2016

Archdiocese of Philadelphia

BENEFITS GUIDE
FOR PARISH AND AGENCY EMPLOYEES

This brochure highlights the major provisions of the benefits program. As an employee, you may be eligible to participate in some or all of these Plans. Please review this brochure carefully so you can make educated enrollment decisions. If you have any questions about the benefits program, please contact your Benefit Coordinator or call the Human Resources staff at the Archdiocese Pastoral Center at 215.587.3910.

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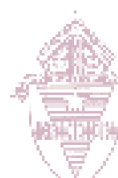


ABOUT YOUR BENEFITS

The Archdiocesan benefits program for Parish and Agency employees helps you get healthy and stay healthy, protect your income while you are working, and build financial security for retirement. It's up to you to choose the options that fit your needs and to make your benefits work for you. ***Benefit options and waiting periods vary by location.*** This **Benefits Guide** reviews your options in detail. In case of any conflicts, the carrier booklets will govern over this brochure.

The Benefits Gateway at http://archphila.org/hrbenefits is another great source for benefits information throughout the year . You'll find the Enrollment Form and more in the Enroll/Library section. *We encourage you to use the Benefits Gateway whenever you have benefit questions. The carriers also have plan booklets and enrollment material.*

Who's Eligible For Coverage

You may be eligible for the benefits highlighted in this **Benefits Guide** if you work at least 20 hours a week as a lay employee of a parish, incorporated agency, or other participating institution of the Archdiocese of Philadelphia. If you enroll, your dependents also may be eligible for some coverages. After you enroll, you may have to complete a waiting period before your Medical and Dental coverage begins. If you have questions about eligibility, contact the Benefit Coordinator at your location.

Cost Of Coverage

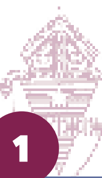
You may be asked to contribute toward the cost of Medical benefits for you and your dependents. The required contribution varies by location, and you will be given information about your share of the cost when you enroll.

If you enroll for Dental, Freestanding Vision, or Voluntary Life/AD&D Insurance (Cigna) coverage for yourself, you pay the full cost before taxes are deducted (pre–tax)–that means tax savings for you. If you enroll for Voluntary Whole Life Insurance, Critical Illness, Voluntary Accident, or Short-Term Disability (STD) coverage, you pay the full cost on a post-tax basis.

How To Enroll Or Change Your Elections

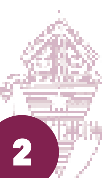
You enroll for benefits when you are first eligible. If you do not elect Voluntary Life or Voluntary AD&D coverage **within 30 days** of first becoming eligible, proof of good health will be required, even at annual enrollment periods.

To enroll, complete and return the Enrollment Form available on the Benefits Gateway website. You may complete the form online and submit it by email. Or, you may print the form, complete it, and submit it to your Benefit Coordinator. If you cannot use the website, ask your Benefit Coordinator to print a form for you. Note: You may change your elections during the annual enrollment period–or during the year if you have a qualified change in status as defined by IRS regulations.



BENEFIT PROGRAM OVERVIEW

Medical/ Prescription Drug and Vision	• Up to four options may be available. The Personal Choice HDHP option includes a tax-advantaged Health Savings Account with an employer contribution. • Each option includes prescription drug coverage and three options include vision coverage. Stand-alone vision coverage is also available.
Dental	• Up to four options may be available–two dental maintenance organization plans and two PPO plans.
Disability	• You may purchase Short-Term Disability (STD) coverage through Unum that may replace up to 60% of your income for as long as three months if you are disabled. Three coverage levels are available, and the coverage is portable. • Your employer pays the full cost for Long-Term Disability (LTD) insurance that may replace up to 60% of your pay.
Voluntary Term Life and Voluntary AD&D Insurance (Cigna)	• You may have the option to buy term Life Insurance and/or Voluntary AD&D (accidental death & dismemberment) Insurance through Cigna. • If you buy Voluntary Life Insurance for yourself, you may buy coverage for your spouse and children. • If you enroll, you pay the full cost.
Voluntary Whole Life Insurance (New York Life)	• You also may have the option to buy whole Life Insurance for you and your family through New York Life. • Whole Life Insurance builds a cash value that you may use for certain expenses or let it grow over time. • If you enroll, you pay the full cost, but your premium will not increase.
Other Voluntary Benefits	• Critical Illness Insurance from Aflac provides a lump-sum payment for certain specified illnesses that you may use for medical bills or other expenses. • Unum Voluntary Accident coverage can help you pay extra bills that can come with injuries or accidents. Coverage is available for you and your dependents
Retirement	• The 403(b) Retirement Plan provides a discretionary employer contribution. • You may add your pre-tax or post-tax contributions to build income for retirement.
Other Programs (if available at your location)	• The Penn Health Behavioral Services Employee Assistance Program (EAP), provides confidential services and resources for emotional, mental, and practical needs. • GlobalFit offers discounts on fitness center memberships. • Plum Benefits offers discounted tickets for movies, events, and more. • The Viriva Credit Union offers a range of financial services.



Coverage For Dependents

Your dependents also may be eligible for Medical, Dental, and Freestanding Vision coverage. Eligible dependents include your:

- spouse (marriage certificate must be made available upon request);
- unmarried dependent children under age 26 (for Dental, up to age 19 or 23 if a full-time student); and
- unmarried handicapped children over age 26 if covered before age 26 and incapable of self-support (for Dental, age 19).

To be covered under the Cigna Voluntary Life or Voluntary AD&D programs, your spouse must be under age 70 and your eligible dependent children must be at least 14 days of age and dependent upon you for support. Other limits may apply to Critical Illness or Voluntary Accident insurance.

> *Dual Coverage–If you and your spouse both work for any Archdiocesan parish, agency, or other institution, only one of you may enroll your children. Also, you may not be covered as an Archdiocesan employee and as your spouse's dependent at the same time.*

Newborns/Newly-Adopted–You must enroll new dependent children within 30 days. If you do not submit an Enrollment Form within 30 days, the delivery will be covered but any other expenses for the child will not be covered. The 30-day period starts at birth or the date you assume legal obligation for support in anticipation of adoption (whichever applies). If you do not submit an Enrollment Form within 30 days, you will have to wait until the next annual enrollment period to enroll the child.

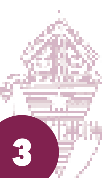
When Dependent Coverage Ends

Health plan coverage for children will end on the last day of the month in which the child reaches age 26 (for Dental, age 19 or age 23 for full-time students).

Extended Medical Coverage–When your covered child reaches age 26, you may extend medical coverage until age 30 if your child is:

- unmarried and under age 30 with no dependents of his or her own;
- a Pennsylvania resident (may be a full-time college student elsewhere); and
- not enrolled in any other health coverage, whether individual, group, or government provided, including Medicare.

If you choose this option, your child will be covered as an individual, not as your dependent. This will affect both your coverage level and the cost of your coverage. For example, if you cover only your child, your coverage level will change to Employee Only and your cost for your coverage will be lower. However, you will pay the full premium for your adult child, so your total cost will increase. You will need to complete a separate enrollment form. See your Benefit Coordinator for more information. There is no requirement that your child be a tax dependent. This extended coverage does not apply to Dental or Vision coverage.



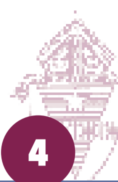
Changing Your Elections

Under IRS rules, benefits that you pay for with pre-tax contributions (Medical, Dental, Freestanding Vision, Voluntary Life Insurance coverage for you, and Voluntary AD&D) stay in effect for the full Plan Year (7/1-6/30), unless you have a change in status and you request the change within 30 days (60 days for CHIP).

Changes in status include:

- change in your marital status (such as marriage, divorce, legal separation, or annulment);
- change in your dependents for tax purposes (such as birth, legal adoption of your child, placement of a child with you for adoption, or death of a dependent);
- certain changes in employment status that affect benefits eligibility for you, your spouse, or your child(ren) (such as, termination of employment, start or return from an unpaid leave, a change in worksite, change between full-time and part-time work, or a decrease or increase in hours);
- your child no longer meets the eligibility requirements;
- entitlement to Medicare or Medicaid (applies only to the person entitled to Medicare or Medicaid);
- change to comply with a state domestic relations order pertaining to coverage of your dependent child;
- your, your spouse's, or child's eligibility for COBRA coverage;
- change in your, your spouse's, or child's place of residence;
- significant increase in the cost of coverage or a significant reduction in the benefit coverage under your or your spouse's health care plan;
- addition, elimination, or significant curtailment of a coverage option;
- change in your spouse's or child's coverage during another employer's annual enrollment period when the other plan has a different period of coverage; and
- a loss of coverage from a governmental or educational institution program.

Loss of Medicaid or CHIP Coverage–If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP or SCHIP) is in effect, you may be able to enroll yourself and your dependents for Medical coverage if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.



MEDICAL COVERAGE

The Medical Plan options offered by your employer may include:

- Personal Choice® HDHP (High Deductible Health Plan with Health Savings Account);
- Personal Choice® PPO (Preferred Provider Organization);
- Keystone POS (Point-of-Service); and
- Keystone Health Plan East HMO (Health Maintenance Organization).

Your local Benefit Coordinator will give you information about the options available to you and your cost for coverage. This section summarizes key features of each option. If you have specific questions, please contact Member Services at **1.800.ASK.BLUE** (275.2583). Provider directories for each option are available at www.ibx.com.

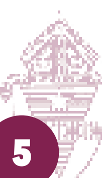
Big Picture

This chart shows key features of each option (the *Medical Option Comparison Chart* later in this section provides a side-by-side look at the options).

Feature	Personal Choice HDHP	Personal Choice PPO	Keystone POS	Keystone HMO
Contributions	Lowest	Varies; Personal Choice PPO is the most expensive.		
Health Savings Account (HSA)	Yes with employer contribution	No	No	No
Provider Choice	Higher benefits when you use Personal Choice PPO network providers, but you may use Out-of-Network providers.		Higher benefits for care from PCP or with referral; lower benefits for Self-Referred care (no referral or Out-of-Network providers)	Benefits paid only for care from PCP or with referral, except for emergency
Preventive Care	In-Network/Referred care on preventive schedule covered at 100% with no deductible.			
Deductible	Yes; applies to all care except preventive	Yes for Out-of-Network care	Yes for Self-Referred care	No
Medical Copays	No	Yes	Yes	Yes
Medical Coinsurance	After deductible, 100% In-Network; 50% Out-of-Network	Most In-Network PPO, Referred POS, and HMO care is covered at 100% (copays may apply); some services covered at 85% or 50%. Personal Choice PPO and Keystone POS pay 70% for Out-of-Network or Self-Referred care.		
Prescription Drugs	Subject to deductible; same copays as the other options	Not subject to deductible. Depending on whether the medication is Generic Preferred, Brand Preferred, or Non-Preferred, your copay for each prescription is $15, $35, or $60 for retail or $37.50, $87.50, or $150 for mail order.		
Vision Coverage	$75 Vision	No (Freestanding Plan available)	$35 Vision	$35 Vision

See Carrier Information For Details

The Medical options cover most services and supplies that are medically necessary and appropriate treatment for your condition. However, some services, such as experimental care or hearing aids, are not covered. For complete details, see the individual Plan booklets provided by Independence Blue Cross or Keystone or contact Member Services. The carrier Plan booklets will govern over this brochure in case of any conflict.



How The Medical Options Differ

All of the options are provided through Independence Blue Cross (IBC) or its Keystone Health Plan East HMO.

Personal Choice HDHP

Personal Choice HDHP is a type of plan that has a higher deductible than more traditional plans and allows you and your employer to contribute to a tax-advantaged Health Savings Account (HSA) if you are eligible. The "deductible" is the amount you pay before the Plan pays benefits for some services. For this option, preventive care is covered at 100% with no deductible. All other expenses, including prescriptions, are subject to the deductible. You receive a higher level of benefits if you use certain providers (see Personal Choice PPO below).

Personal Choice HDHP may be a new option for some employees. To learn more about this option, see A Closer Look at the Health Savings Account (HSA) *section in this brochure. Additional information is available on the Benefits Gateway.*

Personal Choice PPO

Personal Choice HDHP and Personal Choice PPO are "Preferred Provider Organization" (PPO) plans. That simply means you receive a higher level of benefits if you use certain providers carefully chosen by IBC (called staying "In-Network"). You have the freedom to use other providers (called going "Out-of-Network"). If you do, the Plan's benefits are lower, you must file claim forms, some services may not be covered, and you may be responsible for any charges above the Plan allowance determined by IBC.

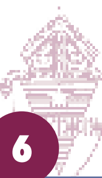
If you choose either of the Personal Choice options, you do not need to choose a Primary Care Physician (PCP), and you do not need any referrals.

Keystone POS

Keystone POS is a Point of Service plan. That's a cross between a PPO and an HMO. If you choose this option, you should select a primary care physician (PCP) from the Keystone POS/HMO network. Generally, to receive the highest level of benefits, your PCP must provide your care or give you a referral. This is called Referred care. Unlike an HMO, you may use other providers without a referral from your PCP and receive a reduced level of benefits. This is called Self-Referred care–you must file claims, the Plan pays less, some services may not be covered, and you may be responsible for charges above the Plan allowance determined by Keystone.

Keystone Health Plan East HMO

The Keystone Health Plan East HMO (Keystone HMO) provides quality health care with minimal out-of-pocket costs. To receive benefits, you must choose a Primary Care Physician (PCP) who will provide your care or give you a referral to Keystone HMO providers. Unlike the other options, all services must be provided by Keystone HMO network providers. If you seek services on your own, without receiving a referral from your PCP, the cost of services will not be covered by the Plan (except for true emergency care).



How The Options Cover Common Services

The **Medical Option Comparison Chart** later in this brochure provides an overview of how each option covers typical services. The IBC or Keystone **Plan Summary Charts** available on the Benefits Gateway or from Member Services, show the details for each option. **Read the Plan Summary Charts before you enroll.**

Here are key facts to know:

Benefit Period

The Benefit Period for Personal Choice HDHP is the Plan Year (7/1-6/30), not the calendar year. The other options have a calendar-year Benefit Period. The deductible, Out-of-Pocket Limit, and any benefit limits (such as a maximum number visits in a year) reset on the first day of the Benefit Period.

Deductible

This is the amount you may be required to pay before the plan pays benefits for some services. The Keystone HMO does not have a deductible.

- **Personal Choice HDHP**–The deductible is based on the Plan Year (7/1-6/30). Except for preventive care, the deductible applies to all services, including prescription drugs. If you have Employee Only coverage, you must meet the individual deductible. If you cover dependents, you must meet the full family deductible (the expenses of everyone covered combined) before the coverage pays 100% of the cost of services.
- **Personal Choice PPO and Keystone POS**–The deductible is based on the calendar year. The deductible applies to most Out-of-Network/Self-Referred care. If you cover dependents and one person meets the single deductible, the plan will pay benefits for that person.

Out-of-Pocket Limit

When your eligible expenses reach the Out-of-Pocket Limit, the plan will begin to pay 100% of eligible expenses for the rest of the calendar year.

- **Personal Choice HDHP**–The Out-of-Pocket Limit also is based on the Plan Year (7/1-6/30). If you cover dependents, once the expenses of one person meet the individual limit, expenses for that individual will be covered at 100%. The deductible, copays, and coinsurance are used to meet the Out-of-Pocket Limit.
- **Personal Choice PPO, Keystone POS, and Keystone HMO**–The Out-of-Pocket Limit also is based on the calendar year. If you cover dependents and one person meets the single Out-of-Pocket Limit, the plan will pay benefits for that person. For Personal Choice PPO and Keystone POS, the Out-of-Pocket Limit for Out-of-Network or Self-Referred care includes only coinsurance; the deductible and copays are not applied.

Out-of-Network/Self-Referred Care

For Personal Choice HDHP, Personal Choice PPO, and Keystone POS, you will pay a larger share of your expenses if you receive Out-of-Network or Self-Referred care. The deductible (if applicable) and Out-of-Pocket Limits are different–and higher. In addition, the providers may bill you for charges that exceed the Plan allowance determined by IBC/Keystone. **This is called "balance billing" and the charges can be significant.** These charges do NOT count toward the Out-of-Pocket Limit. Also, you generally must file claim forms.

Smart Healthcare Consumer Tips

Here are tips to help you take charge of your health and your healthcare dollars:

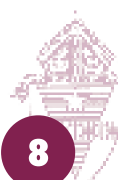
- **Take Care of Yourself**–Commit to improving your fitness and health. Watch your diet, exercise, stop using tobacco, limit alcohol use, and take action to manage stress. If you have a chronic condition, get help managing it and follow the treatment plan.
- **Get Preventive Care**–The medical options cover In-Network preventive care at 100% with no deductible or copays. Learn what's covered and when–and schedule an appointment.
- **Partner With Your Doctor**–People who partner with their physicians to make health care decisions generally are happier with their care and their results.
- **Ask Questions**–Ask as many questions as you need to understand. Why this particular drug or treatment? Is there an alternative? How much will it cost? What are the side effects? Possible outcomes?
- **Be Informed**–Use Ibxpress.com and other resources to learn about health issues, find providers, and evaluate health care quality. This information can help you stay healthy and help you make good treatment decisions.
- **Spend Wisely**–Do your part to manage costs. Use In-Network providers, generic drugs, and an urgent care center instead of the emergency room when appropriate. Before treatment starts, consider the full cost, not just your deductible or coinsurance amount. Check your bills and contact IBC/Keystone or your provider if you have questions.

Preventive Care

Each option covers eligible preventive care services at 100% with no deductible when you receive In-Network or Referred care. There is a list of covered expenses, age, and frequency limits that apply. IBC or Keystone can give you the preventive care schedule (call Member Services).

While you may receive preventive care during your visit, your doctor may order tests that are not covered at100%, such as a urinalysis or an EKG. In that case, some of the charges may be subject to the deductible or copays. Here are steps you can take to make sure preventive care services are paid correctly.

- **When you schedule an appointment**–and during your visit–say that the visit is for an annual routine physical and that your health coverage pays 100% for eligible services. Ask the doctor or staff to let you know if any tests are not considered preventive, so you will be aware of any extra expenses that may occur as a result of those tests.
- **After your visit,** check your Explanation of Benefits (EOB) statements or review any bills for discrepancies. Contact IBC/Keystone to ask about charges not covered at 100%. If you have been charged incorrectly, you can call your provider's office and ask them to recode and resubmit the charges for you.



Prescription Drug Coverage

When you elect any of the Medical options, you automatically receive prescription drug coverage that is administered by FutureScripts®. The Medical Plan uses a Preferred Drug List (called a formulary), which encourages the use of the most clinically-effective and cost-effective medications. An IBC medical committee selects the drugs on the list and updates it four times each year to reflect new medications. Contact Member Services for a copy of the current Preferred Drug List.

If your doctor prescribes a drug that is not on the Preferred Drug List, ask if another drug, such as a generic equivalent or therapeutic alternative, can be used to treat your condition.

Drug Categories

There are three categories of drugs:

- Generic drugs on the Preferred Drug List have the lowest copay. Generic drugs are chemically equal and as effective as the brand-name version–but they can cost up to 85% less!
- Brand-name drugs on the Preferred Drug List have the medium copay. These drugs are selected for their safety, effectiveness, and affordability.
- Brand-name drugs not on the Preferred Drug List have the highest copay.

PRESCRIPTION DRUG BENEFITS AT A GLANCE

Prescription Drug Category	Generic on Preferred Drug List	Brand Name on Preferred Drug List	Drugs NOT on Preferred Drug List
Pharmacy (up to 30-day supply)	$15 copay	$35 copay	$60 copay
Mail-Order (up to 90-day supply)	$37.50 copay	$87.50 copay	$150 copay
You pay the actual cost of the medication if that cost is less than the copay. **For Personal Choice HDHP, the deductible applies**. Mail-order is not covered Out-of Network.			

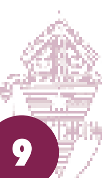
Retail Pharmacy

The FutureScripts network includes more than 60,000 pharmacies. You can locate a participating pharmacy by using the **Find a Participating Pharmacy** feature at www.ibx.com/archdiocese If you use a participating pharmacy, you may receive up to a 30-day supply for one copay.

If you use a non-network pharmacy, Personal Choice PPO, Keystone POS, and Keystone HMO pay 30% of the drug's retail cost; Personal Choice HDHP pays 50%. You must submit a claim form to be reimbursed.

Mail-Order Program

If you use the mail-order program, you will save time because the medicine is delivered to your door. You also will save money because you can receive up to a 90-day supply for only 2.5 times the copay that applies for a month's supply at a retail pharmacy.



Emergency Room Care

True emergency care is covered at 100%–for Personal Choice HDHP, the deductible applies. For the other options, there is a $150 copay that is **not** waived if you are admitted. Some examples of medical emergencies are: apparent heart attack, severe bleeding, loss of consciousness, and severe or multiple injuries. Use of emergency facilities is covered for all medical emergencies–in or out of the network.

Whenever possible, before going to the emergency room, call your doctor or PCP (or the doctor covering for him/her). Of course, in an emergency, get the treatment you need at the nearest facility and then notify your doctor/ PCP and IBC/Keystone.

For Keystone POS or Keystone HMO, benefits are paid only if you report the services to your PCP within 24 hours of receiving emergency room care. For Personal Choice HDHP or Personal Choice PPO, contact Member Services within 24 hours if you receive care at an Out-of-Network facility.

Some conditions, such as earaches, should be treated within 24 hours, but do not need immediate medical treatment. For these "urgent conditions," consider using a network urgent care facility (see the directory at www.ibx.com/archdiocese) or a retail clinic.

Pre-Certification Requirements

The pre-certification review program is designed to ensure that all the services you receive are medically necessary, appropriate, and cost-effective. Generally, when you receive In-Network PPO care, or when your PCP provides or coordinates your care, your doctor/PCP or the hospital will handle any pre-certification for you. However, if you receive Out-of-Network or Self-Referred care–or you are out of your plan's service area–YOU may be required to call **1.800.275.2583** for pre-certification. For the Personal Choice HDHP and Personal Choice PPO plans, this is true even if you use a provider or facility that participates in the BlueCard PPO program.

If you do not get pre-certification when required, benefits may be reduced or not paid at all. The pre-certification requirements for each option vary. See the Plan Summary Charts available on the Benefits Gateway and read the carrier booklet for your option for details. Contact Member Services at the number shown on your ID card if you have questions.

If You Are Outside Your Option's Service Area

Personal Choice HDHP and Personal Choice PPO are provided through Independence Blue Cross. This gives you access to the BlueCard® PPO, a program of participating Blue Cross and/or Blue Shield PPO providers and facilities across the United States. If you are outside the Personal Choice service area, call 1.800.810.BLUE (2583) for information about the nearest participating BlueCard PPO doctors and hospitals. Show your ID card when you receive care. Your claim will be billed through the local plan and then electronically routed to Personal Choice for processing. You will not need to file a claim, but you will be required to pay any applicable In-Network copays.

For Keystone POS or Keystone HMO, contact Member Services at the number shown on your ID card if you are outside the plan's services and need care for an urgent medical condition. Member Services will put you in touch with a Blue Cross Blue Shield traditional provider (called a BlueCard provider) in your travel area so your care will be covered (you will pay your usual copay). Show your ID card when you receive care. If you do not use a BlueCard provider, Keystone POS will pay benefits for eligible services at the Self-Referred level. Keystone HMO will not pay benefits at all.

For Keystone POS or Keystone HMO, If you or a family member will be out of the area for at least 90 days and up to six months, you can apply for a guest membership in a participating plan in your travel area through the Away From Home Care® Program. For details, call Keystone Member Services at the number shown on your ID card.

Pre-Certification Required–Remember that YOU must call for pre-certification when required–even if you use a BlueCard provider. If you don't, benefits may be reduced or not paid at all. For details, see the *Plan Summary* chart for your option on the Benefits Gateway, or call Member Services at the number shown on your ID card.

Vision Coverage With Medical–Or Freestanding

Three of the Medical options include Davis Vision coverage:

- The Keystone POS and Keystone HMO plans include the $35 Vision program that provides benefits for eyeglasses or contact lenses; and
- The Personal Choice HDHP plan includes the $75 Vision program that provides benefits for exams and eyeglasses or contact lenses.

When you use Davis Vision providers, you receive higher benefits. The names ($35 or $75) refer to the reimbursement for certain services. **The Personal Choice HDHP, Keystone POS, and Keystone HMO Plan Summary charts on the Benefits Gateway include the vision benefit chart for that option.**

Freestanding Vision Plan

If you elect the Personal Choice PPO or waive Archdiocese medical coverage, you may enroll in the Freestanding Vision Plan (this is the $75 Vision program). You pay the full cost (separate enrollment form required). Eye exams are covered at 100% every 12 months at participating providers. You also may get eyeglasses with standard lenses at no cost when you choose from a select grouping known as the Davis Collection of Frames. Otherwise, you receive up to a $75 reimbursement for a pair of eyeglasses or for contact lenses once every 24 months. This plan provides the most coverage when you see a Davis Vision provider–conveniently located throughout the area.

Choosing Your PCP–Provider Choice Notice

The Keystone POS and Keystone HMO options allow (POS) or require (HMO) you to designate a Primary Care Provider (PCP). You have the right to designate any PCP who participates in the Keystone POS/HMO network and available to accept you or your family members. Before you complete your enrollment in the Keystone POS or HMO option, you will choose your PCP. Each member of your family can choose a different PCP, and you may choose a pediatrician for your children. You may change your PCP at any time by calling the Member Services number on your ID card or online at www.ibx.com/archdiocese.

> ***Designated Facilities: PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at www.ibx.com/archdiocese.***

You do not need prior authorization from Keystone Health Plan East or from any other person (including a PCP) to obtain access to obstetrical or gynecological care from a Keystone POS/HMO network healthcare professional who specializes in obstetrics or gynecology. However, that healthcare professional 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.

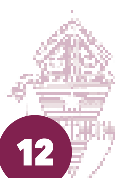
Your local Benefit Coordinator can give you more information about how you select a PCP. A Keystone POS/HMO network directory that includes PCPs and physicians who specialize in obstetrics or gynecology is available from Member Services. You can also access the directory online at www.ibx.com/archdiocese or ibxpress.com.

Important–For the Keystone POS option, benefits will be paid at the Self-Referred (lower) level if you do not choose a PCP. Benefits also will be paid at the lower level if you use a provider without a referral from your PCP–even a provider in the Keystone POS/HMO network.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act requires group health plans to provide coverage for these services to any person receiving plan benefits in connection with a mastectomy: reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and the treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

If you receive medical plan benefits for a mastectomy and elect to have reconstructive surgery, then the plan must provide coverage in a manner determined in consultation with the attending physician and the patient. The plan's benefit for breast reconstruction and related services will be the same as the benefit that applies to other services covered by your medical plan.



MEDICAL PLAN COMPARISON CHART

	Personal Choice HDHP		PPO Personal Choice		Keystone POS		Keystone HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	Referred	Self-Referred	
Using Doctors/ Hospitals	Higher-level benefits	Lower-level benefits	Higher-level benefits	Lower-level benefits	Higher benefit level if PCP provides/refers care	Lower-benefit level if no referral or Out-of-Network	Benefits paid only for HMO providers
Deductible and Out-of-Pocket Limits							
Benefit Period	Plan Year (7/1-6/30)		Calendar Year (1/1-12/31)				
How They Work	**Personal Choice HDHP**– Starts on July 1 and ends on June 30, 2017. Deductible applies to all services except preventive. If you cover dependents, you must always meet the family **deductible** dollar amount before services are covered at 100%. However, once the **Out-of-Pocket Limit** dollar amount ($6,350) is met for one individual, expenses for that individual will be covered at 100%. **All Other Options**– Starts on January 1 and ends on December 31. If you cover dependents, these options cover an individual's expenses if he/she meets the single deductible or Out-of-Pocket Limit.						
Deductible	$1,500/single $3,000/family	$5,000/single $10,000/family	None	$1,000/single $2,000/family	None	$1,000/single $2,000/family	None
Out-of- Pocket Limit	$6,350/single $12,700/family	$10,000/single $20,000/family	$3,000/single $6,000/family	$6,000/single $12,000/family	$3,000/single $6,000/family	$6,000/single $12,000/family	$4,000 /single $8,000/family
Benefits for Common Services							
Inpatient Hospital Care*	100% after deductible	50% after deductible up to 70 days **	100% after copay	70% after deductible up to 70 days**	100% after copay	70% after deductible up to 70 days**	100% after copay
			*If applicable, the copay is $150 per day; 5-copay maximum per admission; copay will be waived if readmitted within 10 days of discharge.				
Outpatient Surgery*	100% after deductible	50% after deductible	100% after $100 copay	70% after deductible	100% after $100 copay	70% after deductible	100% after $100 copay
Emergency Room	100% after deductible	100% after In-Network deductible	100% after copay	100% after copay	100% after copay	100% after copay	100% after copay
			If applicable, the copay is $150 and it is NOT waived if admitted.				
Doctor's Office Visits	100% after deductible	50% after deductible	100% after copay	70% after deductible	100% after copay	70% after deductible	100% after copay
	For primary care or specialist		If applicable, the copay is $15 for primary care and $40 for a specialist.				
Routine Preventive, Well-Baby Care (based on schedule)	100%, no deductible	50%, no deductible	100%	70%, no deductible	100%, no copay or referral required for pediatric immunizations	70%, no deductible	100%
			No referral required for routine GYN exam and no referral or copay for routine mammogram				

	Personal Choice HDHP		PPO Personal Choice		Keystone POS		Keystone HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	Referred	Self-Referred	
Outpatient Laboratory/ Pathology	100%, after deductible	50% after deductible	100%	70%, after deductible	100%	70% after deductible	100%
Outpatient X-ray/ Radiology*	100%, after deductible	50%, after deductible	100% after copay	70% after deductible	100% after copay	70% after deductible	100% after copay
	Includes MRI/ MRA, CT/ CTA, PET scans; if applicable, the copay is $50 for routine/diagnostic, and $100 for MRI/ MRA, CT/CTA scan, or PET scan.						
Maternity*	100% after deductible	50% after deductible up to 70 days **	100% after copay	70% after deductible up to 70 days **	100% after copay	70% after deductible up to 70 days **	100% after copay
			If applicable, the copay is $15 for first OB visit only; for hospital–100% after $150 copay per day; 5-copay maximum per admission; copay will be waived if readmitted within 10 days of discharge.				
Home Health Care*	100%, after deductible	50% after deductible	100%	70%, after deductible	100%	70% after deductible	100%
Outpatient Private Duty Nursing	100% after deductible	50% after deductible	85%	70% after deductible	85%	70% after deductible	85%
	Up to 360 hours per Benefit Period.		For each option, benefits are paid for up to 360 hours per Benefit Period (In-Network/Out-of-Network or Referred/Self-Referred combined).				
Skilled Nursing Facility Care*	100% after deductible	50% after deductible	100% after copay	70% after deductible	100% after copay	70% after deductible up to 60 days per Benefit Period	100% after copay
	120 day maximum per Benefit Period is for In-Network/Out-of-Network combined		If applicable, the copay is $75 per day; 5-copay maximum per admission; copay will be waived if readmitted within 10 days of discharge. Benefits are limited to a maximum of 120 days per Benefit Period (In-Network/Out-of-Network or Referred/Self-Referred combined).				
Outpatient Physical, Occupational, or Speech Therapy	100% after deductible	50% after deductible	100% after copay	70% after deductible	100% after copay	70% after deductible	100% after copay
	30 visit limit for In-Network/Out-of-Network combined (20 visits for Speech Therapy)		If applicable, the copay is $40 per visit limited to 30 visits per Benefit Period (20 visits for speech therapy). Limits for Out-of-Network/Self-Referred care may vary by type of therapy.				
Cardiac Rehabilitation Therapy*	100% after deductible	50% after deductible	100% after $40 copay	70% after deductible	100% after $40 copay	70% after deductible	100% after $40 copay
	36 visit limit for In-Network/Out-of-Network combined		In-Network/Out-of-Network or Referred/Self-Referred care combined is limited to 36 visits per Benefit Period.				
Durable Medical and Prosthetics*	100% after deductible	50% after deductible	50%	50% after deductible	50%	50% after deductible	50%

	Personal Choice HDHP		PPO Personal Choice		Keystone POS		Keystone HMO
	In-Network	Out-of-Network	In-Network	Out-of-Network	Referred	Self-Referred	
Spinal Manipulation	100% after deductible	50% after deductible	100% after copay	70% after deductible	100% after copay	70% after deductible	100% after copay
	20 visits per Benefit Period limit for In-Network/Out-of-Network combined		If applicable, the copay is $40 per visit. In-Network/Out-of-Network or Referred/Self-Referred care combined is limited to 20 visits per Benefit Period.				
Mental Health*	100% after deductible	50% after deductible up to 70 days **	100% after copay	70% after deductible up to 70 days **	100% after copay	70% after deductible up to 70 days **	100% after copay
	Different outpatient benefit limits may apply for Serious Mental Illness and HMO benefits may vary by state. Personal Choice HDHP benefits apply to both inpatient and outpatient mental healthcare and serious mental healthcare. If applicable, the inpatient copay is $150 per day with a 5-copay maximum per admission (waived if readmitted within 10 days of discharge). If applicable, the outpatient copay is $40 per visit.						
Substance Abuse Care*	100% after deductible	50% after deductible up to 70 days **	100% after copay	70% after deductible up to 70 days **	100% after copay	70% after deductible up to 70 days **	100% after copay
	HMO benefits may vary by state. For Personal Choice HDHP, benefits apply to both inpatient and outpatient substance abuse care. If applicable, the inpatient copay is $150 per day with a 5-copay maximum per admission (waived if readmitted within 10 days of discharge). If applicable, the outpatient copay is $40 per visit.						
Injectable Medications*	100% after deductible	50% after deductible	100% after copay if applicable	70% after deductible	100% after copay if applicable	70% after deductible	100% after copay if applicable
	For Personal Choice PPO, no copay for standard injectables. For Keystone POS and Keystone HMO, the office visit copay applies for standard injectables, if applicable. For Personal Choice PPO, Keystone POS, and Keystone HMO, the copay is $75 for biotech or specialty medications.						

**Pre-Certification may be required. See Page 10.*
***The 70-day limit per Benefit Period applies to all Out-of-Network or Self-Referred inpatient medical, maternity, mental health, serious mental illness, substance abuse and detoxification services.*
For Out-of-Network/Self-Referred care, providers may bill you for charges above the Plan allowance, and the amount may be significant.
Contraceptives, abortions and voluntary sterilizations are not covered by any Plan provided for employees of any Archdiocesan agency, parish, or institution. This summary provides a brief overview of each Plan's benefits. ***See the carrier booklets for details and exclusions.***

Prescription Drugs	Personal Choice HDHP	Personal Choice PPO	Keystone POS	Keystone HMO
	Where Received	**Generic on Preferred Drug List**	**Brand on Preferred Drug List**	**Non-Preferred**
	Pharmacy (up to 30-day supply)	$15 copay	$35 copay	$60 copay
	Mail-Order (up to 90-day supply)	$37.50 copay	$87.50 copay	$150 copay
For Personal Choice HDHP only, prescriptions are subject to the deductible. If the drug costs less than the copay, you pay the cost of the drug.				

A CLOSER LOOK AT THE HEALTH SAVINGS ACCOUNT (HSA)

The Personal Choice HDHP medical option comes with a Health Savings Account (HSA), a tax-advantaged "piggy bank" that lets you save for current and future healthcare expenses on a tax-free basis. As with any tax benefit, there are some rules you need to know. Here are key facts:

- **You Can Contribute**–Your payroll deductions for Personal Choice HDHP coverage are lower than any of the other medical options. You can contribute that difference or more–pre-tax–to your HSA.
- **Employer Contributions**–To help you meet the deductible, your employer will contribute $750 (prorated if you participate for less than the full plan year). Your employer will contribute even if you don't–and their contribution may be more than $750 if they share the cost of family medical coverage.
- **Triple Tax Advantage**–Unlike other savings accounts, HSA contributions are not taxed when they go in. The earnings aren't taxed. You don't pay taxes when you use the money for eligible expenses either. That means you get to use 100% of every healthcare dollar. For example, if taxes are 25% and you contribute $1,000, you would save $250. "No taxes" means federal income, FICA (Social Security/ Medicare), and state taxes in most states.
- **Eligibility for HSA Contributions**–You and your employer can contribute to an HSA only if:
  - Your only medical coverage is a high deductible health plan (HDHP), such as Personal Choice HDHP. Note: If you're enrolled in non-HDHP coverage (such as your spouse's plan), you and your employer cannot contribute to an HSA. That also applies if you have access to a Flexible Spending Account or other resource that pays medical/prescription expenses without a deductible.
  - You are NOT enrolled in any part of Medicaid, Medicare, or VA benefits.
  - You are a U.S. citizen or resident alien at least age 18 with a valid U.S. address and Social Security number.
  - You are not claimed as a dependent on anyone else's tax return.
- **HSA Balance Rolls Over and Is Portable**– Any balance left in your HSA at the end of the year rolls over to the next year and builds with your continued contributions. **Even better, your HSA is your account**–and it's portable. You take your HSA with you if your employment ends or you retire.

How Personal Choice HDHP and The HSA Work Together

You can use your HSA to reimburse your eligible health expenses incurred after your HSA is established. For example, assume Joan has Personal Choice HDHP/HSA coverage as of July 1, 2016 and that Joan and her employer each contribute $750 to her HSA. This chart shows how Personal HDHP and the HSA work together:

Personal Choice HDHP Deductible	**$1,500**
Employer Contribution to HSA	($750)
Net Deductible	$750
HSA Contributions ($750 Employer + $750 Employee)	**$1,500**
Medical Expenses	**$900**
Preventive Care (Personal Choice HDHP Pays 100%)	$400
PCP Visits, Tests, Prescriptions (Subject to Deductible)	$500
How HSA Works with HDHP	
HSA Contributions	$1,500
Joan Uses HSA for Her Medical Expenses	($500)
HSA Balance (Rolls Over and Grows with New Contributions)	$1,000

HSA Contribution Limits

The IRS sets a maximum contribution for each calendar year. This maximum includes contributions by you and your employer. This chart shows how much you can contribute to an HSA for the 2016 calendar year, assuming that your employer contributes $750. Keep in mind that the IRS maximum is for the 2016 calendar year (not the Plan Year, 7/1/2016-6/30/2017).

IRS 2016 Annual Maximum	Minus Employer Contribution	Equals Your Maximum HSA contribution
$3,350	($750)	$2,600
$6,750	($750)	$6,000
*May be more if your employer contributes toward the cost of dependent coverage. Catch-Up–If you will be age 55 or older in 2016, you may contribute up to an additional $1,000.		

Please Note:

Penalties apply if you contribute too much. You should not exceed the IRS limit if you contribute less than the maximum monthly amount. For 2016, that would be $216 per month for single coverage or $500 per month for family coverage. These amounts are based on a $750 employer contribution. For information about these limits, see IRS Publication 969 available at irs.gov.

Eligible Expenses

You may use your HSA for eligible health expenses not covered by another source that you incur after your HSA takes effect. For example, you can use it for your expenses before you meet your deductible and for other medical, dental, or vision care expenses. The IRS determines what expenses are eligible. For details, see IRS Publication 502 at irs.gov. If you use your HSA for expenses that are not eligible, you will pay taxes on the distribution plus a 20% excise tax.

HSAs reward you for smart healthcare use because you keep any funds you don't use for future expenses. You keep the savings for using Network providers, buying generic drugs when available, "shopping around" for prescriptions, and asking your doctor questions about treatments and tests.

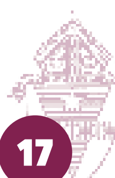
Managing Your HSA

The HSA is administered by *HealthEquity*. You manage your HSA through the website at healthequity.com. Review the *Member Guide* you will receive from HealthEquity after your account is established.

You can be reimbursed for expenses using the direct bill pay feature or your debit card. You also can move your money to investment funds when you have a $2,500 balance–you have a range of investment choices.

The HSA is YOUR account. YOU are responsible for ensuring that you are eligible for HSA contributions, that contributions do not exceed the IRS maximum, and that you use the account only for qualified medical expenses. Be sure to keep your receipts.

The HealthEquity HSA website includes videos, calculators, FAQs, and narrated presentations about how HSAs work, how to use your account, and more. There also is a presentation on the Benefits Gateway. For specific tax questions, speak with your tax advisor.



DENTAL BENEFITS

Your Dental Plan election is separate from your Medical Plan election. Depending on your location, you may have the option to choose one of four plans.

The Dental Plan options include two dental maintenance organization plans (the Concordia Plus DHMO or the Aetna Dental DMO) and two preferred provider organization plans (the Concordia Flex PPO or the Aetna Dental PPO). If you elect coverage, you pay the full cost on a before-tax basis.

Comparing The Options

The **Dental Plan Comparison Chart** shows how each option covers typical dental services.

Concordia Plus DHMO

This is a United Concordia plan. Each covered person chooses a Concordia Plus Primary Dental Office. That office provides or arranges for all eligible dental care. This option pays 100% for periodic exams, cleanings, and fluoride treatments. Reduced copayments apply to more complex procedures.

NEW! Concordia Flex PPO

This option pays the same percentage for In-Network and Out-of-Network services. However, if you use dentists in the extensive Advantage network, you will benefit from the lower negotiated rates, and you cannot be billed for charges above that amount.

Aetna Dental DMO

You select a primary care dentist from the network of participating DMO dentists. Benefits are paid only if your primary care dentist provides your care or gives you a referral to another Aetna network provider for specialized care. Preventive care is covered at 100%; copays apply to other covered services. You may go directly to an Aetna network orthodontist without a referral from the primary care dentist.

Aetna PPO

The Aetna Dental PPO Plan gives you the freedom to use the dentist of your choice. However, when you use a network provider, you get the advantage of the discount offered under the Plan, and your out-of-pocket costs are lower. When you use a non-network dentist, you pay a greater share of the cost, and the Plan discount is not available.

For More Information

See the Plan Summary charts on the Benefits Gateway. Contact the carriers directly by telephone or check the websites for network providers.

Concordia Plus DHMO or Concordia Flex PPO	**Aetna DMO or PPO**
(Advantage network) **1.866.357.3304** www.ucci.com	(PPO II network) **1.877.238.6200** www.aetna.com

DENTAL PLAN COMPARISON CHART

Features and Benefits	ConcordiaPLUS DHMO*	Concordia Flex PPO*		Aetna Dental DMO**	Aetna Dental PPO**	
	Network Only	*In-Network*	*Out-of-Network*	*Network Only*	*In-Network*	*Out-of-Network*
Annual Maximum	Unlimited	$1,500 per year		Unlimited	$1,000 per year	
Deductible	None	$50 per person; $150 per family		None	$50 per person; $150 per family	
Preventive/Diagnostic Services						
Exams	100% once every 6 months	100%, no deductible, once every 12 months		100%, 4 times per calendar year	100%, no deductible In-Network, 2 routine and 2 problem-focused exams per calendar year	
Full Mouth X-rays	100% 1 set every 3 years	100%, no deductible, 1 set every 5 years		100% 1 set every 3 years	100%, no deductible In-Network, 1 set every 3 years	
Bitewing X-rays	100% 1 set every 6 months to age 13, then once every 12 months	100%, no deductible, 1 set every 12 months under age 19 and 1 set every 18 months at age 19 and over		100% 1 set every calendar year	100%, no deductible In-Network, 1 set per calendar year	
Cleanings	100% once every 6 months with no copayment	100%, no deductible, 2 every 12 months for individuals 14 years and over; 1 every 12 months for children up to age 14		100% after copay ($10 child or $12 adult); 2 times per calendar year	100%, no deductible In-Network, 2 times per calendar year	
Fluoride Application	100% once every 6 months up to age 18	100%, no deductible, 1 every 12 months up to age 14		100% once per calendar year up to age 16	100%, no deductible In-Network, once per calendar year, up to age 16	
Basic and Major Services and Orthodontia						
Fillings	100% after copay	90% after deductible	90% after deductible	100% for amalgam after copay	80% after deductible	65% after deductible
Crowns, Bridges, or Dentures	100% after copay	60% after deductible	60% after deductible	100% after copay	50% after deductible	50% after deductible
Endodontics (root canal)	100% after copay	90% after deductible	90% after deductible	100% after copay	After deductible: 80% for anterior teeth or 50% for major teeth	After deductible: 65% for anterior teeth or 50% for major teeth
Periodontics (non-surgical)	100% after copay	90% after deductible	90% after deductible	100% after copay	80% after deductible	65% after deductible
Simple Extractions	100% after copay	90% after deductible	90% after deductible	100% after copay	80% after deductible	65% after deductible
Orthodontia	No lifetime maximum applicable copays	50%, after deductible for diagnostic, active, retention treatment, up to $1,500 lifetime maximum; coverage is for children up to age 19		Screening Exam for adolescents: $30 copay; Diagnostic Records: $150; Orthodontic Retention: $275; Comprehensive Orthodontic Treatment for children up to age 19: $1,845 copay	50%, no deductible, up to $1,000 lifetime maximum; coverage is for children only (appliance must be placed prior to age 20)	
Out-of-Area Care	Up to $50 (each occurrence)	N/A (Provider network is nationwide)		Contact Aetna for details	N/A (Provider network is nationwide)	

** See UCCI Concordia Plus and Concordia Flex PPO Schedules of Benefits on the Benefits Gateway.*
*** See Aetna DMO and Aetna Dental PPO Plan Summaries on the Benefits Gateway.*
*** Coverage is provided for out-of-area care if there are no participating specialists in a 30-mile range of your home zip code.*

DISABILITY INCOME PROTECTION

Disability coverage protects your income when illness or injury prevents you from working. There are two types of coverage: Short-Term Disability (STD), if available at your location, and Long-Term Disability (LTD).

Short-Term Disability (STD) Coverage

You may have the option to purchase Short-Term Disability (STD) coverage if offered at your location. Your Benefit Coordinator can tell you if this coverage is available to you. This coverage is provided by Unum (see Voluntary Protection Benefits in the Enroll/Library section of the Benefits Gateway).

If you enroll, you pay the full cost with after-tax dollars. If you become disabled, the benefits you receive are **not** taxable. STD coverage is portable—that means you can continue coverage if you leave your employer by paying premiums directly to Unum.

Three Options

Three levels of coverage are offered:

- **Option 1**—The first option provides a benefit of up to $400 a month.
- **Option 2**—The Plan pays as much as 30% of your monthly income up to $3,000 per month if you have a qualifying disability.
- **Option 3**—The Plan replaces as much as 60% of your monthly income up to a maximum monthly income of $3,000 per month.

This benefit may be reduced by income you receive from other sources.

Benefits may not be available if you have a pre-existing condition.

Eligibility

If offered at your location, STD coverage is available to active employees between the ages of 17 and 69. If you purchase this coverage and Unum determines that you have a qualifying illness or injury, benefits may begin after 14 days of continuous disability.

Benefits will continue for the duration of your disability for up to a maximum of three months. If you are disabled for at least three months, you may be eligible for Long-Term Disability (LTD) benefits.

Long-Term Disability (LTD) Coverage

Your employer pays the full cost of this coverage that begins to pay benefits after 90 days of continuous disability. The Office of Insurance Services can provide a booklet that explains the plan in detail.

Disability Definition

To qualify for benefits, you must be considered disabled:

- **For the first three years of disability,** you must be under the care of a licensed physician and completely unable to do your regular job.
- **After three years of disability,** you must be unable to perform the duties of any job for which you are, or could become, qualified for by education, experience, or training.

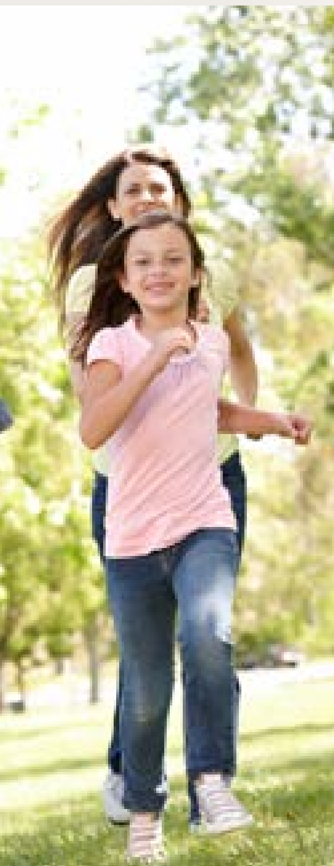
LTD Benefit Amount

While you are totally disabled, the Plan will replace up to 60% of your monthly earnings up to $9,200 per month. This benefit is reduced by income you receive from other sources, such as Social Security or Workers' Compensation. For example, if you become disabled at age 45, your monthly earnings are $5,000 ($60,000 a year), and you are entitled to a Social Security disability benefit of $1,760 a month, your disability benefit would equal:

60% of Monthly Earnings	$3,000
Minus Social Security Benefit	-$1,760
LTD Plan Benefit*	$1,240 a month

**This benefit is taxable.*

Benefits will be paid while you remain disabled as determined by the insurance carrier. Benefits will end if you recover, reach the maximum benefit and or die, whichever occurs first. Benefits may not be available if you have a pre-existing condition.



VOLUNTARY TERM LIFE INSURANCE (CIGNA)

If available at your location, you may elect Voluntary Life insurance that offers survivor protection you can tailor to your needs. This term life insurance is provided through the Life Insurance Company of North America, a Cigna company.

Coverage For You

If available at your location, you may buy Voluntary Life Insurance coverage in $10,000 increments up to $500,000. Proof of good health is required if you do not elect coverage when first eligible (see *Proof of Good Health May Be Required*). If you elect this coverage, you pay the full cost on a pre-tax basis. The cost is based on your age as of July 1 and the amount of coverage. Please refer to the Cigna Life/AD&D brochure on the Benefits Gateway for a complete description of benefit limitations and exclusions.

Limits

- If you are employed at age 70, your coverage amount will be reduced to 65% up to age 75, then to 45% up to age 79, and then to 30% at age 80.
- The Plan will not pay benefits if loss of life is the result of suicide that occurs within the first two years of coverage.

Coverage For Your Family

If you elect Voluntary Life Insurance for yourself, you may buy coverage for your spouse or eligible children. You pay the full cost of this coverage on an after-tax basis. The Spouse Life cost is based on your spouse's age and the amount of coverage. The Child Life rate is a flat amount, regardless of the number of children covered. Proof of good health is required if you do not elect coverage when first eligible (see *Proof of Good Health May Be Required*). Your coverage options are:

- **For Your Spouse**–$10,000 to $200,000
- **For Children**–$5,000 or $10,000 (same option applies to all covered children).

For example, you may buy $50,000 of Voluntary Life Insurance for your spouse and cover each child for $5,000. Benefits are payable to you upon the death of your spouse or child.

Limits

- To be covered, your spouse must be under age 70, and your children must be unmarried and at least 14 days old (coverage for children under 6 months is $500).
- Coverage for dependent children stops when the child reaches age 19 (or age 26 for full-time students).
- The Plan will not pay benefits if loss of life is the result of suicide that occurs within the first two years of coverage.

Proof Of Good Health May Be Required

Proof of good health is required if:

- You elect coverage more than 31 days after you first become eligible;
- You elect Voluntary Life Insurance for yourself and the amount equals the lesser of $200,000 or three times your annual salary rounded to the next higher $10,000;
- You elect Spouse Life coverage of more than $30,000; or
- You want to increase your coverage.

If proof of good health is required, the coverage amount subject to medical evidence will take effect only after the insurance carrier approves.

Enrolling And Naming Your Beneficiary

To enroll, complete and return an Enrollment Form to your Benefit Coordinator (the form is on the Benefits Gateway). You also will use the Enrollment Form to name your beneficiary. A separate form is required if you want to name a trust. If you do not name a beneficiary, your Voluntary Life benefit will be paid in this order: your spouse, your children, your parents, your siblings, or lastly to your estate.

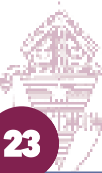
Be sure to update your beneficiary information for life changes, such as marriage or a new child.

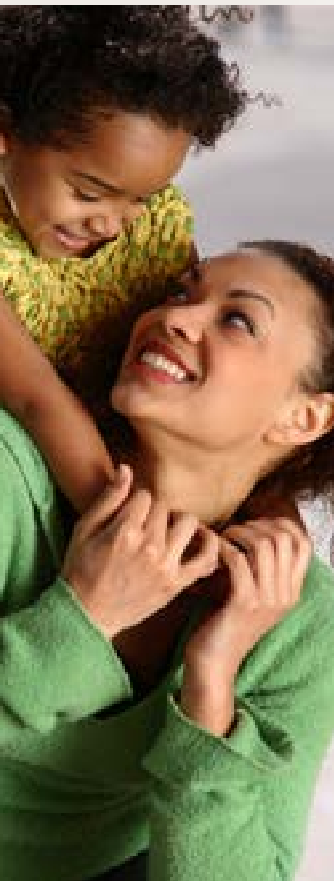
Special Features

These features apply if you buy Voluntary Life Insurance:

- **Additional Benefits**–You have access to Cigna's Will Preparation and Identify Theft services
- **Accelerated Death Benefit**–If you have a terminal illness (as determined under Cigna's terms), you may receive a lump sum benefit of 50% of the coverage amount, up to $200,000 ($100,000 for Spouse Life). The amount paid would be subtracted from your Life Insurance benefit.
- **Accelerated Specified Disease Benefit**–If you or your spouse have cancer, heart disease resulting from heart attack, renal failure, a stroke, AIDS, or certain organ transplants, the Plan will pay up to $12,500 upon receipt of acceptable medical certification of illness.
- **If You Become Disabled or If Your Coverage Ends**–If you become disabled, Cigna may continue your coverage if you meet certain requirements. If your employment ends, you may continue coverage (portability) or convert your coverage to an individual policy (conversion)–provided you apply within 31 days of the date coverage ends.

If you have questions, see the Life/AD&D brochure on the Benefits Gateway or call Cigna at 1.800.732.1603 toll-free Monday through Friday, 8 a.m. to 6 p.m. Eastern time.





VOLUNTARY AD&D INSURANCE

If available, you also may have the option to buy Cigna Voluntary AD&D (accidental death & dismemberment) Insurance for yourself or for you and your family. This coverage also is provided through Cigna.

Coverage Amount And Cost

If available, you may buy Voluntary AD&D coverage for yourself from $10,000 to $300,000. If you elect this coverage, you pay the full cost on a pre-tax basis. Your cost is based on a fixed rate for each $10,000 of coverage. If you insure your family, the cost is slightly higher. For details, see the Cigna Voluntary Life/AD&D brochure on the Benefits Gateway.

Benefits Paid

If you die in a covered accident, your beneficiary receives 100% of the coverage amount. All or part of the benefit is paid for certain serious injuries that occur within one year of a covered accident, as shown in this chart:

For Loss Of:	Benefits Paid Is:
Life	**100%** of coverage amount
Total paralysis of upper and lower limbs; loss of the use of both hands, feet, or eyes (total sight loss); or a combination (such as one hand and one foot); or loss of speech and hearing in both ears	**100%*** of coverage amount
Total paralysis of both lower limbs; total paralysis of upper and lower limbs on one side of the body; loss of one hand, one foot, or sight in one eye; or loss of speech or hearing	**50%*** of coverage amount
Loss of the thumb and index finger of the same hand	**25%*** of coverage amount

**If you have family coverage, the benefit is doubled if your covered child is the person injured to a maximum of $50,000.*

Family Benefit Is A Percentage Of Your Benefit

If you elect family coverage, your spouse and each child are insured for a percentage of your coverage amount, based on the composition of your family at the time of the loss as follows:

For Loss Of:	Benefit Paid Is:
Spouse Only	Spouse insured for **50%** of your coverage amount (up to $150,000).
Spouse and Children	Spouse insured for **40%** of your coverage amount (up to $150,000). Each child is insured for **10%** of your coverage amount (up to $25,000).
Children Only	Each child insured for **15%** of your coverage amount (up to $25,000).
Coverage over $250,000 cannot be more than 10 times your annual earnings. Spouse coverage cannot be more than $150,000 and child coverage cannot exceed $25,000 per child.	

Example–If you are married with children, you choose coverage of $100,000, and your spouse dies, the Plan would pay you a death benefit of $40,000 (40% of $100,000).

Beneficiary

You use the Enrollment Form to enroll and to name your beneficiary. If you also elect Voluntary Life Insurance coverage, the beneficiaries will be the same unless you specifically request to name different beneficiaries for each type of coverage. You are the beneficiary of any Voluntary AD&D benefit paid if you are injured. You also are the beneficiary for any dependent Life or AD&D benefits.

Limits And Exclusions

- To be eligible, the coverage must be offered at your location and you must be a full-time employee working at least 35 hours a week.
- To be covered, your spouse must be under age 70, and your children must be unmarried, at least 14 days old and dependent on you for support.
- The Plan does not cover certain types of accidents. For example, if you are injured while taking a flying lesson, no benefits are paid. You will receive more information about this Plan if you enroll. Please refer to the Cigna Voluntary Life/AD&D brochure on the Benefits Gateway for a complete list of exclusions.

VOLUNTARY WHOLE LIFE INSURANCE (NEW YORK LIFE)

If available at your location, you may elect Whole Life Insurance. This coverage is provided through New York Life Insurance Company.

To create the life insurance that's best for your needs, you can combine Cigna Term Life Insurance and New York Life Whole Life Insurance that's portable and builds a cash value.

Coverage For You

You may buy Voluntary Whole Life Insurance coverage from $5,000 up to $100,000. Proof of good health is NOT required if you enroll when you are first eligible. If you elect this coverage, you pay the full cost on a post-tax basis. The cost is based on your age as of July 1 and the amount of coverage.

Key Facts

- You may elect this coverage if it is offered at your location and you are a full-time employee under age 70.
- This is whole life insurance that pays benefits to your beneficiaries if you die AND builds a cash value.
- Your premium will never increase and you may keep your policy if you leave the Archdiocese or retire.
- The cash value builds tax-deferred. You may borrow against the cash value for various needs, such as children's collage, paying off a mortgage, or supplementing retirement income. Loans against your policy accrue interest and decrease the death benefit and cash value.
- Coverage also is available for your spouse, children, and grandchildren.

For more information and to enroll, contact Legacy Benefits at 215.441.6554 or email dgiusti@legacybenefitsgroup.com

OTHER VOLUNTARY BENEFITS

Depending on your location, you may have the option to elect these additional voluntary benefits. If you enroll, you pay the full cost. Coverage takes effect immediately, the benefits are tax-free, and the coverage is portable. For more information, see Voluntary Protection Benefits in the Enroll/Library section of the Benefits Gateway.

Critical Illness Insurance Through AFLAC

- Aflac Critical Illness coverage provides a lump-sum payment for specified catastrophic conditions that can be used for medical and non-medical expenses.
- Critical Illness benefits include:

Critical Illness Benefit	
Benefits are payable directly to the insured and include the following	
Cancer (Internal or Invasive)	**100%** of coverage amount
Heart Attack	**100%** of coverage amount
Stroke	**100%** of coverage amount
Major Organ Transplant	**100%** of coverage amount
End Stage Renal Failure	**100%** of coverage amount
Coronary Artery By-Pass Surgery	**25%** of coverage amount
Carcinoma in Situ	**25%** of coverage amount

- Annual Cancer Expense Benefits of $5,000 if initially diagnosed while coverage is inforce. For cancer treatment, Aflac will pay the actual expenses incurred in any calendar year, up to $5,000. For skin cancer, Aflac will pay 10% of the actual expenses up to $5,000 each calendar year.
- Depending on the circumstances, you may be eligible to collect benefits more than once for the same and different covered conditions.
- Proof of good health is not required for employee coverage up to $20,000 or spouse coverage up to $10,000.
- Children are automatically covered at 50% of your coverage amount at no additional cost.

To enroll in AFLAC Critical Illness, call TriBen at 1.888.264.2147, Option 8.

Accident Insurance Through Unum

- This coverage from Unum is designed to help you meet out-of-pocket expenses and extra bills that can follow even ordinary accidents.
- Coverage is available for employees, spouses and children.
- Proof of good health is not required.

Sample benefits of accident plan:

Benefit	Payment to Employee
Emergency Room Treatment	$100 per accident
Physician's Office/Urgent Care Treatment	$50 per accident
Ambulance	$200 per accident
Hospital Admission	Standard: $750 per accident
Daily Hospital Confinement	$100/day, up to 365 days per accident
Hospital Intensive Care Confinement	$300/day, up to 15 days per accident
Medical Imaging	$100 per accident
Concussion	$100 per accident
Fractures	Up to $5,000 per accident
Lacerations	Up to $400 per accident.
Physical Therapy (up to 10 treatments)	$15 per treatment
Accidental Death Life Benefit	$25,000 or $50,000 if by Common Carrier

To enroll in Unum Accident Insurance call TriBen at 1.888.264.2147, Option 8.

403(b) RETIREMENT PLAN

While you're working, you are building income for your future through the 403(b) Retirement Plan. Your employer contributes and you can add pre-tax or post-tax contributions. Vanguard administers the Plan.

Enrolling Is Easy!

Your employer contributes automatically if you are eligible. To add your contributions and manage how your account is invested, you need to enroll. With the ENROLL NOW feature, you are just two clicks from your path to a more comfortable retirement:

- Go to Vanguard.com/Enroll and enter your Social Security number, zip code, birth date, and Plan No. 094572. Click Continue and you are halfway there. If this link does not work, use retirementplans.vanguard.com.
- You can choose how much to contribute from each pay–and you can even sign up to increase the amount you save each year automatically. Or, instead of choosing a contribution percentage, you can simply accept a 1% paycheck deduction with a 1% deferral increase each year. Your investment defaults to a Target Retirement Fund appropriate for your age.

It's that easy. You are enrolled and saving for your future. You can change your savings percentage or investment choices on the Vanguard website or by calling **1.800.523.1188**.

How The 403(b) Plan Works

Employer Contributions

Your employer will make a contribution to your 403(b) Plan account after completion of 1,000 hours of service in a calendar year. This employer contribution is discretionary and will be announced each year. This contribution will be made every pay period even if you don't contribute to the Plan. You become vested in the employer contribution when you complete one year of service (that means you own the money in your account).

You Can Contribute Too

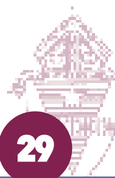
If you are a full-time or part-time employee, you can increase your retirement income by adding your own pre-tax or post-tax savings in a Roth account. You can choose one method or both. You can save any percentage of your pay, up to the annual IRS limit ($18,000) for 2016. If you will be age 50 or older this year, you can save an additional $6,000 a year. Your 403(b) account is yours. You take your vested account with you, even if your employment ends before you retire.

Investment Options

Earnings on contributions are reinvested into your account where they can produce additional earnings. You have a wide range of investment options managed by Vanguard Investments. Keep in mind that the value of your investment will fluctuate and you may gain or lose money. You can change your contribution and investment elections as often as you wish at the Vanguard website or by calling Vanguard. The Vanguard website also has videos, calculators, and other tools to help you make your decisions.

Lay Employees Retirement Plan

If you were a participant in the Lay Employees Retirement Plan, you may also have earned a benefit under that plan. See the Summary Plan Description (SPD) on the Benefits Gateway.



OTHER PROGRAMS

The Employee Assistance Program (EAP) is a free, confidential, resource that provides access to counseling, resources, and support when you need it. The Global Fit program helps you save money on gym memberships. The Viriva Community Credit Union is similar to a bank, but uniquely different.

The Employee Assistance Program (EAP)

If available at your location, the Penn Behavioral Health Services EAP offers:

- Access to a free counseling and referral service to help you resolve problems that may affect your personal or professional life, such as anxiety, stress, parenting or relationship concerns, grief, or substance abuse. All calls to the EAP are confidential, except as may be required by law.
- Trained professionals who will listen to your issue and refer you to a source of professional assistance at a convenient location. Your employer pays the full cost for eligible services (if applicable, your medical coverage may provide benefits for additional counseling).
- Online resources and support for a wide range of work-life concerns including child care, elder care, health and wellness, workplace tools and much more.

Ask your Benefits Coordinator if you are eligible for the EAP. If you are, you can reach EAP representatives at **1.888.321.4433** or online at http://www.pennbehavioralhealth.org (choose EAP under Quick Links). The User Name is pbhadp and the Password is pbhadp.

Global Fit

Get or stay in shape at a local health club and Global Fit will help you save some money. To find out how much you can save on the price of membership simply:

- Go to www.globalfit.com.
- Click on the menu for "Individuals."
- Type "Archdiocese of Philadelphia" in the box labeled "I am eligible through…"

From there you can enter your zip code to locate a health club in the network. With Global Fit, you can get a membership at a lower price than purchasing one.

Save Another $150–If you have Independence Blue Cross medical coverage (including Keystone POS and Keystone HMO), you can receive up to a $150 reimbursement each year on certain gym memberships (providing you go to the gym 120 times per year). Use Global Fit to save on the cost of membership **and** to receive a $150 IBC reimbursement. That adds up to huge savings.

Plum Benefits

This service gives you access to savings on movie tickets, theme parks, hotels, Broadway shows, and more. To use Plum Benefits:

- Go to PlumBenefits.com
- Click on "Become a Member."
- You will be prompted to create an account with your email address and company code (ARCHPHILA215).

Viriva Community Credit Union

Membership is open to anyone who lives, works, worships, volunteers or attends school in Bucks, Delaware, Montgomery or Philadelphia counties in Pennsylvania, or is a family member of an existing member.

As a member of the Viriva Community Credit Union, you are a shareholder, so regardless of account balance, you own an equal share of the organization. As a not-for-profit, the Credit Union is able to return excess income back to its members in the form of better rates on savings and loans, the addition of new and improved services, and excellent member service. **For more information, call Viriva at 215.333.1201 or 1.888.784.7482 (if outside PA). Or, go to www.viriva.com.**

Services Available

Services available to you as a member of the Viriva Community Credit Union include:

- **"Banking" Services**–ATM/debit cards, Visa credit cards, direct deposit, online account access, and electronic bill pay–plus, there are six local branches.
- **Checking/Savings**–Checking account with no minimum balance, savings (Share) accounts, Share certificates (similar to CDs at banks), and market index certificates, traditional, Roth, and education IRAs.
- **Loans**–Competitive rates for personal loans, auto loans, mortgages, home equity lines of credit, revolving lines of credit, and Keystone Best (student) and Keystone PLUS loans.
- **Legal and Financial Support Services**–Notary (free) by appointment, 30 minutes of free legal consultation, and financial checkups.
- **Insurance**–Access to discounts on home and auto insurance.

Important Information

This *Benefits Guide* highlights key features of the Archdiocese of Philadelphia's benefit program for Parish and Agency Employees as of July 1, 2016. The information about benefit changes is considered a Summary of Material Modifications (or SMM).

Although some participating employers may contribute to the Health Savings Accounts (HSAs), the Archdiocese of Philadelphia does not administer the HSAs; they are individual accounts, not an employer-sponsored benefit plan.

In case of any question about plan provisions, the official Plan documents and/or contracts will govern over this brochure or any other communication material. The Archdiocese of Philadelphia reserves the right to change the benefit plans at any time for any reason.