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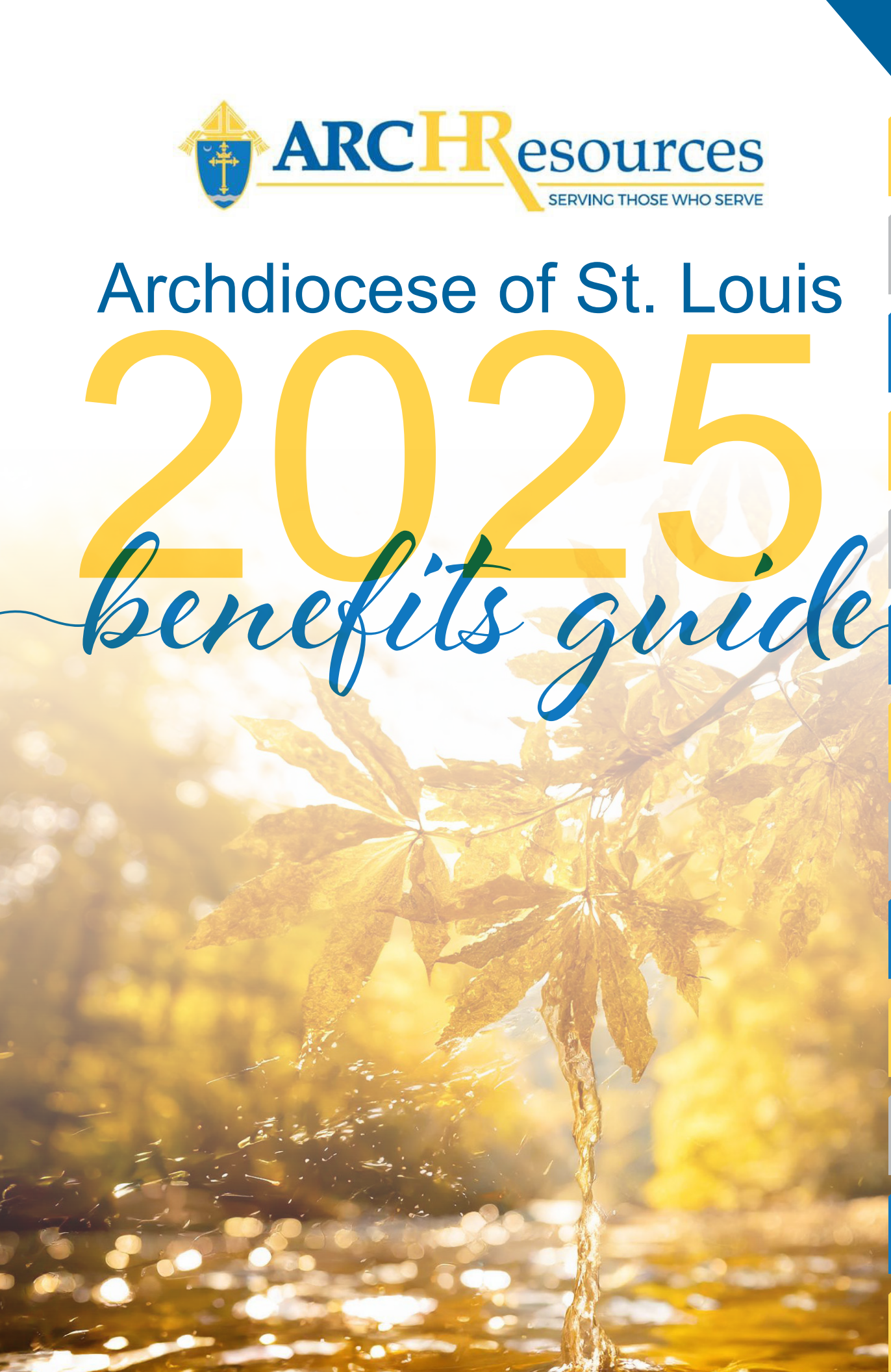
Archdiocese of St. Louis

2025 benefits guide



Quick Content Links

Our Mission Statement

As Catholics in the Archdiocese of St. Louis, in communion with the Bishop of Rome we are called by our Lord Jesus Christ to be His Church and live His Gospel.

With joy, we strive to fulfill our Baptismal calling by prayer and worship, teaching and sharing our faith, serving others, and fostering unity in diversity, guided by the Holy Spirit.

We commit ourselves to the responsible stewardship of all God’s gifts.

Archdiocese of St. Louis
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March 2025

Dear Coworker in the Lord's Vineyard,

As an important member of the Archdiocese of St. Louis, I value your personal development, your spiritual growth, as well as your physical and mental wellbeing.

The Archdiocese provides you with many employee benefits to assist with your wellbeing. As a benefit eligible employee, you are offered a quality health insurance plan, which consists of medical, prescription, dental, and vision benefits. You are also offered a retirement plan, flexible spending accounts, health savings account, long term disability, an employee assistance program, an adoption assistance program, employer-paid life and AD&D insurance, and supplemental life insurance. I am grateful for the faithful service of the Archdiocesan Benefits Committee for their work with the employee benefits plan.

The purpose of this Open Enrollment video is to further your understanding of the health insurance options and benefits available to you, along with informing you of the steps you must take during this Open Enrollment Period. It is important that you take time to review your annual choices and plan information.

The Archdiocese provides many preventative health services, including coverage for an annual physical exam, mammogram screenings, provider-paid health risk assessments, and annual flu vaccines. We promote the importance of having an annual physical/wellness exam with your personal physician. Also available to you is a health screening by a nurse with H & H Health Associates. Please see more information regarding your wellness benefits within this Open Enrollment video.

May God bless you, your family and your service to the Archdiocese of St. Louis.

Sincerely yours in Christ,

+ Mitchell T Rozanski

Most Reverend Mitchell T. Rozanski
Archbishop of St. Louis

Inside This Guide

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Open Enrollment and Benefits Changes

Welcome To Open Enrollment

This year, **Open Enrollment will be held April 14 through April 30.** Open Enrollment is an important time to review, and if necessary, make changes to your 2025-2026 benefits, which go into effect on July 1.

IMPORTANT: All benefit eligible employees must complete enrollment online, at ArchHR. If no action is taken, you will not be enrolled for benefits, regardless of any previous elections.

Health Insurance changes for plan year July 1, 2025 through June 30, 2026:

1. **Health Insurance Rates:** Your employee contributions for the health insurance plan are taken on a pre-tax basis. There is no after-tax option.
2. **Beginning July 1, 2025, two plan options will be available for the coming year.** The HDHP w/HSA will continue to be offered, but renamed the Base (HDHP w/HSA) Plan. The Standard and Premier plans will be replaced with a new option, named the Comprehensive (PPO) Plan. The benefits for the Comprehensive (PPO) Plan include an in-network deductible of $1,250/$2,500, out-of-network $2,500/$5,000; and an in-network out of pocket maximum at $5,000/$10,000, out-of-network $10,000/$20,000.
3. **An annual H&H Health Associates Wellness Screening** will continue to be offered to you. The $125 retirement plan incentive will continue to be offered for plan year May 1, 2025-April 30, 2026.
4. **Benefit Information:** All benefit information and materials, including educational Brainshark videos on Open Enrollment, FSA, and the Base (HDHP w/HSA) Plan, benefit summaries, plan documents, employee handbooks and annual notices can be found on the **Archdiocesan website**.

Different Plan Years For Activity	When
Medical/Dental/Vision Calendar Year Deductibles/maximum out-of-pockets	January 1 – December 31 (calendar year)
Medical and Dependent Care Flexible Spending Account Plan (FSA) with Tristar Claims grace period Deadline to submit claims	July 1 – June 30 (plan year) Until September 15 December 15
Wellness Plan Year	May 1 – April 30 (plan year)

Click here to review the Open Enrollment Brainshark video for more information

Questions

Please email any Benefits questions to **AskHR@archstl.org**.

During the April 14th through April 30th Open Enrollment period, you MUST go online through **ArchHR** and make elections. If no action is taken, your coverage for the upcoming 2025/2026 plan year will be waived. Log onto **ArchHR** to do any of the following:

- Change/enroll, add or waive health insurance coverage. Note: Federal law requires that we obtain documentation of any decision to waive coverage. Even if you waived coverage last year, you must go online to **ArchHR** and waive coverage again for the upcoming plan year.
- Elect the UnitedHealthcare medical plan option, either the Base (HDHP w/HSA) Plan or the Comprehensive (PPO) Plan.
- Add or drop dependents from coverage.
- If applicable, update your spousal surcharge fee or exemption. Review the Spousal Surcharge policy contained in this guide to determine if you qualify for an exemption.
- For those participating in the Comprehensive (PPO) Plan, you may elect to contribute to the Medical Flexible Spending Account. Medical FSAs require an active election each year. Your elections do not carry over from year to year.
- You may elect to contribute to the Dependent Care Flexible Spending Account, no matter if you enroll in the Base (HDHP w/HSA) or Comprehensive (PPO) Plan. Dependent Care FSAs require an active election each year. Your elections do not carry over from year to year.
- Any changes you make will be effective July 1st. You do not need to elect the prescription, dental or vision benefits, as those benefits are automatically included as part of your health insurance plan.
- Elect any HSA Contributions that you want to be payroll deducted, if applicable (only those who elect the Base (HDHP w/HSA) Plan).

Key dates to remember

What Happens	When
Open enrollment begins	April 14
Open enrollment ends	April 30
New benefit elections go into effect	July 1

Changing Coverage during the Year

Don't miss the opportunity to choose the best coverage for you and your family during the Open Enrollment period.

You will not have another chance to make changes to your health insurance coverage and flexible spending account until next year's Open Enrollment period, unless you experience a qualifying event.

Qualifying Events

Your benefit elections will stay in place until the next Open Enrollment period unless you have a "qualifying event" as defined by the IRS. You must log into **ArchHR**, navigate to Benefits and report your qualifying event and changes (QLE) that you need to make to your insurance coverage. Employees have 31 days from the date of the qualifying event date to make the change in **ArchHR**.

Examples of qualifying events are:

- Marriage
- Legal separation
- Divorce
- Birth or adoption of a child
- Change in eligibility of a child
- Death of a dependent
- Change in your/your spouse's employment status
- You or your spouse attains age 65 and is covered by Medicare

Eligibility and Enrollment

Who Is Eligible For Health Insurance Benefits

Please see the table below for your benefits eligibility.

Who Is Eligible For Benefits?	Health Insurance	Flexible Spending Account	Supplemental Life Insurance
Active employee working > 1,000 hours annually	✓	✓	✓
Educator with half-time or more contract	✓	✓	✓
Religious on Official Assignment (excluding Archdiocesan priests)	✓		
Kenrick Glennon Seminarian	✓		
Former Employees on Early Retiree or Continuation of Coverage Plan	✓		

Dependents

Your eligible dependents may include the following:

- Your opposite sex spouse to whom you are legally married as recognized by the laws of the Catholic Church. A spousal surcharge may be applicable if your spouse has available coverage through their employer plan. You will need to review and complete the spousal surcharge attestation. See page 15 of this guide for additional information on the spousal surcharge.
- Your child who is married or unmarried, without respect to student or dependency status, until the child's 26th birthday. **It is the responsibility of the employee/participant to monitor dependent's eligibility.**
- Your unmarried dependent child older than age 26 who is mentally or physically disabled and depends on you for support and care. (Approval from UnitedHealthcare required.)

Monthly Cost For Health Insurance Coverage

The table below shows your employee pre-tax cost and the Archdiocese's cost for your healthcare coverage, which includes medical, prescription drug, vision and dental coverage effective July 1.

Full-Time Employee

HEALTH INSURANCE PREMIUMS FOR FULL-TIME EMPLOYEES AND EDUCATORS			
Medical Plan	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
BASE (HDHP W/HSA) PLAN			
Employee Contribution	$31.00 (5%)	$342.00 (25%)	$463.00 (25%)
Employer Contribution	$589.00 (95%)	$1,028.00 (75%)	$1,388.00 (75%)
Total Monthly Premium	$620.00	$1,370.00	$1,851.00
COMPREHENSIVE (PPO) PLAN			
Employee Contribution	$123.00 (15%)	$455.00 (25%)	$614.00 (25%)
Employer Contribution	$700.00 (85%)	$1,363.00 (75%)	$1,843.00 (75%)
Total Monthly Premium	$823.00	$1,818.00	$2,457.00

Part-Time Employee

HEALTH INSURANCE PREMIUMS FOR PART-TIME EMPLOYEES AND EDUCATORS			
Medical Plan	**Employee Only**	**Employee + One Dependent**	**Employee + Family**
BASE (HDHP W/HSA) PLAN			
Employee Contribution	$248.00 (40%)	$685.00 (50%)	$925.00 (50%)
Employer Contribution	$372.00 (60%)	$685.00 (50%)	$926.00 (50%)
Total Monthly Premium	$620.00	$1,370.00	$1,851.00
COMPREHENSIVE (PPO) PLAN			
Employee Contribution	$329.00 (40%)	$909.00 (50%)	$1,228.00 (50%)
Employer Contribution	$494.00 (60%)	$909.00 (50%)	$1,229.00 (50%)
Total Monthly Premium	$823.00	$1,818.00	$2,457.00

*The percentages above display each payor's contribution to the total premium.

Spousal Surcharge Fee

	Employee Only	**Employee + One Dependent**	**Employee + Family**
Spousal Surcharge Fee	N/A	$200.00	$200.00

The $200 monthly spousal surcharge fee is an additional employee payroll deduction charge to cover a spouse who is eligible for subsidized health insurance through their own employer. Please refer to the Spousal Surcharge Policy found in this guide on Page15 for detailed information.

Medical, Dental and Vision Coverage

Administered by UnitedHealthcare, Delta Dental of MO and DeltaVision

Your health and the health of your family are of great importance to your well being. That is why the Archdiocese of St. Louis offers two UnitedHealthcare (UHC) medical plan choices designed to help you get the care you need. You can choose the Base (HDHP w/HSA) Plan, which has a higher deductible but lower premiums, or the Comprehensive (PPO) Plan, which offers enhanced coverage at a higher premium cost to you.

If you enroll in one of the UHC Plans or make a change to your current UHC Plan, you will receive a new ID card by the end of June. If you do not make any changes to your health insurance, you will not receive new ID cards.

When you enroll for a medical plan with UHC, you will automatically be enrolled in the dental and vision plans.

At-a-Glance Comparison of the Medical, Dental and Vision Plans

PLAN FEATURES	UNITEDHEALTHCARE MEDICAL PLAN – Group #703597			
	COMPREHENSIVE (PPO) PLAN[1]		BASE (HDHP w/ HSA) PLAN[1,2,3] (must meet eligibility)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Employees may choose one of the following UnitedHealthcare Plan Options – The costs outlined on this chart are the costs that are paid by the member. Meeting the deductible first is only applicable where stated				
Calendar Year Deductible (Individual/Family) Copayments do not apply to the deductible	$1,250 / $2,500	$2,500 / $5,000	$2,500 / $5,000	$5,000 / $10,000
Out-of-Pocket Maximum (Individual/Family) Out-of-Pocket maximum includes the deductible and copays	$5,000 / $10,000	$10,000 / $20,000	$5,000 / $9,000	$10,000 / $18,000
Embedded vs Non-Embedded Deductibles and Out-of-Pocket Maximums *Deductibles and Out-of-Pocket Maximums follow a calendar year of January 1st- December 31st.	Embedded, meaning; If more than one person in the family is covered, each person must meet the individual deductible amount stated above until the total amount of deductible expenses paid by all family members meets the overall family deductible. The embedded out-of-pocket maximum amounts will work the same way.		Non-Embedded, meaning: If more than one person in the family is covered, no one in the family is eligible for benefits until the family deductible is satisfied, and the family coverage Out-of-Pocket Maximum stated above applies.	
Coinsurance	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
Office Visits	$30 copay per visit	40%, after deductible	20%, after deductible	40%, after deductible
Hospital Inpatient Stay	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
Outpatient Surgery	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
Outpatient Diagnostic (lab, x-ray, mammography)	No Charge	40%, after deductible	20%, after deductible	40%, after deductible
Emergency Room	$150 copay per visit	$150 copay per visit	20%, after deductible	20%, after deductible
Urgent Care	$50 copay per visit	40%, after deductible	20%, after deductible	20%, after deductible
Vision Examinations (1 exam per calendar year)	$30 copayment	40%, after deductible	20%, after deductible	40%, after deductible
PRESCRIPTION BENEFITS	Pharmacy Retail	Mail Order	Pharmacy Retail	Mail Order
Copays: Tier 1 / Tier 2 / Tier 3	$10 / $35 / $50	$20 / $70 / $100	$10 / $35 / $50 after deductible	$20 / $70 / $100 after deductible
Maximum Supply	30 Days	90 Days	30 Days	90 Days

1 All covered active employees in any of the UnitedHealthcare Plans automatically receive the Delta Dental and the DeltaVision plan benefits.

2 Base (HDHP w/HSA) Plan (HDHP w/HSA) option includes an annual employer contribution to your HSA of either $600 for individual or $1,200 for family coverage (prorated for mid-year enrollments).

3 Participants are expected to follow all Catholic directives when using HSA funds for qualified expenses.

4 Base (HDHP w/HSA) Plan (HDHP w/HSA) includes an Expanded Preventive Drug List, whereby medications on the list may be covered at the applicable copay only, no deductible applies. Please be sure to call UHC at the number on your ID Card to inquire about your prescription drug costs before filling a prescription.

PLAN FEATURES Group #1873-1000	DELTA DENTAL PLAN (automatically enrolled if medical coverage elected)	
Annual Deductible (Individual / Family) Paid by member	$50 / $100	
	PPO Network	**Premier and Non-Network**
Preventative Care (Covered in Full by Delta – Deductible Waived)	100%	100%
Basic Care Paid by Delta	90%	80%
Major Care Paid by Delta	60%	50%
Orthodontia (Children to Age 19 – $2,000 Lifetime Maximum) Paid by Delta	50%	50%
Calendar Year Maximum (Individual / Family) Paid by Member	$2,000 per individual	

PLAN FEATURES Group #20070020	DELTAVISION PLAN (automatically enrolled if medical coverage elected)	
Copays are paid by members. Allowances are amounts that Delta pays towards the cost of materials and anything over that allowance is the member's responsibility (except where stated). For Out-of- Network, reimbursements are amounts that Delta will pay back to members when a member submits a claim.		
	IN-NETWORK	**OUT-OF-NETWORK**
Eye Exam (every 12 months)	$10 copay	Reimbursed up to $40
Eyeglass Lenses (every 12 months) Single/Bifocal/Trifocal	$25 copay	Reimbursed up to $20/$40/$60
Eyeglass Frames (every 24 months)	$150 retail allowance + 20% of costs in excess of allowance	Reimbursed up to $60
Contact Lenses in lieu of eyeglass lenses and frames (every 12 months)	$150 retail allowance after $25 copay	Reimbursed up to $90

The above exhibit attempts to highlight the major provisions of the Employee Benefit Plans. Additional benefits will be found in the respective plan documents. In all cases, the Plan Document or Policy will serve as the legal basis for the terms and provisions of coverage. This document is for illustration purposes only.

For a detailed summary of the plans, including limitations and exclusions, please read the Summary of Benefits located on the **Archdiocesan website**, along with, FAQs, SBCs, drug formulary, and other helpful information.

See eligibility requirements for participation in the Base (HDHP w/HSA) Plan following the Medical, Dental and Vision summaries.

Calendar Year Deductibles, Out-of-Pockets, and Maximums

The UHC Medical, Delta Dental and DeltaVision plans follow a The Medical, Dental and Vision deductibles, out-of-pocket maximums and benefit maximums run on a calendar year.

Medical Coverage

Transfer of Plan Deductibles and Out-of-Pocket Maximums

UnitedHealthcare (UHC) will transfer any amounts you have paid during the current calendar year, since January 1, under your current Archdiocesan UHC plan deductibles and out-of-pocket maximums to your newly selected UHC Base (HDHP w/HSA) or Comprehensive (PPO) plan effective July 1, if you switch between the two Archdiocesan plans. These credits will be applied to your newly selected deductibles and maximum out-of- pockets with UHC.

There are no transfers of deductibles or out-of-pocket maximums into our UHC plan from another employer's health insurance plan (such as a former spouse's plan).

How to Find a UHC Physician

Follow these steps to find a UHC physician, specialist or hospital:

1. Go to **www.uhc.com**.
2. Click on Find a Doctor in the top menu bar, and either sign in or search as a guest. Follow the prompts and please note that the Archdiocesan UHC plan utilizes the "Choice Plus" plan.
3. Continue to follow the prompts to access the information or doctors you are most interested in searching. Please call UHC customer service at **833.748.2404**, if you need assistance. The preferred and more accurate method is to ask your doctor/hospital if they are in-network with UnitedHealthcare Choice Plus.

Healthier habits, healthier lifestyle

Take small steps for lasting change with Real Appeal®, an online weight management support program.

Get healthier, at no additional cost to you

Real Appeal on Rally Coach™ is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your benefits.

Take small steps toward healthier habits

Set achievable nutrition, exercise and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and community along the way

Feel supported with personalized messages, online group sessions led by coaches and a caring community of members.

Get a Success Kit delivered right to your door.

Make the most of tools and resources like weight and food scales, a portion plate and more. Your Success Kit is delivered after you attend your first live group session.

Join today at enroll.realappeal.com or scan this code

United Healthcare | Real Appeal®

Real Appeal is a voluntary weight loss program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Visit with a provider 24/7 — whenever, wherever

With 24/7 Virtual Visits, you can connect to a provider by phone or video[1] through **myuhc.com**® or the UnitedHealthcare® app.

Another way to get care

Providers can treat a wide range of health conditions—including many of the same conditions as an emergency room (ER) or urgent care—and may even prescribe medications,[2] if needed. **With a UnitedHealthcare plan, your cost for a 24/7 Virtual Visit is usually $54 or less.[3]**

Consider 24/7 Virtual Visits for these common conditions and more

- Cough
- Headache
- Sore throat
- Fatigue/weakness
- Nasal discharge
- Difficulty sleeping
- Congestion/sinus pain
- Fever
- Loss of appetite

$54 or less

An estimated 25% of ER visits could be treated with a 24/7 Virtual Visit—bringing a potential $ 2,000[4] cost down to $54 or less

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-866-801-4409**
Download the UnitedHealthcare app

United Healthcare®

1. Data rates may apply.
2. Certain prescriptions may not be available, and other restrictions may apply.
3. The Designated Virtual Visit Provider's reduced rate for a 24/7 Virtual Visit is subject to change.
4. Average allowed amounts charged by UnitedHealthcare Network Providers are not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. Estimated Urgent Care savings are based on $131 difference between average Urgent Care visit cost of $180 and Virtual Visit cost of $54; $2,000.00 difference between the average Emergency Room visit and the average urgent care visit. The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

24/7 Virtual Visits is a service available with a Designated Virtual Network Provider via video, or audio-only where permitted under state law. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. 24/7 Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

Stressed? Anxious? With virtual therapy, getting help may now be easier than ever.

Reaching out may be hard—especially if you might not want anyone to know you're hurting. From the privacy of home and the convenience of your mobile device* or computer, you can receive caring support from a licensed therapist.

Virtual therapy offers confidential counseling and includes:

Private video sessions
Get 1-on-1 support—in your home and at a time that's convenient for you.

Help with coping—for children, teens and adults
Your licensed therapist may provide a diagnosis, treatment and medication if needed.

Similar standard of care as in-person visits
You can see the same therapist with each appointment and establish an ongoing relationship.

Virtual therapy is designed to help treat conditions like:

- ADD/ADHD
- Addiction
- Anxiety
- Depression
- Mental health disorders

A quicker way for the whole family to get care

A virtual visit for mental health care may be a great way for children and teens to get an appointment.

To find a provider and schedule a visit

Sign in or register on **myuhc.com®**. Then, go to **Find Care & Costs > Virtual Care > Behavioral Health Care > Get Started** and call the provider to set up an appointment. Or call the telephone number on your health plan ID card.

*Data rates may apply.

Costs and coverage may vary. Check your plan for details.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.

United Healthcare

Spousal Surcharge Policy

Employees will pay a spousal surcharge to cover a spouse who is eligible for health insurance coverage through their own employer.

The spousal surcharge is an added charge of $200 per month to the usual employee contribution for health insurance. Spousal surcharges are common among employers and assist in managing health plan costs. The Archdiocese Employee Benefit Plan is self-insured and helps pay the cost of each member's healthcare coverage and actual claims. If the employee's spouse moves to his or her employer's plan, it places the costs of those claims with the spouse's employer, thus saving the Archdiocese the cost of those claims. The Archdiocese establishes its premiums based on the actual cost of the claims.

Please note the following instructions:

It is mandatory to elect your appropriate spousal surcharge fee or exemption status. Please do so by logging into **ArchHR** and completing the attestation form if applicable.

Below are exemptions to the spousal surcharge:

- My spouse is not employed.
- My spouse is self-employed, without employer- subsidized health insurance coverage, and is not eligible for employer-subsidized health insurance.
- My spouse is employed with an Archdiocese of St. Louis parish, agency, or school.
- My spouse is employed and is not eligible for his or her employer's health insurance coverage.
- My spouse is employed and my spouse's employer does not offer health insurance coverage.
- My spouse is employed and is eligible for his or her health insurance coverage but the full premium cost is paid by the employee. There is NO employer contribution toward the cost of the health insurance.

To assist in understanding the spousal surcharge fee, please read the Spousal Surcharge Frequently Asked Questions located within this guide.

Dental Coverage

Administered by Delta Dental of Missouri

Our dental plan, provided through Delta Dental of Missouri, is designed to help you maintain a healthy smile through regular preventive dental care, and to fix any problems as soon as they occur.

There are no changes to the Archdiocese dental plan coverage. You are automatically provided with dental coverage, if you are enrolled in the UHC Base (HDHP w/ HSA) or Comprehensive (PPO) medical plan through the Archdiocese of St. Louis. Dental only coverage, without the medical plan, is not available.

Dental Benefits with Delta Dental of Missouri

The Archdiocese has two networks, the Delta Dental Premier network and the Delta Dental PPO network. If you choose to see a Delta Dental PPO dentist, you will save money and stretch your benefits. The Delta Dental PPO network gives you 10% more benefits for Basic and Major services.

You and your eligible dependents have the freedom to choose any dentist. Benefits will be based upon your provider and services. **You do not enroll in the PPO Network or Premier Network.** For example, you may be a patient of a PPO network provider and your dependent may be a patient of a Premier network provider. You are able to change a dentist at any time.

Providers have the ability to join and drop Delta's network, so please be sure to determine if your provider participates in the Delta Dental PPO or Premier Network by either:

- Visiting the Delta Dental website at **www.deltadentalmo.com** and clicking on Find a Provider and then Find a Dentist on the home page and then complete the fields requested.
- Calling Delta Dental's customer service at: **800.335.8266** or calling your dentist's office to see if they are participating in Delta Dental's PPO or Premier Network.

Delta Dental Deductibles and Maximums

Deductibles and maximums run on a calendar year.

You will receive a Delta Dental ID card, only if you enroll in the health insurance as a new enrollee or add dependents, effective July 1. When you receive dental care from a Delta Dental participating dentist, simply present your card and the dentist's office will file the claim for you.

For more benefit details, read the Delta Dental Benefits Summary on the **Archdiocesan website**.

Features Delta Dental Plan		
	PPO Network	Premier Network and Non-Network
A: Preventive Services	100%	100%
B: Basic Routine & Restorative Services	90%	80%
C: Major Services	60%	50%
D: Orthodontics for children up to age 19	50%	50%
Annual Deductible (does not apply to A or D benefits)	$50 Individual / $100 Family	
Maximum Benefit per Year (excluding Ortho)	$2,000 per person	
Ortho Lifetime Maximum (per dependent child)	$2,000	

ARCHDIOCESE OF ST. LOUIS
Group #: 1873 Effective Date: 7/1/25

The dentist you choose can affect your out-of-pocket costs. **To save the most money, visit a dentist in the Delta Dental PPO[SM] Network.**

(The examples to the right illustrate your out-of-pocket costs and savings when receiving sample basic services, such as fillings and simple extractions, based on the corresponding fees and coverage.)

Delta Dental PPO[SM] Network Dentist	
Billed Charge	$495
PPO Allowed Fee	$248
Plan Pays 90% of PPO Fee	-$223
You Pay	$25

Delta Dental Premier® Network Dentist	
Billed Charge	$495
Premier Allowed Fee	$435
Plan Pays 80% of Premier Fee	-$348
You Pay	$87

Out-of-Network Dentist	
Billed Charge	$495
Maximum Plan Allowed (MPA)	$474
Plan Pays 80% of MPA	-$379
You Pay	$116

Benefit Highlights	Delta Dental PPO[SM] Network	Delta Dental Premier® Network	Out of Network
	Based on applicable PPO Maximum Allowable Charge. **Cannot bill more than allowed PPO fee.**	Based on applicable Premier Maximum Allowable Charge. **Cannot bill more than allowed Premier fee.**	Based on applicable Plan Maximum Allowable Charge. **Will bill difference between allowed MPA fee and billed charge.**
Diagnostic and Preventive Services (NO DEDUCTIBLE) • Prophylaxis (cleaning) and oral examinations • Fluoride applications, limited to age 19 • X-rays	**100%**	**100%**	**100%**
Basic Services • Emergency examinations, including treatment for pain • Amalgam fillings • Composites on anterior (front) teeth • Simple extractions • Oral surgery – not covered under the patient's medical plan • Endodontics, including root canal therapy • Periodontics • Crowns • Space maintainers for children to age 23 • Sealants for dependent children under age 19	**90%**	**80%**	**80%**
Major Services • Partial or full removable dentures • Fixed or removable bridgework (including inlays and crowns as abutments) • Dentures • Implants, including bone grafts	**60%**	**50%**	**50%**
Orthodontic Services • For dependent children to age 19 • Lifetime Maximum = $2,000	**50%**	**50%**	**50%**
Calendar Year Deductible (applies to Basic and Major Services only)	**$50 individual $100 family limit**		
Calendar Year Benefit Maximum	**$2,000 per person**		
Dependent Age Limit: 26th birthday			

Eligible dependents may include a spouse and children from birth to the date they reach age 26.

*A new deductible and benefit maximum (not including orthodontia) begins on January 1 of each year. Eligible dependents may include a spouse and children from birth to the date they reach age 26. Please refer to the summary plan descriptions for benefits details, exclusions, limitations and frequency limitations.

DELTA DENTAL

Services Not Covered

- Services for which the participant, absent this coverage, would normally incur no charge.
- Services for which coverage is available under Workers' Compensation or Employers' Liability Laws.
- Services performed for cosmetic purposes or to correct congenital malformations.
- Charges for multiple visit services, which commenced prior to the membership effective date (including, but not limited to, prosthetics and orthodontic care). This is referred to as "treatment in progress."
- Services related to Temporomandibular Joint (TMJ) Dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws), or services for Myofascial Pain Dysfunction (MPD).
- Any services not specifically stated as Covered Services (including hospital or prescription drug charges).
- Replacement of dentures and other dental appliances, which are lost or stolen.
- Services rendered by a dentist beyond the scope of his license.
- Hypnosis.
- Duplicate services provided by another group dental plan.
- Diseases contracted or injuries or conditions sustained as a result of any act of war.
- Denture adjustments for the first six months after the dentures are initially received. **Separate fees may not be charged by participating dentists.**
- Charges for complete occlusal adjustments, crowns for occlusal correction, night guards, bruxism appliances and bite therapy appliances.
- Tooth preparation, temporary crowns, bases, impressions and anesthesia or other services, which are part of the complete dental procedure are considered components of, and included in the fee for, the complete procedure. **Separate fees may not be charged by participating dentists.**
- Analgesia, including nitrous oxide.
- Charges covered under a terminal liability or similar provision of a program being replaced by this program.
- Services rendered by a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- Services provided or paid for by any governmental agency or under any governmental program or law, except charges, which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act and its Amendments).
- Charges for duplication of radiographs.
- Charges for temporary appliances.
- Charges for experimental or investigational services or supplies.
- Services rendered by a member of your immediate family or the immediate family of your spouse.

This document provides a summary of benefits, limitations and exclusions. Complete details are included in the Plan Document maintained by the Archdiocese of St. Louis. If this Benefit Summary conflicts in any way with the Plan Document, the Plan Document shall prevail. The Plan Document is available on the Archdiocese of St. Louis benefits website at www.archstl.org/hrbenefits.

Vision Coverage

Administered by DeltaVision

You are automatically provided the DeltaVision plan, if you are enrolled in the UHC Base (HDHP w/HSA) or Comprehensive (PPO) medical plan through the Archdiocese of St. Louis. Vision only coverage, without the medical plan, is not an available option.

DeltaVision is a smart, affordable way for you to keep an eye on your vision — and your overall health. As a DeltaVision member, you will have access to the EyeMed Insight network, one of the largest and most diverse provider networks in the nation.

More Eye Care Providers: The EyeMed Insight network has 115,000+ provider access points at 26,000 locations nationwide. In Missouri, there are 3,725 providers at 593 locations. Staying in-network can also mean using online vision providers such as Lenscrafters.com, Targetoptical.com, Ray-ban.com, Glasses.com and Contactsdirect.com.

The Choice is Always Yours: Visit **DeltaDentalMO.com/vision** to find a provider near you.

For additional information, see Vision FAQ at the end of this guide or visit the **Archdiocesan website**.

Coverage	In-Network	Out-Of-Network[1]
Exams	$10 copay	$10 copay
Comprehensive Eye Examination (with dilation)	Covered in full after copay	Reimbursed up to $40
Retinal imaging	Up to $39	Not covered
Contact Lens Fit & Follow-up	$40 allowance (copay does not apply)	Not covered
Materials	$25 copay	$25 copay
EYEGLASSES[2] (in lieu of contact lenses)		
Standard Plastic CR-39 Lenses		
• Single	Covered in full after $25 copay	Reimbursed up to $20
• Bifocal		Reimbursed up to $40
• Trifocal		Reimbursed up to $60
• Lenticular		Reimbursed up to $100
Standard Frames	$150 retail allowance	Reimbursed up to $60
CONTACT LENSES[3] (in lieu of eyeglass lenses and frames)		
Elective Contact Lenses	$150 retail allowance after $25 copay	Reimbursed up to $90
Medically Necessary Contact Lenses[4]	$250 retail allowance after $25 copay	Reimbursed up to $250
LENS UPGRADES Available when you use your eyeglass lens benefit		
Polycarbonate Lenses (members age 19 and under)	Covered in full (copay does not apply)	Not covered
Standard Progressive Lenses	Additional $50 copay	Not covered
Photochromic Lenses	Additional $60 copay	Not covered

1. For out-of-network services, you will be reimbursed up to the amount shown, less your copay.
2. A single materials copay applies to standard lenses and frames when purchased together.
3. This benefit is paid only once per calendar year and must be fully utilized at the time of purchase.
4. Only available for conditions of aphakia, keratoconus, or severe anisometropia.

Benefit Frequency	
Eye Exam	Every 12 months
Eyeglass Lenses	Every 12 months
Eyeglass Frames	Every 24 months
Contact Lenses	Every 12 months

DeltaVision Value Discounts

Covered members can take advantage of discounted services and materials at participating discount provider locations.
Polycarbonate Lenses* (members over age 19): $40
Frames: 20% off amount over allowance
Laser Vision Correction: Member discounts up to 15%

*Only applies to single vision lenses. The discount features are not insurance and may be subject to change without notice. Not all providers participate in DeltaVision Value Discounts. Call your provider or visit our website to confirm if they offer discounts.

Refer to your certificate of coverage for full coverage details, limitations and exclusions. For a copy of your Certificate of Coverage, consult your plan administrator or go to the **Archdiocesan website** and click on the Vision Plan.

DeltaVision®

Archdiocese of St. Louis (Effective 1/1/2022)

Vision benefits summary

Vision care services	In-network member cost	Out-of-network member reimbursement
Exam services		
Exam with dilation as necessary	$10 copay	Up to $40
Retinal imaging	Up to $39	Not covered
Contact lens fit and follow-up		
Fit and Follow-up Standard	$40 allowance	Not covered
Fit and Follow-up Premium	10% off retail price less $40 allowance	Not covered
Frames		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $60
Lenses		
Single vision	$25 copay	Up to $20
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $60
Lenticular	$25 copay	Up to $100
Progressive - Standard	$75 copay	Up to $40
Progressive - Premium tier 1/2/3	$110/$120/$135 copay	Up to $40
Progressive - Premium tier 4	$90 copay; 20% off retail price less $120 allowance	Up to $40
Lens options		
Photochromic - Non-glass	$60 copay	Not covered
Polycarbonate - Std – Children under 20	$0 copay	Not covered
Polycarbonate - Standard	$40	Not covered
Anti reflective coating - Standard	$45	Not covered
Anti reflective coating - Premium tier 1/2/3	$57/$68/80% of charge	Not covered
Scratch coating - Standard plastic	$15	Not covered
Tint - Solid or gradient	$15	Not covered
UV treatment	$15	Not covered
All other lens options	20% off retail price	Not covered
Contact lenses		
Contacts - Conventional	$25 copay; 15% off balance over $150 allowance	Up to $90
Contacts - Disposable	$25 copay; plus balance over $150 allowance	Up to $90
Contacts - Medically necessary	$25 copay; $250 allowance	Up to $250
Other		
Hearing Care from Amplifon NetworkCare	Discounts on hearing aids; call 1.877.203.0675	Not covered
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

Frequencies (Plan allows member to receive either contacts and frame, or frames and lens services)

Exam	Once every calendar year
Frame	Once every other calendar year
Lenses	Once every calendar year
Contacts	Once every calendar year

Dependents are covered up to age 26.

Where allowances are shown you are responsible for all charges in excess the allowance in addition to the applicable copay. Allowances are paid only once during the benefit period and must be fully utilized at time of purchase. Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Benefits for Medically Necessary Contact Lenses are limited to conditions of aphakia, keratoconus or severe anisometropia. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. The percentage discounts and flat dollar fixed pricing for certain lens options and retinal imaging are discount features, not insured benefits, and may be subject to change. You are responsible for paying the cost of such items directly to the provider. For out of network benefits you are responsible for paying the provider in full at the time of service and submitting a request for reimbursement.

Member benefits are just the beginning

Additional valuable savings for vision plan members

With a DeltaVision plan, we offer exclusive, members-only special offers on vision-related products and services that members can use above and beyond their vision benefit. It's one way we can help them keep their eyes healthy and save some cash too.

DELTA DENTAL® 877-226-1412 DeltaDentalMO.com @DeltaDentalMO /DeltaDentalMO

DVMO-210723-1187-150D

Save 40% on additional pairs of glasses	Save 20% on any remaining frame balance	Save 20% on any item not covered by the plan	Save 15% on any balance over the conventional contact lens allowance	Save 15% on LASIK	Save up to 64% off retail price on thousands of hearing aids from top brands*

*These discounts are not insured benefits and are available from in-network providers only. *Average savings based on Amplifon Hearing Health Care average member savings data for 2020.*

Important to remember

Here are some tips to help you get the most out of your DeltaVision benefits:

- When the benefit includes an allowance, you are responsible for charges over that allowance in addition to the applicable copay.
- When you visit an in-network provider, you are responsible for your exam copay at the time of your visit and any applicable materials copay(s) at the time of your purchase.
- If you use an out-of-network provider, you must pay the full cost of the services provided at the time they are received. Submit your claim to DeltaVision within 12 months of the date of service for reimbursement. You will be reimbursed the lesser of the provider's charge or the amount shown.
- Exam and material frequencies will restart at the beginning of each calendar year.

The choice is always yours

The Insight vision network gives you choices — lots of them. Be it an independent eye doctor, popular retailer or online option, with the Insight network you get the latest in advanced vision technology to see even the slightest vision issue. And with more providers across more locations, you're free to see the one who fits your needs the best.

Independent providers

The Insight network makes it easy to find a trusted neighborhood eye doctor.

Retail providers

With options including LensCrafters®, Pearle Vision®, Target Optical® and many other favorite regional retailers, you can pick the location and hours that work for you.

Shop online

Staying in-network can also mean using your vision benefits online at:

- Lenscrafters.com
- Targetoptical.com
- Ray-ban.com
- Glasses.com
- Contactsdirect.com

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

We are here to help

With DeltaVision, our goal is to make vision benefits simple. Not only do you have access to an award-winning call center, with extended hours, you also have 24/7 access to benefit information and our Provider Locator through our member portal. Our vision portal at DeltaDentalMO.com/Vision is your one-stop-spot to quickly and easily manage your vision benefit. There, you can:

- View benefit details
- Confirm eligibility
- Check claim status
- Print a replacement ID card
- Locate an in-network provider
- Schedule an appointment online
- Get health and wellness information
- Access currently available special offers for members-only savings!

Visit **DeltaDentalMO.com/Vision** or call **(877) 226-1412** to learn more.

Health Savings Account (HSA)

Provided by Optum Bank (available to those who enroll in the Base (HDHP w/HSA) Plan)

What is an HSA?

An HSA (Health Savings Account) is a tax-free account, owned by you, used to pay for current and future qualified medical expenses (even medical expenses during retirement). It is paired with a High Deductible Health Plan (Base (HDHP w/HSA) Plan) in order to help pay for those initial expenses such as the higher deductible. An HSA has triple tax benefits:

1. The money goes in tax-free
2. The money grows tax-free
3. Your withdrawals for qualified medical expenses – including any earnings – are tax-free.

Who's Eligible?

The HSA is available only if you enroll in the Base (HDHP w/HSA) Plan. You're eligible to elect the Base (HDHP w/HSA) Plan and contribute to an HSA as long as:

- Your only coverage is a qualified high deductible health plan (such as the Base (HDHP w/HSA) Plan).
- You have not signed up for or enrolled in any part of Medicare, Medicaid, Indian Health Services, or TriCare coverage.
- You do not have an HRA.
- You or your spouse do not have a Healthcare FSA.
- You are not eligible to be claimed as a dependent on another's tax return.

Will You Be Enrolling in Medicare Soon?

HSA Contributions should end before you enroll in Medicare. For more information on what happens with your HSA as you retire and consider enrolling in Medicare, see the HSA FAQ.

Click here to review the Base (HDHP w/HSA) Plan Brainshark video for more information on an HSA

Opening Your HSA Account

Once you elect to enroll in the Base (HDHP w/HSA) Plan, Optum Bank will usually be able to complete the process without any action required from you. However, in the rare occasion that Optum Bank requires your assistance, they will send a notification of the documentation needed. Once your account has been established, Optum Bank will mail you an HSA Welcome Kit that contains your HSA debit card, and information regarding registering your HSA and activating your card.

Contributions to the HSA

The Archdiocese of St. Louis will contribute an annual employer contribution into every opened HSA of those who elect the Base (HDHP w/HSA) Plan. The contribution amount is $600 for employee only and $1,200 for all other tiers. The employer contributions are paid over 24 payrolls during the year and are prorated depending on your effective date for coverage under the Base (HDHP w/HSA) Plan.

Along with the employer contribution into your HSA, you will also have the opportunity to elect to make additional contributions into your HSA through payroll deductions. Below are the maximum contribution limits set forth by the IRS. The maximum contribution limits include all contributions made into your HSA, including any contributions made by your employer.

2025 Annual Maximum Contribution Limits		
Coverage Level	**IRS Maximum Contribution Limit**	**Archdiocesan Employer Contribution**
Single	$4,300	$600
Family	$8,550	$1,200
Age 55+ Additional Catch-Up	$1,000	*Employer Contributions count towards the total IRS maximum contribution limits

*Be sure to review the eligibility requirements in order to elect the Base (HDHP w/HSA) Plan and establish an HSA.

403(B) Retirement Plan

Administered by Empower

You may save for your future retirement by making voluntary contributions to a 403(b) and/or Roth option retirement account at any time. The retirement plan offers several investment choices. The record keeper for the Archdiocese is Empower.

As a new hire, to make voluntary salary deferral contributions, wait until after your second pay deposit, then contact Empower at **866.467.7756** or online at website: **http://empowermyretirement.com**.

If you previously worked for the Archdiocese, you may already have an existing account. If not, register for your online account access at **http://empowermyretirement.com** then click on Register and complete the account verification information/process.

Please note: Beneficiary designations made to your Basic Life/AD&D Insurance do not apply to your retirement plan, so be sure to elect a beneficiary specifically for your retirement plan.

Please feel free to contact our dedicated Gallagher Retirement Consultants for any questions.
Sharon Gogel | **314.792.7261** | **Sharon_Gogel@ajg.com**

After one-year of service and completion of 1,000 hours or more from date of hire, your employer will make a 5% contribution into your retirement account each pay period. **If you previously worked for the Archdiocese, and were receiving an employer contribution, please notify your benefits administrator immediately to ensure proper set up of your employer 5% contribution.**

Retirement planning and financial wellness information and educational webinars are updated regularly and available for your reference and viewing on the **Archdiocesan Retirement Plan** page.

Employee Assistance Program

Provided by Saint Louis Counseling

The Employee Assistance Program (EAP) is provided at no cost to you through Saint Louis Counseling. This program provides up to 10 confidential, professional counseling sessions, for family problems, parenting issues, marital relationship conflicts and emotional concerns. It is available to you, your spouse, and any dependent children.

Toll-free confidential phone number: 314.544.3800
National Suicide Prevention Lifeline (24 hours, confidential): 800.273.8255

Adoption Assistance Program

Provided by Good Shepherd Children and Family Services

The Adoption Assistance Program provides up to $4,000 for Full-Time Employees and $2,000 for Part-Time Employees in financial assistance, and up to twenty days of paid leave from work if you adopt an eligible child through Good Shepherd Children and Family Services, a member of Catholic Charities of St. Louis.

Basic Life/AD&D Insurance

Administered by The Hartford

You are automatically enrolled in the Hartford Basic Life and Accidental Death and Dismemberment (AD&D) coverage (effective date of hire), in the amount of one times your basic annual earnings. This benefit is at no cost to you, as it is an employer-paid benefit. **You must designate a beneficiary,** by completing the ***Hartford Beneficiary Designation Form.***

*If you choose to participate in the Hartford Supplemental Life Insurance your beneficiary designation will apply to both the Hartford **Supplemental** Life and the **Basic** Life Insurance plans.

**Please note: The Basic Life Insurance is an employer paid benefit. In compliance with IRS requirements, any basic life insurance amount over $50,000 will result in imputed taxable income to the employee. The imputed amount will be added and taxed quarterly and this will be visible on your pay stub.*

Supplemental Life Insurance

Administered by The Hartford

You have the option to apply for Supplemental Life Insurance through The Hartford; this coverage is at your own expense. You can choose to enroll in employee, spouse, and/or dependent child(ren) supplemental life coverage. Premiums are based on your (the employee) age and coverage amount elected. Depending on the amount elected, and when you enroll in coverage, Evidence of Insurability (EOI) may be required. For additional supplemental life plan and cost information, please visit the **Archdiocesan website**.

If you want to purchase supplemental life coverage, complete the process online through ArchHR either during Open Enrollment, or, within 31 days from date of hire.

Note: Employees must log into **ArchHR**, click on the Benefits tile and report a Qualifying Life Event to drop dependent child(ren) supplemental life insurance coverage upon attainment of age 26 (of your youngest child), as this is not an automatic process.

Long-Term Disability

Administered by UNUM

Long-Term Disability insurance automatically becomes effective the first of the month after you have completed 90 days of employment. Your employer pays for this benefit. The policy provides 60% income protection per month in the event of a long-term disability. For detailed plan information, please visit the **Archdiocesan website**.

Flexible Spending Accounts (FSA)

Administered by TriStar Benefit Administrators

What is a Flexible Spending Account (FSA)?

Flexible Spending Accounts (FSAs) allow a participant to set aside a portion of their salary before taxes into an account that can be used during the plan year for paying certain out-of-pocket health expenses. This increases your take home pay since deductions are taken out before taxes. IRS rules limit the amounts that can be contributed to each plan type.

Check out the FSA Brainshark located on the Archdiocesan website for more information.

There are two types of FSAs allowed by the IRS:

- **Healthcare FSA:** Allows you to pay for medical expenses not covered by your medical insurance coverage, such as deductibles or copayments, dental or vision care. Because the FSA is a separate plan, it is not necessary for you to participate in your employer's medical insurance plan to take advantage of these savings. The full contribution amount is available at the beginning of the plan year, but you will forfeit any unspent money at the end of the plan year (the "use-it-or-lose-it" rule).

- **Dependent Care FSA:** Allows you to pay for qualified dependent care expenses, such as child care or elderly care, while continuing to work or attend school full-time. Funds can only be spent after they are contributed, but you will forfeit any unspent money at the end of the plan year.

Health and Dependent Care FSA Contributions

At the beginning of the plan year, you decide the pre-tax contributions to your accounts, and those funds are deducted from your paycheck each pay period. Because they are separate accounts, you cannot shift money between accounts.

Healthcare Account: **$3,300** maximum per plan year. You have until September 15, 2026 to incur Healthcare claims for the 7/1/2025 to 06/30/2026 plan year. All Healthcare claims have to be submitted to TRISTAR by December 15, 2026. Plan carefully as any unused Healthcare contributions at the end of the plan year are forfeited. These incur/ submit claim due dates apply to the Dependent Care FSA as well.

Once the amount has been decided, changes can only be made if a change in the following has occurred:

- Marital status (marriage, death, divorce)
- Number of dependents (birth, adoption, placement for adoption)
- Employment status (termination, commencement of employment)
- Dependent ceases to satisfy eligibility requirements
- Child reaches the age of 13 – Applies to Dependent Care FSA only
- Change in child care provider, change in cost or change in coverage – Applies to Dependent Care FSA only

Please visit **www.changeofstatus.com** for more information on allowable changes.

Dependent Care Maximums on Plan Contributions

- Single, Head of Household or Married, Filing a Joint Tax Return: **$5,000**
- Married, Filing a Separate Tax Return: **$2,500**

Utilizing Your FSA

Online Account Features

- View Account Balances
- View Transactions
- Online Claims Submission

Submitting a Claim

Once you've paid for a qualifying expense, you can submit an FSA claim with:

- A copy of the Explanation of Benefits (EOB); or
- The providers detailed invoice with proof of payment; or
- The retailer's itemized receipt

There are five ways to submit a claim form and supporting documents:

- **Mail to:** TRISTAR Benefit Administrators 5820 S Eastern Ave Ste, 250 Las Vegas, NV 89119
- **E-mail to:** flex@tristargroup.net
- **Fax to:** 702.216.1623
- **File online:** tristar.summitfor.me
- **Submit via mobile app**

Once your claim is approved, you will be reimbursed.

Maximize Your Flexible Spending Account

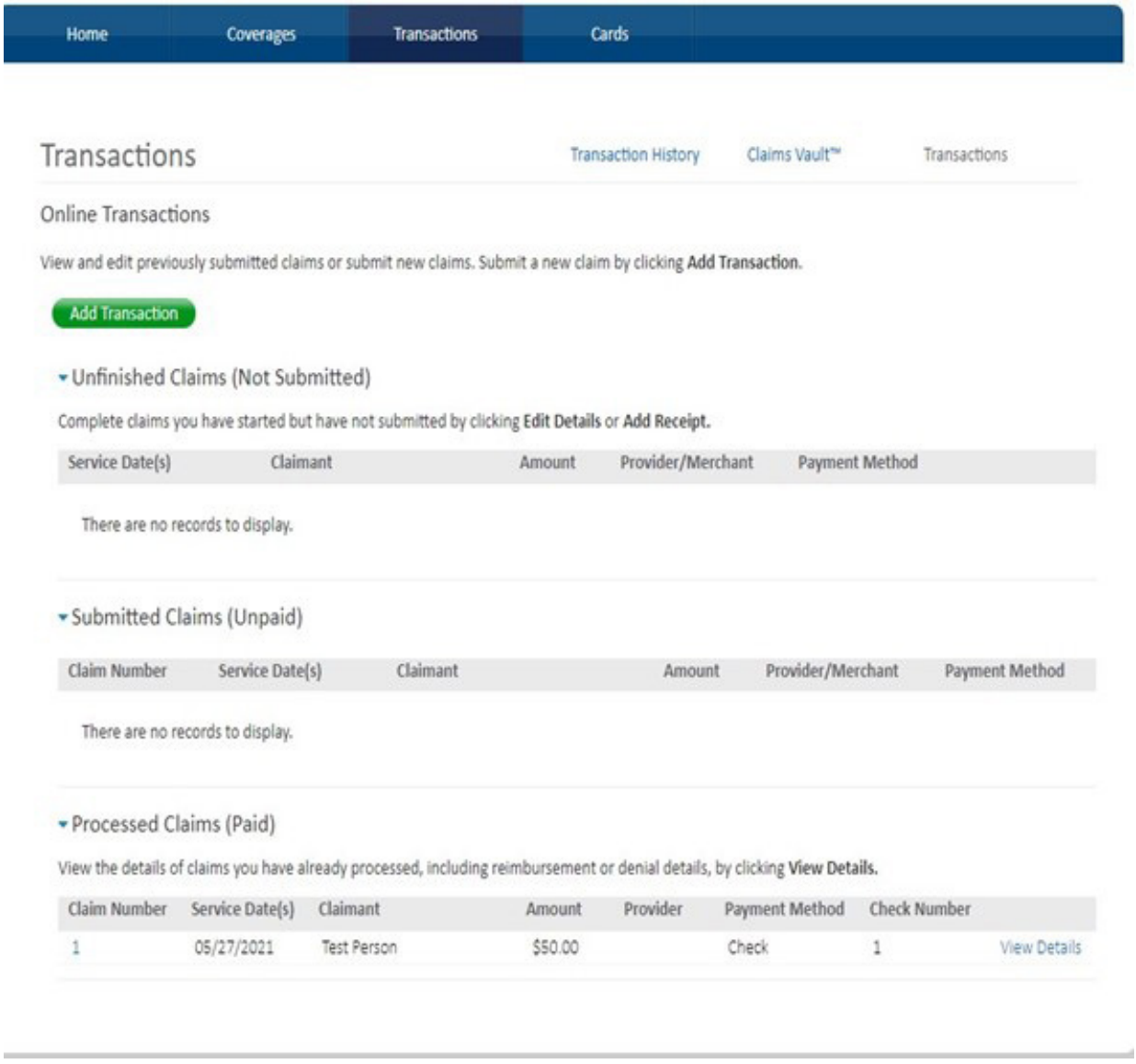
It's important to remember that if you don't use all your money in your Medical and Dependent Care FSA accounts, you will lose it all at the end of the plan year. Planning ahead is the key. Here are some ways you can maximize your Flexible Spending Accounts.

- Save your receipts in a folder so at the end of the year so you can estimate how much you and your family spent. This will give you a start on next year's estimate for your Flexible Spending Accounts.
- Develop a monthly spending plan for expected health care expenses to help you spend your Flex dollars and avoid losing leftover money at the end of the year.
- Be aware that FSA money used during the plan year must be used for expenses that were incurred during same plan year and the plan year's grace period.
- Don't wait until the end of the year to make preventative health appointments. Schedule teeth cleanings, eye exams and health checkups throughout the year.
- Be smart -compare costs and do some research to make the most of your Flex dollars.

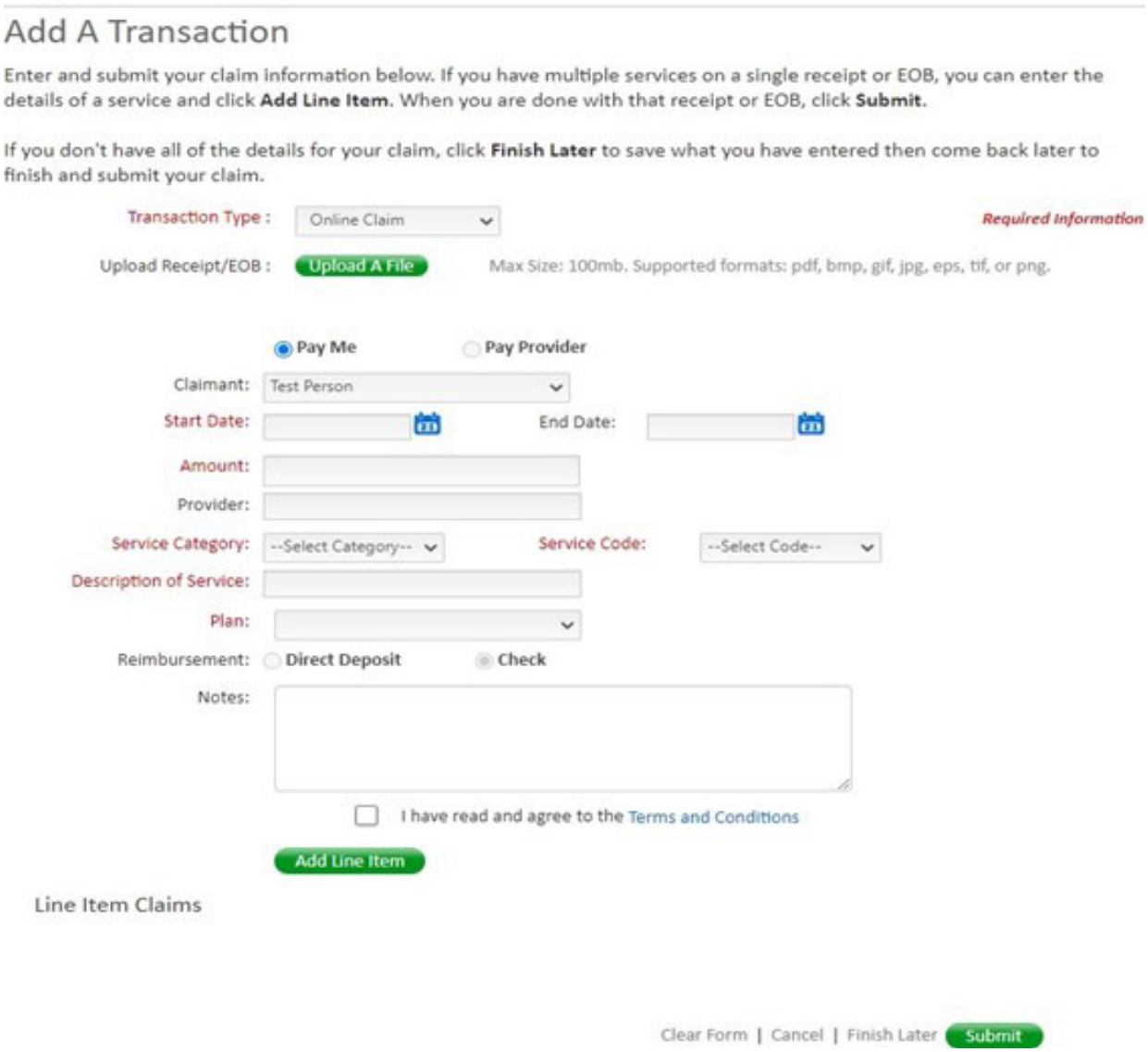
Submit your FSA Claims Oline

1. Log on to **tristar.summitfor.me**
2. Click on the following located in the middle of the screen

3. Click on **"Add Transaction"**



4. Select Transaction Type **“Online Claim”.**



5. Choosing Online claim allows you to upload the receipt in the form of a pdf document, bump, gif, jpg, eps, tif or png. Click on upload a file.
6. Enter the claims information.
7. Click Add Line Item
8. Click Submit in the lower right-hand corner.
9. You will receive reimbursement for the claim via a check in the mail or direct deposit if we have your banking information on file. Reimbursements are issued on a weekly basis.

You can access your Flexible Spending Account information on your mobile device with the Mobile Summit app for Apple and Android.

Locating and Loading the Mobile Summit App

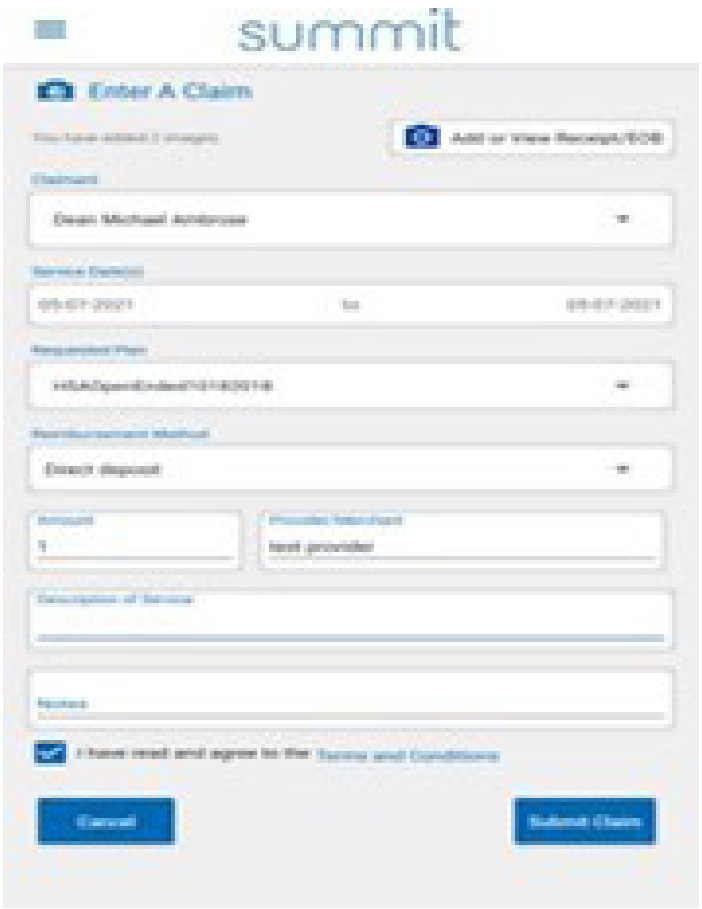
Search for “Mobile Summit” on the App store for Apple products or in the Google Play store for Android products, and load as you would any other app.

Logging in

Mobile Summit uses the same login credentials as the online participant portal. Once you have registered online, log in to Mobile Summit using the same username and Password and TPA Code (127). After logging in to the Mobile app, you will be on the home page which lists your navigation options.

Enter a Claim

Mobile Summit provides a quick, convenient and secure way to file claims using your smartphone’s camera. Enter claim information including Claimant, Service Dates, Amount, Provider/Merchant, and Reimbursement Method, then upload a photo of the itemized statement/receipt or EOB and submit for processing



Employee Wellness Incentive Program

Maintaining or improving your health with regular preventive care, along with following the advice of your doctor, can help you stay healthy. Routine checkups and screenings can help you avoid serious health problems, allowing you and your doctor to work as a team to manage your overall health, and help you reach your personal health and wellness goals.

Visit the Archdiocesan website for additional benefit related information and updates.

The Retirement Plan Contribution

Get an extra $125 added to your retirement plan just for making healthy choices.

Open enrollment is the perfect time to review your retirement plan contributions. Financial security is known to be an important piece of overall wellness and peace of mind.

Plan Year Beginning May 1, 2025 through April 30, 2026

Benefit eligible employees, with at least one year of service and either working a minimum of 1,000 hours annually or a teacher with a half-time or more contract, may annually complete one of the following in order to receive an Archdiocesan paid, $125 contribution to their Archdiocese of St. Louis sponsored 403(b) retirement plan:

A. Receive an annual wellness exam with your physician of choice between May 1, 2025 and April 30, 2026 and submit the **employee wellness form** to H&H Health Associates. The deadline for H&H to receive the wellness form is May 7, 2026.

OR

B. Participate in the Archdiocesan paid, confidential H&H Health Associates health screening between May 1, 2025 and April 30, 2026.

Important Notes

- Participation in the health insurance plan is not a requirement to be eligible to receive the $125 retirement contribution.
- If you were hired on or before May 1, 2025, and have been working either a minimum of 1,000 hours annually or are a teacher with a half-time or more contract, you have fulfilled the one year of service requirement.
- You MUST BE AN ACTIVE EMPLOYEE at the end of the wellness plan year (April 30th) in order to receive the $125 retirement contribution.
- Religious sisters, brothers, and priests are eligible for an annual Archdiocesan paid H&H health screening; however, they are not eligible to receive the $125 retirement plan contribution.
- If you receive an H&H health screening, you do not need to submit the employee wellness form.
- The $125 retirement plan contribution will be processed in the fall of 2026, if you met the above criteria.

H&H Health Associates Wellness Screenings

The H&H wellness screening involves a venipuncture blood draw (takes about 3-4 minutes total) to scientifically determine one's current health status. The wellness survey is a brief, confidential questionnaire that focuses on lifestyle habits, employee benefits, & general health interests.

If you want to participate in an H&H wellness screening, you have two options to make your appointment. You can call H&H directly (M-F, 8:30am-5pm CST) at **314.845.8302** or register on the H&H Health website.

H&H Health Associates Instructions For On-line Registration for an Archdiocese Wellness Screening (Spring 2025 and Fall 2026)

Simply click on the following link **https://wellness.hhhealthassociates.com?companyCode=archdiocese** to register.

First Time Web Users: Enter Company Code: "ARCHDIOCESE" to set up your user profile.

Once submitted, you will receive an email to validate your account. Click on the link within the email to activate the account, then log in & choose how you would like to participate.

Existing Users: Enter your username (email address) & password.

If you forgot your password, simply use the "Forgot Password" feature to reset it.

Then choose to participate at the Archdiocesan Wellness Screening by selecting an appointment time, or choose to participate at an approved clinic (1,600+ nationally).

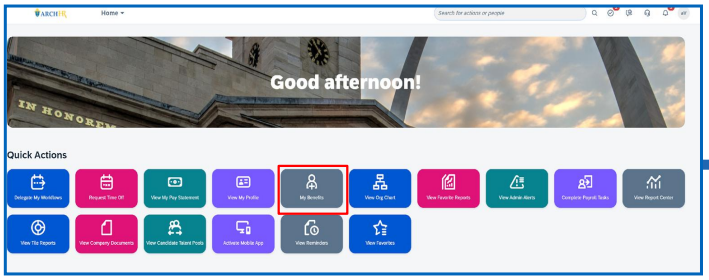
- **ON-SITE WELLNESS SCREENING PARTICIPANTS:** Arrive 5 minutes prior to your appointment. Turn in your completed consent form (& wellness survey, if not already completed on-line) to the on-site examiner at the H&H health screening event.
- **WALK-IN CLINIC PARTICIPANTS:** At the time of registration, complete your on-line wellness survey. Take the lab paperwork (received via email) along with a photo ID to the approved clinic. No copay or insurance info needed for the blood draw. At the time of registration, complete your on-line wellness survey.

If you experience any problems with your on-line registration (Google Chrome is the recommended web browser), or if you prefer to register by phone, please contact H&H Health Associates (M-F, 8:30am-5pm CST) at **314.845.8302** / **800.832.8302**.

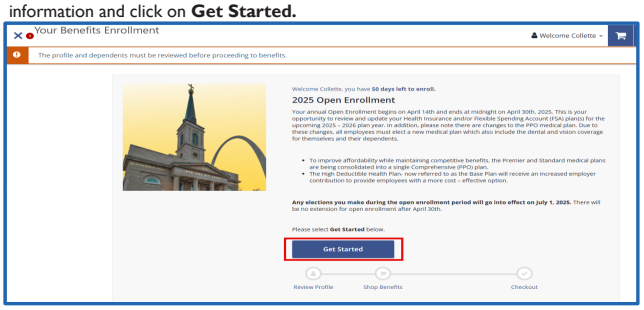
Quick Reference Guide: Employee Open Enrollment

Quick Reference Guide: Employee Open Enrollment

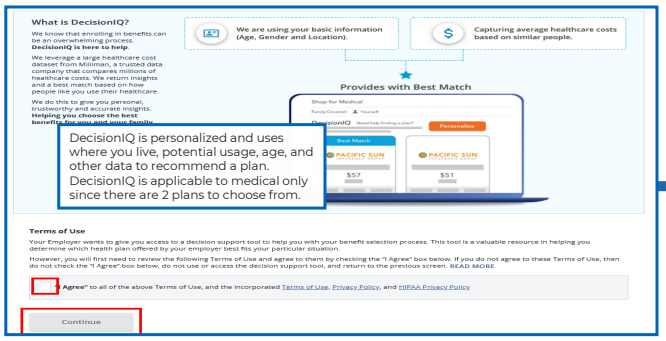
1. From your Home Page, click on the **My Benefits** tile.



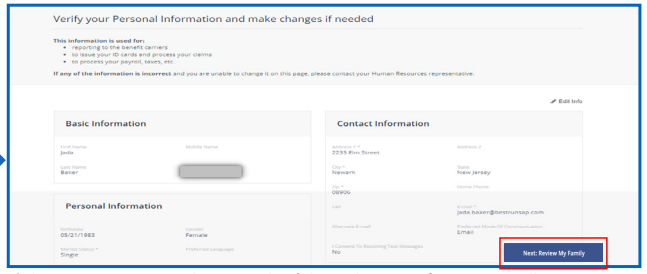
2. You will now see your **Benefits Portal**. Please read the Open Enrollment information and click on **Get Started.**



3. Review DecisionIQ decision support information, click **I Agree** and then **Continue**. This will only be presented if you have not accessed the system before.



4. Verify your personal information. Please note that any changes to your personal information must be completed in **your ArchHR Core Profile*** Click on **Next: Review My Family.**

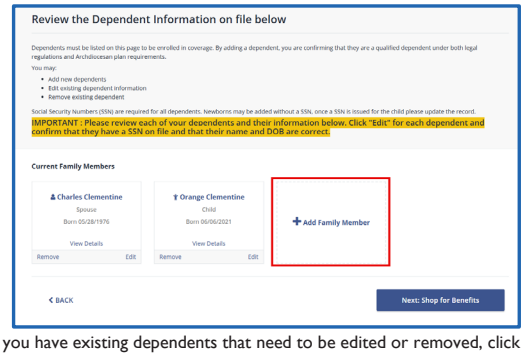


**This is a separate step done outside of the ArchHR Benefits Open Enrollment process.*

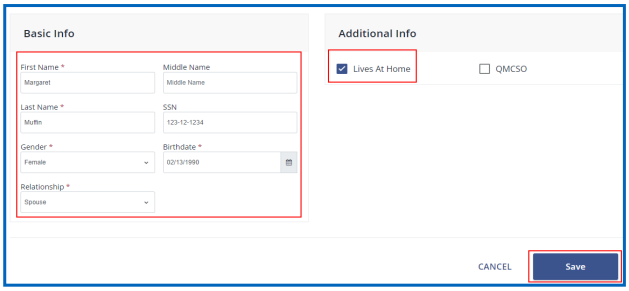
Last Modified Date: May 12, 2025

Quick Reference Guide: Employee Open Enrollment

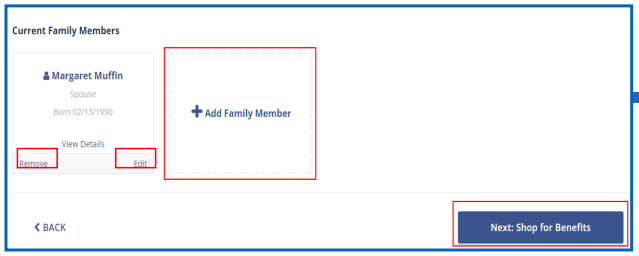
5. To add a dependent click **+ Add Family Member.**



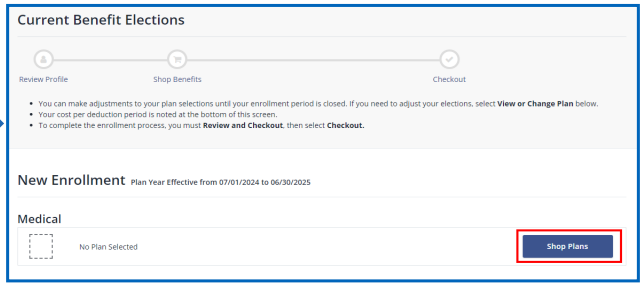
6. Enter the specific information for **each dependent** to be covered. TIP: If the dependent does NOT live at home, uncheck the 'Lives at Home' box and enter their address. **Click Save.**



7. If you have existing dependents that need to be edited or removed, click on **"Remove" or "Edit"** within the dependent tile. When dependent adds, removals, and edits are complete, click on **Next: Shop for Benefits.**

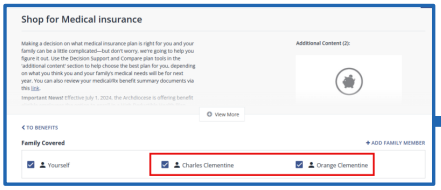


8. Begin your enrollment by clicking **Shop Plans** for Medical.



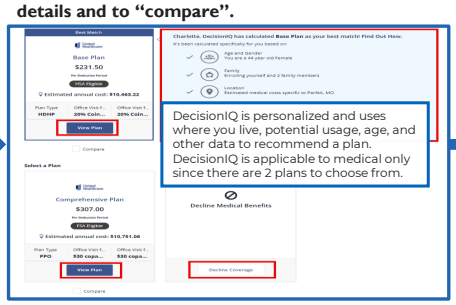
Quick Reference Guide: Employee Open Enrollment

9. Select or add any **dependents you would like to cover** based on the benefit type in the **Family Covered Box**.



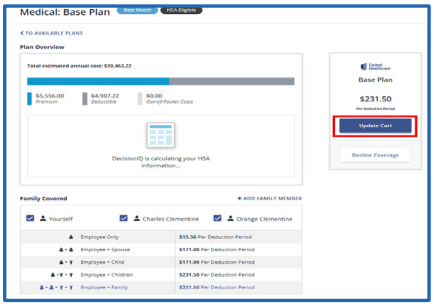
Eligible Dependents are auto-selected as a default

10. DecisionIQ is available to assist you when making a choice for Medical/Rx benefits. Click on **View Plan to see details and to "compare".**

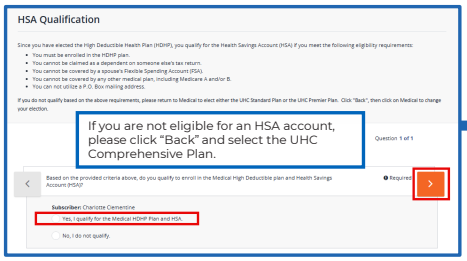


DecisionIQ is personalized and uses where you live, potential usage, age, and other data to recommend a plan. DecisionIQ is applicable to medical only since there are 2 plans to choose from.

11. Identify the **Medical plan** you would like to enroll in and click **Update Cart.**

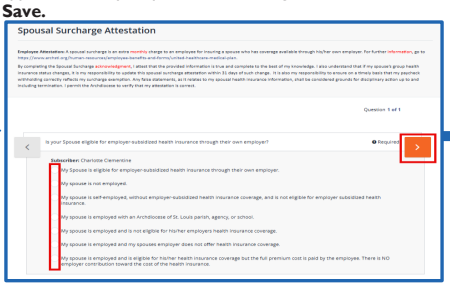


12. If enrolling in the **Base Medical plan**, review and answer the eligibility question for HSA plan enrollment. Click the right **Arrow**, then **Save.**

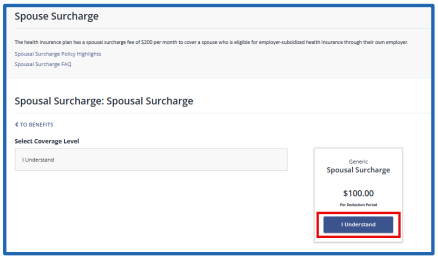


If you are not eligible for an HSA account, please click "Back" and select the UHC Comprehensive Plan.

13. If you are choosing to cover a Spouse, you must complete the **Spousal Surcharge Attestation.** Select the applicable survey response, click the right **Arrow**, and **Save.**

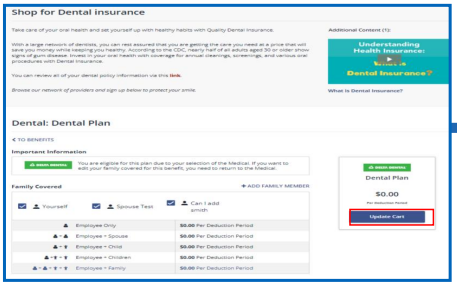


14. Depending on your answer, you may see the **Spousal Surcharge** page. Select **I Understand**.

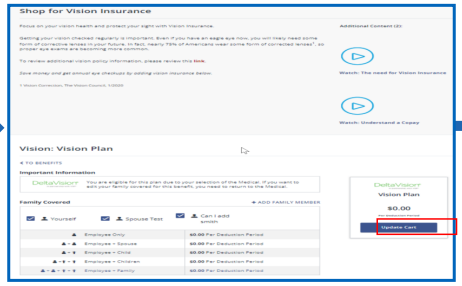


Quick Reference Guide: Employee Open Enrollment

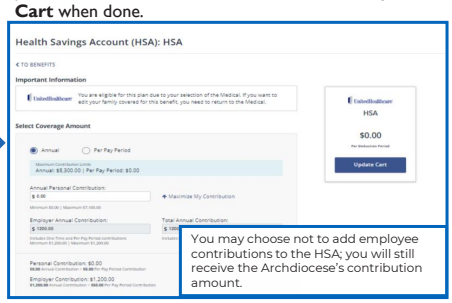
15. Review the **Dental plan** you will be enrolled in and click **Update Cart.**



16. Review the **Vision plan** you will be enrolled in and click **Update Cart.**

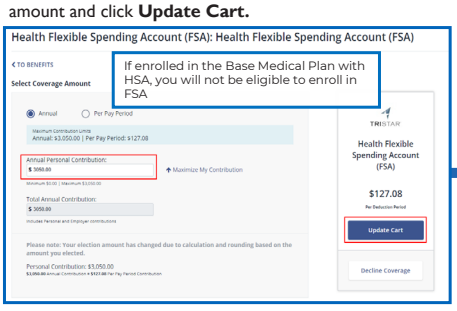


17. If enrolling in the **HSA plan**, you can enter a personal contribution amount, if desired. Click **Update Cart** when done.



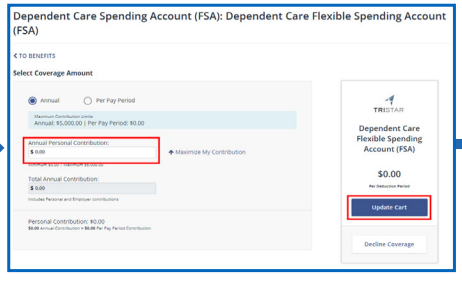
You may choose not to add employee contributions to the HSA; you will still receive the Archdiocese's contribution amount.

18. If you are eligible and choose to enroll in a **Health Flexible Spending Account**, enter your contribution amount and click **Update Cart.**

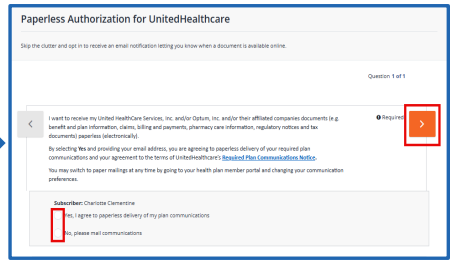


If enrolled in the Base Medical Plan with HSA, you will not be eligible to enroll in FSA

19. If you are eligible and choose to enroll in a **Dependent Care Flexible Spending Account**, enter your contribution amount and click **Update Cart.**

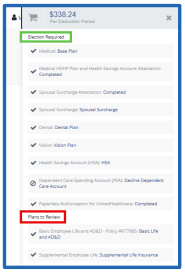


20. If you are enrolling in Medical, you will be required to complete the Paperless Authorization. Select your preference, the **Arrow** to the right, and **Save.**



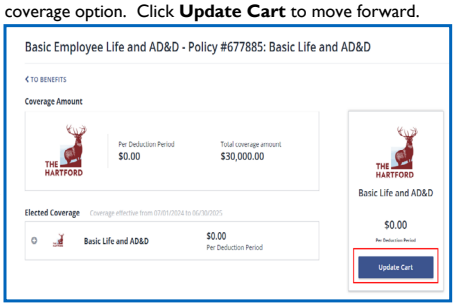
Quick Reference Guide: Employee Open Enrollment

21. All benefits that require election are now complete, proceed to Step **26** to check out or continue to review other benefits for the upcoming year.

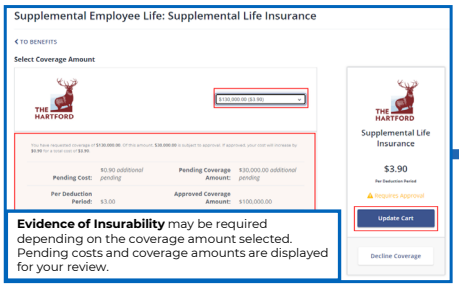


22. Select **View or Change** to modify or review any current benefit elections that will copy forward if no action is taken.

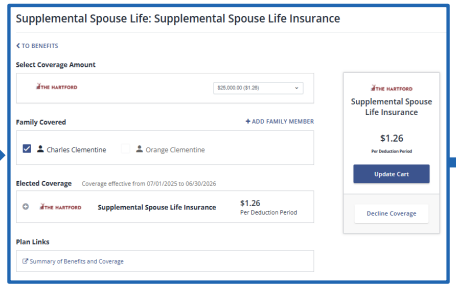
23. Basic Life and AD&D and Basic Long-Term Disability, are provided with no cost to you. They will not have a decline coverage option. Click **Update Cart** to move forward.



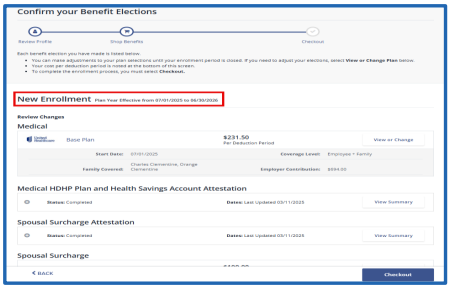
24. If enrolling in **Supplemental Life Insurance**, choose your desired **coverage amount** from the drop down. Click **Update Cart or Decline Coverage.**



25. Repeat Step 24 as needed for **Supplemental Spouse and/or Dependent Life.**

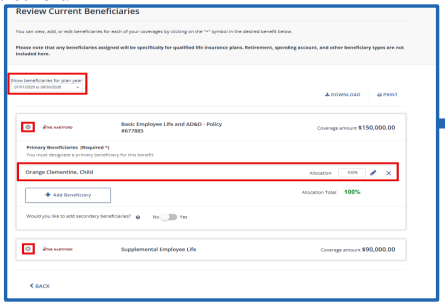


26. Review your Benefit Elections. All offerings must have an enrollment or decline on file. If you already have Beneficiaries on file, select **Checkout**.

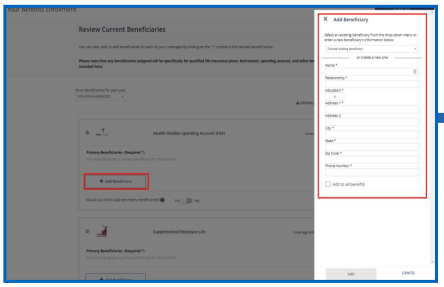


Quick Reference Guide: Employee Open Enrollment

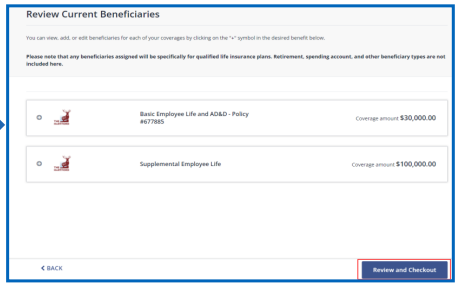
27. Beneficiaries: To review Beneficiaries, select the plan year, expand the selection, and review the current allotment.



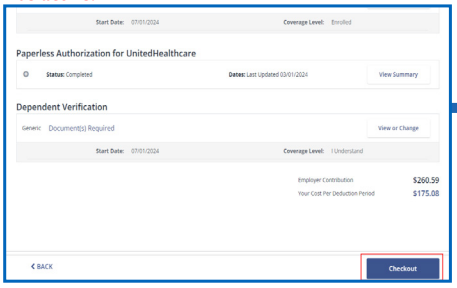
28. Beneficiaries: Click **+ Add Beneficiary.** Enter beneficiary information. The allocation must equal 100% across all beneficiaries. Click **Add.**



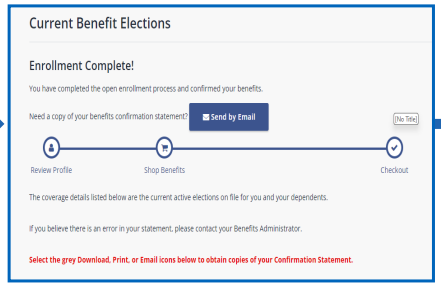
29. Once beneficiary information is complete click **Review and Checkout.**



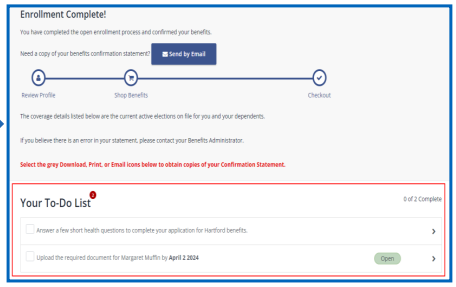
30. Review all elections and **Checkout.** **Note: if you do not complete this step, your elections will not be active.**



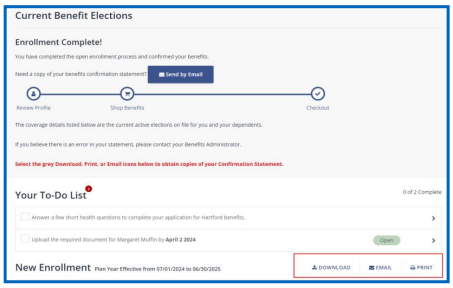
31. Your Enrollment is Complete!



32. Review and complete any additional tasks on **Your To-Do List.**



33. Download, Print, or Email your Benefits Confirmation Statement.



SPOUSAL SURCHARGE **FREQUENTLY ASKED QUESTIONS**

Spousal Surcharge Basics

1. **What is a Spousal Surcharge?**

   - A spousal surcharge is an extra charge that an Archdiocesan employee pays for electing to insure a spouse who has subsidized health insurance coverage available to them through their own employer.
   - The Archdiocesan spousal surcharge is an added charge of $200 **per month** to the usual employee contribution for health insurance.
   - For a list of the current Archdiocesan health insurance premium rates please visit the Archdiocesan Website.

2. **Why did the Archdiocese of St. Louis implement a Spousal Surcharge policy?**
   The spousal surcharge encourages those who have medical coverage available through their employer to take advantage of that coverage. The Archdiocese Employee Benefit Plan is self-insured and helps pay the cost of each member's healthcare coverage and actual claims. If the employee's spouse moves to their employer's plan and uses that benefit instead, it saves the Archdiocese the cost of the claims and will help keep our medical plans more affordable. The Archdiocese establishes its premiums on the basis of the cost of the actual claims which ultimately makes the plan more affordable to the employee.

3. **What is a Spousal Surcharge Employee Attestation?**
   An employee's attestation is the employee's acknowledgement that any information provided regarding their spouse's employment status is true and complete to the best of their knowledge. The attestation also recognizes that if the spouse's group health insurance status changes, it is the employee's responsibility to notify their employer's business manager/local benefits contact **within *31 days of such change***. It is also the employee's responsibility to ensure on a timely basis that their paycheck withholding correctly reflects any surcharge exemption. Any false statements, as it relates to their spousal health insurance, shall be considered grounds for disciplinary action up to and including termination. The attestation also permits the Archdiocese to verify that the information provided is correct.
   Throughout the year, if your spouse experiences a qualified event change in insurance eligibility at their employment, you will be able to change your exemption status.

4. **How do I submit a new or changed Spousal Surcharge Attestation?**

   - By completing the ***Spousal Surcharge*** section on ArchHRbenefits regarding any changes **within 31 days of the event**.
   - During Open Enrollment*, changes and attestations are elected through ArchHRbenefits.

   **See the Spousal Surcharge Open Enrollment Online Action section in this document for additional Open Enrollment instructions.*

5. **What are the exemptions to the Spousal Surcharge?**

   The spousal surcharge fee will *not* be added if the Spousal Surcharge Exemption is submitted *on time* and *the enrolled spouse is designated as one of the following*:

   - My spouse is not employed.
   - My spouse is self-employed, without employer-subsidized health insurance coverage, and is not eligible for employer subsidized health insurance.
   - My spouse is employed with an Archdiocese of St. Louis parish, agency, or school.
   - My spouse is employed and is not eligible for his/her employer's health insurance coverage.
   - My spouse is employed and my spouse's employer does not offer health insurance coverage.
   - My spouse is employed and is eligible for his/her health insurance coverage but the full premium cost is paid by the employee. There is NO employer contribution toward the cost of the health insurance.

Effective Dates & Billing Rules of the Spousal Surcharge

6. **When does the Spousal Surcharge go into effect?**

   If you are not exempt from the surcharge and you and your spouse enroll in the Archdiocese Health Insurance Plan, the effective date of the surcharge fee would be the same as the effective date of enrollment with health insurance coverage.
   - If you are a new hire, the effective date of your health insurance and spousal surcharge fee is the 1st of the following month.
   - If enrolling due to a qualifying event and the effective date of your health insurance enrollment is on or between the 1st and the 15th of any given month, you owe the full health premium and spousal surcharge for that month.
   - If enrolling due to a qualifying event and the effective date of your health insurance enrollment is on or after the 16th of any given month, you do not owe any health insurance premium or spousal surcharge for that month.
   - This amount is deducted on a pre-tax basis just as your health insurance employee contribution is deducted on a pre-tax basis. There is no after-tax option.
   - There is no prorating of the health insurance premium or the surcharge.
   - The Archdiocese will not be retroactively reimbursing anyone for surcharge amounts already paid.

7. **What happens if I am paying the Spousal Surcharge Fee and fail to change my employee attestation to a Spousal Surcharge Exemption?**

   The Archdiocese will **not** be retroactively reimbursing for surcharge amounts already paid. You will be exempt from the surcharge **after** the change to the surcharge has been made on ArchHRbenefits marking the spousal surcharge exemption **and** according to the aforementioned payroll deduction rules.

Spousal Surcharge Open Enrollment Online Action

8. **When is the Archdiocese of St. Louis Annual Open Enrollment period?**

   April 14th - April 30th

   - ✓ If you elect to cover your spouse, you will need to review your spouse's surcharge eligibility every Open Enrollment period.
   - ✓ If you need to make a spousal surcharge fee or exemption change, you will need to go online through ArchHRbenefits during Open Enrollment to make a change.
   - ✓ Changes during the annual Open Enrollment period are effective July 1.

9. **If you already have your Spousal Surcharge Employee Attestation of a fee or exemption in place prior to July 1, will I need to do anything at Open Enrollment each year?**

   - First, please review your spouse's employment status and eligibility for coverage at this time.
   - If your appropriate spousal surcharge fee or exemption is not changing, no action is required.
   - If you need to make a spousal surcharge change, go online to ArchHRbenefits to change your election.

10. **If I am cancelling my spouse's coverage on the Archdiocese health insurance plan during Open Enrollment, do I need to do anything in regards to canceling the Spousal Surcharge?**

    If you are removing your spouse from your health insurance plan effective July 1, you would continue through the online Open Enrollment screens and click on *"Not Covering a Spouse"* in the spousal surcharge screen.

11. **What happens if I fail to go online during Open Enrollment and elect the Spousal Surcharge Exemption?**

    - Your payroll deduction will continue to automatically include the $200 monthly spousal surcharge for your spouse's Archdiocesan health care plan.
    - Outside of Open Enrollment, you may login to ArchHRbenefits for any new benefit enrollments or changes.
    - Additionally, in the event employees do not complete the Spousal Surcharge election accurately, they may be subject to their coverage under the plan being terminated or they may be subject to other disciplinary actions up to and including termination.

Spouse's Employment and Medical Coverage Eligibility Status

12. **My spouse is currently between jobs. Can I enroll my spouse while they are job searching?**

    Yes, you can enroll your spouse in the Archdiocesan health plan without a spousal surcharge while they are unemployed. However, if at any time your spouse becomes eligible for coverage through a new employer, you must login to ArchHRbenefits and change your spousal surcharge status **within 31 days** of your spouse's eligibility in the new employer's plan.

13. **What happens if my spouse finds a new job and I forget to notify the Office of Human Resources and they remain enrolled in the Archdiocese Plan with the Spousal Surcharge Exemption?**

    You owe your employer the cost of the spousal surcharge for however many months your spouse was enrolled while they were eligible for insurance through their own employer. It is the responsibility of each employer to resolve issues such as these.

14. **What if my spouse is going to school and is eligible for a student health plan from the school?**

    The spousal surcharge only applies to spouses who are actively employed and eligible for group medical coverage through their employer. If your spouse is eligible for coverage as a student, they would be eligible for the Archdiocesan health care plan and you are eligible for an exemption. If you previously elected an exemption, no action is required of you. If your spouse's student status has changed and now you want to apply for an exemption or need to pay the fee, please go online to ArchHRbenefits.

15. **What if my spouse and I are both Archdiocesan employees?**

    If you are married to a benefit eligible Archdiocesan employee, you are eligible for an exemption.

SPOUSAL SURCHARGE **FREQUENTLY ASKED QUESTIONS**

16. **What if my spouse has to pay 100% of his insurance where they work?**

    You are eligible for an exemption. You will only have to pay the $200 monthly spousal surcharge if your spouse has access to employer-subsidized coverage, where the employer is paying part or all of the insurance plan costs. To find out if your spouse's employer is paying part of the plan cost, your spouse should ask their HR/benefits representative.

17. **Is my spouse required to enroll other family members into his/her employer sponsored group medical coverage?**

    No. Dependent children up to the age of 26 years old are still eligible to enroll in the Archdiocesan health insurance plan without the additional surcharge.

18. **Whose health insurance plan will cover my children, the Archdiocesan plan or my spouse's employer's plan?**

    If your spouse's employer provides coverage for children and your children meet the eligibility requirements for both plans, you and your spouse will need to decide as to which plan(s) to enroll in. We recommend comparing the key features of both plans, to help with your decision.

19. **My spouse's employer holds open enrollment at a different time of the year. What should we do?**

    The Archdiocese of St. Louis Open Enrollment may be a qualifying life event for your spouse to enroll in their employer's health insurance plan. Your spouse should ask their employer's HR/Benefits representative if they can enroll due to the Archdiocesan Open Enrollment or due to this significant cost change, effective July 1. You can login to ArchHRbenefits to enroll or cancel insurance as a qualifying life event, in this case.

20. **What happens if my working spouse's group medical coverage is terminated because they lose their job? Does my spouse have to elect and exhaust COBRA/Continuation of Coverage before being eligible for enrollment in the Archdiocesan health plan?**

    A spouse is not required to elect COBRA/Continuation of Coverage. If a spouse loses other coverage due to losing their job, this qualifies as a life event, and the spouse can then be enrolled in the Archdiocesan plan. To enroll and be exempt from the surcharge, the employee must login to ArchHRbenefits and mark the Spousal Surcharge Exemption, **within 31 days** of the spouse losing coverage.

21. **Does my spouse's Medicare coverage have any bearing on the Spousal Surcharge?**

    No, Medicare eligibility or coverage is neither a reason for a spousal surcharge exemption nor a cause for the surcharge fee. Medicare has no bearing on the Spousal Surcharge Policy.

22. **If I am in the Archdiocesan Early Retiree Plan or the Continuation of Coverage Plan, am I subject to the Spousal Surcharge?**

    You are exempt from the spousal surcharge since you pay the full premium.

Questions?

Please email any Benefits questions to AskHR@archstl.org and we will be happy to assist you.

Revised 3/2025

Frequently Asked Questions

Q: Is the dental program changing on July 1, 2025?
A: No, there are no changes to the Archdiocesan dental coverage. However, providers have the ability to join and drop Delta's network, so please be sure to determine if your provider participates in the Delta Dental PPO or Premier Network.

Q: How do I find a dentist who participates in a Delta Dental network?
A: It's easy to find a participating provider near you. Visit Delta Dental's website at www.DeltaDentalMO.com, and click on "Find a Dentist," or call Delta Dental's Customer Care team at 800-335-8266, and press 2, then follow the prompts. Please be sure to confirm that the dentist participates in the **Delta Dental PPO℠ Network** or **Delta Dental Premier® Network.** Delta Dental also has a mobile app that you can use to search for participating dentists and many other uses such as viewing your ID card and your claims history.

Keep in mind that when you receive services from a dentist in the **Delta Dental PPO℠ Network**, your Basic and Major services are covered at a higher level than when you see a dentist in the **Delta Dental Premier® Network**.

- You will receive greater savings when you visit a dentist in the **Delta Dental PPO℠ Network.**
- As always, you may see a dentist who participates with **Delta Dental** or a dentist who is out-of-network. When your covered services are performed by an out-of-network dentist, your out-of-pocket costs may be higher.

Q. If my dentist does not currently participate with Delta Dental, can he or she join one or both of the networks?
A: You can let your dentist know that he or she can ask about joining one or both of Delta Dental's networks by emailing Delta Dental at service@dentaldentalmo.com, or by contacting Delta Dental's Professional Relations team at 800-392-1167. If your dentist currently participates in the **Delta Dental Premier® Network** only, he or she can ask about joining the **Delta Dental PPO℠ Network**.

Q: Will I receive a Delta Dental identification card (ID card)?
A: If you are a new participant to our dental program, you will receive a Delta Dental ID card at your home address. If you are currently covered under the Archdiocese's dental plan, you will not receive a new Delta Dental ID card. Your current ID card is still valid. Simply show your card to a dentist who participates in one of the Delta Dental networks, and your dentist's staff will file the claim for you.

Q: How do I file a claim if I go to a dentist who is not in a Delta Dental network?
A: If you use a dentist who does not participate with Delta Dental, you may complete the standard American Dental Association (ADA) claim form that most dentists use for their billing. This form may be downloaded from Delta Dental's website at www.DeltaDentalMO.com.

Claims should be sent to the following address, which is also listed on the back of your Delta Dental ID card:

Delta Dental of Missouri
P.O. Box 8690
St. Louis, MO 63126-0690

Q: Will Delta Dental provide a benefit "predetermination" before I receive extensive dental treatment?
A: "Predetermination" is the process of reviewing a dental treatment plan and identifying the eligible benefits prior to the services being given. Although it is not required, Delta Dental recommends that you receive a predetermination of benefits for any proposed dental treatment in excess of $200. Dentists who participate in the Delta Dental networks are very familiar with this process and will gladly submit the predetermination documents for you. If you use an out-of-network dentist, simply ask the dentist to forward a copy of the treatment plan to Delta Dental. If you have questions about benefit predetermination, please call Delta Dental's Customer Care team at 800-335-8266, and a representative will be happy to help you.

DeltaVision Frequently Asked Questions

How can I reach customer service?
Customer service representatives are available by phone at 877-226-1412.

Will I need my ID card for my appointments?
Although an ID card is not required, members should present their ID card at the time of service to help expedite the process.

What if I lose my DeltaVision® ID card?
Note that the ID Card is not required for services to be rendered. In the event of a lost or misplaced member ID card, please contact our customer service center at 877-226-1412 for a full replacement.

What is my member identification number?
Your unique member ID number can be found on your DeltaVision ID card.

Will I be required to pay a co-pay when I visit a provider?
Yes, you'll be asked to pay your $10 copay for the exam. If materials are purchased, the applicable materials copay will also be applied.

What if I have an emergency, such as lost, stolen or broken glasses?
If an emergency arises, call customer service at 877-226-1412 to verify eligibility and find a network provider.

What network do I have available to me?
DeltaVision now uses the EyeMed Insight network. Visit our vision portal at DeltaDentalMO.com/Vision to search for a provider and easily manage your vision benefit.

Do I need a claim form if I see a network provider?
Claim forms are not required for services received from in- network providers. Participating providers will file all in-network claims.

How do I get reimbursed for an out-of-network visit?
Out-of-network providers require members to pay for their services. You will need to submit a Member Reimbursement Claim Form with your itemized paid receipt. A claim form can be found on the member portal at DeltaDentalMO.com/vision. Claim forms can be submitted only through the member portal or mailed to:

First American Administrators, Inc.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Can I choose contact lenses instead of eyeglasses?
Yes, subject to plan frequency and co-pay, you can use your benefits to purchase contact lenses in lieu of eyeglasses.

I am interested in LASIK. What coverage do I have?
DeltaVision members have access to:

- Free LASIK exam ($100+ value)
- Access to 680+ credentialed LASIK providers
- 15% off standard LASIK prices or 5% off promotional LASIK prices at providers in the U.S. Laser network

How can I find an in-network provider?
Provider information is updated and made available to members via:

- **Website.** Members can use our online provider search engine to locate a provider. Members can find providers, based on distance from a city, state and ZIP with a search radius between five and 50 miles. The results can include a printable provider directory and driving directions with a map for easy reference. The online provider search engine can be found at DeltaDentalMo.com/Vision
- **Customer Service.** Members can call our toll-free telephone number, 877-226-1412.

Health Savings Account (HSA) Frequently Asked Questions

How does the HSA work?

- When you enroll in the Base (HDHP w/HSA) Plan, you are eligible for the HSA.
- An HSA is a tax-advantaged savings account that you can use to pay for eligible out-of-pocket expenses until you meet the Base (HDHP w/HSA) Plan's deductible.
- The Archdiocese of St. Louis contributes to your HSA each year, and you can also make your own tax-free contributions, up to IRS-established limits.
- Any balance in your HSA rolls over to the next year and continues to grow. You own your HSA even if you change medical plans, leave the Archdiocese, or retire.
- You must be enrolled in a high-deductible health plan to contribute to an HSA. You can still use it, however, as long as there are funds in the account.
- Many people consider their HSA as their retirement health savings program. After $1,000 has accumulated in your HSA account, you can invest it or let it grow over time in your account.
- HSAs also offer a triple tax advantage:
  1. Your contributions go in pre-tax, which lowers the amount of taxes coming out of your paycheck.
  2. Any interest earnings are tax-free.
  3. When you use your HSA for an eligible medical, dental, vision, or prescription drug expense, the withdrawal is tax-free too.
- The HSA is the individual's responsibility, not the employer's. It is your responsibility to manage your HSA like you'd manage a bank account. This includes retaining any and all documentation and receipts you may need, monitoring your balance, reporting the information on your personal tax return, or other activities.

NOTE: You should consult with your tax advisor for more information and details.

What medical expenses can be paid from an HSA?

You can use the money in your HSA to pay for eligible health care expenses for yourself and your tax dependents.* Examples of eligible expenses include:

- Medical plan deductibles and coinsurance.
- Prescription drug coinsurance.
- Dental and orthodontic care.
- Vision care.
- If you leave the Archdiocese of St. Louis or retire, you can use the money in your HSA to pay premiums for Continuation of Coverage, Medicare Part B (for people over age 65), or Long-Term Care coverage. A full list of qualifying expenses can be found in **IRS Publication 502.**

*Tax dependents, as defined by the IRS, are those living in the same principal residence for more than half of a taxable year; younger than age 19 (or 24 if a student), or permanently and totally disabled. (Note that this IRS rule is for HSAs and differs from eligibility rules for other medical plans.)

Can I make lump-sum contributions to my HSA?

Yes. You can make a lump-sum contribution directly to your HSA account through Optum Bank. You can also change your contributions at any time during the plan year, no more than once a month, by logging on to the **ArchHR portal** and changing your elections. You are responsible for ensuring that any lump-sum contribution you make (combined with your payroll deductions and company contribution) does not exceed the annual maximum contribution permitted by the IRS and is made before the federal income tax return deadline for that year. You will report your lump-sum contributions when you file your income taxes.

Can I have both an HSA and FSA at the same time?

No. IRS rules state you cannot have both an HSA and a general purpose Health Care FSA at the same time.

How much can be contributed toward an HSA in a year?

Maximum contribution limits on HSAs are set by the IRS and may vary by calendar year. It is important to remember that the maximum includes both employee- and employer-contributed funds. Since the Archdiocese of St. Louis will be contributing $600 for individual plans, and $1,200 for family plans (Employee + 1 or more), these amounts will have to be taken into account when considering whether the maximum has been met or not for the year. The annual contribution limits for 2025 are as follows:

- Individual: $4,300
- Family: $8,550
- Age 55 and older: Additional $1,000 catch-up contribution

The Archdiocese of St. Louis allows you to make contributions through payroll deductions. Your contribution election, and employer contributions to your HSA, is divided by 24 paychecks.

How do I submit a claim for reimbursement from my HSA?

You will receive a Optum Bank debit card that you can use at the point of service (i.e., doctor's or dentist's office, hospital, urgent care center, pharmacy, etc.) for immediate payment from your HSA. If you do not use your debit card, you may elect your "Reimburse Me," or "Pay Provider" request through Optum Bank online.

Can I use my HSA for non-medical expenses?

Technically, no you cannot. While you can use your HSA for financial emergencies, if needed, withdrawals will be considered a taxable distribution and you'll pay a 20% penalty if they're used for non-medical expenses. Once you reach age 65, you may use your account balance for any expense, without penalty. Keep in mind that it is your responsibility to report any non-qualified expenses as taxable on your tax return.

If I have expenses before I have sufficient funds in my HSA, can I reimburse myself for my out-of-pocket medical expenses once the funds are in my HSA?

HSA funds can be accessed and used as soon as money is available in the account. Claims for reimbursement can be submitted anytime, but will be pended and not paid until such time as funds become available in the account. The same concept holds true for the debit card. It can be swiped, but those transactions will be declined at the point-of- sale unless there is enough money currently in the account to cover the charge.

NOTE: A fee will be applied for insufficient fund denials.

Can I use my HSA to pay for medical services I receive in other countries?

Yes. You can use your HSA to pay for medical services provided outside the U.S., as long as the treatment is a qualified medical expense. Remember that those services must meet the IRS guidelines.

What should I do with my receipts for the HSA?

Claims for reimbursement from an HSA do not have to be substantiated by a third party. So while you do not need to submit an Explanation of Benefits (EOB), receipts, provider statement, or other similar documentation to Optum Bank, it is your responsibility to prove the funds were used for qualified medical expenses should there ever be a personal audit or inquiry by the IRS. Therefore, it is strongly recommended that you retain all receipts, EOBs, or other similar documentation. There is no time limit on when you can be reimbursed from your HSA or how long you need to save your receipts. Optum Bank allows you to upload and save your receipts and any paperwork through their website or mobile app.

Will someone notify me if I've exceeded my allowable contribution amount?

No. It is your responsibility to keep track of your balance, deposits, and withdrawals, much like a normal bank account.

Can I use the funds in my HSA to pay the expenses for other family members?

Yes. You may use the funds in your HSA to pay the qualified medical expenses for a spouse or tax dependent even if that person is not covered under the Base (HDHP w/HSA) Plan.

What if my spouse has an HSA too?

If your spouse is enrolled in a medical plan with an HSA and is eligible to make contributions, you can each make contributions to your own HSA. Joint HSAs are not permitted by the IRS.

If my spouse and I are both over 55, can both of us make "catch-up" contributions?

Yes, if you have established individual HSAs. If only one spouse has an HSA in his or her name, only that spouse can make a catch-up contribution.

If my employment with the Archdiocese of St. Louis ends for any reason, can I pay my health insurance premiums with an HSA while I'm unemployed?

Generally, yes. You may use your HSA to pay health premiums if you are collecting federal or state unemployment benefits, or if you have COBRA/ Continuation of Coverage through a former employer. In addition, you may be able to pay for Medicare expenses (if over age 65) using HSA funds.

What happens to my HSA if I leave the Archdiocese of St. Louis?

Since you own your HSA, you have a number of options. You may choose to keep the funds in your HSA account or roll the funds over to a different account. (If you keep the funds in your account, maintenance fees will apply.)

Can I purchase long-term care insurance, or pay for Medicare or COBRA/Continuation of Coverage premiums, with money from my HSA?

Yes. You can if you have tax-qualified, long-term care insurance, according to the IRS. The amount considered a qualified medical expense depends on your age (see IRS Publication 502 for details).

What happens if I take a leave of absence?

Your payroll-deducted contributions to the HSA may stop during a leave period. However, you can make contributions directly to your HSA on your own through Optum Bank's website.

What happens to my HSA when I become eligible for Medicare?

Once you are enrolled in Medicare, you can no longer make contributions to your HSA. However, you can continue to use your account to pay for things other than medical expenses without penalties. Note that the amount withdrawn will not be subject to the 20% penalty you would be charged if you withdraw funds for non-medical expenses before you become Medicare-eligible.

How does eligibility work if I am not eligible for or enrolled in Medicare at the beginning of the benefit plan year (July 1), but will become eligible during the plan year?

On the date you become enrolled in Medicare, contributions to the HSA must stop. If you sign up for Social Security after your full retirement age, you may be paid up to six months of retroactive benefits. If this occurs, you will be retroactively enrolled in Medicare. HSA funds contributed year-to-date would still be available for you to use for qualified medical expenses subject to typical rules of an HSA set by the IRS. The HSA contributions for the year are capped at 1/12th of the annual contribution maximum times the number of months you were eligible to contribute to the HSA. For example, if you are eligible from January through March, but enroll in Medicare in April, you can contribute for three months or one-fourth of the annual maximum plus any applicable catch-up contribution (if you are between ages 55 and 65).

What if I decide to cancel the Base (HDHP w/ HSA) Plan and HSA due to a qualifying life event or the next Open Enrollment period?

If you cancel the Base (HDHP w/HSA) Plan and HSA due to a qualifying life event, the contribution you're allowed would be prorated based on the number of months you were enrolled. For example, if you have Employee + Family coverage, your contribution limit for the full 12 months of 2025 is $8,550. However, if you cancel after 10 months due to a qualifying life event, the contribution you're allowed would be $7,125. If you decide to switch to a different medical plan during the next Open Enrollment period and you have an HSA, you may continue to use your HSA for qualified health expenses at any time now or in the future, but you may not make any further contributions to your HSA (unless you re-enroll in the Base (HDHP w/HSA) Plan during a subsequent Open Enrollment).

What happens to my HSA upon my death?

Make sure to designate a beneficiary when you set up your HSA. If you are married and have named your spouse as beneficiary, he or she becomes the owner of your HSA if you die and can use it with all of the same advantages. If you are not legally married or choose someone other than your spouse as beneficiary, the account will no longer be treated as an HSA upon your death. It will pass on to your beneficiary or become part of your estate and be subject to any applicable taxes. You can designate your beneficiaries online through Optum Bank.

ARCHResources
SERVING THOSE WHO SERVE

Frequently Asked Questions for the Archdiocesan Wellness Incentive Retirement Contribution (WIRC) & Employee Wellness Screening

Wellness Incentive Retirement Contribution (WIRC) & Investment Questions

Q. What are the current wellness plan year dates?
A. May 1, 2025– April 30, 2026.

Q. What is the Wellness Incentive Retirement Contribution (WIRC) for the current year?
A. The amount is $125 for the current wellness plan year.

Q. How do I know if I am currently an eligible employee for the Wellness Incentive Retirement Contribution?
A. You are a benefit eligible employee, with at least one year of service, hired on or before May 1, 2025 and you are working at least 1,000 hours annually or a teacher with a half time or more contract.

Q. If I am no longer actively employed with the Archdiocese, or no longer benefit eligible, and I previously completed the wellness program will I still receive the WIRC?
A. The Wellness Incentive Retirement Contribution (WIRC) is for active benefit eligible employees. If you are no longer an active benefit eligible employee with the Archdiocese of St. Louis at the end of the Wellness Plan year, April 30th, you will not receive the WIRC.

Q. If I am eligible and complete a wellness exam/screening, how will I receive the Wellness Incentive Retirement Contribution (WIRC)?
A. The funds will be processed in the fall of 2026 and will be automatically deposited in your Archdiocese of St. Louis employer sponsored retirement account. The contribution is in addition to your normal monthly employer percentage contribution.

Q. How will the Wellness Incentive Retirement Contribution (WIRC) be invested?
A. If you have designated an investment allocation, then the contribution will be invested according to your designated investment election. If you do not have a designated investment allocation, then the contribution will be invested in the default fund. You can adjust your investment funds at any time.

Q. If I participate in both the voluntary and employer retirement account, can I designate which account to deposit the Wellness Incentive Retirement Contribution (WIRC)?
A. No. The WIRC will be deposited as an employer retirement account contribution.

Q. Can I get the Wellness Incentive Retirement Contribution (WIRC) in cash instead of being deposited in the lay employer retirement account?
A. No. The WIRC can only be received as a contribution to your lay employer 403(b) retirement account.

Q. Can I opt out of receiving the Wellness Incentive Retirement contribution (WIRC)?
A. No.

Q. Once the Wellness Incentive Retirement Contribution (WIRC) is deposited in my employer retirement account, can I request a distribution of the amount?
A. Yes, however, you must be eligible for a distributable event (Distribution/In-Service Withdrawal) as defined in the Plan Document.

Q. Will a vesting schedule apply to the Wellness Incentive Retirement Contribution (WIRC)?
A. No, as with all Contributions to the 403(b)-retirement plan, the contribution will be 100% vested immediately.

The Health Insurance Plan

Q. Can I get the employee wellness screening if I am benefit eligible but not enrolled in the UnitedHealthcare (UHC) Base (HDHP w/HSA) or Comprehensive (PPO) Plan?
A. Yes. The benefit of the exam/screening is to identify health risk factors early to be engaged in good health practices.

Q. Do I need to have the wellness exam/screening to be in the UHC Base (HDHP w/HSA) or Comprehensive (PPO) Plan?
A. No. There is no longer a wellness prerequisite to enroll in either of the Medical Plans, whether or not you had a wellness exam/screening. You may participate in either the UHC Base (HDHP w/HSA) or Comprehensive (PPO) Plan.

Q. If I receive a serious diagnosis, will you terminate my health insurance plan?
A. No. Your health insurance continues, and we have no knowledge of any diagnosis. We only want to encourage all participants to receive a wellness screening and to be engaged in good health practices.

Wellness Screening Questions

Q. If I am a benefit eligible employee and have less than one year of service (hired after May 1st) can I still receive the H&H Employee Wellness Screening?
A. Yes, a benefit eligible employee with less than one year of service can still receive the H&H Employee Wellness Screening.

Q. If I am an Archdiocesan priest, brother, or sister may I receive the H&H Employee Wellness Screening?
A. Religious priests, brothers, and sisters are eligible for an annual Archdiocesan paid H&H wellness screening; however, they are not eligible to receive the Wellness Incentive Retirement Contribution.

Q. Can I get the health screening any time during the wellness plan year or just in September and March?
A. For your convenience, you can get the screening anytime during the plan year between May 1st and April 30th. The screening must be scheduled through H&H Health Associates (314.845.8302) or online at http://wellness.hhhealthassociates.com. You will be directed to an H&H approved lab close to your home or work. The Archdiocese will sponsor onsite H&H Health screenings at multiple locations during the fall and spring each year, if feasible.

Q. Will the health results of my exam/screening be sent to the Archdiocese or my employer?
A. No. Individual health data will not be shared with your employer, the Archdiocese, our insurance provider, or any other entity. The alternative health screening is being conducted by H&H Health Associates or an H&H approved lab and will be managed in a completely confidential, HIPAA compliant manner.

Q. Does the physician who conducts my wellness exam have to be my primary care physician?
A. No. Any physician you choose, who meets the definition of a physician under the UHC health plan, can conduct your wellness exam.

Q. Does the annual wellness exam require an employee copayment or coinsurance?
A. Maybe. The UHC plan generally covers preventive services, as specified in the health care reform law, at 100% without charging a copayment, coinsurance, or deductible, as long as they are received in the UHC health plan's network. UHC covers other routine services, which may require a copayment, coinsurance, or deductible. Always refer to your plan documents for your specific coverage. Medical treatment for specific health issues or conditions, on-going care, laboratory tests or other health screenings necessary to manage or treat an already-identified medical issue or health condition are considered diagnostic care, not preventive care.

Q. If I do not complete the wellness screening for the current wellness plan year, to I need to do anything?
A. No.

Q. If I get the employee wellness screening during the current wellness plan year, do I need to complete the Physician Wellness form?
A. No. A Physician Wellness form is not required if you receive your employee wellness screening through H&H Health Associates.

Frequently Asked Questions for the Archdiocesan Wellness Incentive Retirement Contribution (WIRC) & Employee Wellness Screening

Q. Can my spouse/child participate in the employer paid H&H wellness screening?
A. No. The H&H screening is a benefit provided to employees only. Your spouse/child may see the physician for a wellness exam, as the UHC plan typically covers preventive services.

Q. If I fail to have a wellness exam/screening prior to April 30, can I ask for extra time?
A. **No. You have a full wellness plan year notice, from May 1st to April 30th to complete the wellness screening. Extra time allowances will not be granted due to administrative requirements.**

Q. May I receive both an annual wellness exam from a physician and a health screening from H&H Health Associates?
A. Yes. The two covered preventive actions are not mutually exclusive.

Q. Should I get an H&H screening in lieu of an annual wellness exam by a physician?
A. While the H&H screening is a good wellness tool, it does not replace the importance of a comprehensive wellness exam and lab work by a physician on a regular and long-term basis. We encourage you to develop a physician/patient relationship to enhance your quality of life.

Q. What is the H&H Comprehensive Wellness Screening scope of testing?
A. The comprehensive Wellness Screening panel from H&H Health Associates looks at a wide array of different diseases/illnesses, including diabetes, kidney function, nerve conduction & muscle contraction, heart rhythm, bone health, cellular repair, fluid balance, damage to bones/liver/heart, iron reserves & saturation, heart disease risk, thyroid function, immune system disorders, anemia, clotting ability, infections, etc.

Q. What are the tests included in the H&H Employee Wellness Screening?
A. Below is a full listing of all test results...

Triglycerides	Sodium	White Blood Cell Count	Basophils
Total Cholesterol	Potassium	Red Blood Cell Count	TSH
HDL Cholesterol	Chloride	Hemoglobin	Hemoglobin A1C
LDL Cholesterol	Carbon Dioxide	Hematocrit	Bilirubin Direct
VLDL Cholesterol	Calcium	MCV	UIBC
Cholesterol Ratio	Protein	MCH	Neuts (Absolute)
Total Iron	Albumin	MCHC	Lymphs (Absolute)
TIBC	Globulin	RDW	Eos (Absolute)
Iron Saturation	Albumin/Globulin Ratio	Platelet Count	Baso (Absolute)
Glucose	Bilirubin Total	Neutrophils	Mono (Absolute)
BUN	Alkaline Phosphate	Lymphocytes	PSA (if Male, 50+)
Creatinine	AST (SGOT)	Monocytes	
BUN/Creatinine Ratio	ALT (SGPT)	Eosinophils	

Q. If I miss the spring or fall Archdiocesan Wellness Events, how can I get an H&H Employee Wellness Screening?
A. H&H Employee Wellness Screenings are available at over 1,600+ walk-in clinics nationally. Please contact H&H directly at 800.832.8302 or wellness.hhhealthassociates.com

On average, 25% of any population screened are considered "High Risk", meaning the individual is either completely unaware of a chronic illness/disease, or they are aware of a condition, but it is not under adequate control.

Important: This guide's Frequently Asked Questions and Description is intended to give you an overview of the Wellness Incentive Plan offered by the Archdiocese of St. Louis. Any of the benefit plans offered by the Archdiocese of St. Louis may be amended, revoked, suspended, or terminated at the Archdiocese's sole discretion at any time.

Revised 6/2024

Annual Notices

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer rights Act of 1998, we provide benefits under the Plan for patients who choose to have breast reconstruction in connection with a mastectomy.

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending physician:

- All stages of reconstruction of the breast on which mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

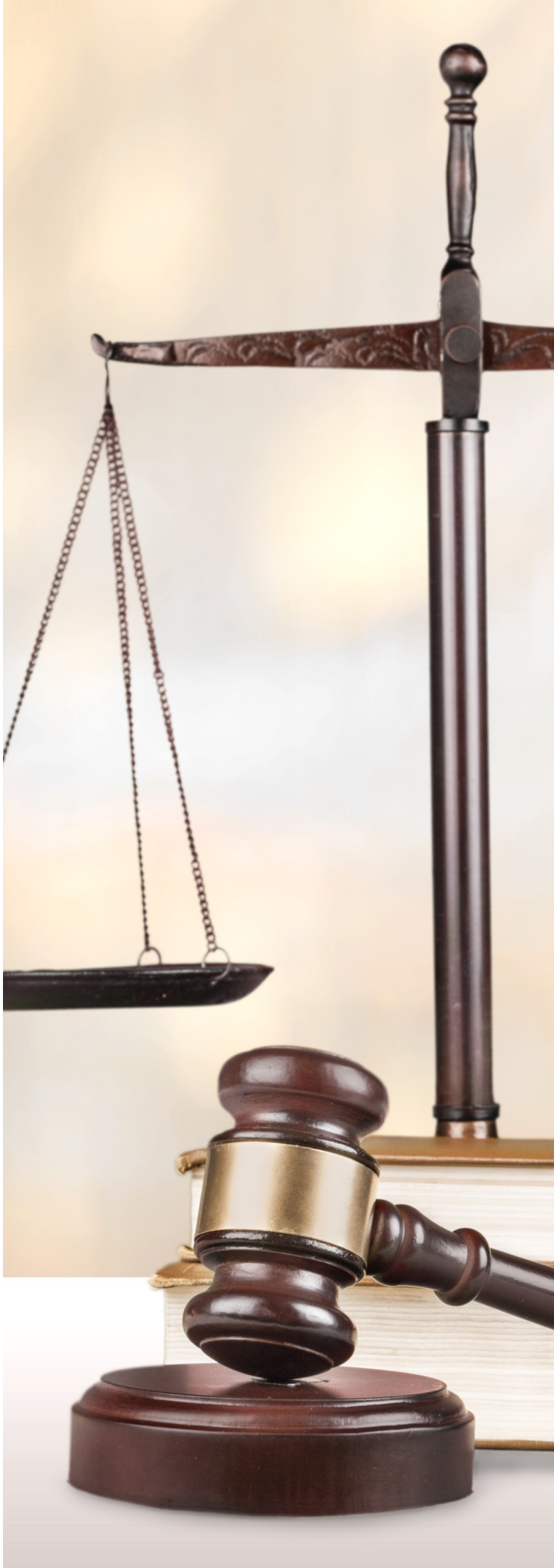
The amount you must pay for such Covered Health Services (including copayments and any annual deductible) are the same as are required for any other Covered Health Service. Limitations on benefits are the same as for any other Covered Health Service.

Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other healthcare provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, call the toll-free member phone number on your ID card.



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 **877.KIDS.NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in the following state, you may be eligible for assistance paying your employer health plan premiums. The following list of state is current as of July 31, 2024. Contact your state for more information on eligibility.

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)
Illinois is not an eligible state.

Health Insurance Portability And Accountability Act (HIPAA) Privacy Notice

The use and disclosure of your Protected Health Information ("PHI") by the Plans is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). This Notice of Privacy Practices is intended to summarize the HIPAA regulations. PHI includes all individually identifiable health information created, received, sent to other people or companies, or maintained by the Plans. The Plans are required by law to maintain the privacy of PHI. This Notice is effective beginning April 14, 2003, and the Plans are required to comply with the terms of this Notice.

Please view the Archdiocesan Employee Benefits Website at **https://resources.archstl.org/article/253521/2025-open-enrollment** to obtain the complete HIPAA Privacy Notice. If you want a copy mailed to your home address, you may contact the Office of Human Resources at **AskHR@archstl.org**.

Annual Rights and Resource Disclosure

Healthcare coverage can sometimes be complex and confusing, but it doesn't have to be. The Annual Rights and Resource Disclosure guide is designed to help you get the most from your health insurance with UnitedHealthcare® benefits. UnitedHealthcare works with the National Committee for Quality Assurance® (NCQA) and state and federal regulators to ensure members receive this information on an annual basis.

Please view the **Archdiocesan website** to obtain the complete Annual Rights and Resource Disclosure guide. If you want a copy mailed to your home address, you may contact the Office of Human Resources at **AskHR@archstl.org**.

Contact Information

If you have specific questions about any of the benefit plans, please contact the administrator listed below, or your human resources department at **AskHR@archstl.org**.

Benefit	Carrier	Phone	Website
Medical	UnitedHealthcare Policy #703597	833.748.2404	www.myuhc.com
Pharmacy	OptumRx	833.748.2404	www.myuhc.com (click "Pharmacies & Prescriptions" to get to the OptumRx homepage)
HSA	Optum Bank	866.234.8913	www.optum.com
Dental	Delta Dental of Missouri Policy #1873-1000	Toll-Free: 800.335.8266 Local: 314.656.3001	www.deltadentalmo.com
Vision	DeltaVision Policy #20070020	Claims and Customer Service: 877.226.1412	www.deltadentalmo.com/vision
Flexible Spending Account	TriStar Benefit Administrators Policy #A03100-A03999	800.456.4584 Option 4	www.tristar.summitfor.me
Life Insurance	Hartford Life Policy #677885	800.523.2233	www.archstl.org/human-resources/employee-benefits-and-forms/life-insurance-plans
Long Term Disability	Unum Policy #374488	800.868.1773 x. 53049	www.unum.com
Retirement Plan	Empower	866.467.7756	www.participant.empower-retirement.com/participant/login
Employee Assistance Program	Saint Louis Counseling	314.544.3800	www.saintlouiscounseling.org

Notes

This benefit guide prepared by

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