2026 HIGHLIGHTS: LAY BENEFITS

DIOCESE OF
KANSAS CITY-ST. JOSEPH

Table of Contents

Medical Summary 3

Medical 4
- HDHP Base Plan
- HDHP Buy-Up Plan
- In-Network Only Plan

KC Hospital Network Comparison 7

Omada Complete Program 13

Wellness 18

HSA-Health Savings Account 19

FSA-Flexible Spending Account 20

HSA v. FSA 21

Dental 22

Vision 23

Disability 25
- Short-Term Disability
- Long-Term Disability

Basic Life and AD&D 26
- Basic Life and AD&D
- Voluntary Term Life and AD&D
- Voluntary Whole Life Insurance

Voluntary Accident 27

Voluntary Critical Illness 27

Voluntary Hospital Indemnity 28

EAP-Employee Assistance Program 29

Retirement 30
- Pension Plan
- 403(b) Plan

Notices 32

Frequently Asked Questions 35

Contact Information 36

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

<table>
<tr><th colspan="4">MEDICAL</th></tr>
<tr><th>HDHP Base Plan</th><th colspan="3">Cigna Network</th></tr>
<tr><td rowspan="5">Deductible: $4,000/$8,000
Coinsurance: 80%
Primary Care: Deductible + Coinsurance
Specialist: Deductible + Coinsurance
Out of Pocket Maximum: $5,000/$10,000</td><td rowspan="5">In-Network Benefits
ER: Deductible + Coinsurance
Urgent Care*: Deductible + Coinsurance
Hospitalization: Deductible + Coinsurance
Prescriptions:
Retail: Deductible + Coinsurance
Mail Order: Deductible + Coinsurance</td><th colspan="2">Monthly Cost (non-wellness)</th></tr>
<tr><td>Employee</td><td>$150.00</td></tr>
<tr><td>EE + Spouse</td><td>$534.00</td></tr>
<tr><td>EE + Child(ren)</td><td>$484.00</td></tr>
<tr><td>Family</td><td>$671.00</td></tr>
<tr><th>HDHP Buy-Up Plan</th><th colspan="3">Cigna Network</th></tr>
<tr><td rowspan="5">Deductible: $3,400/$6,800
Coinsurance: 100%
Primary Care: Deductible
Specialist: Deductible
Out of Pocket Maximum: $3,400/$6,800</td><td rowspan="5">In-Network Benefits
ER: Deductible
Urgent Care: Deductible
Hospitalization: Deductible
Prescriptions:
Retail: Deductible
Mail Order: Deductible</td><th colspan="2">Monthly Cost (non-wellness)</th></tr>
<tr><td>Employee</td><td>$183.00</td></tr>
<tr><td>EE + Spouse</td><td>$583.00</td></tr>
<tr><td>EE + Child(ren)</td><td>$529.00</td></tr>
<tr><td>Family</td><td>$732.00</td></tr>
<tr><th>In-Network Only Plan</th><th colspan="3">Cigna Network</th></tr>
<tr><td rowspan="5">Deductible: $2,000/$4,000
Coinsurance: 100%
Primary Care $20 Copay
Specialist: $20 Copay
Out of Pocket Maximum: $2,000/$4,000</td><td rowspan="5">In-Network Benefits
ER: Deductible
Urgent Care $25 Copay
Hospitalization: Deductible
Prescriptions:
Retail: $15/$50/Deductible
Mail Order: $15/$125/Deductible</td><th colspan="2">Monthly Cost (non-wellness)</th></tr>
<tr><td>Employee</td><td>$183.00</td></tr>
<tr><td>EE + Spouse</td><td>$553.00</td></tr>
<tr><td>EE + Child(ren)</td><td>$501.00</td></tr>
<tr><td>Family</td><td>$736.00</td></tr>
</table>

Medical

HDHP BASE PLAN

The High Deductible Health Plan-Base Plan has 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 Cigna plan subscribers.

If services are received from an in-network Cigna provider, eligible expenses will be paid at the 80% coinsurance level after deductible. If you receive services from a provider outside the Cigna 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 mycigna.com or call 800-997-1654.

HDHP Base Plan	
Deductible	$4,000 - Individual $8,000 - Family
Coinsurance	80%
Out-of-Pocket Max[1]	$5,000 - Individual $10,000 - Family
Primary Office Visit	Deductible + Coinsurance
Specialist Office Visit	Deductible + Coinsurance
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	$836.00	$686.00 (80%)	$100.00	$150.00
Employee + Spouse	$1,779.00	$1,245.00 (70%)	$484.00	$534.00
Employee + Child(ren)	$1,612.00	$1,128.00 (70%)	$434.00	$484.00
Family	$2,235.00	$1,564.00 (70%)	$621.00	$671.00

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 CIGNA pays 100% of benefits.*

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

HDHP BUY-UP PLAN

The High Deductible Health Plan-Buy-Up Plan has 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 Cigna plan subscribers.

If services are received from an in-network Cigna provider, eligible expenses will be paid at the 100% coinsurance level after deductible. If you receive services from a provider outside the Cigna 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 mycigna.com or call 800-997-1654.

HDHP Buy-Up Plan	
Deductible	$3,400- Individual $6,800 - Family
Coinsurance	100%
Out-of-Pocket Max[1]	$3,400 - Individual $6,800 - 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	$913.00	$730.00 (80%)	$133.00	$183.00
Employee + Spouse	$1,942.00	$1,359.00 (70%)	$533.00	$583.00
Employee + Child(ren)	$1,760.00	$1,231.00 (70%)	$479.00	$529.00
Family	$2,440.00	$1,708.00 (70%)	$682.00	$732.00

[1]*Total of deductible and coinsurance members pay each year towards covered charges before CIGNA 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

IN-NETWORK ONLY PLAN

This is an In-Network only plan that provides no Out-of-Network benefits, with a lower deductible than the HDHP plans.

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

To locate an in-network medical provider, please visit mycigna.com or call 800-997-1654.

In-Network Only Plan	
Deductible	$2,000 - Individual $4,000 - Family
Coinsurance	100%
Out-of-Pocket Max	$2,000 - Individual $4,000 - Family
Primary Office Visit	$20 Copay
Specialist Office Visit	$20 Copay
Routine Preventive[1]	100% Covered
Urgent Care	$25 Copay
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	$913.00	$730.00 (80%)	$133.00	$183.00
Employee + Spouse	$1,845.00	$1,292.00 (70%)	$503.00	$553.00
Employee + Child(ren)	$1,668.00	$1,167.00 (70%)	$451.00	$501.00
Family	$2,543.00	$1,717.00 (70%)	$686.00	$736.00

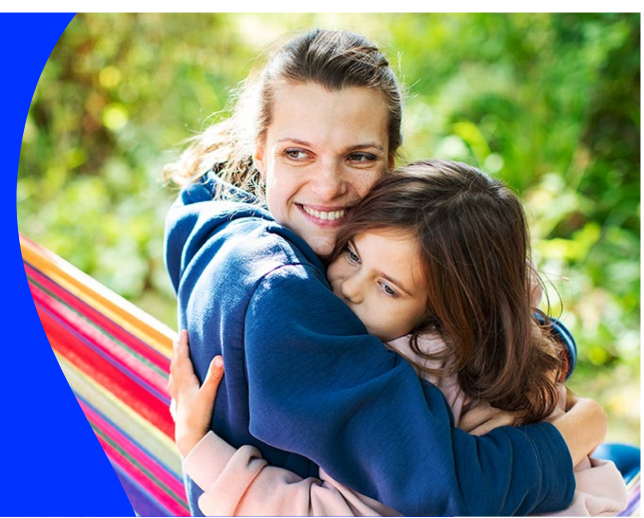
[1]*Routine Preventive care covered at 100%; a list of these services can be found at* **diocesekcsj.millercares.com**.

KC Hospital Network Comparison

KC Area Hospitals	Cigna OAP Network	Cigna Local Plus
Advent Health System (Shawnee Mission)	Y	Y
Advent Health System (South Overland Park)	Y	Y
Advent Health System (College Boulevard)	Y	Y
Belton Regional Medical Center (HCA)	Y	Y
Cass Medical Center (HCA)	Y	Y
Center Point Medical Center (HCA)	Y	Y
Children's Mercy Hospital	Y	Y
Children's Mercy Hospital (Kansas)	Y	Y
Excelsior Springs Medical Center	Y	Y
Lafayette Regional Medical Center (HCA)	Y	Y
Lawrence Memorial Hospital	Y	Y
Lee's Summit Hospital (HCA)	Y	Y
Liberty Hospital	Y	Y
Menorah Medical Center (HCA)	Y	Y
North Kansas City Hospital	Y	Y
Olathe Medical Center	Y	Y
Overland Park Regional (HCA)	Y	Y
Providence Medical Center*	Y	Y
Ray County Memorial Hospital	Y	Y
Research Medical Center (HCA)	Y	Y
St. Joseph Medical Center*	Y	Y
Saint Luke's Hospital	Y	
Saint Luke's Hospital Community Hospital	Y	
Saint Luke's East Hospital	Y	
Saint Luke's Northland Hospital	Y	
Saint Luke's South Hospital	Y	
St. Mary's Medical Center*	Y	Y
University Health Truman Medical Center	Y	
University Health Lakewood Medical Center	Y	
University of Kansas Health System	Y	Y
Western Missouri Medical Center	Y	
*Client Specific Network Arrangement - hospitals will not appear on myCigna.com		

Choose a plan with confidence.

Cigna One Guide service can help.



We understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why **Cigna One Guide® service is available to you now**.

Call a One Guide® representative during preenrollment to get personalized, useful guidance.

Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers to any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.

Don't wait until the last minute to enroll.

Call **888.806.5042** to speak with a Cigna One Guide representative today.

Access Cigna One Guide – after enrollment – in the way that's most convenient for you:

myCigna.com® or the **myCigna® App**

Live chat

Phone

After enrollment, the support continues for Cigna Healthcare℠ customers.

One Guide service will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler health care journey for you and your family.

One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find hospitals and health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan documents.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT.) (CHLIC), Connecticut General Life Insurance Company, or (its) their affiliates, and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc. (CHC-TN), and Cigna HealthCare of Texas, Inc. In Utah, all products and services are provided by Cigna Health and Life Insurance Company (Bloomfield, CT). Policy forms: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

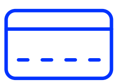
901993 c 09/24 © 2024 Cigna Healthcare.

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

So many ways to help manage your health.

Get to know the full value of myCigna.

Now it's easier than ever to manage your health and make the most of your health plan with myCigna®.* From programs that help improve your health to tools that help manage your health spending, there's so much you can do.



View, print and send ID cards

Find in-network doctors, hospitals and medical services

Compare quality of care information, including patient reviews from Cigna Healthcare℠ customers

Manage and track claims

See cost estimates for medical procedures

Use the click-to-chat feature to connect with a live Cigna Healthcare rep

Feel better protected Cigna Healthcare is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on myCigna.

Visit myCigna today. Not registered yet? Start here.

Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.

Download the myCigna App for your mobile device. Disponible en Español.

* Actual myCigna features may vary depending on your plan and customer profile.

The Apple logo is a trademark of Apple Inc., registered in the U.S. and other countries. App Store is a registered service mark of Apple Inc. Android and Google Play are trademarks of Google LLC. Amazon, Kindle, Fire and all related logos are trademarks of Amazon.com, Inc., or its affiliates.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group.

956262 b 08/23 © 2023 Cigna Healthcare. Some content provided under license.

Advice and Support at Your Fingertips.

Nurse advocates* are ready with answers on Cigna Healthcare's Health Information Line.

Unsure about a fever? Have questions about a medication? We're here to help.

Cigna Healthcare's no-cost Health Information Line puts you in touch with a personal nurse advocate* via chat or phone. They're here to answer your health questions and help you make the best choice for your needs.

Nurse advocates are available for questions like:

- I've had a fever for 2 days. Should I go to the emergency room?
- Is virtual care a good option for my needs?
- Is there a good orthopedic doctor in my area?
- I take a maintenance medication. How can I save on my prescription and get it delivered?

Cigna Healthcare's no-cost Health Information Line is always confidential.

- **Chat**
  Monday–Friday
  9:00 am–8:00 pm ET,
  excluding holidays via
  myCigna.com or the
  myCigna App.
- **Call**
  24/7/365.
  Just dial the number on the back of your Cigna Healthcare ID card.

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

*Nurse advocates hold current nursing licensure in a minimum of one state, but are not practicing nursing or providing medical advice in any capacity as a health advocate.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (CHLIC), Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation.

949501 a 08/24 © 2024 Cigna Healthcare. Some content provided under license.

Health care that's there for you when and where you need it

Head-to-toe virtual care from MDLIVE.

Virtual care is making access to high-quality healthcare more convenient and affordable — for you and every covered member of your family. That's why Cigna Healthcare℠ has partnered with MDLIVE® to offer a broad suite of convenient virtual care options — available by phone or video, and in English or Spanish

Primary Care[1]

Easy, fast appointments, referrals, prescriptions, lab work and diagnostic tests

- Preventive care and wellness screenings available at no additional cost to identify conditions early.[2]
- Manage chronic conditions and establish a relationship with the same primary care provider (PCP) through routine care.
- Receive orders for biometrics and blood work at local facilities.[3]

Urgent Care

On-demand 24/7 or schedule a time that works for you

- Convenient, affordable alternative to urgent care centers and the emergency room.
- Care for many minor illnesses and injuries, such as infections, cold & flu, and sinus problems.
- Includes pediatric care, allowing your child to be seen quickly and from the comfort of their home.

Dermatology[4]

Fast, customized care for skin, hair, and nail conditions — no appointment required

- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more.
- Upload photos and describe symptoms for board-certified dermatologists to review.
- Diagnosis and customized treatment plan, usually within 24 hours.

Behavioral Care

Talk therapy and psychiatry from the privacy of home, with no waiting rooms

- Access to licensed therapists and board-certified psychiatrists.
- Schedule an appointment that works for you and have recurring sessions with the same provider.
- Care for topics such as anxiety, stress, life changes, grief and depression.

Prescriptions available through home delivery or at local pharmacies, if appropriate.

Disclosures listed on next page.

961333 08/23

It's easy to connect to care.

Virtual care visits are convenient and easy, whether you choose on-demand care or to schedule an appointment. And you can select an appointment in English or Spanish.

1.

Access MDLIVE by logging into myCigna.com® or by using the myCigna® app.

2.

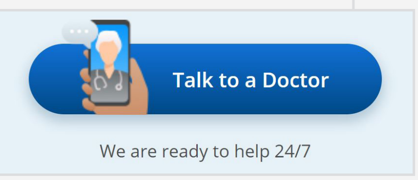
Find the "Talk to a Doctor" button on the homepage. You may have to scroll down.

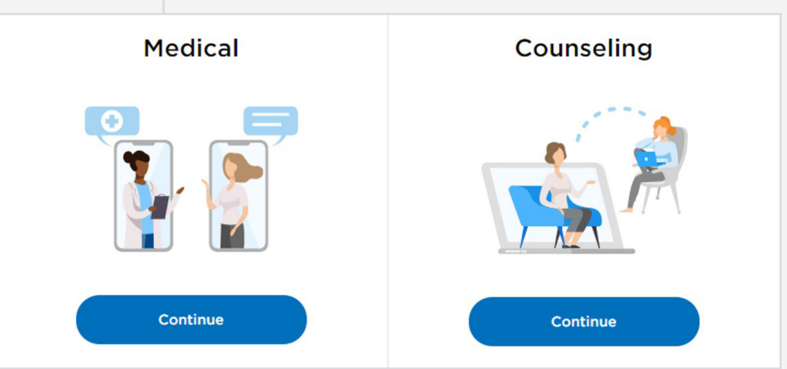
3.

Select the type of virtual care you need — Medical or Counseling. Estimated cost will be shown.[5]

4.

Schedule your appointment or start your visit today.





Visit myCigna.com or **call MDLIVE at 888.726.3171** when you need virtual care.

1. Virtual primary care through MDLIVE is only available for Cigna Healthcare medical members aged 18 and older.
2. Appointments are required. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.
5. Prices shown on myCigna are not a guarantee. Coverage falls under your plan terms and conditions.

Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs.

In California: Services may be available on an in-person basis or via telehealth from the enrollee's primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with California law. Enrollees that have coverage for out-of-network benefits may receive services either via telehealth or on an in-person basis using the enrollee's out-of-network benefits. Note: out-of-network benefits, if available, will generally include higher out-of-pocket financial responsibility and no balance-billing protections. Please refer to your benefit plan documents for specific information about your benefit plan and out-of-network benefits.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT), Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Express Scripts, Inc., or their affiliates. Policy forms: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

961333 08/23 © 2023 Cigna Healthcare. Some content provided under license.

Omada Complete Program

Access a health program built just for you

Exciting News: Access Coming Soon!

Stay tuned for more updates on how to apply for the Omada Program.

The best part: the program—up to a $1,700 value—is no cost to you if you're eligible to join.

Which program can help you?

Manage diabetes more easily

Control your blood sugar with less stress and more confidence.

Take control of your blood pressure

Learn ways to lower your blood pressure outside of just medication with dedicated support.

Lose weight

No food restrictions. No counting calories. Lose weight and improve your overall health.

What do you get as a member?

At no cost to you, each program provides:

- A dedicated health coach
- A clinical specialist (if eligible)
- A personalized care plan
- Weekly lessons
- Online peer group and communities

Members love Omada

"The health coaches make the difference! There is no criticism! There is positive reinforcement and celebration of successes, no matter how small."

- Amy, Omada member

Stay Tuned,

Coming Soon!

If you or your covered adult dependents are enrolled in the company medical plan offered through Cigna, are at risk for type 2 diabetes or heart disease or are living with diabetes or high blood pressure, and are accepted into the program, you'll receive the program at no cost.

*Certain features and smart devices are only available if you meet program and clinical eligibility requirements.

The no cost CGM excludes Medicare, Medicaid, and other government payers. The Abbott FreeStyle Libre 14 day system is available to eligible participants with a valid prescription and compatible smartphone. Setup is required for continuous glucose monitoring. The circular shape of the sensor housing, FreeStyle, Libre, and related brand marks are marks of Abbott. FreeStyle Libre 14 day system: Failure to use FreeStyle Libre 14 day system as instructed in labeling may result in missing a severe low or high glucose event and/or making a treatment decision, resulting in injury. If readings do not match symptoms or expectations, use a finger stick value from a blood glucose meter for treatment decisions. Seek medical attention when appropriate or contact Abbott at 855-632-8658 or FreeStyleLibre.us for safety info.

Images, including apps, do not reflect real members or information about a specific person.

Testimonials are based on members' real experiences and individual results. We do not claim that these are typical results that members will achieve. Results may vary. The Omada® program is administered by Omada Health, Inc., an independent third party service provider. All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group or its affiliates. The Omada® program is not administered by Cigna Healthcare. It is administered solely by Omada Health, Inc. which is responsible for the program.

Take control of your medication fills.

Choose how often and where you want to fill your prescriptions.

Having options can help make the things you do on a regular basis a little easier – such as refilling your prescriptions. With the Cigna 90 Now^{SM} program, you decide how and where you fill your maintenance medications.

Choose how much you want to fill.

- **30-day supply.** You have the option of switching to a 90-day (or 3-month) supply at any time.
- **90-day (or 3-month) supply**.[1] You'll make fewer trips to the pharmacy for refills (four times a year instead of every month). And you're more likely to stay healthy – with a 90-day supply on hand, you're less likely to miss a dose.[2]

Choose where you want to fill.

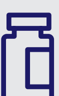
Retail pharmacies

There are thousands of pharmacies in your network – including local independent pharmacies, grocery stores, retail chains and wholesale warehouse stores. To find an in-network pharmacy near you, log in to the **myCigna® App**[3] or **myCigna.com**®.

- Every pharmacy in your network can fill **30-day** prescriptions.
- Select retail pharmacies can fill **90-day** prescriptions. For example, **Walgreens® Pharmacy** is approved to fill 90-day supplies. If you choose to fill this amount, make sure you use an approved pharmacy.

Home delivery with Express Scripts® Pharmacy[4]

Home delivery is a convenient option when you're taking a medication on a regular basis. It's simple, safe – and saves you trips to the pharmacy.



What are maintenance medications?

They're the medications you take on a regular basis to treat an ongoing health condition, such as asthma, diabetes, high blood pressure or high cholesterol.

By choosing home delivery, you can:

- **Easily manage** your medications from your phone or online
- Get standard shipping **at no extra cost**[5]
- Fill up to a **90-day supply** at one time
- Talk to **helpful pharmacists**, 24/7
- Sign up for **free automatic refills** or refill reminders so you don't miss a dose
- Use a **flexible payment plan** to make it easier to pay for your medication

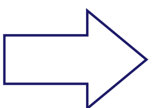
To learn more, go to **Cigna.com/homedelivery**.

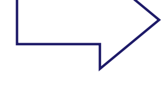
All sources and disclosures appear at the end of this document.

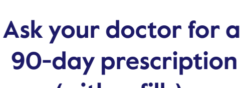
967144 C90N Vol WAGs 01/24

Offered by Cigna Health and Life Insurance Company or its affiliates. In Utah, plans are offered by Cigna Health and Life Insurance Company.

How to fill a 90-day supply.





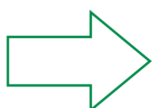


Ask your doctor for a 90-day prescription (with refills).

Ask their office to send it electronically to an approved in-network retail pharmacy or to Express Scripts® Home Delivery.

Get your 90-day supply of medication. You'll fill again in 3 months.

How to fill a 30-day supply.



Ask your doctor for a 30-day prescription.

Ask their office to send it electronically to any in-network retail pharmacy.

Get your 30-day supply of medication. You'll fill again in a month.

1. Certain medications may only be packaged in less than a 90-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
2. Internal Cigna Healthcare analysis performed Jan 2019, utilizing 2018 Cigna Healthcare national book of business average medication adherence (customer adherent > 80% Proportion Days Covered), 90-day supply vs. those who received a 30-day supply taking antidiabetics, blood pressure medications and statins.
3. Not all plans offer Express Scripts® Pharmacy as a covered pharmacy option. Log in to the myCigna App or myCigna.com, or check your plan materials, to learn more about the pharmacies in your plan's network. Cigna Healthcare maintains an ownership interest in Express Scripts® Pharmacy's home delivery services. However, you have the right to fill prescriptions at any pharmacy in your plan's network. You won't be penalized regardless of where you fill your prescriptions.
4. App/online store terms and mobile phone carrier/data charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
5. Standard shipping costs are included as part of your prescription plan.

Para obtener ayuda en español llame al número en su tarjeta de Cigna Healthcare.

Health benefit plans vary, but in general to be eligible for coverage, a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and medically necessary. If your plan provides coverage for certain prescription drugs with no cost-share, you may be required to use an in-network pharmacy to fill the prescription. If you use a pharmacy that does not participate in your plan's network, your prescription may not be covered, or reimbursement may be limited by your plan's copayment, coinsurance or deductible requirements. Refer to your plan documents for costs and complete details of your plan's prescription drug coverage.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, review your plan documents or contact a Cigna Healthcare representative.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT) (CHLIC), Connecticut General Life Insurance Company, Express Scripts, Inc., or their affiliates, and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna Healthcare of Arizona, Inc., Cigna Healthcare of California, Inc., Cigna Healthcare of Colorado, Inc., Cigna Healthcare of Connecticut, Inc., Cigna Healthcare of Florida, Inc., Cigna Healthcare of Georgia, Inc., Cigna Healthcare of Illinois, Inc., Cigna Healthcare of Indiana, Inc., Cigna Healthcare of St. Louis, Inc., Cigna Healthcare of North Carolina, Inc., Cigna Healthcare of New Jersey, Inc., Cigna Healthcare of South Carolina, Inc., Cigna Healthcare of Tennessee, Inc. (CHC-TN), and Cigna Healthcare of Texas, Inc. In Utah, all products and services are provided by Cigna Health and Life Insurance Company (Bloomfield, CT). Policy forms: OK – HP-APP-1 et al., OR – HP-POL38 02-13, TN – HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

967144 C90N Vol WAGs 01/24 © 2024 Cigna Healthcare. Some content provided under license.

Finding mental health support can sometimes feel difficult.

With Cigna Total Behavioral Health®, you have easy-to-navigate access to support.

The help you need to feel better

Finding a path to feeling better mentally and emotionally can feel overwhelming. Even on the best days, taking that next step is difficult without special support. As a Cigna Healthcare℠ customer, you have access to so much to help you, including digital resources, aid with stress and anxiety, therapy, coaching and care for more complex behavioral health needs. Here's an example of how it works. Know that we are here for you 24/7 and you don't have to face things alone.

Behavioral care that meets you where you are

We have many convenient options to address your unique mental health needs — including face-to-face, phone and video appointments, as well as virtual providers that use secure messaging. **You'll also get up to three visits with a licensed clinician in our employee assistance program network at no cost to you.**[1] We also make it easy to find care when you need it — including therapist matching, provider appointment searches, help with scheduling appointments and online scheduling options.[2]

Unlimited real-time support

Get immediate care and support, 24/7/365. Our licensed clinicians provide consultations in the moment to help you with a care plan or to talk about what you're going through.

100% follow up

After you've engaged with our team, we'll check in with you to make sure your needs are being met. If you need additional support, we can help with that, too.

A special navigator to help and guide you

This is your single point of contact for whatever needs or concerns you have throughout your path to care.

Help finding the right therapist

Our provider matching considers factors like your age, your reason for seeking treatment, the type of treatment you're looking for, your preference for virtual vs. in-person care delivery options, and more.

myCigna.com support

Answer a few questions to be guided to recommendations for support, to help you along your journey quickly and easily. Here's a video on how easy it is to use. You can also access behavioral health coaching, peer support and self-guided learning activities in apps like **Happify and iPrevail to help build resilience and decrease stress**.

Behavioral specialty coaching and support services

Our coaches provide dedicated support for a broad range of conditions, like:

- Autism spectrum disorder
- Eating disorders
- Substance use
- Opioid and pain management
- Intensive behavioral case management

We also provide support for teens, parents and families, which empowers individuals to be effective advocates for their family member or their own mental health needs.

The **Changing Lives by Integrating Mind and Body®** (CLIMB) program is for individuals struggling to cope with the mental and emotional aspects of chronic stress. CLIMB is an educational group coaching program where members learn skills to help them build resiliency.

Guidance for losing weight, quitting tobacco and reducing stress

Lifestyle management programs can help you reach your goals through phone support and online coaching.

Services to help manage life events

- Up to **three free sessions** with a licensed clinician[1] in our employee assistance program network
- Support for a range of topics, including: parenting, relationships, child care and adoption, pet care, education, identity theft support, legal and financial consultation services[4]

Care for every step of your journey

Our team of licensed mental health clinicians ensure you and your family have the care you need for each stage of the journey, across all levels of care. For example, we can help with:

- Locating a health care professional or facility in our nationwide network, including Centers of Excellence (COEs) that have earned a top ranking for quality and cost-effective care in areas like adult mental health, child and adolescent mental health, eating disorder and substance use treatment[5]
- Finding community resources and programs
- Accessing other wellness and lifestyle programs available to you

To learn more, visit myCigna.com and click the Wellness tab, then select Mental Health Support. You can also chat with us 9am-8pm ET or call the toll-free number on your ID card 24/7.

1. Virtual or face-to-face. Visits per issue per year vary based on plan coverage. Simply call Cigna Healthcare or click to chat from myCigna to obtain an authorization code to give to your provider. Some restrictions apply, please check with your employer to confirm services included in your plan.
2. Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs.
3. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com. The MyCigna mobile app does not have the same functionality/capability that is available on myCigna.com. App/online store terms and mobile phone carrier/data charges apply.
4. Legal consultations related to employment matters are excluded.
5. The Cigna Center of Excellence designation is a partial assessment of quality and cost-efficiency and should not be the only basis for decision-making (as such measures have a risk of error). Individuals are encouraged to consider all relevant factors and talk with their physician about selecting a health care facility. Quality designations and ratings found in Cigna Healthcare's online provider directories are not a guarantee of the quality of care that will be provided to individual patients. Providers are solely responsible for any treatment provided and are not agents of Cigna Healthcare.

Programs and services are subject to all applicable program terms and conditions. Product availability may vary by location and plan type and is subject to change. Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Express Scripts, Inc., or their affiliates. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.
984422b 10/24 © 2024 Cigna Healthcare. Some content provided under license.

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.

2026 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 a CIGNA medical insurance plan.

2027 Medical Premium Discount Program

Save $600 on the annual cost of health insurance in 2027.

The following requirements must be completed by **October 31, 2026**:

1. Submit a Physician Screening Form after completing an annual Preventive Exam.
2. Complete the Health Assessment on the Cigna wellness portal.

All full-time employees on one of the CIGNA 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.**

AVAILABLE TO EMPLOYEES ENROLLED IN THE CIGNA HDHP BUY-UP AND BASE 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 2026, the annual contribution limits are as follows:

- Single Coverage: $4,400
- Family Coverage: $8,750

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 21 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

FSA *Flexible Spending Account*

HealthEquity™

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.

2026 FSA ENROLLMENT OPTIONS

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 a CIGNA HDHP 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 or 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 $660 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.	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 $660 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.

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

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.

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.

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**.

©2023 Vision Service Plan. All rights reserved.
VSP, Eyeconic, eyeconic.com, and WellVision Exam are registered trademarks, and VSP LightCare and VSP Premier Edge are a trademarks of Vision Service Plan.
All other brands or marks are the property of their respective owners. 119521 VCCM

Classification: Public

SHORT-TERM DISABILITY

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

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

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

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).

VOLUNTARY WHOLE LIFE INSURANCE

Portability

The policy remains with you when your employment ends.

Guaranteed Cash Value

The policy builds cash value, which can be 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

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

- 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

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-$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.

Voluntary 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

EAP *Employee Assistance Program*

EMPLOYER PAYS 100%

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

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

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

Program Benefits:

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

The single source for confidential support, expert information and valuable resources, when you need it most. 24 hours a day.
Call: 877.595.5281 **TDD:** 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

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

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 Creative Planning 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.

What does a 403(b) plan offer?

- Automatic payroll deductions to help you make saving a habit
- Reduced taxable income, through pre-tax contributions
- Long-term savings and growth potential across a variety of investment options

The tax advantages, plus plan features and benefits, make a 403(b) plan with Principal® an ideal way to help accumulate funds for your retirement. And Principal® brings you the expertise, investment options and personal services to help keep things simple.

Pretax contributions

When you participate in a 403(b) plan, you contribute by convenient payroll reduction before federal income tax withholding is calculated. This helps reduce your currently taxable income so you can save dollars for retirement that otherwise would have gone to pay income taxes. Depending on the terms of the plan, you may contribute up to 100% of your annual includible compensation, up to $23,500 in 2025. You can contribute an additional $7,500 in 2025 if you are age 50 or older.

Tax-deferred accumulation

Current federal income taxes on all contributions, interest and earnings in your 403(b) plan are deferred until withdrawal, usually at retirement. Tax-deferred earnings, coupled with the power of compounding, can provide greater growth than might be possible with currently taxable savings methods. Remember that income taxes are payable when you withdraw money from your account. And since retirement accounts should be considered long-term investments, federal restrictions and a 10% federal early withdrawal penalty may apply to withdrawals prior to age 59½.

Investment flexibility

Principal® offers an array of investment options from well-known investment managers.
This provides the flexibility you might need to design a program tailored to your individual needs. Keep in mind that investment values in the variable options will fluctuate so that your investments, when withdrawn, can be worth more or less than the original cost. Remember all investment involves risk, including possible loss of principal. Your financial advisor can assist in choosing the options that will match your long-term goals.

Tax-free loans

Tax-free loans, available under some employer plans, enable you to borrow against a portion of your accumulated account value, subject to certain limitations, without permanently reducing your account balance. Defaulted loan amounts (not repaid on time) will be taxed as ordinary income and may be subject to a 10% federal early withdrawal penalty if you are under age 59½.

Access to your contributions

Generally, depending on your employer's plan and the investment option, your account contributions can be distributed in any of the following events:

- Age 59½
- Severance from employment
- Your death or disability
- Financial hardship (no employer contribution)

Again — a 10% federal early withdrawal penalty may apply to withdrawals prior to age 59½.

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)**

Personalized investment advice

Our plan also includes personalized investment advice from licensed advisors at Creative Planning. Whether it's determining how much to save or which investment options to utilize, help is just a phone call or email away.

For first time enrollments or information on investment options, contact Creative Planning 403(b) team:
Toll-Free: 1-866-427-4015
Email: 403b@creativeplanning.com
Jay Jasnoski, AIF: 913-955-3607
Email: jay.jasnoski@creativeplanning.com

Notices

Notice of Special Enrollment Rights

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

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

Notice of Patient Protections

Your plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you can designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, 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 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 March 17, 2025. 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 March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Notices

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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.

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 your 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 AN 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 AN 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.

Contact Information

Medical
Cigna Group # 3347033
Phone - 800-997-1654
Web - **mycigna.com**

Dental
Delta Dental of Missouri
Phone - 800-335-8266
Web - **www.deltadentalmo.com**
Core Group #9182-1000
Enhanced Group #9183-1000

Vision
VSP Group #30052141
Phone - 800-877-7195
Web - **www.vsp.com**

Life, Term Life and Disability
Sun Life Financial Group#162135-1-G
Phone - 800-786-5433
Web - **www.sunlife.com**

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
Creative Planning
Jay Jasnoski, AIF
Direct - 913-955-3607
Email - **jay.jasnoski@creativeplanning.com**
Toll-Free - 1-866-427-4015
403(b) Team - **403b@creativeplanning.com**

Lay Pension Plan
Gallagher Retirement Services
Phone - 844-605-1386
Email - **diocese.kc.st.joseph@ajg.com**

Human Resources
Carol Anne Hoppins
Director
Phone - 816-714-2311
Email - **hoppins@diocesekcsj.org**

Brett Nieman
Manager
Phone - 816-714-2339
Email - **nieman@diocesekcsj.org**

Leslie Holland
Specialist
Phone - 816-714-2386
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**

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