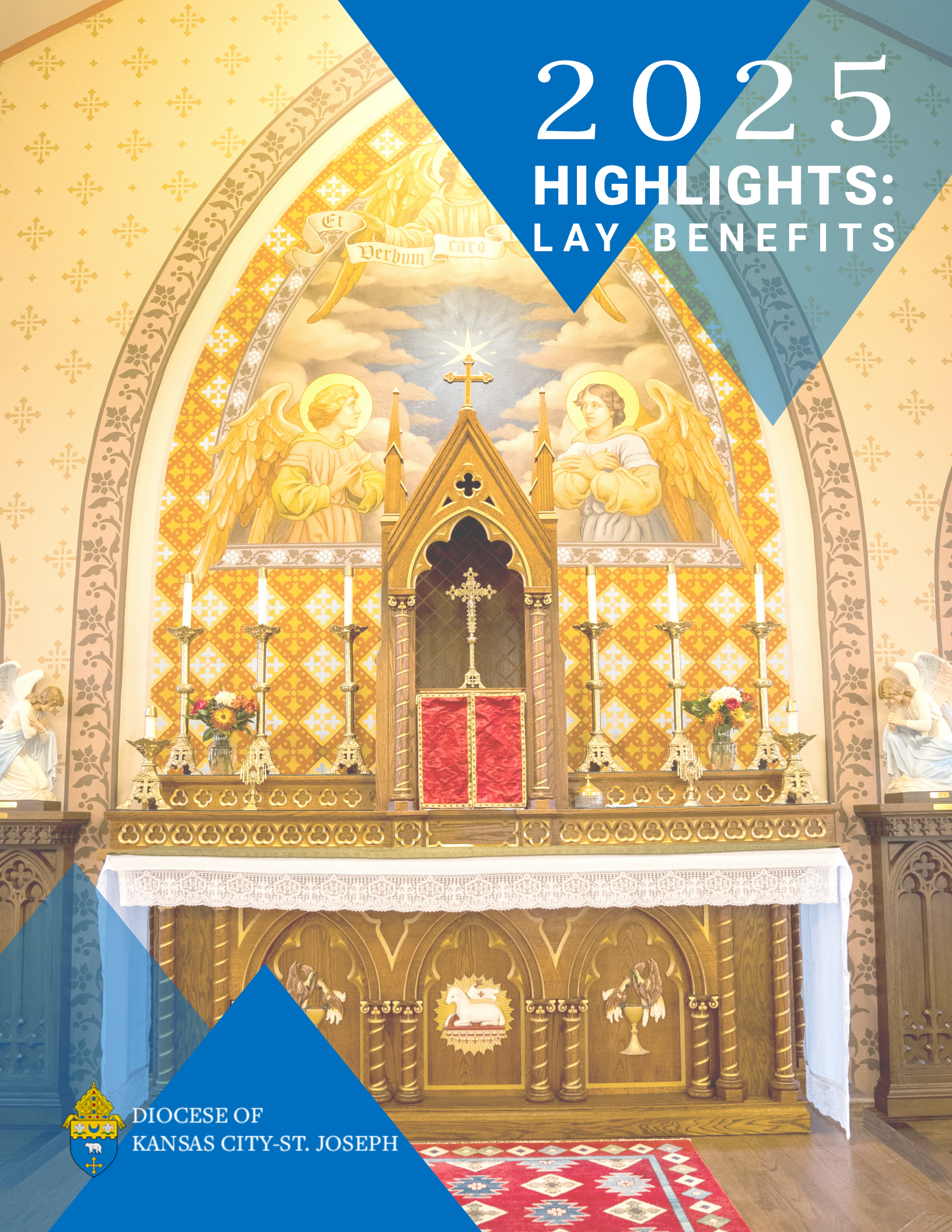


2025 HIGHLIGHTS: LAY BENEFITS

DIOCESE OF
KANSAS CITY-ST. JOSEPH

Table of Contents

This document is intended to give a summary description of the plan and is not a contract. For complete benefit information please refer to the plan documents for each benefit. In the event of a discrepancy between this brochure and the plan document, the plan document will prevail. Possession of this document is not a guarantee of coverage. See full summary of benefits at https://diocesekcsj.millercares.com/.

Medical Summary

BlueCross BlueShield of Kansas City

MEDICAL			
BlueSaver PPO/HSA	**(Preferred Care Blue Network)**		
Deductible: $3,300/$6,600 Coinsurance: 100% Primary Care: Deductible Specialist: Deductible Out of Pocket Maximum: $3,300/$6,600	**In-Network Benefits** ER: Deductible Urgent Care: Deductible Hospitalization: Deductible Prescriptions: Retail: Deductible Mail Order: Deductible	**Monthly Cost (non-wellness)**	
		Employee	$191.00
		EE + Spouse	$607.00
		EE + Child(ren)	$551.00
		Family	$763.00
BlueSaver Plus PPO/HSA	**(Preferred Care Blue Network)**		
Deductible: $4,000/$8,000 Coinsurance: 80% Primary Care: Deductible + Coinsurance Specialist: Deductible + Coinsurance Out of Pocket Maximum: $5,000/$10,000	**In-Network Benefits** ER: Deductible + Coinsurance Urgent Care*: Deductible + Coinsurance Hospitalization: Deductible + Coinsurance Prescriptions: Retail: Deductible + Coinsurance Mail Order: Deductible + Coinsurance	**Monthly Cost (non-wellness)**	
		Employee	$155.00
		EE + Spouse	$556.00
		EE + Child(ren)	$505.00
		Family	$699.00
Spira Care EPO			
Deductible: $2,000/$4,000 Coinsurance: 100% Primary Care*: Deductible Specialist: Deductible Out of Pocket Maximum: $2,000/$4,000 *No member cost at Spira Care Center	**In-Network Benefits** ER: Deductible Urgent Care*: Deductible Hospitalization: Deductible Prescriptions: Retail: $15/$50/Deductible Mail Order: $15/$125/Deductible	**Monthly Cost (non-wellness)**	
		Employee	$191.00
		EE + Spouse	$577.00
		EE + Child(ren)	$522.00
		Family	$766.00

Medical

BlueCross BlueShield of Kansas City

BLUESAVER PPO/HSA

BlueSaver is a Preferred Provider Organization coupled with an option to enroll in a Health Savings Account (HSA), a tax-advantaged, individually-owned account. The plan includes a network of hospitals and physicians who have agreed to allow substantially greater discounts to Blue Cross Blue Shield plan subscribers.

If services are received from an in-network Blue Cross Blue Shield provider, eligible expenses will be paid at the 100% coinsurance level after deductible. If you receive services from a provider outside the Blue Cross Blue Shield network, eligible expenses will be paid at the 60%/40% coinsurance level after deductible.

To view a full summary of benefits, please visit **diocesekcsj.millercares.com**.

To locate an in-network medical provider, please visit members.bluekc.com or call 816.395.3558.

BlueSaver PPO/HSA	
Deductible	$3,300- Individual $6,600 - Family
Coinsurance	100%
Out-of-Pocket Max[1]	$3,300 - Individual $6,600 - Family
Primary Office Visit	Deductible
Specialist Office Visit	Deductible
Routine Preventive[2]	100% Covered
Urgent Care	Deductible
Inpatient Hospital	Deductible
Emergency Room	Deductible
Prescription Drugs	Deductible
Mail Order	Deductible

Monthly Premium				
Medical Plan Options	**Total Premium**	**Employer Pays**	**Employee Pays w/ Wellness Discount**	**Employee Pays w/o Wellness Discount**
Individual	$952.00	$761.00 (80%)	$141.00	$191.00
Employee + Spouse	$2,023.00	$1,416.00 (70%)	$557.00	$607.00
Employee + Child(ren)	$1,834.00	$1,283.00 (70%)	$501.00	$551.00
Family	$2,542.00	$1,779.00 (70%)	$713.00	$763.00

[1]Total of deductible and coinsurance members pay each year towards covered charges before BCBSKC pays 100% of benefits.

[2]Routine Preventive care is covered at 100%; a list of these services can be found at https://diocesekcsj.millercares.com/

Medical

BlueCross BlueShield of Kansas City

BLUESAVER PLUS PPO/HSA

BlueSaver Plus is a Preferred Provider Organization coupled with an option to enroll in a Health Savings Account (HSA), a tax-advantaged, individually-owned account. The plan includes a network of hospitals and physicians who have agreed to allow substantially greater discounts to Blue Cross Blue Shield plan subscribers.

If services are received from an in-network Blue Cross Blue Shield provider, eligible expenses will be paid at the 80% coinsurance level after deductible. If you receive services from a provider outside the Blue Cross Blue Shield network, eligible expenses will be paid at the 60%/40% coinsurance level after deductible.

To view a full summary of benefits, please visit **diocesekcsj.millercares.com.**

To locate an in-network medical provider, please visit members.bluekc.com or call 816.395.3558.

BlueSaver PPO/HSA	
Deductible	$4,000 - Individual $8,000 - Family
Coinsurance	80%
Out-of-Pocket Max[1]	$5,000 - Individual $10,000 - Family
Primary Office Visit	Deductible
Specialist Office Visit	Deductible
Routine Preventive[2]	100% Covered
Urgent Care	Deductible + Coinsurance
Inpatient Hospital	Deductible + Coinsurance
Emergency Room	Deductible + Coinsurance
Prescription Drugs	Deductible + Coinsurance
Mail Order	Deductible + Coinsurance

Monthly Premium				
Medical Plan Options	**Total Premium**	**Employer Pays**	**Employee Pays w/ Wellness Discount**	**Employee Pays w/o Wellness Discount**
Individual	$870.00	$715.00 (82%)	$105.00	$155.00
Employee + Spouse	$1,853.00	$1,297.00 (70%)	$506.00	$556.00
Employee + Child(ren)	$1,680.00	$1,175.00 (70%)	$455.00	$505.00
Family	$2,329.00	$1,630.00 (70%)	$649.00	$699.00

Employer will contribute to the HSA $25.00 monthly for employee only election and $50.00 monthly for the dependent election.

[1]Total of deductible and coinsurance members pay each year towards covered charges before BCBSKC pays 100% of benefits.

[2]Routine Preventive care is covered at 100%; a list of these services can be found at **diocesekcsj.millercares.com.**

Medical

BlueCross BlueShield of Kansas City

SPIRA CARE EPO

Spira Care is an Exclusive Provider Organization. In this plan, all primary care appointments and procedures at the Spira Care Center are 100% covered. For other medical needs like specialty care or hospitalization, Spira Care works like a traditional health plan with an annual deductible. Members can see more than 3,000 physicians and specialists at over 11,000 access points in the BlueSelect Plus network.

The Spira Care Center provides primary care, urgent care, lab tests, X-rays, counseling and even some prescriptions filled. Members can meet one-on-one with a professional Care Guide that can answer questions, explain benefits and provide post-appointment guidance.

To view a full summary of benefits, please visit **diocesekcsj.millercares.com.**

To locate an in-network medical provider, please visit members.bluekc.com or call 816.395.3558.

Spira Care/BlueSelect Plus	
Deductible	$2,000 - Individual $4,000 - Family
Coinsurance	100%
Out-of-Pocket Max	$2,000 - Individual $4,000 - Family
Primary Office Visit	Deductible ($0 Spira)[2]
Specialist Office Visit	Deductible
Routine Preventive[1]	100% Covered
Urgent Care	Deductible ($0 Spira)[2]
Inpatient Hospital	Deductible
Emergency Room	Deductible
Prescription Drugs	$15 Tier 1 $50 Tier 2 Deductible
Mail Order	$15 Tier 1 $125 Tier 2 Deductible

Monthly Premium				
Medical Plan Options	**Total Premium**	**Employer Pays**	**Employee Pays w/ Wellness Discount**	**Employee Pays w/o Wellness Discount**
Individual	$952.00	$761.00 (80%)	$141.00	$191.00
Employee + Spouse	$1,922.00	$1,345.00 (70%)	$527.00	$577.00
Employee + Child(ren)	$1,738.00	$1,216.00 (70%)	$472.00	$522.00
Family	$2,555.00	$1,789.00 (70%)	$716.00	$766.00

[1]Routine Preventive care covered at 100%; a list of these services can be found at ***diocesekcsj.millercares.com***

[2]No member cost for services at a SpiraCare Center, prescriptions offered at your regular copay level.

Wellness

Our wellness program is designed to encourage and reward employees for taking proactive steps to maintaining a healthy lifestyle and identifying health risks before they become serious health conditions. All wellness initiatives are designed to support employee health and wellbeing to create a culture of good health within the organization.

2025 Wellness Initiatives

Open to all employees:

- Wellness Campaigns
- Flu Vaccination Clinics & Blood Drive
- Wellness Newsletter

Note: In-Person Health & Wellness Coaching is available to employees on the BCBS medical insurance plan.

2026 Medical Premium Discount Program

Save $600 on the annual cost of health insurance in 2026.

The following requirements must be completed by **October 31, 2025**:

1. Submit a Physician Screening Form after completing an annual Preventive Exam.
2. Complete the Health Assessment on the BCBS wellness portal.
3. Earn 3,000 points on the BCBS wellness portal.

All full-time employees on one of the BCBS medical plans are eligible to participate.

For complete details and instructions, refer to your medical premium discount packet found at **diocesekcsj.millercares.com** under the Wellness tab.

Questions?

See the Wellness Packet for complete details and instructions at **diocesekcsj.millercares.com.**

@WellnessProgramDioceseKCSJ

IN-NETWORK HOSPITAL AND PROVIDER COMPARISON

	Preferred-Care Blue (PPO & HSA)	Blue Select Plus (Spira)
Centerpoint Medical Center	✓	
Children's Mercy Hospital	✓	✓
Liberty Hospital	✓	✓
Menorah Medical Center	✓	
North Kansas City Hospital	✓	✓
Olathe Medical Center	✓	✓
Overland Park Regional Medical Center	✓	
Research Medical Center	✓	
Saint Mary's Medical Center	✓	
Saint Luke's Hospital	✓	
Saint Joseph's Medical Center	✓	
AdventHealth	✓	✓
Truman Medical Center	✓	✓
University of Kansas Hospital	✓	✓
Total Hospitals In-Network*	55	9
Primary Care Providers*	1,617	779
Specialist Providers*	4,682	2,727

CATHOLIC HOSPITALS

St. Joseph Medical Center and St. Mary's Medical Center are part of the Blue Cross Blue Shield network and follow the moral teaching of the Catholic Church. St. Joseph Medical Center was one of 750 hospitals awarded an 'A' for its efforts in protecting patients from harm and meeting the highest safety standards in the US. Employees covered under the Blue Cross Blue Shield plan (excluding Spira Care), who choose St. Joseph and St. Mary's for medical care will not incur out-of-network expenses. St. Joseph and St. Mary's provide a full spectrum of healthcare services for men, women and children.

Saint Joseph Medical Center

Saint Mary's Medical Center

Health Savings Account (HSA)

AVAILABLE TO EMPLOYEES ENROLLED IN THE BLUESAVER & BLUESAVER PLUS PLANS

The HSA is:

A tax-exempt account established for the purpose of saving for qualified medical, dental, and vision expenses for an individual and/or spouse and dependents.

- HSAs are designed to provide eligible individuals with triple federal tax benefits:
  1. HSA contributions are tax-free.
  2. Interest and other earnings on HSA contributions accumulate tax-free.
  3. Amounts distributed from an HSA for qualified medical expenses are tax-free.
- The HSA balance can roll over from year to year.

Employees may contribute to their personal HSA without exceeding annual limits.

For 2025, the annual contribution limits are as follows:

- Single Coverage: $4,300
- Family Coverage: $8,550

Additional HSA Fees:

- $1.50 monthly fee for paper statements

Not sure if HSA is right for you?

See the HSA/FSA Comparison Chart on page 11 to determine which might be the right choice for you.

Enrollment in any of the following will prevent you from being able to contribute to a Health Savings Account (HSA):

- General-purpose health flexible savings account (FSA) or health reimbursement arrangement (not to include a Limited Flexible Spending account or a Flexible Spending Account for Dependent Day Care)
- Medicare of Medicaid
- Tri-Care
- Health Reimbursement Account

YOUR HSA TAX BENEFITS

CONTRIBUTIONS ARE TAX-FREE

INTEREST AND OTHER EARNINGS ON CONTRIBUTIONS ARE TAX-FREE

AMOUNTS DISTRIBUTED FROM QUALIFIED EXPENSES ARE TAX-FREE

Flexible Spending Account (FSA)

HealthEquity Building Health Savings

The FSA is a tax-exempt account established for the purpose of paying for qualified medical, dental, and vision expenses. When you use tax-free dollars to pay for certain expenses, such as healthcare, prescription drugs, eye-glasses, and childcare expenses, you realize an increase in your spending power, and substantial tax savings.

FSA ENROLLMENT OPTIONS

HEALTH CARE FSA

$3,200

LIMITED PURPOSE FSA

$3,200

DEPENDENT CARE FSA

$5,000

Health Care FSA

- Pays for out-of-pocket eligible medical, dental and vision expenses incurred by the employee, spouse or dependents.
- Deductions for a health care FSA are exempt from federal, state and local taxes.
- Only expenses NOT reimbursed by insurance can be claimed.

Limited Purpose FSA

- Available to employees enrolled in the BlueSaver HSA medical plan.
- Allows reimbursement of expenses that are not covered under the HSA plan, such as dental and/or vision services.

Dependent Care FSA

- Eligible expenses include:
  - Expenses paid to a dependent care center or provider for care of a dependent under age 13.
  - Expenses paid for care of a dependent over age 13 who is physically or mentally incapable of caring for themselves.
  - Expenses paid for elder care.

Important Notes:

- If you have elected to have money set aside in a pre-tax FSA, changes to election amounts are only permitted during open enrollment if there is a significant change in your family status (marriage, divorce, death of a spouse, birth of a child, termination of a spouse's employment, etc.).
- If your employment ends, reimbursement of expenses incurred during your employment must be submitted within 90 days of your termination date. The IRS requires that any funds left in the account be forfeited.
- The US Department of Treasury allows a carryover of up to $640 of unused health care FSA funds remaining at the end of the plan year.

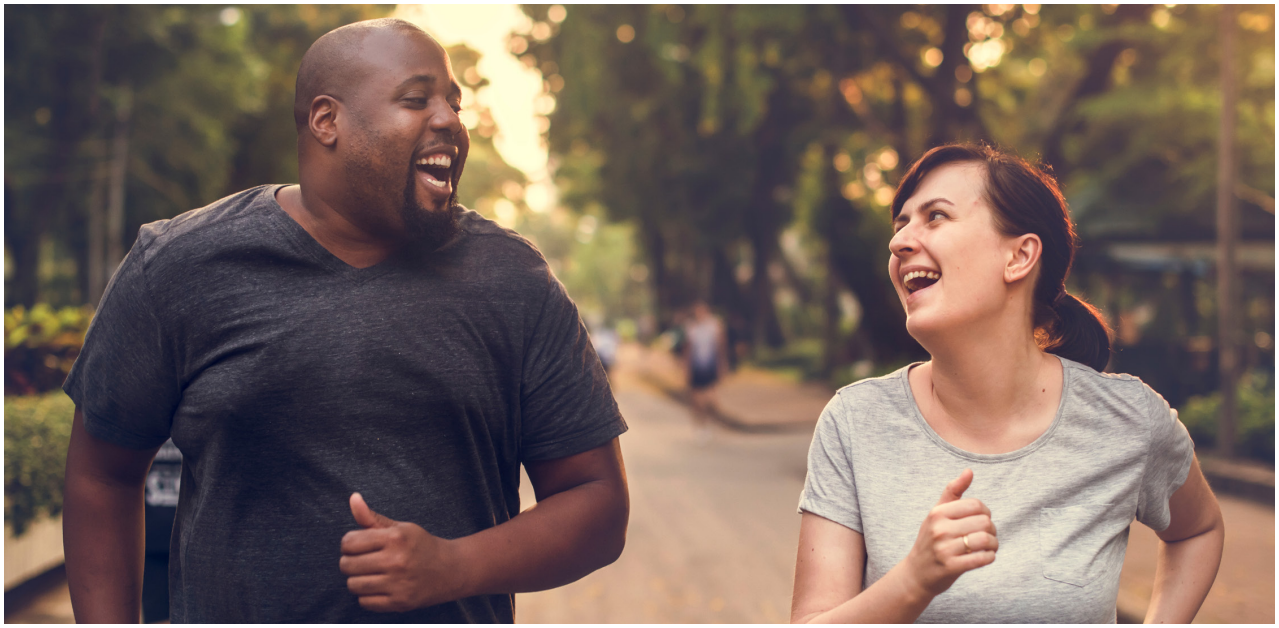
HSA v. FSA

	HSA	Health Care FSA
What does it stand for?	Health Savings Account	Health Care Flexible Spending Account
Who owns it?	Employee	Employer
Who funds the account?	Employee	Employee
What type of corresponding health plan is allowed?	Eligibility requires opening and maintaining a qualifying high-deductible health plan, the Blue Saver PPO/HSA.	A full purpose health care FSA is compatible with any type of health plan coverage. A limited purpose health care FSA is typically used in conjunction with participation in an HSA and its qualifying high-deductible health plan.
Can unused amounts be carried over?	Yes. The individual owns the account and any contributions made to it, regardless of the source or timing of the contribution.	Yes, the plan allows up to $610 to carry forward to future plan years.
Is the account portable between employers?	Yes. The individual owns the account.	No. FSAs cannot be rolled to a new employer.
How is it funded?	Money is deposited directly into the account. Contributions can be made through pre-tax salary deductions.	Based on the employee's annual election, the employer designates a specific amount of wages to be deducted pre-tax from the employee's payroll check.
What are the tax benefits for employees?	Contributions are tax deductible and interest and capital gains on investments are tax-free. Withdrawals for qualifying medical expenses are tax- free, although state taxes may apply.	Employee contributions are exempt from federal and FICA tax as well as most state and local tax. Reimbursements are tax-free.
What health care expenses can be paid from the account?	Funds can be used for any qualified medical expense as defined under Section 213(d) of the Internal Revenue Code (IRC), except for health insurance premiums, with specific exceptions.	Funds can be used for eligible health care expenses as defined under Section 213(d) of the IRC except for health insurance premiums.
Is the annual amount of the contribution available on the first day of coverage?	Only the amount currently available in the HSA may be used to reimburse qualified expenses.	Yes. The total amount elected by the employee for the plan year is available on the first day, regardless of the amount contributed.
What if I retire or change jobs?	The individual continues possession of the account and the funds therein.	Unused funds are forfeited.

Kansas City

LIFESTYLE PROGRAM BENEFIT

Lose weight and feel your best.



Blue KC invites you to get healthier with a new covered benefit that helps you lose weight and feel your best. If you qualify, we'll match you with a program that fits your lifestyle and keeps you on track with one-on-one support from a trained health coach, including virtual options.

Blue KC has partnered with Solera to offer you a personalized experience from leading health solutions like WW (Weight Watchers® reimagined). And the best part? **It's completely paid for by your health plan if you qualify.**

Pick the right program for you

Choose from a variety of programs, from virtual personal coaching to small group meetings. Each program has milestones to help you stay on track and earn free tools.

Get free digital tools!

After you qualify and are matched to a lifestyle program, we'll send a **smart scale** within a week (digital programs only) and an **activity tracker** after 4 weeks.*

It's a covered benefit – that means no cost!

If you qualify, this benefit is paid for 100%. And so is your matching lifestyle program.

*For participants who complete four weeks of activity meeting Diabetes Prevention Program guidelines. Applies to select activity tracker models. Limited to one per person. While supplies last. Solera Health reserves the right to discontinue at any time. Solera4me is provided by Solera Health, an independent company.

GO ONLINE.

Find out if you qualify: Take a 1-minute quiz at **Solera4me.com/BlueKC**.

Dental

DELTA DENTAL®

Benefits	Core Plan		Enhanced Plan	
	Delta PPO Network	Out-of-Network	Delta PPO Network	Out-of-Network
Diagnostic and Preventive Services • Oral exams (all types), twice per benefit period. • Bitewing x-ray, one set per benefit period; Periapical x-ray, up to 4 x-rays per benefit period. • Full-mouth x-rays once in any 60 consecutive months. • Cleanings (all types), twice per benefit period. • Fluoride, once per benefit period for dependents under age 14. • Emergency palliative treatment. • Sealants for dependent children under 16, once per tooth per lifetime, limited to non-decayed 1st and 2nd permanent molars. • Space maintainers, once in 5 years, to age 16.	100 %	90%	100%	100%
Basic Services • Restorative services using synthetic porcelain and plastic material (white) on front teeth and amalgam. • Simple extractions	80%	70%	90%	80%
Major Services • Surgical Extractions and other Oral Surgery Periodontics: treatment for diseases of gums and bone supporting the teeth. • Endodontics: root canal filling and pulpal therapy. • Prosthetics: bridges and dentures; a replacement will be covered only once in 5 years, but not during the first 12 months of Major Services coverage. • Crowns, jackets, labial veneers, inlays and onlays when required for restorative purposes, once in 5 years.	Not Covered	Not Covered	60%	50%
Orthodontic Services • For eligible dependents to age 19 who begin treatment while covered by this plan. • Note: a 24 month waiting period applies	Not Covered	Not Covered	50%	50%
Deductible (applies to Basic and Major Services only)	$50 per person		$50 per person	
Policy Year Benefit Maximum	$1,000 per person		$2,000 per person	
Separate Lifetime Orthodontic Maximum	Not Covered		$1,500 per child to age 19	
MAXAdvantage - Claims paid for cleanings, exams, x-rays, fluoride treatments do not apply to benefit maximum.	Not Covered		Applies	

Monthly Premium			
Core Plan	**Total Premium**	**Employer Pays**	**Employee Pays**
Individual	$26.00	$10.00	$16.00
Individual + 1	$45.00	$10.00	$35.00
Family	$84.00	$10.00	$74.00
Enhanced Plan	**Total Premium**	**Employer Pays**	**Employee Pays**
Individual	$50.00	$10.00	$40.00
Individual + 1	$88.00	$10.00	$78.00
Family	$151.00	$10.00	$141.00

Vision

Your VSP Vision Benefits Summary

THE CATHOLIC DIOCESE OF KC-SJ and VSP provide you with a choice of affordable vision plans. Choose the eye care essentials, or upgrade to give your eyes extra love.

PROVIDER NETWORK:
VSP Choice

EFFECTIVE DATE:
01/01/2025

vsp vision care

BENEFIT	DESCRIPTION	COPAY
Core Coverage with a VSP Provider		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every calendar year	$10 Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		**$25**
FRAME*	• $170 Featured Frame Brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club frame allowance • $80 Costco frame allowance • Every other calendar year	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every calendar year	Included in Prescription Glasses
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every calendar year	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.	
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.	
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.	

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

BENEFIT	DESCRIPTION	COPAY
Enhanced Coverage with a VSP Provider		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every calendar year	$10 Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		**$25**
FRAME*	• $220 Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $200 Walmart/Sam's Club frame allowance • $110 Costco frame allowance • Every calendar year	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every calendar year	Included in Prescription Glasses
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Anti-glare coating • Average savings of 40% on other lens enhancements • Every calendar year	$0 $80 - $90 $120 - $160 $40
CONTACTS (INSTEAD OF GLASSES)	• $180 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $60
VSP LIGHTCARE™+	• $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • Every calendar year	$25
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 30% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% savings from a VSP provider within 12 months of your last WellVision Exam.	
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.	
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.	

Monthly Premium	Core Plan	Enhanced Plan
Individual	$8.38	$12.03
Individual + Spouse	$16.72	$24.02
Individual + Child(ren)	$17.89	$25.69
Family	$28.61	$41.10

Put Your Eyes at Ease with VSP LightCare

Why UV and Blue Light Coverage?

Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health.

With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor.

DEFEND YOUR EYES INDOORS AND OUT:

Wear blue light filtering glasses indoors to help defend against digital eye strain. Excessive blue light exposure from digital screens and fluorescent lighting may contribute to dry eyes, blurred vision, tired eyes, sore eyes, headaches, and watery eyes—all possible symptoms of digital eye strain.

Always wear sunglasses outdoors. Shield your eyes from the sun's ultraviolet rays that can damage your corneas and cause eye-related diseases like cataracts. 100% UVA and UVB protection is the best choice for your sunglasses.[1]

PROVIDER CHOICES YOU WANT

With thousands of private practice doctors and more than 700 Visionworks® retail locations nationwide, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

vsp PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Plus, if you prefer to shop online, you can use your benefits in-network on **eyeconic.com®**.[2] Select from a wide selection of ready-made sunglasses and blue light filtering glasses for everyone.

vsp vision care

Your VSP LightCare Coverage Includes:*

Eye Exam

A fully-covered WellVision Exam®.[3]

Eyewear

Use your frame and lens allowance toward ready-made:

- non-prescription sunglasses *or*
- non-prescription blue light filtering glasses

*Register and log in to **vsp.com** to review your benefit information. Based on applicable laws; benefits may vary by location.

Questions? **Visit vsp.com | 800.877.7195**

1. Tips for Choosing the Best Sunglasses, American Academy of Ophthalmology, June 2021. **2.** To find out whether your employer participates in Eyeconic®, log in to **vsp.com** to check your vision benefits. **3.** Less any applicable copay.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Disability

Sun Life

SHORT-TERM DISABILITY

EMPLOYER PAYS 100%

What, Why and When	Provides income protection in the event you become either totally or partially disabled as indicated by the attending physician.
Elimination Period	First of the month coincident with or next following date of employment
Weekly Benefit	70% of an insured person's weekly earnings
Maximum Benefit	$750 per week
Maximum Benefit Duration	17 Weeks
Maternity Leave	Covers maternity leave. Benefit duration for normal delivery is 6 weeks and 8 weeks for cesarean.

LONG-TERM DISABILITY

EMPLOYER PAYS 100%

What, Why and When	Provides income protection in the event you become either totally or partially disabled as indicated by the attending physician.
Elimination Period	120 calendar days of disability caused by accidental injury or sickness
Monthly Benefit	60% of insured person's monthly earnings
Maximum Benefit	$5,000 per month
Maximum Benefit Duration	Later of age 65 or Social Security Normal Retirement Age

Basic Life and AD&D

Sun Life

BASIC LIFE AND AD&D

EMPLOYER PAYS 100%

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

One times your annual earnings to a maximum of $50,000. Benefit reduced 50% at age 70.

If disabled before age 60, coverage will continue for the length of the disability, but not beyond the earlier of age 65, or the date of retirement. If disabled after age 60, but before age 65, coverage may continue for up to one year, but not past the earlier of age 65, or the date of retirement.

Accidental Death and Dismemberment

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

Accelerated Death Benefit

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

VOLUNTARY TERM LIFE AND AD&D

EMPLOYEE PAYS 100%

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

Employee

- Coverage is available in $10,000 increments up to 5 times annual salary (rounded to the next higher $10,000);
- Minimum coverage: $10,000
- Maximum coverage: $500,000
- Guarantee issue: $200,000
- Benefits reduce to 50% at age 70

Spouse

- Coverage is available in $5,000 increments up to 2.5 times the employee's annual salary (rounded to the next higher $5,000); not to exceed 50% of the employee's elected benefit amount;
- Minimum coverage: $5,000
- Maximum coverage: $250,000
- Guarantee issue: $50,000; (not to exceed 50% of employee amount)

Dependent

- Dependent coverage is only available if the employee is insured for Voluntary Coverage;
- Provides coverage for all dependent children up to age 26 in the following amounts: $1,000, $5,000 or $10,000 (not to exceed 50% of employee amount).

NEW YORK LIFE

VOLUNTARY WHOLE LIFE INSURANCE

EMPLOYEE PAYS 100%

Portability

The policy remains with you when your employment ends.

Guaranteed Cash Value

The policy builds cash value, which can accessed through policy loans and withdrawals, to help pay for unexpected emergencies or a child's college education. Loans against this policy accrue interest and decrease the death benefit and cash value by the amount of the outstanding loan and interest.

Convenient Payments

Premiums are automatically deducted from your paycheck.

Affordability

You benefit from competitive rates and liberalized underwriting.

Flexibility

You can customize your policy with optional policy riders.

Coverage for Additional Family Members

Spouses, children, and grandchildren (ages 15 days to 25 years) may also be eligible for guaranteed coverage.

Voluntary Accident

Sun Life

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.

EMPLOYEE PAYS 100%

Coverage Highlights

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

Basic Plan - Monthly Premium	
Employee	$11.51
Employee + Spouse	$17.98
Employee + Children	$19.37
Family	$25.84

Enhanced Plan - Monthly Premium	
Employee	$14.57
Employee + Spouse	$24.48
Employee + Children	$25.87
Family	$35.78

Voluntary Critical Illness

Sun Life

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:

EMPLOYEE PAYS 100%

- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant

Benefit Description:

- Coverage available in increments of $10,000 from $10,000-$30,000
- Guarantee issue coverage
- Spouse coverage available in increments of $5,000 from $5,000-$15,000 (not to exceed 50% of employee coverage)
- Child coverage available in $5,000 increments from $5,000-$10,000 (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.
- Specific costs for your age and smoking status can be found in the BSwift enrollment portal.

Hospital Indemnity

Sun Life

Hospital Indemnity insurance helps with out-of-pocket medical costs incurred with a hospital stay. Sun Life's Hospital Indemnity plan provides flexible options that make it easy to meet cost and coverage goals. Employees with hospital stays of 10 days or more may receive additional Extended Hospitalization benefits.

Here are some benefits available under our Hospital Indemnity plan:

- **No health questions required to enroll**.
- **Covered conditions**: Plans can include coverage for hospital confinements due to accident and sickness, mental and nervous disorders, substance abuse, routine pregnancy, and newborn routine care.
- **Benefit options**: Benefits are available for hospital confinements, stays in rehabilitation units, intensive care units, intermediate step down units, emergency room treatment and more.
- **First Day benefits:** Benefits can include a First Day Hospital &/or First Day ICU.
- **Benefits can add up:** Add additional value to your plan by including the option for benefits, such as First Day, Hospital Confinement, or ICU benefits, to be paid on the same day.
- **Extended Hospitalization benefit:** Covered employees and dependents with hospital/ICU confinements of 10 consecutive days or more can receive additional benefits for the duration of their confinement.
- **No lifetime maximums:** There is no limit to the number of hospital claims that may be submitted. This may be of particular interest to employees with chronic conditions.
- **Portable:** In approved states, employees who terminate employment and who meet other eligibility criteria may apply to port this insurance. In other states, Continuation will be available.
- **Complements other plans:** Hospital Indemnity complements Critical Illness, Cancer and Accident coverage in their goal to help protect employees from out-of-pocket medical expenses. Benefits are paid regardless of what other coverages employees may have.
- **Wellness Screening Benefit:** When included, this benefit can help to promote healthy lifestyles and early detection. We will pay employees a defined amount, once per benefit year, when we receive proof of an eligible health screening (full list enclosed if included). We may also pay the employee for spouse or child screening

Benefits	Low Plan	High Plan
First day in the hospital (&/or First Day ICU)	$1,000	$2,000
Hospital confinement (Up to 30 days)	$100/day	$200/day
ICU confinement (Up to 10 days)	$100/day	$200/day
Extended hospitalization	$100/day	$200/day

Monthly Rates	Low Plan	High Plan
Employee	$15.22	$27.91
Employee + Spouse	$32.12	$59.17
Employee + Children	$25.79	$46.64
Employee + Family	$42.69	$77.90

Employee Assistance Program

Sun Life

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

EMPLOYER PAYS 100%

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

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

Program Benefits:

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

The single source for confidential support, expert information and valuable resources, when you need it most. 24 hours a day.
Call: 877.595.5281 **TDD:** 800.697.0353
Online: guidanceresources.com
Web ID: EAPBusiness

WHEN TO USE YOUR EAP

- **STRESS, GRIEF OR LOSS**
- **RELATIONSHIP AND FAMILY CHALLENGES**
- **LEGAL OR FINANCIAL CHALLENGES**
- **SUBSTANCE DEPENDENCE OR ADDICTION**

PENSION PLAN

EMPLOYER PAYS 100%

The Lay Pension Plan provides a benefit to eligible lay employees based on salary and the number of years of credited service. Combined with Social Security benefits and savings or investments, the Plan will help to meet personal living expenses during retirement.

Eligibility

Regular, full-time lay employees of parishes, schools and participating institutions in the Diocese.

Transferring

Transferring from one participating employer to another within the Diocese does not change an employee's "Date of Hire," as long as there is no break in service.

Vested Pension

An employee may leave the Diocese with a "Vested Pension" – the right to future benefits – after five years of continuous, full-time service. Note: As of July 1, 1998, a participating employee, prior to completing 5 years of continuous service, may incur a break in service up to 36 months without the loss of credited service.

Spouse

The spouse of a deceased, vested employee may apply for a surviving spouse benefit on the deceased employee's normal retirement date, age 65. A surviving spouse benefit is the amount that would have been paid (based on service to the date of death) if the employee had elected a 50% survivor annuity on the employee's normal retirement date.

Distribution

The plan is administered by Gallagher Retirement Services. All contributions to the plan are held in a Trust Fund and are not eligible for distribution until age 55. Additional details can be found in the Summary Plan Description.

Contact

Gallagher Retirement Services
844.605.1386
diocese.kc.st.joseph@ajg.com

How to Calculate Your Pension

Formula	Example
Average Monthly Compensation*	$2,500
1.35%	x 0.0135
Years of Service (Up To 40 Years)	x 20
Estimated Monthly Pension Benefit at age 65	**$675**

***What's my Average Monthly Compensation?**

Average of highest consecutive 60 months salary received during the 15 years prior to termination.

Retirement

403(B) PLAN

EMPLOYEE PAYS 100%

You may choose to invest in a 403(b) program. All lay employees full-time and part-time are eligible to participate in the 403(b) plan. Many investment options are available through AIG, and contributions are deducted from your paycheck.

Your AIG representative will advise you as needed, including investments, retirement planning and enrollment.

Traditional 403(b)

Traditional 403(b) plans are similar to a 401(k) plan, and contributions are deducted before Federal and State income taxes.

ROTH 403(b)

You may contribute after-tax money to the Roth 403(b) that allows tax-free withdrawals of principal and interest.

Changes to contribution amount can only be made during:

- **Open Enrollment in late October (Effective Jan 1)**
- **Semi-annual enrollment in June (Effective July 1)**

For first time enrollments or information on investment options, contact Carolina Duin to set up a new AIG account.

Carolina Duin, Financial Advisor
AIG Retirement Services
816.490.2794
carolina.duin@corebridgefinancial.com

corebridge financial

Notices

Notice of Special Enrollment Rights

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

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

Notice of Patient Protections

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

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

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator 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 eight 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, 2024. Contact your State for more information on eligibility –

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

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

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

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

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

Frequently Asked Questions

DOES MY DEDUCTIBLE GO TOWARDS MY OUT OF POCKET MAX? Yes – office and prescription copays also apply toward the out of pocket max.

IF I HAVE AN OFFICE VISIT COPAY, DO I STILL HAVE TO PAY MY DEDUCTIBLE? All plans are different. In general, you will pay the copay at the time of service and that copay will be applied to your out-of-pocket maximum. The copay applies to most services in the doctor's office, but lab work and minor surgery may be subject to the deductible and coinsurance.

WHAT IS COINSURANCE? It is the percentage of the health care costs that you and your insurance company split. For example, if your coinsurance is 20% and you have a $1,000 bill, you will pay 20% of that ($200) and your insurance company will cover the rest. Coinsurance applies after the deductible is met.

WHAT DOES "IN-NETWORK" MEAN? The approved list of providers (doctors, nurses, clinics, hospitals, etc.) that your insurance company uses.

WHY DO I HAVE TO STAY IN-NETWORK? You don't necessarily have to, but staying in-network gives you better rates and discounts. It also protects you from balance-billing, which can be expensive and does not apply toward your out-of-pocket maximum.

WHAT HAPPENS IF I GO OUT OF NETWORK? You will still be seen by a provider, but you will be subject to the out of network costs.

WHAT IS A DEPENDENT? A dependent is a legally married spouse or child under the age of 26. See you HR or benefits plan administrator for more information on eligible dependents.

WHAT HAPPENS WHEN MY CHILD TURNS 26? They must become responsible for their own healthcare coverage (unless they are deemed unable to care for themselves, i.e. disabled, at the end of the calendar year.)

MY CHILD IS UNDER 26 AND MARRIED – CAN THEY STILL BE ON MY PLAN? Yes, the child can still be covered, but their spouse will not be eligible for coverage under your plan.

WHEN CAN I DROP A DEPENDENT? This requires a "qualifying life event," which is considered one of the following: birth or adoption of a child, death, marriage or divorce, change in employment status, aging out of dependent status (turning 26), or becoming a citizen. These events open up a special enrollment period, giving you a specified number of days to make changes to coverage.

HOW LONG DO I HAVE TO ADD A DEPENDENT AFTER A QUALIFYING LIFE EVENT? Depending on the event, you have between 30-60 days to change coverage.

WHY DON'T I HAVE TO SHOW MY INSURANCE CARD WHEN I GET MY PRESCRIPTION FILLED AT A RETAIL PHARMACY? Once your pharmacy has entered your insurance information, they won't have to enter it again unless you change insurance plans or companies.

DO I HAVE TO USE MY INSURANCE TO PAY FOR PRESCRIPTIONS? In some instances, a prescription may cost less when insurance isn't used; for example, $4 generics at some pharmacies. You may want to ask your pharmacist about the cost of the medication with and without insurance to determine which is best. It's very important to understand that any prescriptions purchased outside of the insurance plan will not count towards your out of pocket maximum.

WHAT IS A HSA? A Health Savings Account (HSA) is a medical savings account that allows you to make deposits tax free. Money saved in the HSA can be used to pay for qualified medical expenses (including dental and vision) also without being taxed.

IF I LEAVE MY CURRENT COMPANY, WHAT HAPPENS TO FUNDS IN MY HSA? The funds are yours to keep.
WHAT IS A FSA? A Flexible Spending Account (FSA) is similar to a HSA in that it is tax free, but you usually have to use the funds within the year. Some employers may offer a grace period or carryover for a portion of funds to be used in the following year.

CAN I HAVE A HSA AND A FSA TOGETHER? Yes – you can have both if your company offers a limited purpose FSA for only dental and vision expenses.

WHAT MAKES A DEPENDENT CARE FSA DIFFERENT FROM A MEDICAL FSA? A dependent care FSA must be used for the care of those dependents who are under age 13 or a dependent/spouse who is legally disabled. Funds must be used for in-home care, daycare, after-school programs, etc. while you are working.

WHAT IS THE DIFFERENCE BETWEEN SHORT-TERM AND LONG-TERM DISABILITY?
Short-term disability (STD) provides income replacement on a weekly basis when you are unable to work for a period of time due to your own illness or injury.

Long-term disability (LTD) starts once the STD benefits end. It provides monthly income replacement when you are unable to work for an extended period of time due to your own illness or injury. LTD typically lasts until your normal retirement age.
WHY DO ORTHODONTIA BENEFITS HAVE A LIFETIME MAXIMUM, EVEN IF I CHANGE ORTHODONTISTS? The lifetime maximum is an industry standard adhered to by most dental insurance companies.

I'M 65 – WHAT DO I DO ABOUT MEDICARE IF I WANT TO KEEP WORKING AND STAY ON MY EMPLOYER'S GROUP PLAN? You don't have to sign up for Medicare if you want to remain on your employer's health plan. But, within eight months of turning 65, you have to enroll in Medicare Part B to avoid incurring penalties.

Notices

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

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

If you believe you've been wrongly billed, you may contact the entity responsible for enforcing the federal and/or state balance or surprise billing protection laws. Visit https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act 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 Medical Bill Rights page.

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

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

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

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

Contact Information

Medical
Blue Cross Blue Shield of Kansas City
Phone - 816.395.3558
Web - **www.bluekc.com**
Group Number - 10262000

Dental
Delta Dental of Missouri
Phone - 800.335.8266
Web - **www.deltadentalmo.com**
Group Number, Core - 9182-1000
Group Number, Enhanced - 9183-1000

Vision
VSP
Phone - 800.877.7195
Web - **www.vsp.com**
Group Number - 30052141

Life, Term Life and Disability
Sun Life Financial
Phone - 1.800.786.5433
Web - **www.sunlife.com**
Group Number - 162135-1-G

New York Life
Micah Coston
Phone - 660.254.0328
Email - **mjcoston@ft.newyorklife.com**

FSA
HealthEquity/WageWorks
Phone - 877.924.3967
Web - **healthequity.com/wageworks**

HSA
UMB
Phone - 866.520.4472
Web - **hsa.umb.com**

403(b) Plan
AIG Retirement Services
Carolina Duin
Phone - 816.490.2794
Email - **carolina.duin@corebridgefinancial.com**
Web - **corebridgefinancial.com**

Lay Pension Plan
Gallagher Retirement Services
Phone - 1.844.605.1386
Email - **diocese.kc.st.joseph@ajg.com**

Human Resources
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Director
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Brett Nieman
Generalist
Phone - 816.714.2339
Email - **nieman@diocesekcsj.org**

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Email - **holland@diocesekcsj.org**

Lisa Farkas
Administrative Assistant
Phone - 816.714.2313
Email - **farkas@diocesekcsj.org**

Jennifer Richey
Training & Compliance Coordinator
Phone - 816.714.2313
Email - **richey@diocesekcsj.org**

Wellness
See the Wellness Packet for complete details & instructions at: **diocesekcsj.millercares.com**

The Miller Group - Broker
Robert Falke
Sr. Account Executive
Email - **robertf@millercares.com**

Heather Price Nana
Account Manager
Email - **heatherp@millercares.com**

DIOCESE OF KANSAS CITY-ST. JOSEPH

View your benefits at your benefits website: diocesekcsj.millercares.com

PLANS ARRANGED BY:
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www.millercares.com
(816) 333-3000

THE ROBERT E. millergroup