THE ARCHDIOCESE OF KANSAS CITY IN KANSAS

2022 EMPLOYEE BENEFITS GUIDE

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WELCOME

Welcome To Your 2022 Benefits Guide!

At the Archdiocese of Kansas City in Kansas, our employees are our most valuable assets. We are committed to providing a comprehensive employee benefits program to help everyone stay healthy, feel secure, and maintain a quality work-life balance.

This guide is intended to provide a high-level summary of your benefits. To see plan documents and view your benefits online, please visit archdiocesekck.millercares.com.

Who is Eligible?

To be eligible to receive these benefits, you must be a full-time employee working 30 or more hours per week for the school or calendar year, excluding temporary and seasonal employees. Once eligible, you may also enroll your eligible dependents. Your eligible dependents include your legal spouse of the opposite gender and dependent children (until the end of the calendar year in which they turn 26).

Newly hired employees are required to enroll or waive enrollment in the Archdiocese benefits within 30 days after your date of hire. Coverage in all benefits will begin the first of the month following 30 days from your hire date.

2022 Open Enrollment

Open Enrollment will begin at 12:01am on November 2nd and end at 11:59pm on November 12th. Elections you make during Open Enrollment will become effective January 1, 2022.

Qualified Life Events

You may change your benefit elections during the open enrollment period. Generally, such elections will remain in place until the next open enrollment. However, you may change your benefit elections during the year if you experience a qualifiying life event, including:

- Marriage
- Birth of your child
- Adoption or placement for adoption of your child
- Death of your spouse or dependent child
- Change in employment status of employee, spouse, or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid
- Enrollment in coverage through the Health Insurance Marketplace

Benefit changes outside of open enrollment must be completed inside your Paylocity/Enterprise Benefits portal within 30 days after the qualifying life event. If you do not complete this process within 30 days of the qualifying life event, you will have to wait until the next Open Enrollment period to make changes, unless you experience another qualifying life event.

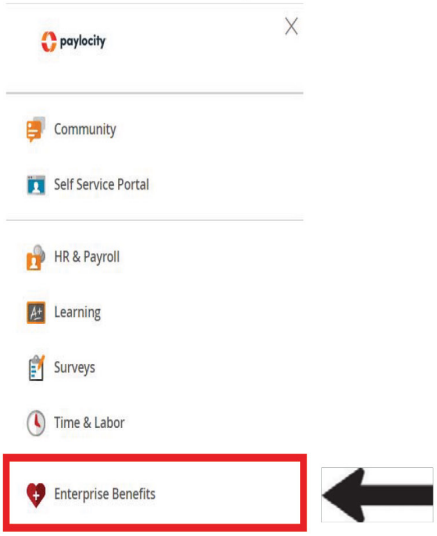
Information in this guide is provided for illustrative purposes only. For more detailed information, please refer to your summary plan description found at archdiocesekck.millercares.com. In the case of a discrepancy, the actual plan documents will prevail.

OPEN ENROLLMENT INSTRUCTIONS

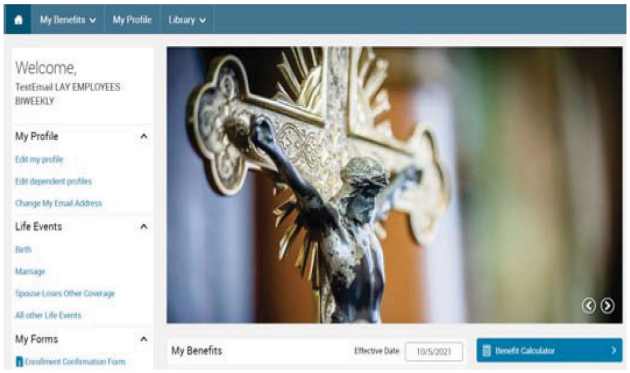
To Begin Open Enrollment:

1. Log into your Paylocity Account.

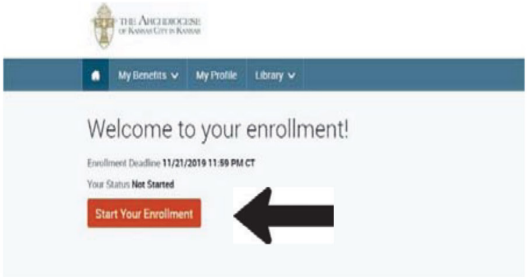
2. Use the Menu to navigate to Enterprise Benefits.



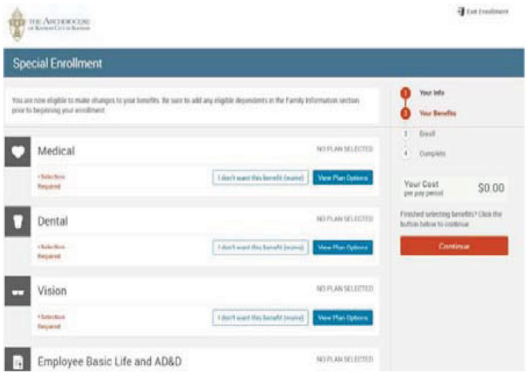
3. You will be directed to the page below.



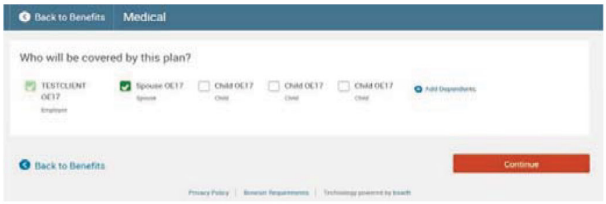
4. Click "Start Your Enrollment".



5. View plan options for each benefit.

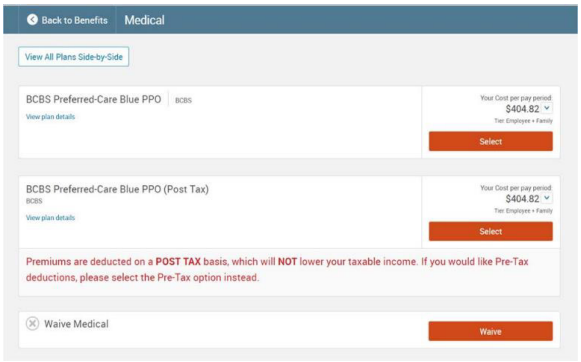


6. Select all applicable dependents for each benefit and click "Continue".

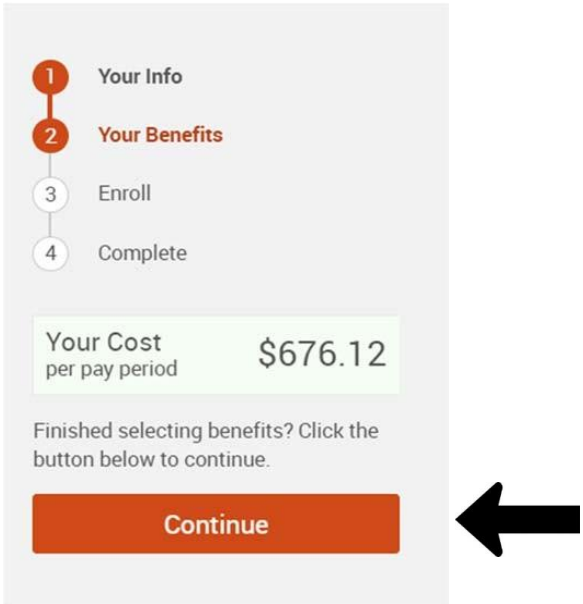


OPEN ENROLLMENT INSTRUCTIONS (CONT.)

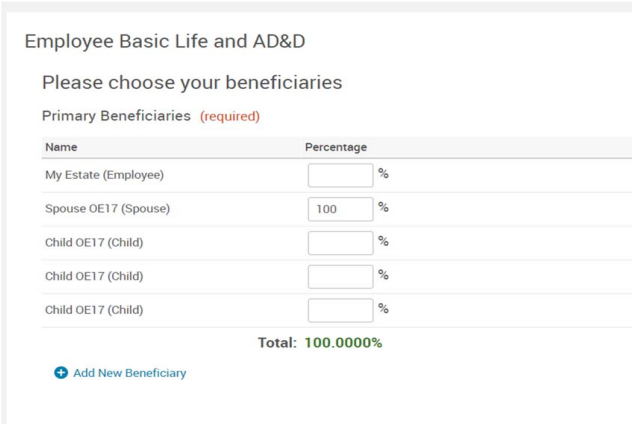
7. “Select” the coverage you want for each benefit plan or “Waive” if you do not want coverage.



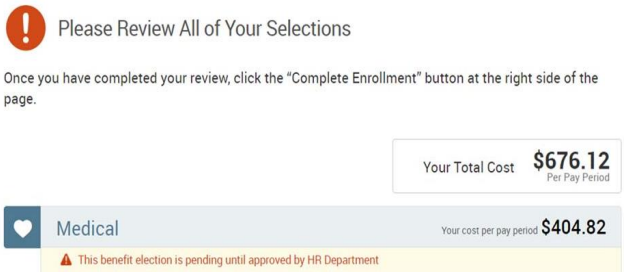
8. When you have selected all of your benefits, click “Continue”.



9. Next, please choose your beneficiaries, then click “Continue”.



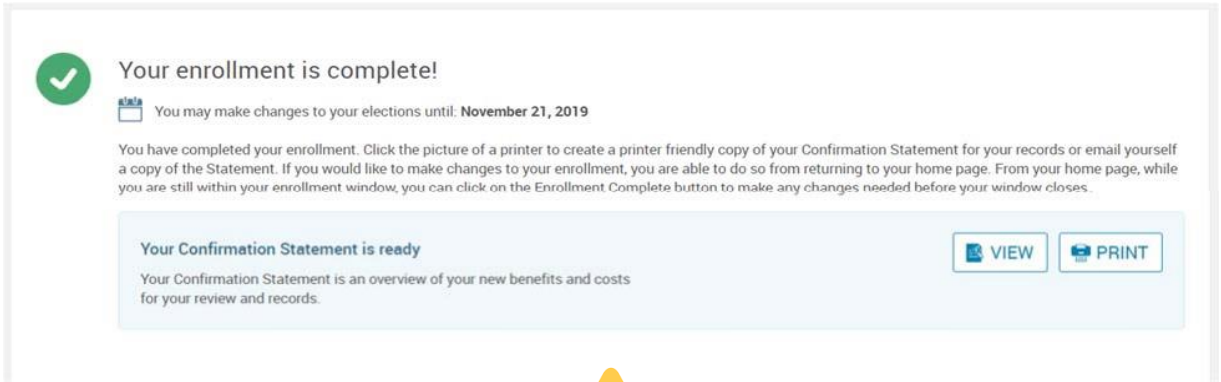
10. Review your selections for accuracy.



OPEN ENROLLMENT INSTRUCTIONS (CONT.)

11. When you have completed enrollment, read the agreement and check, “I agree”.

12. Click “Complete Enrollment”. Review then ***print or email your confirmation for your records.***



Your confirmation will be your verification that your benefit elections are correct.
You will want to check your first payroll statement in January to ensure your deductions are correct.

NEW HIRE ENROLLMENT INSTRUCTIONS

2022 New Hire Enrollment Information

Newly hired employees are required to enroll or waive enrollment in the archdiocesan benefit plans within 30 days of hire. Coverage in all benefits will begin the first of the month following 30 days of hire.

We offer you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. This guide describes your benefit options for 2022. Please read it carefully for important information you will need in order to make decisions about your benefit elections.

Please see your onsite entity administrator if you have any questions about the enrollment process.

St. Benedict, St.Mary

BENEFITS OVERVIEW

The Archdiocese and your employer are committed to providing a comprehensive benefits package to our employees. Providing you and your eligible dependents with a competitive, flexible, and affordable benefit program is important to us.

Your benefit needs are as unique and individual as the life you lead. This benefit guide will help you to choose the benefits that best meet the needs of you and your family.

The benefit guide provides a brief overview of your employee benefits program. We encourage you to review this important information about the benefits available to you. It is intended to be a general summary of benefits, and it is not a legal document. Please visit **archdiocesekck.millercares.com** for more detailed information regarding the full scope of coverage, limitations, and any exclusions that may apply.

Keep in mind that your out-of-pocket costs will be lower if you receive care from an in-network doctor and facility. To find an in-network doctor, please visit **myhealthtoolkitkc.com**. For more information or to see plan documents, visit **archdiocesekck.millercares.com**. Check the list below to select the benefits that best meet your personal needs.

Benefit	Who Pays the Cost
Medical / Pharmacy Coverage	Employer & Employee
Dental Coverage	Employer & Employee
Voluntary Vision Coverage	Employee
Employee Assistance Program	Archdiocese Welfare Benefit Fund & Employer
Basic Life and AD&D Coverage	Employer
Dependent Life Coverage	Employer & Employee
Voluntary Supplemental Life	Employee
Short Term Disability	Archdiocese Welfare Benefit Fund & Employer
Long Term Disability	Employer & Employee
Flexible Spending Account	Employee
Health Savings Account	Employee

All Saints, Kansas City, KS

BENEFITS OVERVIEW

Cost to Participate

Your employer will continue to pay at least 60% of your cost to participate in the Medical and Dental plans. The chart below shows your share of the per pay period cost compared to the employer's contribution. You are responsible for 100% of the cost to participate in the Vision plan. All deductions will come out of the first two paychecks each month.

	Coverage Type	Employee per Pay Period Contribution	Employer per Pay Period Contribution
Medical PPO Plan	Employee Only	$118.24	$177.36
	Employee & Spouse	$367.72	$551.58
	Employee & Child(ren)	$310.96	$466.44
	Family	$383.04	$624.96
Medical HDHP Plan	Employee Only	$51.50	$200.09
	Employee & Spouse	$312.96	$469.44
	Employee & Child(ren)	$264.68	$397.02
	Family	$326.04	$531.96
Dental	Employee Only	$7.64	$11.46
	Employee & Spouse	$22.20	$33.30
	Employee & Child(ren)	$19.12	$28.68
	Family	$24.50	$36.75
Vision	Employee Only	$4.48	$0
	Employee & Spouse	$9.03	$0
	Employee & Child(ren)	$10.34	$0
	Family	$16.48	$0

EFFECTS OF HEALTHCARE REFORM

Summary of Benefits Coverage

Under the Patient Protection and Affordable Care Act (PPACA or ACA), insurance companies and group health plans must provide consumers with a concise document detailing, in plain language, simple and consistent information about health plan benefits and coverage. This Summary of Benefits and Coverage (SBC) document will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options. It will summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
A copy of the SBC can be found on the benefits portal at **archdiocesekck.millercares.com.**

Women's Preventive Care Guidelines

In August 2011, the U.S. Department of Health and Human Services (HHS) announced additional preventive care services, developed by the independent Institute of Medicine, to cover women's preventive services without charging a copayment, coinsurance or a deductible. In addition to requiring 100% coverage for well-women visits and various types of screenings, the HHS has included coverage for FDA-approved contraception methods. The Archdiocese Health Plan is not required to comply with these rules, even as a non-grandfathered plan, therefore coverage for contraception continues to be excluded under our plan.

Preventive Services

Our health plan continues to cover routine preventive services for all members. The PPO plan also covers one mammogram and one colonoscopy per calendar year at 100%, regardless if it is a routine or diagnostic service. The high deductible health plan (HDHP) covers only preventive mammograms and colonoscopies at 100%. Covered preventive services may have age and/or gender limitations in line with recommendations of the National Preventive Services Task Force. As these recommendations may change from time to time, please verify with Blue Cross Blue Shield or OptumRx what specific preventive services and types of breast pumps are covered in full.

Certain breast pumps are also covered at 100% for members on both the PPO and HDHP.

St. John the Baptist, Kansas City, KS

MEDICAL

You have the flexibility to seek care from an in-network or out-of-network provider. It is important to note that you receive the maximum benefits from the plan when you seek services from in-network providers.

The Blue Cross Blue Shield network offers the best national access to providers. To find out if your physician is in network, please visit their website at: **myhealthtoolkitkc.com**. You may also direct your questions to the Customer Service number located on the back of your identification card.

Below is a brief summary of the medical plans available to you and your family. For more detailed information, please refer to the Summary of Benefits and Coverage (SBC) provided by Blue Cross Blue Shield.

	PPO Plan BCBS	HDHP BCBS
Calendar Year Deductible (Individual/Family)	$750 | $1,500 Combined with Prescription Drug Benefits	$3,000 | $6,000 Combined with Prescription Drug Benefits
Calendar Year Out-of-Pocket Max (Individual/Family)	$6,500 | $13,000 Combined with Prescription Drug Benefits	$6,500 | $13,000 Combined with Prescription Drug Benefits
Coinsurance	80%	90%
Routine Preventive Care	100% Covered	100% Covered
Physician Office Visit	$25 Copay	Ded + Coinsurance
Urgent Care	$50 Copay	Ded + Coinsurance
Emergency Room	$100, then Ded + Coinsurance	Ded + Coinsurance
Inpatient Hospital Care	Ded + Coinsurance	Ded + Coinsurance
Outpatient Hospital Care	Ded + Coinsurance	Ded + Coinsurance
Chiropractic Care (20 visit limit per year)	$25 Copay + Ded + Coinsurance	Ded + Coinsurance
Lab Services	100%	Ded + Coinsurance

Natural Family Planning - For Members Covered by the Health Plan

This benefit includes office visits and materials (such as the Clear Blue Easy Fertility Monitor and test strips) and is available through programs approved by the archdiocese. The following programs are considered to be approved: Billings Method, Creighton Model, Couple to Couple League, and Marquette Method. The archdiocese will cover 100% of costs up to a maximum of $400 per calendar year for the insured employee or their spouse. The benefit is limited to $400 total per family. Please submit copies of receipts to the archdiocese Human Resources office by January 31 of the following year.

Gianna Family Care - For Members Covered by the Health Plan

The Archdiocese Health Plan provides coverage at Gianna Family Care, which is a membership and faith-based medical practice located in Shawnee, Kansas. Charges from the Gianna Family Care medical practice will be treated as follows:

- Membership and other physician fees will be reimbursed at 90% of billed amount for the PPO plan. The HDHP will be subject to the deductible then covered at 90%.
- Any other fees, such as labs or medications, if billed by Gianna, will be covered as out of network.

A claim form and itemized receipt must be submitted to Blue Cross Blue Shield for reimbursement and can be found on the benefits portal at **archdiocesekck.millercares.com**. For more information on this practice, visit: **www.giannafamilycare.com**.

MEDICAL

BlueCross BlueShield

PPO Plan	Employee per Pay Period Contribution	Employer per Pay Period Contribution
Employee Only	$118.24	$177.36
Employee + Spouse	$367.72	$551.58
Employee + Child(ren)	$310.96	$466.44
Employee + Family	$383.04	$624.96

High Deductible Plan	Employee per Pay Period Contribution	Employer per Pay Period Contribution
Employee Only	$51.50	$200.09
Employee + Spouse	$312.96	$469.44
Employee + Child(ren)	$264.68	$397.02
Employee + Family	$326.04	$531.96

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

Holy Name Jesus, Kansas City, KS

The Optum Oncology Case Management Program

The Optum Oncology Case Management program is a comprehensive cancer support program that uses structured approaches to assist in the management of all aspects of cancer care for persons in active treatment. We provide clinical support services for participants utilizing our science-based proprietary clinical guidelines to improve participant compliance and enhance the quality of life or improve end-of-life care.

In addressing the full spectrum of oncology care management, Case Managers employ telephonic support, educational mailings and findings from assessments to assist in supporting participants undergoing active curative treatment and also those who are in treatment but living with a terminal disease.

Core Elements of the Optum Oncology Case Management Program

Primary Case Manager Model - Certified Case Managers or Oncology Certified Nurses with extensive oncology nurse training are accessible to participants 24/7.

Unique case management method - Issues, Goals, Actions and Outcomes ("IGAOs") arranged into 7 Care Domains for organizing and prioritizing patient and treatment centered goals.

Proprietary Oncology Boundary Guidelines for over 200 sites/stages of cancer

Benefits

- Personalized care plans, educational and psychosocial support
- Efficient utilization and coordination of healthcare services/providers
- Improved quality of life measures
- Demonstrated cost reductions

Process

- Triage Engine (patient identification using proprietary targeting algorithms)
- RN outreach for specialized clinical screening and program introduction (incl. patient consent)
- Comprehensive clinical initial and ongoing assessments with care plan development in a Primary Nurse Case Manager environment
- Systematic and nurse driven acuity adjustment tailoring program engagement levels to meet patient needs
- Multi-disciplinary team approach to support the patient and his/her caregiver(s) and providers
- Case Closure upon completion of active cancer treatment and all goals being addressed (or coverage changes)

VALUE OF ONCOLOGY CM

Focus on Cancer

Cancer is the second most costly and lethal disease in the U.S., costing $201B annually, with $77B in direct medical costs[1].

Focus on participants in active cancer treatment:

- Chemotherapy
- Radiation therapy
- Biopharmacologics
- Surgery
- Combination therapies
- Palliative care therapy

Optum Solution Components

- Expert clinical team approach with highly experienced primary nurse case management model.
- Assessments for safety issues, care support issues and symptom management needs.
- Individualized real-time care plans.
- Board-certified oncologist medical directors.
- NCQA and URAC accredited

Ease of Implementation

- Oncology Case Management added by BCBS as a purchased program
- Group-specific data included in BCBS daily/weekly transmissions (membership, claims, precerts, Rx, etc)
- Program candidates can be identified as early as 2 business days after data feeds are established/updated

[1]American Cancer Society Facts & Figures 2013.

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TELADOC

Telehealth is a rapidly growing area of health care that is available to all health plan participants. Teladoc allows you to talk to a doctor anytime, anywhere by phone consult. It's an affordable, convenient option for treating many medical conditions. Once you set up your Teladoc account, you can request a consult; a Teladoc doctor is then just a call or click away.

Set up your account:

1. Go to https://www.teladoc.com and click "Set up Account."
2. Fill in required fields as indicated by the *
3. Select "no" for username.
4. Select "my employer or insurance provider offers me access" in response to how you found out about Teladoc.
5. "Who is your employer or insurance provider?" – begin typing "Archdiocese of Kansas City" and a drop down will appear. Enter your BCBS ID in the drop-down field.
6. Enter your user ID/Password and security question, then click "Finish."

Request a Consult:

Once your account is set up, a doctor is always a call or click away.

1. Visit the Teladoc website and click "Request a consult."
2. Select the type of consult you want.
3. Talk to a doctor within an hour.

When can I use Teladoc?

Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you are considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For common skin problems

Get the care you need

Teladoc doctors can treat many conditions, including:

- Cold and flu symptoms
- Allergies
- Urinary tract infection
- Respiratory infection
- And more!

For Dermatologist services, you simply take up to 5 photos of the skin issue and send them to the Teladoc doctor. You will get a response within 48 hours.

Meet our Doctors

Teladoc is simply a new way to access qualified doctors. All Teladoc doctors:

- Are practicing PCPs, pediatricians, family medicine physicians and dermatologists
- Average 15 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years meeting NCQA standards

TELADOC

Caregiver Benefits

If you're caring for a parent or other loved one not covered by your health insurance, you can add that person to your Teladoc account as your care recipient. You or your care recipient will be able to request a physician visit for a $45 charge. You can even join a three-way visit.

***Important Note:** Neither your care recipient nor this $45 charge is covered by the archdiocese health plan.*

Don't Pay More for the Same Thing!
Just because two places fix the same problem doesn't mean they cost the same.

Telemedicine services through Teladoc provide members on the medical plan the opportunity to seek care at a lower cost for certain medical conditions. There is no cost for members on the PPO plan to engage with a Teladoc provider. Using this service is more cost effective than the copays associated with office visits and urgent or emergent care facilities. Those on the HDHP can engage with a Teladoc provider for a fee of $45. Federal guidelines require a fee be tied to services for members on the HDHP, however, this fee is still lower than the potential cost members may incur if they are seen in an office, urgent care or emergency setting.

Teladoc

PPO $0 Copay HDHP $45

- Smartphone access
- Appointments by video or phone
- Confidential visits
- Available during holidays

Office Visit

PPO $25 Copay HDHP $66*

- Additional costs may be incurred during an office visit for tests and labs that physician may run.
- Limited availability for appointments

Urgent Care

PPO $50 Copay HDHP $110*

- Average wait time of 15-45 minutes
- Additional costs may be incurred during an urgent care visit for tests and labs that physician may run.

Emergency Room

PPO $100 Copay HDHP $159*

- Average wait time of 2.4 hours
- Additional costs may be incurred during an emergency room visit for tests and labs that may run.

*Estimated cost based on the archdiocese 2019 claims data, as costs may vary depending on test administered during your visit.

Medical Condition	Telemed	Office Visit	Urgent Care	ER
Bronchitis/Allergies	X	X	X	
Cold & Flu	X	X	X	
Ear Infection	X	X	X	
Respiratory Conditions	X	X	X	
Sinus Infections	X	X	X	
Urinary Tract Infection	X	X	X	
Poison Ivy	X	X	X	
Pink Eye	X	X	X	
Regular health care needs		X		
Specialist Guidance		X		
Sick Visits		X	X	
Minor Illnesses		X	X	
Injuries		X	X	
Rays & Lab Tests		X	X	
Flu or Cold, Fever	X	X	X	
Setting & Casting		X	X	
Broken Bones		X	X	
Cuts Requiring Stitches		X	X	
Headaches and Chills		X	X	
Sprains and Strains		X	X	
Minor Burns		X	X	X
Immunizations		X	X	
Flu Shots		X	X	
Foreign Objects in Eye		X	X	X
Heart Attacks or Chest Pain				X
Stroke or Stroke Symptoms				X
Unconscious Patients				X
Serious Accidents				X
Uncontrollable Bleeding				X
Head Trauma				X
Serious Abdominal Pain				X

Engage with Teladoc Today!

Please note that the pricing outlined above is an estimate for Teladoc services only. Pricing for telemedicine visits through your primary care physician may vary.

PRESCRIPTION DRUG BENEFITS

OptumRx is the Pharmacy Benefit Manager for our prescription drug benefits. Your plan includes a list of prescription drugs that are preferred by the plan because they help control rising prescription drug costs. This list, sometimes called a formulary, has a wide selection of generic and brand name medications. This information can be accessed after benefits are active January 1, 2022. Members will need to register on OptumRx.com in order to view the Formulary Drug List.

You will want to use a participating retail pharmacy for short term prescriptions (such as antibiotics to treat infections). Be sure to show your OptumRx's prescription benefit card to the pharmacist and pay your retail copayment for each prescription.

Long term medications (those taken for three (3) months or more) may be filled through the OptumRx's Broad 90 day Pharmacy Network. You may fill your long term medications at a local retail pharmacy like Walgreens, Target, Wal-Mart and many grocery stores. OptumRx also offers a mail order pharmacy option through their Home Delivery pharmacy, often called Mail Service Pharmacy. Specialty medications are filled through OptumRx's specialty pharmacy.

Prescription Drugs	PPO Plan BCBS	HDHP BCBS
Calendar Year Deductible (Individual/Family)	Not Applicable	$3,000 / $6,000 Combined with medical benefits
Retail (30 day Supply) Generic Brand Formulary Non-Formulary	 Lesser of $10 or actual cost 25% or minimum of $25 40% or minumum of $40	*After Plan Deductible:* Lesser of $10 or actual cost 25% or minimum of $25 40% or minumum of $40
Mail Order (90 day Supply) Generic Brand Formulary Brand Non-Formulary	 $25 Copay 25% or minimum of $62.50 40% or minimum of $100	*After Plan Deductible:* $25 Copay 25% or minimum of $62.50 40% or minimum of $100
Specialty (30 day Supply) Generic Brand Formulary Brand Non-Formulary	 25% of discounted cost 25% of discounted cost 25% of discounted cost	*After Plan Deductible:* 25% of discounted cost 25% of discounted cost 25% of discounted cost

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to the Optum's Summary Plan Description.

To find a participating retail pharmacy near you, contact OptumRx's Customer Service department at 855-524-0381 or log on to OptumRx.com
Hours of Operation: 24 hours a day, 7 days a week.

MEDICATION MANAGEMENT PROGRAM Tria Health

Helping You Manage Your Medications and Reduce Your Health Care Costs!

The Tria Health Program is provided at no additional cost to you through your insurance plan with the Archdiocese of Kansas City in Kansas. This confidential program is designed to improve your health, reduce your healthcare costs, and ensure you're receiving the best care from your medications.

Tria Health's programs offer you clinical guidance through the complexities of health care. Tria pharmacists act as your personal medication experts and work with you and your physician to achieve 3 primary goals:

1. To assure your medications are safe
2. Verify your medication as affordable as possible
3. Confirm the appropriateness of the medication to treat your condition

Pharmacy Advocate (PA) Program:

The PA program offers one on one confidential counseling with a Tria Health Pharmacist to discuss how effective your medications are in treating your conditions. Your Tria Pharmacist will work with you and your physicians to reduce the risk of medication related problems.

Examples of medication related problems include:

- Nausea or other uncomfortable side effects
- Your prescription is too expensive to fill every month
- The medication dosage is too low or too high and isn't effectively treating your condition

You can enroll by...

Mail
Eligible individuals will receive an enrollment packet in the mail. This will include an enrollment form and envelope for you to send back to Tria Health.

Online
You may enroll online by visiting the website: www.triahealth.com/patients

Who participates?

Individuals who have one or more chronic conditions and take multiple medications. Active participants in the PA Program will be eligible to receive **FREE generic copays and 50% off brand copays** on medications that are used primarily to treat chronic conditions.

Participants say...

"I would recommend Tria's PA program for the cost saving benefit alone, but I really like the idea that one central place is coordinating with all my doctors to make sure my prescriptions play well together."
"We are very happy with this program. It only takes 10 minutes or so every 6 months."

Programs for All Plan Members:

The programs below are designed to help all plan members receive the best results from their medications and reduce the risk of medication-related problems.

Program		Details
Affordable Med		Saves you time and money by identifying less expensive, effective alternatives for your brand medications
Med Safety Alerts		Prevents the risks associated with taking medications that cause an adverse reaction together
Tria Clinical Alerts		Identifies when taking an additional medication in conjunction with your current treatment can improve your condition
Compliance Alerts		Forget to take your medications? Do side effects cause you to skip your meds? Compliance Alerts help find solutions to help you take your medications as prescribed
Tria Help Desk		Your complete and confidential resource anytime you have a medication-related question. Call us toll free at 1-888-799-TRIA (8742)

MEDICATION MANAGEMENT PROGRAM Tria Health

Tria Health - Personalized Health Care

Tria Health is a free and confidential benefit available through your health plan. If you have a chronic condition or take multiple medications, Tria Health's pharmacists are ready to support you in managing your health. Not only will Tria Health's pharmacists make sure your medications are working as intended and that you're on the right medications, but they can support you by creating a care plan that is specific to your needs and share it with your doctor. Talk to a pharmacist over the phone and receive the personalized care you deserve.
Active participants will receive free generics and reduced select brand medications used to treat targeted chronic conditions. Participants with diabetes will also have free access to a blood glucose meter and testing supplies.

Why Participate?

Your Tria Health pharmacist can help:

- Make sure your medications are working as intended.
- Help you save money - Tria saves patients an average $250 per year!
- Answer any questions you have about your health.
- Coordinate care with your doctor(s) - Over 95% of recommendations made by Tria Health were accepted by an individual's physician.

Tria Help Desk

The Tria Help Desk is a toll-free resource where all members can speak directly with a Tria Health clinical pharmacist to receive information ranging from less expensive drug therapies to learning more about potential drug-to-drug interactions. Members can access the Tria Help Desk at 1.888.799.TRIA Monday-Friday from 8am to 9pm and Saturday from 9am to 8pm.

By participating in Tria Health, do members need to change where they get their prescriptions filled? Does this change the relationship with their physicians?

No, participation in Tria Health will not require members to change where their prescriptions are filled. After a member has enrolled in the Pharmacy Advocate Program, the Tria clinical pharmacist will notify the member's physician to inform them about the program. After a member has an appointment with their Tria pharmacist, their physician will receive a summary of the discussion. Tria Health clinical pharmacists work with the members' physicians in order to ensure all members are receiving the best medical and prescription care possible!

How often do members speak with a Tria Health clinical pharmacist?

Pharmacists will keep in touch with each member approximately 2 or 3 times throughout the year, depending on each member's personal care plan, which is discussed during their initial consultation. All members, however, have unlimited access to the Tria Help Desk, where they can speak with a Tria Health Clinical Pharmacist regarding any medication issue.

How long does an initial consultation take?

The initial consultation can last anywhere from 20 to 45 minutes depending upon the complexity of your medical care.

Is this like insurance?

Tria Health is an enhancement to your health insurance that is designed to reduce your medical costs and keep you healthy.

How do I check eligibility for myself and my dependents?

Any plan member can check eligibility for themselves and/or dependents by calling 1.888.799.TRIA or visiting triahealth.com. Or take Tria Health's online Medication Risk Quiz. Eligible members must have one or more chronic conditions and take multiple medications.

Ready to Get Started?

To schedule your first appointment, visit www.triahealth.com/enroll or call 1-888-799-8742 to speak with a Tria Health member advocate.

HEALTH SAVINGS ACCOUNT (HSA)

If you elect the High Deductible Health Plan (HDHP), you may elect to open a Health Savings Account (HSA).

Please Note: You cannot contribute to an HSA if: 1) you are covered by a Flexible Spending Account (FSA) even if the FSA is your spouse's, unless it is a Limited Purpose FSA that doesn't cover medical expenses, or 2) are enrolled in Medicare or any other health insurance coverage.

Features of an HSA include:

- HSA funds can be used for qualified medical, dental, and vision expenses.
- You can only use what you contribute; funds will be deposited into your HSA.
- HSA money is yours to keep. Unlike a Flexible Spending Account (FSA), unused money in your HSA isn't forfeited at the end of the year; it continues to grow tax deferred.
- HSA is portable. It remains open and funds are available to you even if you leave the employer where you worked when you established or contributed to the HSA.

Annual Contribution Limits	
Individual	**Family**
$3,650	$7,300
If age 55 or older, $4,650	If age 55 or older, $8,300

HSA holders 55 and older can contribute an extra $1,000 per year, increasing the annual contribution limit to $4,650 for individual coverage and $8,300 for family coverage.

St. John the Baptist, Kansas City, KS

FLEXIBLE SPENDING ACCOUNTS (FSA)

Your employer offers you the opportunity to participate in three different Flexible Spending Accounts (FSAs) administered by Paylocity: a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account and a Limited Purpose Flexible Spending Account. Each account allows you to set aside money to pay for certain expenses on a pre-tax basis.

Save on Your Taxes with an FSA

With an FSA, the money you contribute is never taxed - not when it is deducted from your paycheck and deposited to your account, not when you are reimbursed with the funds from the account, and not when you file your income tax return at the end of the year. Paying fewer taxes means you keep more of the money you make.

How to Save with an FSA	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security Taxes	$11,701	$12,355
After-Tax dollars spend on eligible expenses	$0	$2,000
Spendable income after expenses	$36,299	$35,645
Tax savings with the Medical and Dependent Care FSA	$654	N/A

You must actively re-enroll each year to participate in a Flexible Spending Account by making an annual contribution election during Open Enrollment. Once you elect a contribution amount you cannot change that amount during the plan year, unless you experience a qualifying change of status event.

Account Type	Maximum Annual Contribution	Last Date to Incur Expenses	Last Date to File Claims	What happens to any unused balance at the end of the year?
Health Care FSA	$2,750*	December 31, 2022	March 31, 2022	You can carry over up to $550 of your unused balance year-to-year**
Dependent Care FSA	$5,000 ($2,500 if married and filing separately)	December 31, 2022	March 31, 2022	Any funds left in your account at the end of the year will be forfeited
Limited Purpose FSA	$2,750*	December 31, 2022	March 31, 2022	You can carry over up to $550 of your unused balance year-to-year**

*This amount is projected to be increased to $2,850 for 2022.

**Amounts in excess of $550 will be forfeited.

Health Care Flexible Spending Account

This account allows you to pay for a wide range of unreimbursed medical, dental and vision care expenses with pretax dollars. The following over-the-counter items are now eligible for FSA spending: Acid Controllers, Allergy & Sinus Medications, Antibiotic Products, Anti Itch & Insect Bite, Digestive Aids, Laxatives, Pain Relievers, Respiratory Treatments, Sleep Aids & Sedatives, Stomach Remedies, and Menstrual Supplies.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Dependent Care Flexible Spending Account

This account is designed for you to pay, with pretax dollars, for qualified child care expenses for dependents under the age of 13 (or who are physically or mentally incapable of self care) and for adult day care services for dependent adults who are unable to care for themselves and live with you at least 8 hours each day. The dependent care provided must be necessary for you (and your spouse, if you are married) to work or attend an accredited school or institution on a full-time basis. Funds may not be used to pay for overnight camps, care provided by a dependent, spouse or child under the age of 19, and care provided while you are not at work. Qualifying Dependent Care Expenses are those that enable you to be gainfully employed, including:

- Day-Care Centers
- Nannies
- Babysitters
- Adult Day-Care Services
- Day Camps

Dependent care services must have been "incurred," or fully provided and completed, for the service period before you can be reimbursed for your dependent care expenses. This is important to remember because most providers require prepayment of dependent care services at the beginning of the service period before they provide dependent care services.

Important Note:
Before you enroll in a Dependent Care FSA, you should evaluate the tax advantages, as well as the impact on your tax liability and your ability to take advantage of the Dependent Care Tax Credit.
For a detailed listing of eligible and ineligible expenses, refer to IRS Publication 503, which is available from the IRS website at: **https://www.irs.gov/publications/p503**

Limited-Purpose Flexible Spending Account

This account is an option only available to those who elect the HDHP medical plan and open a Health Savings Account (HSA). This account is much like the Medical Care FSA, however, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents. Qualified dental expenses include cleanings, fillings, crowns and braces. Qualified vision expenses include contact lenses, eyeglasses, eye exams, and vision correction procedures.

Important Note:
No double dipping: Expenses reimbursed under your Limited Purpose Flexible Spending Account cannot be reimbursed under any other plan or program including a Health Savings Account (HSA). Only your eligible out-of-pocket expenses may be reimbursed.

How Do Flexible Spending Accounts Work?

Each year, you decide whether you want to participate in any of the Flexible Spending Accounts.

- If you decide to participate, you must first determine how much you want to contribute to your FSA(s). The amount is based upon your estimate of how much money you and your family will spend in deductibles, copayments, and other eligible expenses in the upcoming plan year.
- During open enrollment, you enroll in the FSA(s) and elect the amount to contribute to your plan(s).
- Beginning with the first pay period of the new plan year, the amount you elected will be automatically deducted from your pay check in equal increments throughout the year and deposited into your account.

For Health Care or Limited Purpose FSAs, your entire election amount is available to use on the first day of your plan year.

For Dependent Care FSAs, the funds are only available as they are deposited into your account. You then use your funds to pay for eligible health care or dependent care expenses.

Important Note:
If you participate in the Health Care/Limited Purpose and Dependent Care FSAs, you cannot use money from your Health Care/Limited Purpose FSA to pay for Dependent Care expenses, or vice versa.

FLEXIBLE SPENDING ACCOUNTS (FSA)

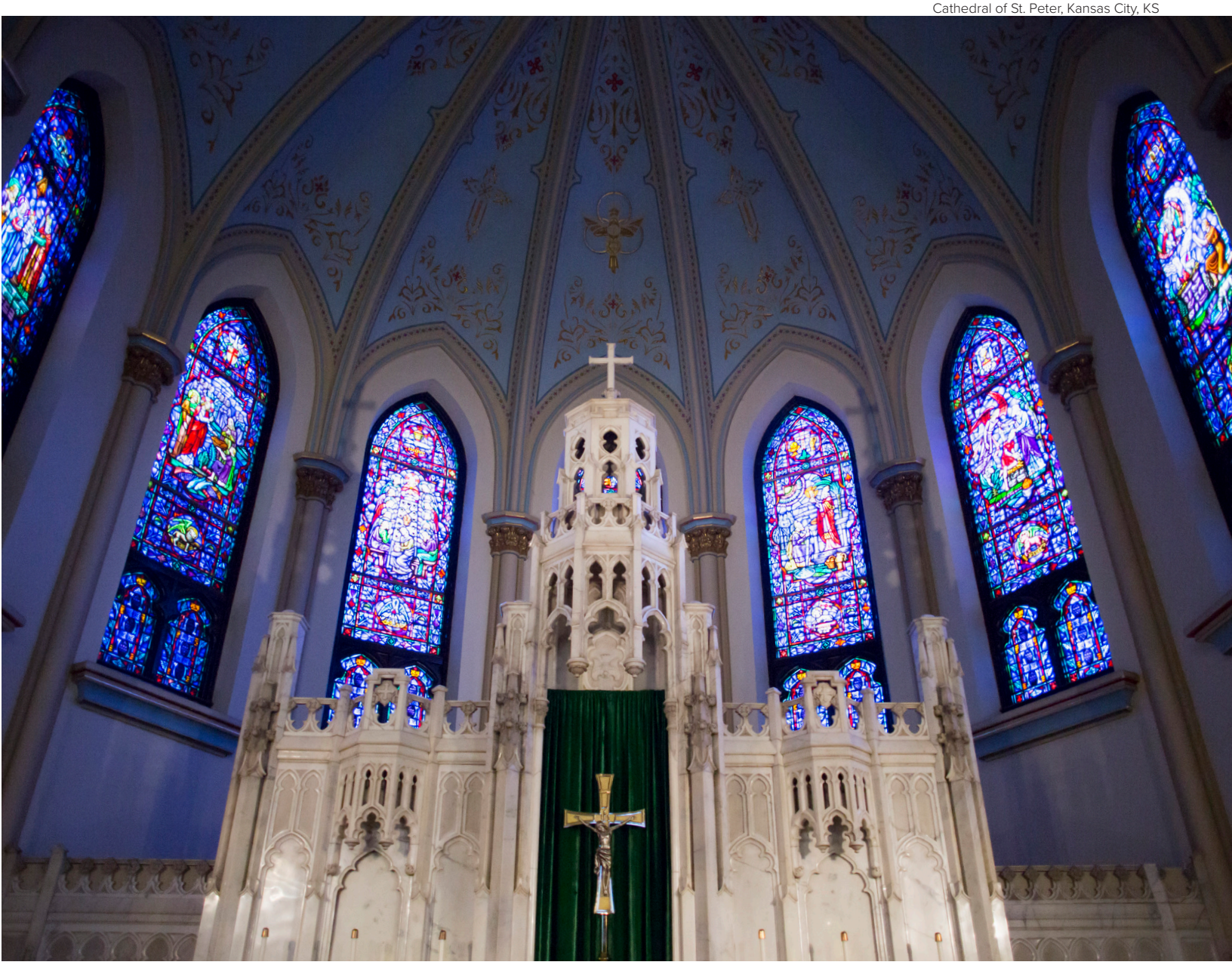
Annual Carryover of Unused Funds

Your employer allows employees who contribute to a Health Care or Limited Purpose FSA to carry over $550 of unused amounts remaining at the end of the plan year to be paid or reimbursed for qualified medical expenses you incur in the following plan year. Only those who have FSA coverage through December 31st of the previous plan year can carry over an amount into the next plan year.

Annual Open Enrollment

If you currently contribute to a Flexible Spending Account, please note that elections for the current benefit plan year will not roll over to the new benefit plan year. You must actively re-enroll each year by making an annual contribution election during Open Enrollment.

Cathedral of St. Peter, Kansas City, KS



DIFFERENCES BETWEEN HSA & FSA

Both HSAs and FSAs allow employees to set aside money for health costs referred to as "qualified expenses" which include deductibles, copayments, coinsurance, prescription medications, dental and vision care and can help save you money and make budgeting for medical costs easier. However, knowing which account to select can be confusing. The information provided here is designed to assist you in making the right decision for you and your family.

The first key difference between the two types of accounts is that HSAs are not available to everyone. If you aren't eligible for an HSA, it makes your decision much easier. Only those who have elected the High Deductible Health Plan (HDHP) can select an HSA. In addition, the HDHP must be your only health insurance plan, you must not be covered by Medicare or any other health coverage, and you cannot be claimed as a dependent on someone else's tax return.

	Health Savings Account (HSA)	Flexible Spending Account (FSA)
Eligibility	Employees on the HDHP	Employees not on HDHP Plan
2022 Contribution Limits	$3,650/$7,300 Over 55: $1,000 catch-up	$2,750 (projected to increase to $2,850 for 2022)
Eligible Medical Expenses	Qualified medical expenses defined under IRC § 213(d) incurred after the HSA is opened, except for amounts distributed to pay health insurance premiums. HSAs can be used to pay premiums for Temporary Continuation of Coverage, Long Term Care, and health insurance for retirees.	Qualified medical expenses are those specified in the plan that would generally quality for the medical and dental expenses deduction. e.g. Copays, coinsurance, deductible, prescription drugs, braces, dental and eyecare expenses.
Account Owner	Employee	Employer
Require Proof of Expenses	No; however, the member should be prepared to substantiate to the IRS the expense has been incurred, the amount of the expense and its eligibility	Yes, you need to retain proof of payment. Validation will be required except for debit card swipes for set copays associated with the health or pharmacy benefit.
Changes to Contributions	On an ongoing basis	Only for qualifying events, such as marriage, birth, or during open enrollment.
Disbursement of Funds	Only funds paid in to the account are available for healthcare expenses	The entire annual contribution amount is available at the beginning of the year, even if the account is not fully funded yet.
Portability and Forfeiture	Yes; HSA balance is not forfeited when the member changes employers or health plans	**Option 1**. Upon termination, participation in the Health FSA will cease and no further contributions will be made on your behalf. You have 90 days after the date of termination to submit claims for health care expenses that were incurred prior to the date of termination. **Option 2**. Before your last day of work you can fund the remaining months of contributions to your Health FSA, so all contributions for the year have been made before you leave employment. You will then be allowed to continue to incur health care expenses and submit receipts through the end of the calendar year in which your employment terminates. Submit claims after your employment terminates by contacting Paylocity at batinfo@paylocity.com or 1.800.631.3539
Balance Carry Over (or rollover)	Unused funds are rolled over into the following year and beyond	Up to $550 of unused funds can be carried over to the following year, with the remainder of the unspent balance being forfeited.
Investment Options	Yes, but amount varies by HSA bank	No
Expiration	Never expires or lost	All money in an FSA expires and is lost at the end of the year, up to $550 may be rolled over to the next plan year.

DENTAL

Maintaining good dental health by getting regular checkups may prevent you from having major expenses later. The plan covers routine checkups and comprehensive coverage for other types of dental work you might need. Our plan also offers you the flexibility to seek treatment from any provider. As with our Health Plan, you will maximize your dental benefits if you use a Delta Dental provider due to the agreements Delta has in place with their contracted dentists. Should you decide to use a non-participating dentist, please be advised that your provider may balance bill you for any amount over the Delta Dental Maximum Plan Allowance.

Even though you are not required to use a Delta Dental provider, you have access to the largest dental network in the state of Kansas. To learn more about the Delta Dental network, if your dentist participates in the network, or for more information regarding our dental plan provider, please visit their website at: www.deltadentalks.com. Please click on the "Dentist Search" link located halfway down the home page under the section titled "Searching for a Dentist." In the "Dentist Search" section, you may choose either the "Delta Dental Premier" or "Delta Dental PPO" providers. You can search for providers by name, city and state or zip code. Inquiries may also be made by calling Customer Service at: (800) 234-3375. (This number can also be found on your identification card).

Below is a brief summary of the dental plans available to you and your family. Please refer to the Delta Dental benefit summaries for more detailed information.

Services	Description	Benefit Amount
Type I Procedures	Exams, cleanings, fluoride treatments (2 per year)	Plan pays **100%** of the Maximum Plan Allowance, This benefit does not apply towards the Annual Maximum
Type II Procedures	Regular fillings (amalgam or composite), extractions, non-surgical root canals	After deductible is met, the plan pays **80%** of the Maximum Plan Allowance
Type III Procedures	Inlays, crowns, dentures, implants	After deductible is met, the plan pays **60%** of the Maximum Plan Allowance
Type IV Procedures	Orthodontia services For adults and children	After deductible is met, the plan pays **50%** of the Maximum Plan Allowance up to a Lifetime Maximum Benefit of **$2,500**
Annual Deductible	Applies to Type II, III, and IV Procedures	**$25** per person
Annual Maximum	Per covered person	**$2,500**

Employee Cost per Pay Period	Employee Share	Employer Share
Employee Only	$7.64	$11.46
Employee + Spouse	$22.20	$33.30
Employee + Child(ren)	$19.12	$28.68
Family	$24.50	$36.75

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

VISION

Regular eye examinations help determine your need for corrective eyewear and may also detect general health problems in their earliest stages.

Vision benefits are offered through VSP and Eyemed. The Voluntary Vision program provides comprehensive coverage for all of your routine vision needs. You pay the full cost of coverage through pre-tax payroll deductions.

Using your **VSP** benefit is easy. Create an account at **vsp.com/eye-doctor**. Find an eye care provider who's right for you. To find a VSP provider, visit **vsp.com/eye-doctor** or call 800-877-7192. At your appointment, tell them you have VSP; no ID card is necessary. That's it! VSP handles the rest. Average annual savings with VSP coverage is over $400 vs. what you might pay for an exam and glasses without coverage.

Using your **Eyemed** benefit is easy. Create an account at **eyemed.com**. Find an eye care provider who's right for you. To find an EyeMed provider, visit **eyemed.com/en-us/provider** or call 866-289-0614. At your appointment, tell them you have EyeMed; no ID card is necessary. That's it! EyeMed handles the rest. Average annual savings with EyeMed coverage is 71% vs. what you might pay for an exam and glasses without coverage.

Benefit	Ameritas using VSP Network	Ameritas using Eyemed Network
Eye Exam	$15 Copay	$15 Copay
Materials	$20 Copay	$20 Copay
Lenses Single Vision Bifocal Trifocal	Covered in Full	Covered in Full
Frames	$175 allowance	$175 allowance
Contacts Fitting & Evaluation Medically Necessary Elective	Up to $60 Copay 100% Covered $160 allowance	Up to $60 Copay 100% Covered $160 allowance
Frequency Exam Lenses Frames	12 months 12 months 24 months	

Employee Cost per Pay Period	
Employee Only	$4.48
Employee + Spouse	$9.03
Employee + Child(ren)	$10.34
Family	$16.48

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

LIFE and AD&D

Basic Life and AD&D

Term Life Insurance and Accidental Death and Dismemberment coverage is provided as a measure of protection to your beneficiaries in the event of your death.

Term Life Insurance

Benefit is paid by employer at a flat $25,000. Benefit reduced 50% at age 70.
If disabled before age 60, coverage will continue for the length of the disability, but not beyond the earlier of age 65, or the date of retirement. If disabled after age 60, but before age 65, coverage may continue for up to one year, but not past the earlier of age 65, or the date of retirement.

Accidental Death and Dismemberment

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

Accelerated Death Benefit

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

Option to buy Dependent Life/Spouse

Spouse: $4,000
Child: $2,000

Voluntary Term Life and AD&D

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

Employee

- Coverage is available in $10,000 increments
- Minimum coverage: $10,000
- Maximum coverage: $150,000
- Guarantee issue: $150,000
- Benefits reduce to 50% at age 70

Spouse

- Dependent coverage is only available if the employee is insured for Voluntary Coverage.
- Coverage is available in $5,000 increments (rounded to the next higher $5,000); not to exceed 50% of the employee's elected benefit amount;
- Minimum coverage: $5,000
- Maximum coverage: $75,000
- Guarantee issue: $75,000

Child

- Dependent coverage is only available if the employee is insured for Voluntary Coverage.
- Provides coverage for all dependent children up to age 26 in the following amounts: $5,000 or $10,000 (not to exceed 100% of employee amount).

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

UNDERSTANDING BENEFIT PAYMENT TAXATION

SUPPLEMENTAL HEALTH

Understanding the taxation of our supplemental health policies

A serious illness or injury could be a life-changing event. Sun Life offers Accident, Cancer, Critical Illness and Hospital Indemnity policies that can provide cash benefits to employees for these events.

It is important for employers and employees to understand the state and federal tax implications of benefit payments from an Accident, Cancer, Critical Illness or Hospital Indemnity Insurance policy.

The following content is provided as information only. Sun Life and its respective representatives cannot provide tax or legal advice. Employers and employees are encouraged to consult their own advisors regarding any tax or legal questions.

Federal taxation

Generally, the federal tax implication of these policies is as follows.

Premium paid using pre-tax dollars:

- If the **employee pays** the premium for this insurance with **pre-tax dollars**, the benefit payments are **taxable** at the federal level.
- If the **employer and the employee both contribute** to the payment of the premiums using **pre-tax dollars**, the proceeds from the benefit payments are **taxable** at the federal level.
- If the **employer pays 100%** of the premium for the employee for this insurance, the proceeds from the benefit payments are **taxable** at the federal level.

Premium paid using post-tax dollars:

- If the **employee pays** the premium for this insurance with **post-tax dollars**, the proceeds from the benefit payments are ***not* taxable** at the federal level.

Premium paid using a combination of pre- and post-tax dollars:

- If the **employee pays a portion of the premium** for this insurance with **post-tax dollars**, only the **portion attributable to the employer** contribution is **taxable** at the federal level. The three year lookback rule under Federal Treasury Regulation 1.105-1(d)(2) is used to determine the taxable percentage of the benefits payments.

This taxation applies to policies for the employee, the spouse, and the dependent child.

Sun Life uses the prior taxable/nontaxable rules to determine whether it will tax report the benefit payments to the IRS and the employee. The IRS requires insurance companies to issue a 1099 form for any taxable benefits paid of $600 or more per year. Receiving a 1099 does not always indicate a taxable event has occurred.

State taxation

Tax laws vary by state, and employees should consult a tax advisor for the tax implications for their state of residence.

Health Savings Accounts

Regarding Employees Covered or Considering Coverage under Health Savings Accounts (HSA) Established in Connection with High Deductible Health Plans (HDHP): Based on the limited available IRS regulatory guidance, Sun Life believes its Accident, Cancer, Critical Illness and Hospital Indemnity[1] policies are appropriate for use with an HSA and may be purchased when employees and/or their family members are covered under an HDHP. However, Sun Life cannot provide legal or tax advice. If there are legal or tax questions, we suggest that employees consult their own legal or tax advisor before purchasing this insurance.

DISABILITY

Sun Life Financial

Short-Term (STD) Archdiocese/Employer paid

What, Why, and When	Provides income protection in the event you become either totally or partially disabled as indicated by your attending physician.
Waiting Period	7 days
Weekly Benefit	67% of an insured person's weekly earnings
Maximum Benefit	$500 per week
Maximum Benefit Duration	12 Weeks
Maternity Leave	Covers maternity leave. Generally, benefit duration for normal delivery is 6 weeks and 8 weeks for cesarean.

Long-Term (LTD) Employer/Employee paid

What, Why, and When	Provides income protection in the event you become either totally or partially disabled as indicated by the attending physician.
Waiting Period	12 weeks of disability caused by accidental injury or sickness
Monthly Benefit	50% of insured person's monthly earnings
Maximum Benefit	$3,000 per month
Maximum Benefit Duration	Later of age 65 or Social Security Normal Retirement Age

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

St. John the Baptist, Kansas City, KS

VOLUNTARY ACCIDENT

Sun Life Financial

Health insurance covers medical expenses, but it doesn't usually cover indirect costs that can arise with a serious or even a not-so-serious injury. You may end up paying out of your own pocket for unexpected expenses like transportation, over-the-counter medication, childcare, and extra help around the house. With accident insurance, the benefits you receive can help take care of these extra expenses.

Coverage Highlights

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

Low Plan - Per Pay Period Premium	
Employee	$7.72
Employee + Spouse	$12.56
Employee + Children	$14.29
Family	$19.13

High Plan - Per Pay Period Premium	
Employee	$11.00
Employee + Spouse	$18.72
Employee + Children	$21.60
Family	$29.32

VOLUNTARY CRITICAL ILLNESS

Sun Life Financial

Helps protect you in the event that you are diagnosed with a critical illness. Provides a lump-sum benefit to help you cover out-of-pocket expenses. Some examples of a critical illness may include:

- Heart Attack
- Stroke
- Cancer
- Major Organ Transplant

Benefit Description:

- Coverage available in increments of $10,000 from $10,000-$40,000
- Guarantee issue coverage
- Spouse coverage available in increments of $10,000 from $10,000-$40,000 (not to exceed 100% of employee coverage)
- Child coverage available in $5,000 increments from $5,000-$20,000 (not to exceed 50% of employee coverage)
- Benefits are paid directly to you, unless assigned to someone else.
- Coverage supplements existing medical benefits and can help cover the costs of out-of-pocket expenses.
- Continuation of coverage beyond employment with continued premium payments.

Rates are available in the Paylocity Enterprise Benefit portal

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

VOLUNTARY HOSPITAL INDEMNITY

Sun Life Financial

Covers out-of-pocket expenses not covered by your medical plan while confined to a hospital. You have the option to purchase hospital indemnity insurance to help with unexpected costs such as child care, deductibles, and lost income.

Benefits	Plan 1
First day in the hospital (Regular bed)	$1,000
Hospital confinement (Up to 30 days)	$100/day
ICU confinement (Up to 10 days)	$100/day
Extended hospitalization	$100/day

Per Pay Period Rates	
Employee	$8.90
Employee + Spouse	$18.81
Employee + Children	$15.28
Family	$25.19

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

All Saints, Kansas City (St. Joseph)

EMPLOYEE ASSISTANCE PROGRAM

Sun Life Financial

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

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

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

Program Benefits:

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

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

WHEN TO USE YOUR EAP

STRESS, GRIEF OR LOSS

RELATIONSHIP AND FAMILY CHALLENGES

LEGAL OR FINANCIAL CHALLENGES

SUBSTANCE DEPENDENCE OR ADDICTION

This is a brief summary only. Certain restrictions and exclusions apply.
For exact terms and conditions, please refer to your summary plan description.

401(k) Retirement Savings Plan

The Archdiocese of Kansas City in Kansas knows how important it is to save for the future. That's why we are pleased to offer our employees a comprehensive program for building their retirement income through a 401(k) Savings Plan with matching employer contributions.

The Archdiocese works with Investing for Catholics (IFC) and Mutual of America (MOA), who have joined forces to meet the unique needs of Catholic organizations and their employees.

Together, IFC and MOA deliver retirement plans that provide MOA's robust recordkeeping, administration, participant communications, and education services, combined with IFC's fiduciary and investment selection and portfolio management services.

Eligible employees may invest in a traditional 401(k) plan, a Roth 401(k) plan, or both.

Eligibility

All regular full and part-time employees age 18 or older are eligible to participate in the plan and are immediately fully vested in the plan on the day they begin contributing. However, Priests, Archbishop, Vowed Religious Brothers and Sisters are excluded from the plan. These employees may be eligible for the Archdiocesan 403(b) Plan.

Contribution Limits

The plan allows employees to contribute up to the annual IRS maximum dollar limitation. During the 2022 calendar year, the IRS maximum limitation is $19,500. However, for participants who will reach age 50 on or before December 31, 2021, the dollar limitation is $26,000. Please note that the $6,500 of catch-up contributions is for participants 50 and over only.

Employer Contributions

Regular full-time employees working 30 hours or more per week are automatically enrolled with a 1% contribution. Employees are encouraged to make additional voluntary contributions.

Regular full-time employees are also eligible for employer matching contributions available at 50% of employee contribution- up to a maximum of 4% (match would equal 2%). Additionally, an employer-funded discretionary 2% will also be contributed to the employee's account.

Regular part-time employees working less than 30 hours per week may establish an account and make voluntary contributions. Employees in this category are not eligible for the employer match or the discretionary contributions.

The formula for the Matching Contribution is the lesser of:

- One half of your salary reduction contribution (Traditional and Roth) or
- % of your eligible compensation

Non-matching Contribution

- The plan also includes a discretionary non-match 2% employer contribution.

***Employees whose customary employment is less than 30 hours in any one week are excluded from the employer contributions.*

Traditional Contributions

The 401(k) Savings Plan allows you to save for retirement on a regular basis by contributing a portion of your salary to your 401(k) account before taxes are withheld. Any interest and investment earnings in your account grow tax-deferred until withdrawn.

RETIREMENT

Mutual of America Financial Group
Retirement Services • Investments

Designated Roth Contributions

The 401(k) Savings Plan also permits you to elect after tax Designated Roth Contributions. Since Designated Roth Contributions are included in taxable compensation in the year in which they are made, they are not subject to federal income tax upon withdrawal and the investment earnings on Designated Roth Contribution may also be tax free if the withdrawal is considered a "qualified distribution."

A "qualified distribution" is a distribution made:

(a) after a 5-year tax period that starts with the first tax year in which Designated Roth Contributions are made and

(b) to an eligible employee who is then age 59½ or older, or has become totally disabled, or to a beneficiary because an eligible employee has died.

Investment Options

IFC selects low-cost, globally diversified mutual funds screened to closely align with the USCCB investing guidelines. These funds serve as the underlying investment options and building blocks for IFC's prudent and professionally managed Catholic Values Target Date and Risk-based Portfolios. The Target Date Portfolio series serves as the default investment for the Archdiocesan retirement offering.

You can invest your 401(k) contributions in any of our managed portfolios or underlying mutual funds. These investment alternatives offer a mix of equity, interest, and fixed income investment options to suit a wide variety of risk tolerance levels and retirement savings objectives.

Rolling Over Outside Accounts

Our 401(k) Savings Plan allows you to rollover both Traditional Contributions and Designated Roth Contributions from a former employer's eligible retirement plan. An eligible retirement plan may be a 401(k).

Vesting

The value of your contributions to the plan and earnings are 100% vested immediately. The value of employer match contributions, discretionary contributions and generated earnings are also immediately vested at 100%. This means that all funds in your account are always 100% vested.

Accessing Your Account

You can log on to www.mutualofamerica.com whenever you like to review your account balances, transfer assets among the various interest and investment alternatives and change your asset allocations. The website also provides recent performance results for all funds as well as fund objectives to help you make investment choices that match your needs and goals.

Contacting Mutual of America

Mutual of America customer service: 1-800-441-0726 plan #98503k

Contacting Investing for Catholics

To learn more about the investments, or to speak with our plan investment advisor about your situation, please email Mary Brunson, Co-Founder and Vice President of Investing for Catholics, at mary@ifa.com, or call 949-428-0432.

Contact Information of Previous Archdiocese Plans:

Lincoln Financial Group
1-800-341-0441
Contract: #891526+006
Plan ID 2462
ER ID 2593-001

VOYA Investment Services
(formerly ING)
913-661-3755
Archdiocese Plan Billing Number VT5564

Frozen Lay Pension Plan
If you were employed full time before 01/01/2014 you may have a benefit when you end employment.
CBIZ: 866-715-7954

NOTICES

Notice of Special Enrollment Rights

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

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

Notice of Patient Protections

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

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

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Go to **archdiocesekck.millercares.com** for more information.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay in excess of 48 hours (or 96 hours).

HIPAA Privacy

Your employer is required by law to take reasonable steps to ensure the privacy and inform you about the uses of your protected health information (PHI). The use and disclosure of PHI is regulated by the federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A more complete description of your privacy rights and protections is available to you on request. Contact the Human Resources Department with any questions or to request a copy of the full HIPAA privacy notice.

NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916-440-5676

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/third-party-liability/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA - Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA - Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS - Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/Pages/index.aspx

LOUISIANA - Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740. TTY: Maine relay 711

MASSACHUSETTS - Medicaid AND CHIP
Website: www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA - Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

NOTICES

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA - Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS - Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH - Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT - Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid and CHIP
Website: www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

NOTICES - CONTINUATION COVERAGE RIGHTS

You are getting this notice because you recently gained coverage under a group health plan (the Plan). **This notice explains continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**

In general, continuation coverage can become available to you and other members of your family when group health coverage would otherwise end, such as when you leave an employer. You may also have other options available to you when you lose group health coverage, such as enrolling in another health plan. Some of those options - such as enrolling in coverage through the Health Insurance Marketplace or Medicare - may offer lower premiums than continuing your continuation coverage.

What is continuation coverage?

Continuation coverage is a continuation of Plan coverage when it would otherwise end because of changes in your life known as qualifying events (which are listed below). After a qualifying event, continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect continuation coverage must pay the premiums for it.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse or child of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- The employee dies;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than his or her gross misconduct;
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The employee becomes divorced or legally separated from his or her spouse.

In addition, dependent children will become qualified beneficiaries if they lose coverage due to a change in dependent status.

How is continuation coverage provided?

The Plan will offer continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Human Resources Department.

Once the Plan Administrator receives notice of a qualifying event, continuation coverage will be offered to all qualified beneficiaries, each of which will have an independent right to elect coverage. Covered employees may elect continuation coverage on behalf of their spouses, and parents may elect continuation coverage on behalf of their children.

How long can I stay on?

This is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. There are also ways in which this 18-month period of continuation coverage can be extended:

NOTICES

Disability extension of 18-month period of continuation coverage – If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be able to extend your coverage up to an additional 11 months, for a maximum of 29 months. The disability would have to have started before the 60th day of coverage and must last at least until the end of the 18-month period of coverage.

Second qualifying event extension – If your family experiences a second qualifying event during the 18 months of continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting coverage if: 1) the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated; or 2) if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides Continuation Coverage?

Yes. Instead of enrolling in continuation coverage, you and your family could get coverage through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP) or another group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan). You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect continuation coverage and later enroll in Medicare Part A or B before the coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the continuation election, continuation coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of continuation coverage.

If you are enrolled in both continuation coverage and Medicare, Medicare will generally pay first (primary payer) and continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If you have questions...

Questions concerning your Plan or your continuation coverage rights should be addressed to your Human Resources Department. For more information about your rights under the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa. For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CONTACTS

The Archdiocese of Kansas City in Kansas, in partnership with the following vendors, strives to meet your benefit needs. If you have any questions regarding your benefits, please visit:

https://www.archdiocesekck.millercares.com

or contact the corresponding vendor listed below. If you still have questions, please contact your onsite Benefits Administrator or the Human Resources office of the archdiocese.

Benefit	Vendor Name	Customer Service
Health Care Plan	Blue Cross Blue Shield	888-495-9340 MyHealthToolKitKC.com
Prescription Drug Benefits	OptumRx	855-524-0381 OptumRx.com
Medication Management	Tria Health	888-799-8742 triahealth.com
Cancer Care Advocacy	Alere Oncology Management	855-814-5077
Telemedicine	Teladoc	800-TELADOC (835-2362) teladoc.com
Dental Plan	Delta Dental of Kansas	800-234-3375/316-264-4511 deltadentalks.com
Vision Plan	VSP Eyemed	800-877-7195 vsp.com 844-225-3107 eyemed.com
Life and AD&D	Sun Life Financial	800-979-5128 usebglifeclaimsinbox@sunlife.com
Disability STD/LTD	Sun Life Financial	781-304-5599-STD 781-304-5537-LTD
Voluntary Tem Life and AD&D, Accident and Critical Illness Insurance	Sun Life Financial	888-551-2084
Voluntary Hospital Indemnity	Sun Life Financial	866-376-9480
Flexible Spending Accounts (FSA)	Paylocity	800-520-2687 batinfo@paylocity.com
Health Savings Accounts (HSA)	Paylocity	800-631-3539 batinfo@paylocity.com
Employee Assistance Program (EAP)	Sun Life Financial	877-595-5281 guidanceresources.com
401K/Retirement	Mutual of America	800-441-0726 / Plan #98503k
Archdiocese Human Resources		Maura Dodson mdodson@archkck.org 913-647-0362
Frozen Lay Person (frozen 12/31/2013)	CBIZ	866-715-1354 Local 913-345-0500 Ask for Archdiocese Pension rep

THE ARCHDIOCESE OF KANSAS CITY IN KANSAS

To see plan documents and view your benefits online, please visit archdiocesekck.millercares.com

PLAN ARRANGED BY:

The Robert E. Miller Group
(816) 333-3000
www.millercares.com