MRI, CT Scan, PET)	Deductible + Coinsurance	Deductible + Coinsurance	Zero Cost at Independent Imaging Centers
Lab Services	$25 Copay at LabCorp or Quest Deductible + Coinsurance at other facilities	$25 Copay at LabCorp or Quest Deductible + Coinsurance at other facilities	N/A
Outpatient Physical, Occupational, Speech	$25 Copay (30 visits per year, per service)	$25 Copay (30 visits per year, per service)	N/A
Mental & Behavioral Visits	$25 Copay	$25 Copay	Zero Cost with MyCatholicDoctor & Rovi Health
Maternity Care - Labor & Delivery	Deductible + Coinsurance	Deductible + Coinsurance	Pay Deductible Only with Nurse Navigation ***must engage within 12 weeks of pregnancy***
Chiropractic Care	$25 Copay (20 visits per year)	$25 Copay (20 visits per year)	N/A

MEDICAL

CENTRUS		TIER Per Pay Period	CIGNA	
EMPLOYEE SHARE	EMPLOYER SHARE		EMPLOYEE SHARE	EMPLOYER SHARE
$111	$258	Employee Only	$63	$250
$344	$803	Employee + Spouse	$292	$680
$290	$677	Employee + Child(ren)	$247	$575
$378	$881	Employee + Family	$322	$751



MEDICAL

Group #:

Centrus Health Direct

A High-Performance Network That Drives Savings & Quality

Access to a High-Quality Provider Network

The Centrus network is designed so you can pay less for healthcare while still receiving high-quality care. We provide access to a network of top-tier healthcare providers across Kansas and Missouri, and still growing!

The strength of the Centrus network is reflected in the health systems that choose to participate. Members have access to trusted providers, including NKC Health, The University of Kansas Health System, and AdventHealth. Even more telling, both NKC Health and The University of Kansas Health System have selected Centrus Health Direct as the network for their own employee health plans.

Kansas Counties in the Centrus Network

- Atchison
- Douglas
- Jefferson
- Johnson
- Leavenworth
- Linn
- Miami
- Wyandotte

Cost-Efficiency

Centrus partners with select hospitals and providers that focus on high-quality care. This approach helps employers control costs without compromising access or quality.

Quality Care

Centrus prioritizes quality by partnering with top-tier providers, including health systems recognized through hospital quality ratings.

Local Solutions

Kansas City health systems created Centrus to serve the local community through a network designed specifically for the region.

A few providers in the network:

NKC Health, The University of Kansas Health System, LMH Health, AdventHealth, Amberwell, Children's Mercy Kansas City, MOSAIC Life Care, Olathe Health, Children's Mercy Health Network, Select Specialty Hospital, Comprehensive Foot and Ankle Centers, MAWD Pathology Group, UIC United Imaging Consultants, Briarcliff Surgery Center, KC Physician Partners, Midwest Anesthesia Associates, Orthopedic Health of Kansas City, Sunflower Medical Group, Quest Diagnostics, Encompass Medical Group, Digestive Health Specialists, KCUC Urology & Oncology, labcorp, Discover Vision Centers, Lawrence Surgery Center

centrushealthdirect.com

Group #:

Finding a Health Care Provider: Centrus Network

Access the provider search tool in three steps

1. Visit centrushealthdirect.com

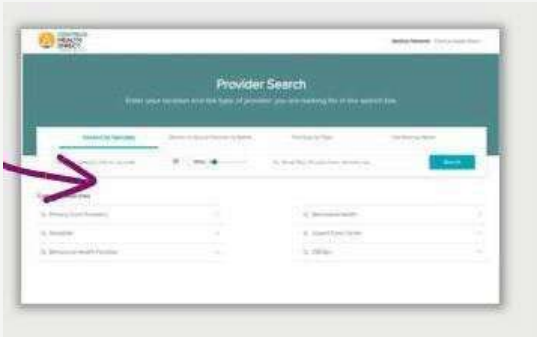
Select Find A Provider at the top right corner of the home page.



2. Choose how you want to search

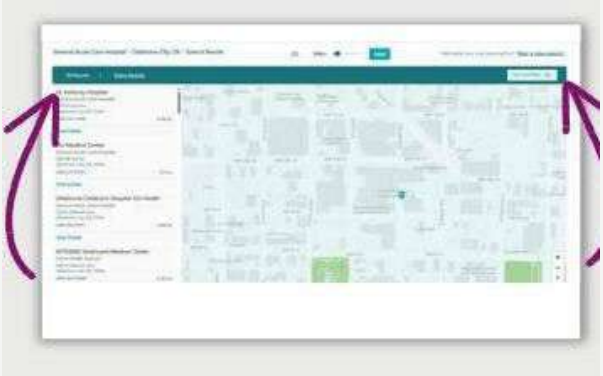
- Doctor by specialty
- Doctor or group practice by name
- Facility type
- Facility name

Enter your address, city or ZIP code and mile radius. Enter your search criteria, then select Search.



3. Review your search results

- Use the toggle above the list to view practitioners or group practices.
- Use Sort and Filter to refine Broad and Focused results.
- Select View Details for more information about a practitioner or group practice.



Group #: KCKHP

Finding a Health Care Provider: Cigna Network

Cigna Healthcare offers a nationwide PPO network with more than 1.5 million providers and over 6,400 facilities.

Three ways to find a network provider:

- If you are enrolled, visit myCigna.com and log in with your user ID and password.
- Visit Cigna.com and select Find a Doctor, Dentist or Facility. Select PPO.
- Call Sage or CNN during business hours.

Features on myCigna.com:

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

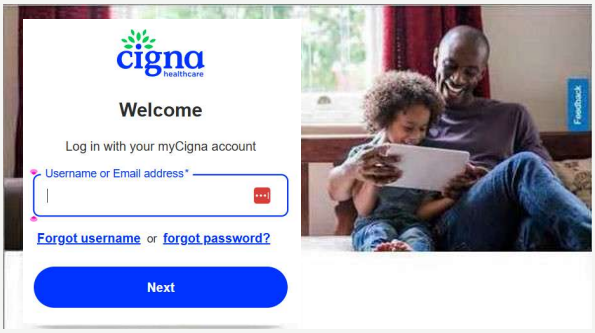
In-network and out-of-network care

Your provider choices can affect what you pay out of pocket. The network includes:

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

Option 1

Log in to myCigna.com



To search without logging in

1. Visit Cigna.com and select Find a Doctor, Dentist or Facility.
2. Choose Employer or School.
3. Enter your location and select the search type.
4. Log in, register, or continue as a guest.
5. Complete the I Live in field and select Continue.
6. Select the PPO option shown on your screen.

Option 2

Call Sage or CNN during business hours.

Sage: 855-929-5956
CNN: 913-600-7150 or 913-600-7130

Offered by Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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 additional costs (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 elective items, such as a charting application, are not reimbursable.

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 the patient and reimbursable at the out-of-network benefit level by submitting a claim to Sage (12-month maximum).

Prenatal/Obstetric Care: $60/month covered with KerixHealth affiliation. $80/month billed to the patient and reimbursable at the out-of-network benefit level by submitting a claim to Sage.

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

Reimbursements will be submitted as out-of-network claims and processed the same way as the rest of your out-of-network benefit. After you have satisfied your out-of-network deductible, you will be reimbursed at 60% under both the Centrus and Cigna plans.

Timely Filing: Complete reimbursement requests must be received by the TPA within 365 days of the last day of the month for which the monthly fee applies. Requests received after 365 days will be denied. Reimbursement instructions can be found on page 21 of this benefit guide.

MEMBER PORTAL GUIDE:

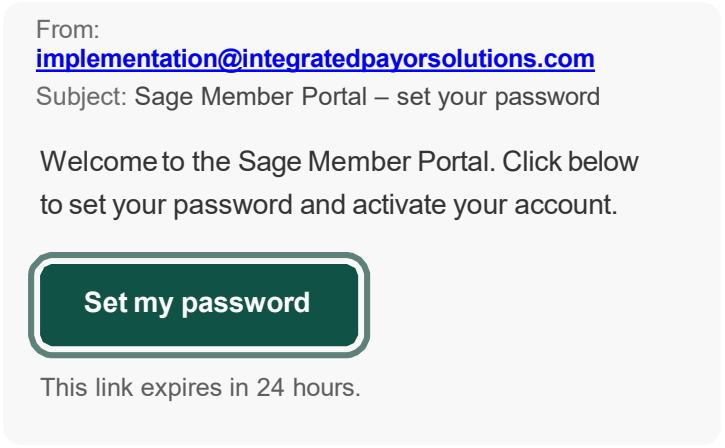
Getting into your Sage portal

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

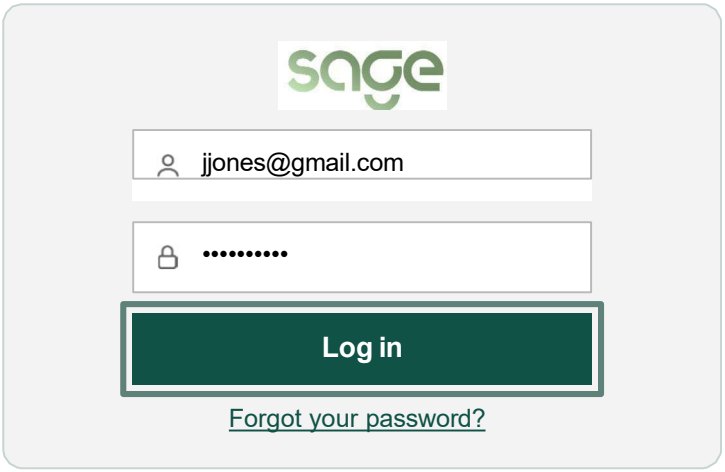
The employee's username is the **email address on file**. Each family member's username is that same email plus the **last two digits of their member ID**.

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

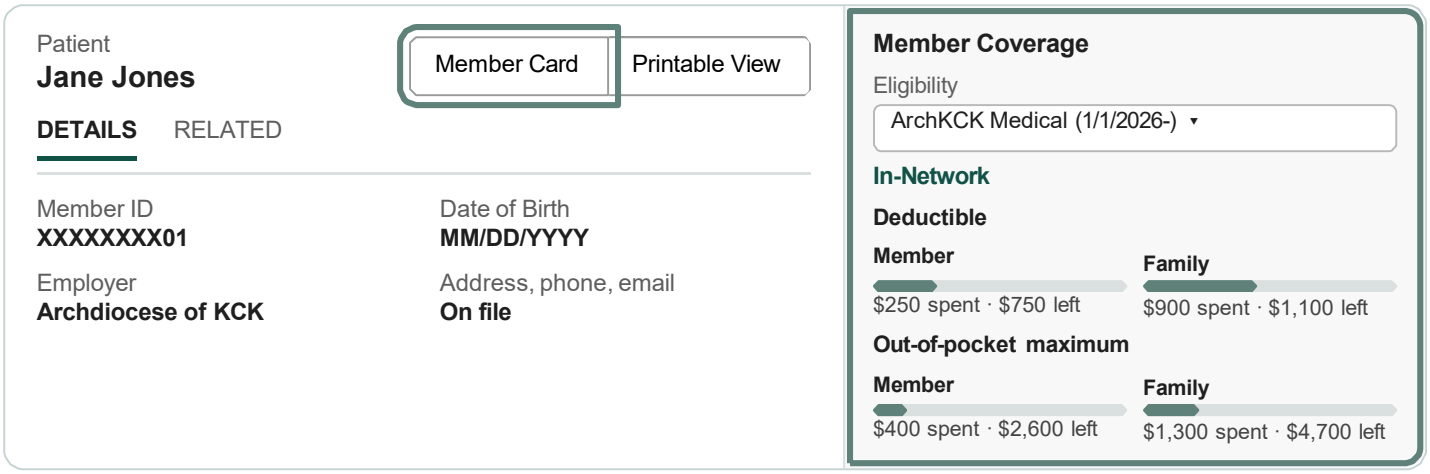


Members
Your ID card and benefits used

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?

- 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 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, 2027. 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 prescription benefit card to the pharmacist and pay your retail copayment for each prescription.

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

PRESCRIPTION DRUGS	CENTRUS PLAN	CIGNA PLAN
Tier 1 Retail (30-Day Supply)	$0 Copay	Lesser of $10 or actual cost
Tier 1 Mail Order (90-Day Supply)	$0 Copay	Lesser of $10 or actual cost
Tier 2 Retail (30-Day Supply)	25% of cost up to $50	25% of cost up to $100
Tier 2 Mail Order (90-Day Supply)	25% of cost up to $50	25% of cost up to $100
Tier 3 Retail (30-Day Supply)	40% of cost	40% of cost
Tier 3 Mail Order (90-Day Supply)	40% of cost	40% of cost
Specialty Drugs	25% of cost up to $300	25% of cost up to $500

PRESCRIPTION DRUGS

Optum Rx®

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

If you have any questions
call OptumRx: 855-524-0381

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.

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**. After you register, use the QR code anytime to search the **Formulary Drug List** and see whether your medication is covered and which tier it falls under.

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.

CONCIERGE NURSE NAVIGATORS

CONCIERGE NURSE NAVIGATORS

Nurse Navigation Available to All Enrolled Members of the Medical Plan

CONCIERGE NAVIGATION - Let's find the highest-quality doctors 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)

***Important Note: If your service date changes, notify your Nurse Navigator right away to update the waiver, or it may not apply.**

MATERNITY CARE: PAY DEDUCTIBLE ONLY - CALL WITHIN 12 WEEKS OF PREGNANCY

Contact a Concierge Nurse Navigator **before** week 12 to qualify.

*Copays and coinsurance still apply

For assistance navigating the complex healthcare system
Contact your local Concierge Nurse Navigators

CONCIERGE NURSE NAVIGATORS



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



Heather Burns, Clinical Support
913-600-7140 voice/text (HIPAA secure)
Heather@mynursenavigators.com



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

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:

Jill- 913-600-7150
Jessica- 913-600-7130
Heather- 913-600-7140

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

Rovi Health **Mental health care, made for real life.**

BEHAVIORAL HEALTH • INCLUDED WITH YOUR PLAN

$0 Cost to Members

Connect with a therapist who fits your needs, identity, schedule, and preferences.

The right fit, without the long search.

- **100+** specialties & preferences
- **100%** Master's-level or Doctoral
- **20+** languages
- Appointments booked within 24 hours
- In-person care through partner networks

Get started

Scan the QR code or visit www.rovi.health.

Find out how Rovi Health can help you!
Contact your dedicated Nurse Navigators:

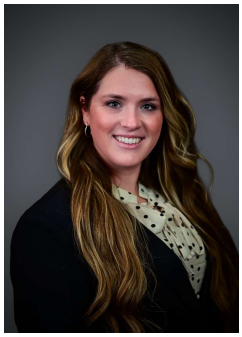
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Jessica@mynursenavigators.com

DIRECT PRIMARY CARE

You 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 9-1-1.

DIRECT PRIMARY CARE

KerixHealth

Affordable
Accessible
Exceptional

Primary Care Redefined

Embracing the Direct Primary Care 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

Call us today at 303-501-2600 for your first appointment

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, 2027	March 31, 2028	**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.**
DependentCare FSA*	$7,500 ($3,750 if married and filing separately)	December 31, 2027	March 31, 2028	**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.
2027 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	Allowed during open enrollment and a qualifying life event.
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 ACCOUNT (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 under age 13.

	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.
2027 Contribution Limits	$7,500 ($3,750 if married and filing separately)
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	Allowed during open enrollment and a qualifying life event.
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.***

OUT-OF-NETWORK CLAIMS: HOW TO FILE

Same-Day Reimbursements Made Simple

Sage offers same-day reimbursements for eligible medical expenses requested through Venmo or Zelle, based on your benefit coverage.

1 Get an itemized receipt or superbill

Your documentation must include:

- Patient name and one identifier (date of birth, address, or phone number)
- Date of service and procedure codes (CPT) Charges and
- proof of payment
- Provider name and one identifier

2 Choose a payment method

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

Include your username or handle for same-day reimbursement.
If those apps are not an option, we will issue a paper check. Please allow up to 30 calendar days for processing.

3 Email your reimbursement request

TO archkckbenefits@SageTPA.com

SUBJECT Reimbursement Request for First Name Last Name

Your email must include:

- First and last name
- Provider name and date of service
- Total payment made
- Payment method: Venmo, Zelle, or paper check
- Venmo or Zelle username, if applicable
- Itemized receipt or superbill

4 Sage verifies and processes your request

Sage will review the submission, process the request, and confirm when it is complete.

IMPORTANT
Processing begins after all required information is received and remains subject to plan coverage and review. Complete documentation must be received within 365 days of the date of service. Requests received after that deadline will be denied.

Questions? Email us: archkckbenefits@SageTPA.com Or call 855-929-5956

OUT-OF-NETWORK CLAIMS: HOW TO FILE

Prescription Drug Claims

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

Flexible Spending Account

1. Log in at https://access.paylocity.com/
2. Go to Spending Accounts / Benefits
3. Select File a Claim
4. Enter the claim details and upload the receipt or EOB
5. Add the claim to the Claims Basket and submit

Required documentation: patient name, provider name and address, date of service, and amount charged.

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

1. Log in at www.mutualofomaha.com/my-benefits
2. Select "Submit Claim"
3. Complete the required form(s) and attach the required documents
4. Confirm and submit the form(s)

Forms may also be downloaded and submitted using either option below.

Fax

ATTN: Claims
402-997-1869

Mailing Address

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

OUT-OF-NETWORK CLAIMS: HOW TO FILE

Vision (VSP)

1. Log in at vsp.com
2. Go to My Benefits
3. Select Submit a Claim
4. Complete the form and upload the receipt
5. Submit the claim

Receipt must include the provider's name, patient name, date of service, services received, and cost.

Dental

1. Log in at deltadentalins.com
2. Go to Claims & Visits, then select How to File a Claim
3. Download the claim form
4. Complete and sign the form (the dentist must also sign)
5. Mail the originals and keep copies

The required statement or receipt must include:

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

Mail to: Delta Dental of California, P.O. Box 997330, Sacramento, CA 95899-7330

Gianna Family Care

Email claims to archkckbenefits@sagetpa.com and include:

- Receipt or superbill showing the patient identifier, CPT codes, charges/payment, and provider identifier
- Provider name
- Date of service
- Total paid and payment method (Venmo, Zelle, or check); include the username if needed

DENTAL

Group #: 51636

The plan covers routine checkups and comprehensive dental care, with the flexibility to seek treatment from any provider.

MANAGE YOUR DENTAL BENEFITS

CREATE YOUR ONLINE ACCOUNT

Visit DeltaDentalKS.com and register using the member ID shown on your dental ID card.

- Review benefits, eligibility and plan maximums
- View claims and Explanation of Benefits (EOBs)
- Access or print your member ID card
- Find a dentist and estimate dental costs

DELTA DENTAL MOBILE APP

Scan to download the app. Use it to view your mobile ID card, find a dentist, check coverage, estimate costs and review claims.

Need help? 800-234-3375

DENTAL BENEFITS

SERVICES	DESCRIPTION	BENEFIT AMOUNT
Type I Procedures	Exams, cleanings, fluoride treatments (2 per year)	Plan pays 100% of the Maximum Plan Allowance; does not apply toward the Annual Maximum
Type II Procedures	Regular fillings, extractions, nonsurgical root canals	After the deductible, plan pays 80% of the Maximum Plan Allowance
Type III Procedures	Crowns, dentures, implants	After the deductible, plan pays 60% of the Maximum Plan Allowance
Type IV Procedures	Orthodontia for adults and children	After the deductible, plan pays 50% of the Maximum Plan Allowance, up to a $2,500 lifetime maximum
Annual Deductible	Applies to Type II, III and IV procedures	$25 per person
Annual Maximum	Per covered person	$2,500

PER-PAY-PERIOD COSTS

COVERAGE	EMPLOYEE COST 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

*The Dental Care Cost Estimator provides an estimate only and does not guarantee exact fees, plan payment or out-of-pocket costs.

VISION

Group #351035

Vision benefits are offered through VSP. This voluntary plan provides comprehensive coverage for routine vision needs and is paid through pre-tax payroll deductions.

USING YOUR VSP BENEFITS

ACCOUNT & ID CARD

Register or log in at VSP.com to verify coverage and eligibility. Use Ameritas.com to print or download your ID card and access VSP through single sign-on.

FIND CARE & MANAGE CLAIMS

Select Find a Doctor in your VSP account to verify participating providers. View claim status and history online or in the VSP Vision Care app. Shop online at Eyeconic.com.

QUESTIONS?

VSP
Benefits, claims or providers
800-877-7195

Ameritas
Administration or ID cards
800-487-5553

VISION BENEFITS

BENEFIT	VSP NETWORK
Eye Exam	$15 copay
Materials	$20 copay
Lenses	Single vision and bifocal/trifocal lenses covered in full*
Frames	$175 allowance
Contacts	Fitting and evaluation: up to $60 copay Medically necessary: 100% covered Elective: $160 allowance
Frequency	Exam: every 12 months Lenses: every 12 months Frames: every 24 months

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

PER-PAY-PERIOD COSTS

COVERAGE	EMPLOYEE COST
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 employer at 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

VOLUNTARY 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.

GUARANTEED ISSUE LIFE

Group #: G000CV3Y

100% Employee Paid

AVAILABLE TO NEW HIRES WHEN FIRST ELIGIBLE

Voluntary term life insurance lets you add protection for yourself and your eligible dependents. Guaranteed issue coverage does not require medical questions or an exam.

COVERAGE AVAILABLE

WHO	COVERAGE
Employee	$10,000 increments, up to $150,000
Spouse	$5,000 increments; up to 100% of the employee election, maximum $75,000
Children under age 26	$5,000 increments per child, maximum $10,000 per child

WHAT "GUARANTEED ISSUE" MEANS

You may elect coverage up to the limits above without providing evidence of insurability. If you waive coverage when first eligible, enroll later, or request an amount above the guaranteed issue limit, health information will be required.

MONTHLY COST PER $1,000 OF COVERAGE

AGE	EMPLOYEE / SPOUSE	ALL CHILDREN
Under 25	$0.06	$0.10
25–29	$0.06	$0.10
30–34	$0.08	$0.10
35–39	$0.10	$0.10
40–44	$0.14	$0.10
45–49	$0.23	$0.10
50–54	$0.36	$0.10
55–59	$0.56	$0.10
60–64	$0.71	$0.10
65–69	$1.27	$0.10
70–74	$2.10	$0.10
75–79	$3.70	$0.10
80–84	$3.70	$0.10
85–89	$3.70	$0.10
90–100	$3.70	$0.10

Employee and spouse rates are based on the employee's age as of the effective date and adjust annually when the employee enters a new age band. Spouse coverage ends when the employee reaches age 70, regardless of the spouse's age.

SCAN FOR A CUSTOMIZED PRESENTATION

Questions or enrollment support: Pam Eisenberg | 617-716-9920
Pamela.Eisenberg@Mutualofomaha.com

DISABILITY

Mutual of Omaha

Short-Term (STD)

100% Employer Paid;
Buy-Up 100% Employee 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	$250 per week with a Voluntary STD buy-up option of 40% to $1,000 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 isportable 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 costsor 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

Group#: G000CV3Y

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

Mutual of Omaha

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.

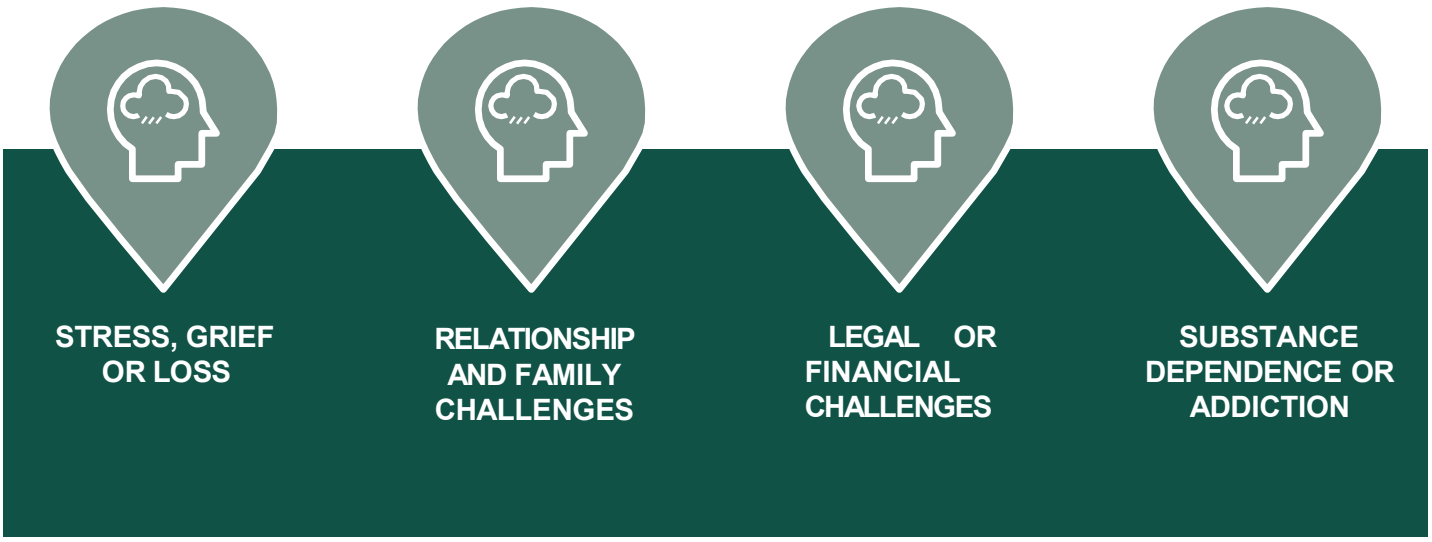
mutualofomaha.com/eap
or call us: 1-800-316-2796

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.

WHEN TO USE YOUR EAP



TRAVEL ASSISTANCE

Worldwide support for business and personal travel

Travel Assistance connects you with professionals who can provide local medical referrals and other emergency support while you are away from home.

WHO IS COVERED You, your spouse and dependent children on a single trip lasting up to 120 days and more than 100 miles from home.

PRE-TRIP ASSISTANCE

Call before departure for help with:

- Passport, visa and other documentation required for foreign travel
- Travel and health advisories, including inoculation requirements
- Domestic and international weather forecasts
- Daily foreign currency exchange rates
- Consulate and embassy locations
- Translation and interpreter services for international travel emergencies

EMERGENCY TRAVEL SUPPORT

- Telephone translation and interpreter services available 24/7
- Referrals to local attorneys or consular offices, with help maintaining family and business communications
- Help with lost, stolen or delayed baggage while traveling on a common carrier
- Coordination of emergency payments or cash through your available credit sources
- Recording and retrieving emergency messages between you, your family or business associates
- Coordination of replacement credit cards, airline tickets and other travel documents
- Return of an unattended rental vehicle when evacuation or repatriation is necessary

* Travel Assistance is brought to you by Mutual of Omaha Insurance Company. Services are provided by AXA Assistance USA (AXA).

** Pre-trip assistance is available at any time and is not subject to the 100-mile travel radius.

WORLDWIDE TRAVEL ASSISTANCE

For inquiries within the U.S.

1-800-856-9947

Services are available for business and personal travel.

Outside the U.S., call collect

(312) 935-3658

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.

"Youare 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 accountis 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

WHO IS ELIGIBLE

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

THE FOUR PARTS OF MEDICARE

A Hospital Insurance

Inpatient hospital care Skilled nursing facility care Hospice care Home health care

B Medical Insurance

Doctor and specialist services
Outpatient medical and surgical services
Lab and diagnostic testing
Durable medical equipment and preventive care Certain outpatient drugs and infusions

C Medicare Advantage

Private plans that provide Parts A and B benefits Many plans include Part D prescription coverage Premiums, copays and coinsurance vary by plan Plans may include dental, vision and hearing benefits

D Prescription Drug Coverage

Covers prescription medications Monthly premiums vary by plan Formularies and member cost sharing vary by plan Some plans include an annual drug deductible

ENROLLMENT

WHEN TO ENROLL

- Part A: Your Initial Enrollment Period lasts seven months: the three months before your 65th birthday month, your birthday month and the three months after.
- Part B: Priests retiring from active ministry should begin the Special Enrollment Period process 60 days before group coverage ends.
- Parts C and D are not applicable to priests.

HOW TO ENROLL

- Call 1-800-MEDICARE (1-800-633-4227).
- Apply online at ssa.gov through your My Social Security account.
- If you have Part A but not Part B, complete Form CMS-40B.

FREE LOCAL MEDICARE SUPPORT

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

Contact a local Medicare advisor for help understanding your enrollment options at no cost to you.

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.

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 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 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
Plan Administrator	Sage TPA	855-929-5956
Network	Cigna PPO Network Centrus Network	Cigna.com **centrushealthdirect.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 or 913-600-7130 or 913-600-7140
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
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**

