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 offers comprehensive benefits that ease some of the concerns for protection against personal financial loss. You have the opportunity to choose the benefits that best meet your needs. Benefit options and waiting periods vary by location.

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, Voluntary Life insurance for you, or Voluntary AD&D coverage, you pay the full cost before taxes are deducted—this means tax savings for you. If you enroll for Critical Illness, Voluntary Accident, or Short-Term Disability (STD) coverage, you pay the full cost on an after-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 change in status.

Benefits Gateway Website
This brochure summarizes the major provisions of the benefit plans. Enrollment forms and more benefits information is available in the Enroll/Library section of the Benefits Gateway website (http://archphila.org/hrbenefits).

We encourage you to use the Benefits Gateway whenever you have benefit questions. The carriers also have plan booklets and enrollment material. In case of any conflicts, the carrier booklets will govern over this brochure.
### 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 available. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>• Up to three options may be available—two options are similar to an HMO; the third is a PPO-style plan.</td>
</tr>
</tbody>
</table>
| 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. |
| Cigna Voluntary Life and Voluntary AD&D Insurance | • You may have the option to buy Life Insurance and/or Voluntary AD&D (accidental death & dismemberment) Insurance.  
• 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. |
| 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                      | • The Employee Assistance Program (EAP), if available, provides confidential services and resources for emotional, mental, and practical needs.  
• GlobalFit offers discounts on fitness center memberships.  
• If available, 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).

<table>
<thead>
<tr>
<th>Feature</th>
<th>Personal Choice HDHP</th>
<th>Personal Choice PPO</th>
<th>Keystone POS</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>Lowest</td>
<td>Varies;</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal Choice PPO is the most expensive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Savings</td>
<td>Yes with employer contribution</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Account (HSA)</td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Choice</td>
<td>Higher benefits when you use Personal Choice PPO network providers, but you may use Out-of-Network providers.</td>
<td>Higher benefits for care from PCP or with referral; lower benefits for Self-Referred care (no referral or Out-of-Network providers)</td>
<td>Benefits paid only for care from PCP or with referral, except for emergency</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>In-Network/Referred care on preventive schedule covered at 100% with no deductible.</td>
<td>Yes for Out-of-Network care</td>
<td>Yes for Self-Referred care</td>
<td>No</td>
</tr>
<tr>
<td>Deductible</td>
<td>Yes; applies to all care except preventive</td>
<td>Yes for Out-of-Network care</td>
<td>Yes for Self-Referred care</td>
<td>No</td>
</tr>
<tr>
<td>Medical Copays</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Coinsurance</td>
<td>After deductible, 100% In-Network; 50% Out-of-Network</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>Subject to deductible; same copays as the other options</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

*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 are 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 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 are 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 are combined).

- **Personal Choice PPO and Keystone POS**—The deductible is based on the calendar year. The deductible applies to most Out-of-Network/Self-Referral 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, you must meet the full family Out-of-Pocket Limit (the expenses of everyone covered are combined). The deductible, copays, and coinsurance are used to meet in 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-Referral care includes only coinsurance; the deductible and copays are not applied.
Out-of-Network/Self-Referral 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-Referral 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.

BE SMART
Make the most of your healthcare dollars
• Before you receive care, think about the cost. Receive In-Network/Referred care and use generic drugs if available.
• Ask questions before you start taking a new drug or have a test.
• If appropriate, use an urgent care center instead of the emergency room.
• Check your bills and your Explanation of Benefit (EOB) statements. Contact IBC/Keystone or your provider if you have questions. Save EOBs and receipts!

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 and age and frequency limits 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 at 100%, 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.
• 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

<table>
<thead>
<tr>
<th>Prescription Drug Category</th>
<th>Generic on Preferred Drug List</th>
<th>Brand Name on Preferred Drug List</th>
<th>Drugs NOT on Preferred Drug List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy (up to 30-day supply)</td>
<td>$15 copay</td>
<td>$35 copay</td>
<td>$60 copay</td>
</tr>
<tr>
<td>Mail-Order (up to 90-day supply)</td>
<td>$37.50 copay</td>
<td>$87.50 copay</td>
<td>$150 copay</td>
</tr>
</tbody>
</table>

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.
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.
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.
# MEDICAL PLAN COMPARISON CHART

<table>
<thead>
<tr>
<th>Using Doctors/ Hospitals</th>
<th>Personal Choice HDHP</th>
<th>PPO Personal Choice</th>
<th>Keystone POS</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>Referred</td>
<td>Self-Referred</td>
</tr>
<tr>
<td></td>
<td>Higher-level benefits</td>
<td>Lower-level benefits</td>
<td>Higher benefit level if PCP provides/refers care</td>
<td>Lower-benefit level if no referral or Out-of-Network</td>
</tr>
</tbody>
</table>

## Deductible and Out-of-Pocket Limits

<table>
<thead>
<tr>
<th>Benefit Period</th>
<th>Plan Year (7/1-6/30)</th>
<th>Calendar Year (1/1-12/31)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How They Work</strong></td>
<td>Start on July 1 and end on June 30, 2016. Deductible applies to all services except preventive. If you cover dependents, you must meet the family deductible and Out-of-Pocket Limit.</td>
<td>Start on January 1 and end on December 31. If you change options, new deductible starts on January 1, 2016 for Personal Choice PPO, Keystone POS, or Keystone HMO or on July 1, 2015 for Personal Choice HDHP. If you cover dependents, the options cover an individual’s expenses if he/she meets the single deductible on Out-of-Pocket Limit.</td>
</tr>
</tbody>
</table>

| **Deductible** | $1,500/single $3,000/family | $1,000/single $2,000/family |
| **Out-of-Pocket Maximum** | $6,350/single $12,700/family | $3,000/single $6,000/family |

## Benefits for Common Services

<table>
<thead>
<tr>
<th>Inpatient Hospital Care*</th>
<th>100% after deductible</th>
<th>50% after deductible up to 70 days **</th>
<th>100% after copay</th>
<th>70% after deductible up to 70 days**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery*</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100% after $100 copay</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>100% after deductible</td>
<td>100% after In-Network deductible</td>
<td>100% after copay</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Doctor’s Office Visits</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Routine Preventive, Well-Baby Care (based on schedule)</td>
<td>100%, no deductible</td>
<td>50%, no deductible</td>
<td>100%</td>
<td>70%, no deductible</td>
</tr>
</tbody>
</table>

If applicable, the copay is $150 per day; 5-copay maximum per admission; copay will be waived if readmitted within 10 days of discharge.

For primary care or specialist

If applicable, the copay is $15 for primary care and $40 for a specialist.

No referral required for routine GYN exam and no referral or copay for routine mammogram
<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network Coverage</th>
<th>Out-of-Network Coverage</th>
<th>In-Network Coverage</th>
<th>Out-of-Network Coverage</th>
<th>Keysten POS Referred</th>
<th>Keysten POS Self-Referred</th>
<th>Keysten HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Laboratory/Pathology</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100%</td>
<td>70%, after deductible</td>
<td>100%</td>
<td>70% after deductible</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient X-ray/Radiology*</td>
<td>100% after deductible</td>
<td>50%, after deductible</td>
<td>100% after copay</td>
<td>70% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Maternity*</td>
<td>100% after deductible</td>
<td>50% after deductible up to 70 days **</td>
<td>100% after copay</td>
<td>70% after deductible up to 70 days **</td>
<td>100% after copay</td>
<td>70% after deductible up to 70 days **</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Home Health Care*</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100%</td>
<td>70%, after deductible</td>
<td>100%</td>
<td>70% after deductible</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient Private Duty Nursing</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>85%</td>
<td>70% after deductible</td>
<td>85%</td>
<td>70% after deductible</td>
<td>85%</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care*</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible up to 60 days per Benefit Period</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Outpatient Physical, Occupational, or Speech Therapy</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible up to 30 visits per Benefit Period</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Cardiac Rehabilitation Therapy*</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible up to 36 visits per Benefit Period</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Durable Medical and Prosthetics*</td>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>50%</td>
<td>50% after deductible</td>
<td>50%</td>
<td>50% after deductible</td>
<td>50%</td>
</tr>
</tbody>
</table>

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.

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.

Up to 300 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).

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).

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.

In-Network/Out-of-Network or Referred/Self-Referred care combined is limited to 36 visits per Benefit Period.
### Spinal Manipulation

<table>
<thead>
<tr>
<th>Personal Choice HDHP</th>
<th>PPO Personal Choice</th>
<th>Keystone POS</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100% after copay</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

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*

<table>
<thead>
<tr>
<th>Personal Choice HDHP</th>
<th>PPO Personal Choice</th>
<th>Keystone POS</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>Referred</td>
<td>Self-Referred</td>
</tr>
<tr>
<td>100% after deductible</td>
<td>50% after deductible up to 70 days **</td>
<td>100% after copay</td>
<td>70% after deductible up to 70 days **</td>
</tr>
</tbody>
</table>

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*

<table>
<thead>
<tr>
<th>Personal Choice HDHP</th>
<th>PPO Personal Choice</th>
<th>Keystone POS</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>Referred</td>
<td>Self-Referred</td>
</tr>
<tr>
<td>100% after deductible</td>
<td>50% after deductible up to 70 days **</td>
<td>100% after copay</td>
<td>70% after deductible up to 70 days **</td>
</tr>
</tbody>
</table>

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*

<table>
<thead>
<tr>
<th>Personal Choice HDHP</th>
<th>PPO Personal Choice</th>
<th>Keystone POS</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
<td>Referred</td>
<td>Self-Referred</td>
</tr>
<tr>
<td>100% after deductible</td>
<td>50% after deductible</td>
<td>100% after copay if applicable</td>
<td>70% after deductible if applicable</td>
</tr>
</tbody>
</table>

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.

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*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.

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### Prescription Drugs

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Personal Choice HDHP</th>
<th>Personal Choice PPO</th>
<th>Keystone POS</th>
<th>Keystone HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where Received</td>
<td>Generic on Preferred Drug List</td>
<td>Brand on Preferred Drug List</td>
<td>Non-Preferred</td>
<td></td>
</tr>
<tr>
<td>Pharmacy (up to 30-day supply)</td>
<td>$15 copay</td>
<td>$35 copay</td>
<td>$60 copay</td>
<td></td>
</tr>
<tr>
<td>Mail-Order (up to 90-day supply)</td>
<td>$37.50 copay</td>
<td>$87.50 copay</td>
<td>$150 copay</td>
<td></td>
</tr>
</tbody>
</table>

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” for current and future health expenses. You and your employer can contribute if an HDHP plan is your only coverage and you meet other IRS requirements.

The HSA gives you a tax-effective way to pay eligible health expenses that are not covered by another source. If you follow IRS rules, HSA contributions, earnings, and reimbursements are not taxable. This is your triple tax advantage! “No taxes” means federal income, FICA (Social Security/Medicare), and state taxes in most states. Even better, unused HSA dollars roll over from year to year, and you keep your HSA if you leave your employer.

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, 2015 and that Joan and her employer each contribute $750 to her HSA. This chart shows how Personal HDHP and the HSA work together:

<table>
<thead>
<tr>
<th>Personal Choice HDHP Coverage</th>
<th>Eligible Expenses</th>
<th>Joan Pays</th>
<th>Personal Choice HDHP Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>$500</td>
<td>$0</td>
<td>$500</td>
</tr>
<tr>
<td>Other Medical and Prescription Expenses (apply to the deductible)</td>
<td>$600</td>
<td>$600</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$1,100</td>
<td>$600</td>
<td>$500</td>
</tr>
</tbody>
</table>

HSA Balance Rolls Over—The employer $750 contribution covers Joan’s expenses with $150 left. Plus Joan contributed $750. That leaves a $900 balance that rolls over to the next year!

Are You Eligible for HSA Contributions?

You and your employer may contribute to an HSA only if:

- Your only medical coverage is a high deductible health plan (HDHP), such as Personal Choice HDHP.
- You are NOT enrolled in any part of Medicaid, Medicare, or VA benefits.
- You are a U.S. citizen or resident alien age 18 or older with a valid physical U.S. address and Social Security number.
- You are not claimed as a dependent on anyone else’s tax return

Other Coverage—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.
**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 2015 calendar year, assuming that your employer contributes $750. Keep in mind that the IRS maximum is for the 2015 calendar year (not the Plan Year, 7/1/2015-6/30/2016).

<table>
<thead>
<tr>
<th>IRS 2015 Annual Maximum</th>
<th>Minus Employer Contribution</th>
<th>Equals Your Maximum HSA contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,350</td>
<td>($750)</td>
<td>$2,600</td>
</tr>
<tr>
<td>$6,650</td>
<td>($750)</td>
<td>$5,900</td>
</tr>
</tbody>
</table>

**Please Note:**

- If your employer contributes toward the cost of dependent coverage, your employer’s HSA contribution may be more than $750.
- If you are 55 or older, you may make a catch-up contribution ($1,000 maximum).
- Penalties apply if you contribute too much. You should not exceed the IRS limit if you contribute less than the maximum monthly amount. For 2015, that would be $216 per month for single coverage ($216 x 6 months) or $491 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](http://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](http://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.

**Managing Your HSA**

The HSA is administered by The Bancorp HSA. You manage your HSA through the website ([thebancorphsa.com](http://thebancorphsa.com)). Review the Welcome Guide you will receive from The Bancorp HSA after your account is established.

You can be reimbursed for expenses using the direct bill pay feature, your debit card, or by check. 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 Bancorp 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 three plans.

The Dental Plan options include two dental maintenance organizations (the ConcordiaPLUS DHMO or the Aetna Dental DMO) and a preferred provider organization (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.

ConcordiaPLUS 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.

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.

<table>
<thead>
<tr>
<th>Concordia PLUS</th>
<th>Aetna</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.866.357.3304</td>
<td>1.877.238.6200</td>
</tr>
<tr>
<td><a href="http://www.ucci.com">www.ucci.com</a></td>
<td><a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
</tbody>
</table>
**DENTAL PLAN COMPARISON CHART**

<table>
<thead>
<tr>
<th>Features and Benefits</th>
<th>ConcordiaPLUS DMHO*</th>
<th>Aetna Dental DMO</th>
<th>Aetna Dental PPO**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
<td></td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>$1,000 per year</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>None</td>
<td>None</td>
<td>$50 per person; $150 per family</td>
</tr>
<tr>
<td><strong>Preventive/Diagnostic Services</strong></td>
<td>100%, as shown below</td>
<td>100%, as shown below</td>
<td>100%; no deductible; 100% after deductible</td>
</tr>
<tr>
<td><strong>Exams</strong></td>
<td>100% once every 6 months</td>
<td>100% 4 times per calendar year</td>
<td>2 routine and 2 problem-focused exams per calendar year</td>
</tr>
<tr>
<td><strong>Full Mouth X-rays</strong></td>
<td>100% once every 3 years</td>
<td>100% 1 set every 3 years</td>
<td>100% 1 set every 3 years</td>
</tr>
<tr>
<td><strong>Bitewing X-rays</strong></td>
<td>100% once every 6 months to age 13, then once every 12 months</td>
<td>100% 1 set every calendar year</td>
<td>100% 1 set per calendar year</td>
</tr>
<tr>
<td><strong>Cleanings</strong></td>
<td>100% once every 6 months with no copayment</td>
<td>100% after copay ($10 child or $12 adult); 2 times per calendar year</td>
<td>100% 2 times per calendar year</td>
</tr>
<tr>
<td><strong>Fluoride Application</strong></td>
<td>100% once every 6 months up to age 18</td>
<td>100% once per calendar year up to age 16</td>
<td>100% once per calendar year, up to age 16</td>
</tr>
</tbody>
</table>

**Basic and Major Care**

<table>
<thead>
<tr>
<th>Services</th>
<th>ConcordiaPLUS DMHO*</th>
<th>Aetna Dental DMO</th>
<th>Aetna Dental PPO**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fillings</strong></td>
<td>100% after copay*</td>
<td>100% for amalgam after copay**</td>
<td>80% after deductible; 65% after deductible</td>
</tr>
<tr>
<td><strong>Crowns, Bridges, or Dentures</strong></td>
<td>100% after copay*</td>
<td>100% after copay**</td>
<td>50% after deductible; 50% after deductible</td>
</tr>
<tr>
<td><strong>Endodontics (root canal)</strong></td>
<td>100% after copay*</td>
<td>100% after copay**</td>
<td>After deductible: 80% for anterior teeth or 50% for major teeth After deductible: 65% for anterior teeth or 50% for major teeth</td>
</tr>
<tr>
<td><strong>Periodontics (non-surgical)</strong></td>
<td>100% after copay*</td>
<td>100% after copay**</td>
<td>80% after deductible; 65% after deductible</td>
</tr>
<tr>
<td><strong>Simple Extractions</strong></td>
<td>100% after copay*</td>
<td>100% after copay**</td>
<td>80% after deductible; 65% after deductible</td>
</tr>
<tr>
<td><strong>Other Covered Services</strong></td>
<td>100% after copay*</td>
<td>100% after copay**</td>
<td>50% after deductible; 50% after deductible</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td>No lifetime maximum* applicable copays</td>
<td>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)</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Area Care</strong></td>
<td>Up to $50 (each occurrence) for emergencies***</td>
<td>Contact Aetna for details</td>
<td>N/A (Provider network is nationwide)</td>
</tr>
</tbody>
</table>

* See UCCI ConcordiaPLUS Schedule 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 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 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:

<table>
<thead>
<tr>
<th>60% of Monthly Earnings</th>
<th>$3,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minus Social Security Benefit</td>
<td>$1,760</td>
</tr>
<tr>
<td>LTD Plan Benefit*</td>
<td>$1,240 a month</td>
</tr>
</tbody>
</table>

*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, or die, whichever occurs first. Benefits may not be available if you have a pre-existing condition.
Voluntary Life Insurance coverage is provided through the Life Insurance Company of North America, a Cigna company. Please refer to the Cigna Life/AD&D brochure on the Benefits Gateway for a complete description of benefits, limitations, and exclusions.

Coverage For You
If available at your location, you may elect Voluntary Life insurance that offers survivor protection you can tailor to your needs.

Voluntary Life Insurance coverage is provided through the Life Insurance Company of North America, a Cigna company. Please refer to the Cigna Life/AD&D brochure on the Benefits Gateway for a complete description of benefits, limitations, and exclusions.

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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 Identity 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.

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:

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

*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:

<table>
<thead>
<tr>
<th>For Loss Of:</th>
<th>Benefit Paid Is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse Only</td>
<td>Spouse insured for <strong>50%</strong> of your coverage amount (up to $150,000).</td>
</tr>
<tr>
<td>Spouse and Children</td>
<td>Spouse insured for <strong>40%</strong> of your coverage amount (up to $150,000). Each child insured for <strong>10%</strong> of your coverage amount (up to $25,000).</td>
</tr>
<tr>
<td>Children Only</td>
<td>Each child insured for <strong>15%</strong> of your coverage amount (up to $25,000).</td>
</tr>
</tbody>
</table>

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.
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:

<table>
<thead>
<tr>
<th>Critical Illness Benefit</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (Internal or Invasive)</td>
<td>100% of coverage amount</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>100% of coverage amount</td>
</tr>
<tr>
<td>Stroke</td>
<td>100% of coverage amount</td>
</tr>
<tr>
<td>Major Organ Transplant</td>
<td>100% of coverage amount</td>
</tr>
<tr>
<td>End Stage Renal Failure</td>
<td>100% of coverage amount</td>
</tr>
<tr>
<td>Coronary Artery By-Pass Surgery</td>
<td>25% of coverage amount</td>
</tr>
<tr>
<td>Carcinoma in Situ</td>
<td>25% of coverage amount</td>
</tr>
</tbody>
</table>

- Annual Cancer Expense Benefits of $5,000 if initially diagnosed while coverage is in force. 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.
Accident Insurance
• 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:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Payment to Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Treatment</td>
<td>$100 per accident</td>
</tr>
<tr>
<td>Physician's Office/Urgent Care Treatment</td>
<td>$50 per accident</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$200 per accident</td>
</tr>
<tr>
<td>Hospital Admission</td>
<td>Standard: $750 per accident</td>
</tr>
<tr>
<td>Daily Hospital Confinement</td>
<td>$100/day, up to 365 days per accident</td>
</tr>
<tr>
<td>Hospital Intensive Care Confinement</td>
<td>$300/day, up to 15 days per accident</td>
</tr>
<tr>
<td>Medical Imaging</td>
<td>$100 per accident</td>
</tr>
<tr>
<td>Concussion</td>
<td>$100 per accident</td>
</tr>
<tr>
<td>Fractures</td>
<td>Up to $5,000 per accident</td>
</tr>
<tr>
<td>Lacerations</td>
<td>Up to $400 per accident.</td>
</tr>
<tr>
<td>Physical Therapy (up to 10 treatments)</td>
<td>$15 per treatment</td>
</tr>
<tr>
<td>Accidental Death Life Benefit</td>
<td>$25,000 or $50,000 if by Common Carrier</td>
</tr>
</tbody>
</table>
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 2015. 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.
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)**

The EAP is not available at all locations; ask your Benefit Coordinator. If you are eligible, additional materials and contact information will be made available. The EAP includes the following components:

- Access to a confidential toll-free number 24 hours a day, seven days a week, where you can speak directly to a master’s level counselor who will help answer questions and direct you to trained professional counselors.
- Up to three visits for you and your eligible dependents through a network of high-quality EAP providers located at offices near where you live or work at no cost to you.
- Online resources and support on a wide range of work-life concerns including child care, elder care, health and wellness, workplace tools and much more.

**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](http://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 a $150 IBC reimbursement. That adds up to huge savings.
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, 2015. 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.