DIOCESE of COLUMBUS

CHANGE FORM
for
EMPLOYEE BENEFITS

QUALIFYING EVENTS

- Birth, adoption or guardianship of a child;
- Court Administrative Order;
- Marriage;
- Divorce;
- Loss of Coverage (includes loss of employment by spouse); or
- Death

Please note that no exceptions can be made for you to change your enrollment benefit selections unless one of the above life-changing events occurs and you make the change no later than 31 days after the date of the qualifying event.

Full-Time Employee = works 30 or more hours per week

Are eligible for: These employer paid benefits:

- Employer Paid $50,000 Group Life Insurance
- Group STD
- Group LTD
- LTD Buy-Up
- Medical Coverage, Base or Enhanced
- Dental Coverage, Base or Enhanced
- Vision Coverage, Base or Enhanced
- Voluntary Employee Life Insurance, Spousal Life Insurance and Dependent Life Insurance
- Medical flex spending account and Dependent care account

Part-Time Employee = works less than 30 hours but at least 15 hours per week

Are eligible for:

- Dental Coverage, Base or Enhanced, employee pays full premium
- Vision Coverage, Base or Enhanced, employee pays full premium
- Voluntary Employee Life Insurance, Spousal Life Insurance, and Dependent Life Insurance

Part-Time Employee = works less than 15 hours per week is not eligible for Benefits

Religious Employee = Sisters and Priests who are working within the Diocese of Columbus full time

Are eligible for:

- Medical Coverage, Base or Enhanced
- Dental Coverage, Base or Enhanced
- Vision Coverage, Base or Enhanced
- Medical flex spending account

Diocesan Priest = Priest under the Diocese of Columbus

Are eligible for:

- Medical Coverage, Base or Enhanced
- Dental Coverage, Base or Enhanced
- Vision Coverage, Base or Enhanced
- Group Priests' Life Insurance
- Voluntary Employee Life Insurance
- Medical flex spending account

Retired Diocesan Priests

Are eligible for:

- Dental coverage, Base or Enhanced
- Vision coverage, Base or Enhanced

DIOCESE OF COLUMBUS

BENEFIT RATES EFFECTIVE - January 1, 2024 through December 31, 2024

The effective date of coverage for new hires is the first day of the month following his or her hire date.

If a Diocesan employee's spouse is not eligible for medical insurance at his/her place of employment or if a Diocesan employee's spouse is not offered medical insurance at his/her place of employment, then the Diocesan employee must complete a Spousal Employment Statement Form. See below. An eligible employee who chooses single + one or family coverage--- which includes his/her spouse--- and his/her spouse has access to other medical coverage or spouse is receiving any cash/credit from employer to purchase medical coverage elsewhere, the employee must pay the additional spousal premium listed below to receive coverage for the spouse.

Aetna, P. O. Box 981106, El Paso, TX 79998-1106, (800) 238-6716, www.aetna.com

Health Enhanced Plan (Self - Funded Plan)	Monthly Premium	**Employee Share**	Employer Share
Single	$ 1,114.00	**$223.00**	$ 891.00
Single + One	2,404.00	**$480.00**	1,924.00
Single + One + Spousal Premium Program	2,404.00	**1,513.00**	891.00
Family	2,752.00	**550.00**	2,202.00
Family + Spouse Premium Program	2,752.00	**1,596.00**	1,156.00
Health Base Plan (Self - Funded Plan)			
Single	$ 792.000	**$ 108.00**	$ 684.00
Single + One	1,705.00	**256.00**	1,449.00
Single + One + Spousal Premium Program	1,705.00	**1,032.00**	673.00
Family	1,950.00	**293.00**	1,657.00
Family + Spouse Premium Program	1,950.00	**1,072.00**	878.00

Aetna, P. O. Box 14094, Lexington, KY 40512-4094, 1-877-238-6200, www.aetna.com

Dental Enhanced Plan (Self - Funded Plan)	Monthly Premium	**Employee Share**	Employer Share
Single	$ 49.00	**$ 18.00**	$ 31.00
Single + One	97.00	**35.00**	62.00
Family	149.00	**54.00**	95.00
Dental Base Plan (Self Funded Plan)			
Single	28.00	**4.00**	24.00
Single + One	54.00	**8.00**	46.00
Family	95.00	**12.00**	83.00

Vision Service Plan (VSP), www.vsp.com, 1-800-877-7195; for more Information, contact the Insurance Office at (614) 224-1221

Vision Service Plan (VSP) – Enhanced Plan	Monthly Premium	**Employee Share**	Employer Share
Single	$ 11.00	**$ 11.00**	None
Single + One	21.00	**21.00**	None
Family	32.00	**32.00**	None
Vision Service Plan (VSP) – Base Plan			
Single	$ 6.00	**6.00**	None
Single + One	11.00	**11.00**	None
Family	16.00	**16.00**	None

CATHOLIC DIOCESE OF COLUMBUS
SPOUSAL EMPLOYMENT STATEMENT

____
Spouse's Name

This is to verify that my spouse is NOT eligible for, OR enrolled in, any other group health coverage and/or is NOT receiving any cash/credit from an employer to purchase health coverage elsewhere.

Please check the applicable category description, and ATTACH any documentation listed as required - (Notary witness is NOT required for these categories):

- Group health coverage is not offered to my spouse - MUST provide verification letter from spouse's employer
- My Spouse is self-employed - MUST provide verification of self-employment: i.e., tax I.D. #, invoice, etc.
- Spouse is also an employee of the Diocese
- My Spouse is enrolled at his/her place of employment as primary health insurance coverage - A copy of the spouse's group health insurance card (both sides) MUST be attached for a spouse to be enrolled as secondary coverage.

____
Spouse's Employer Name

____
Spouse's Employer Address **Phone**

I certify and confirm that this is a true statement by my signature below.

____
Diocesan Employee Name (please print) **Diocesan Employee Signature** **Date**

The following categories **require Notary Witness:**

- Spouse is not employed
- Spouse is retired

NOTE: The employee is responsible for notifying the individual responsible for payroll at his/her location for any changes that occur during the year in regards to his/her spouse's employment or benefit status before any change will be made to this Program.

Witness by Notary,

STATE OF______________________ COUNTY OF______________________

BEFORE ME, the undersigned, a Notary Public, personally appeared______________________

who executed the above Spousal Employment Statement as a free and voluntary act.

IN WITNESS WHEREOF, I have signed my name and affixed my official notarial seal

this day of______________________, 20________. ______________________

(SEAL) **Notary Public** **My Commission Expires**

PLEASE SCAN and EMAIL to:
Catholic Diocese of Columbus
Attention: Insurance Office
197 East Gay Street
Columbus, OH 43215-3766
tdepassio@columbuscatholic.org

If we do not receive this correctly completed form from you, you will be charged a spousal premium.

DIOCESE of COLUMBUS

2024 ENHANCED MEDICAL PLAN BENEFIT SUMMARY

Administered by Aetna | P. O. Box 981106 | El Paso, TX 79998-1106 | (800) 238-6716 | www.aetna.com

PLAN PROVISIONS	NETWORK BENEFITS	NON-NETWORK BENEFITS *
Deductible	$500 Single; $1,000 Family	$1,000 Single; $2,000 Family
Coinsurance	90% Plan; 10% Member	70% Plan; 30% Member
Out-of-Pocket Maximum (O-P-M)	$3,500 Single; $7,000 Family	$4,500 Single; $9,000 Family
Lifetime Maximum Policy Benefit	**NONE**	**NONE**
	YOU PAY:	**YOU PAY:**
Physician Office Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Specialist Physician Office Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Well Baby/Child Care	100% paid by Plan	Deductible then coinsurance of 30% until O-P-M reached
Comprehensive Physical Exams, Routine	100% paid by Plan	Deductible then coinsurance of 30% until O-P-M reached
Obstetrical Office Visits (Pre & Post Natal)	100% paid by Plan	Deductible then coinsurance of 30% until O-P-M reached
Allergy Services – Testing, Serum, Injections	Deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Professional Fees for Surgical/ Medical Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Inpatient Hospital Services	Subject to deductible then coinsurance of 10% until O-P-M reached	**With Prior Notification** - Deductible then coinsurance of 30%
Emergency Care	Subject to deductible then coinsurance of 10% until O-P-M	Deductible then coinsurance of 30% until O-P-M
Emergency Ambulance Services	100% of Eligible Expenses paid by Plan	Covered as Network Benefit
Urgent Care Services	Subject to deductible then co-insurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
CVS Minute Clinics Non-CVS Minute Clinics	100% paid by Plan 10%;after deductible is met	Deductible then coinsurance of 30%
Outpatient Hospital & Alternate Facility Services	Deductible then coinsurance of 10% until O-P-M reached.	Deductible then coinsurance of 30% until O-P-M reached.
Outpatient Mental Health & Substance Abuse Services	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Inpatient Mental Health & Substance Abuse	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached

Prosthetic Devices & Durable Medical Equipment	Subject to Deductible then coinsurance of 10% **over $1,000 requires prior approval**; Maximum $2,500 (except diabetic DME items)	Deductible then coinsurance of 30%; **over $1,000 requires prior approval**; Maximum $2,500 (except diabetic DME items)
Outpatient Rehabilitation Services (Limitations Apply)	Subject to deductible then coinsurance of 10% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Prescription Benefit – Retail Pharmacy	Tier I - $10 Tier II – 25% (min $50 – max $100) Tier III – 40% (min $100 –max $150)**	Deductible then coinsurance of 30%
Prescription Benefit – Mail Order 90-Day Supply	Tier I - $25 (includes CVS retail stores) Tier II – 25% (min $125 – max $225) Tier III –40% (min $225 – max $325)**	Not Covered

Specialty Drugs involves process through the Prudent Rx Copay Program

What is PrudentRx Copay Program?
PrudentRx Copay program combines an innovative specialty copay plan design strategy and improved member experience to help optimize savings from non-needs-based manufacturer copay cards and reduce member costs. The program allows members to pay $0 Out of pocket for all specialty medications on the plan's Exclusive Specialty drug list dispensed by CVS Specialty, regardless if a copay card is available.

2024 BASE MEDICAL PLAN BENEFIT SUMMARY

Administered by Aetna | P. O. Box 981106 | El Paso, TX 79998-1106 | (800) 238-6716 | www.aetna.com

PLAN PROVISIONS	NETWORK BENEFITS	NON-NETWORK BENEFITS *
Deductible	$1,500 Single; $3,000 Family	$3,000 Single; $6,000 Family
Coinsurance	70% Plan; 30% Member	50% Plan; 50% Member
Out-of-Pocket Maximum (O-P-M)	$5,000 Single; $10,000 Family	$8,500 Single; $17,000 Family
Lifetime Maximum Policy Benefit	**NONE**	**NONE**
	YOU PAY:	**YOU PAY:**
Physician Office Services	Subject to deductible then coinsurance of 30% until O-P-M reached	Deductible then coinsurance of 50% until O-P-M reached
Specialist Physician Office Services	Subject to deductible then coinsurance of 30% until O-P-M reached	Deductible then coinsurance of 50% until O-P-M reached
Well Baby/Child Care	100% paid by Plan	Deductible then coinsurance of 50% until O-P-M reached
Comprehensive Physical Exams, Routine	100% paid by Plan	Deductible then coinsurance of 50% until O-P-M reached
Obstetrical Office Visits (Pre & Post Natal)	100% paid by Plan	Deductible then coinsurance of 50% until O-P-M reached
Allergy Services – Testing, Serum, Injections	Deductible then coinsurance of 30% until O-P-M reached	Deductible then coinsurance of 50% until O-P-M reached
Professional Fees for Surgical/ Medical Services	Subject to deductible then coinsurance of 30% until O-P-M reached	Deductible then coinsurance of 50%
Inpatient Hospital Services	Subject to deductible then coinsurance of 30% until O-P-M reached	**With Prior Notification - Deductible then coinsurance of 50%.**
Emergency Care	Deductible then coinsurance of 30%	Deductible then coinsurance of 50%
Emergency Ambulance Services	100% of Eligible Expenses paid by plan	Covered as Network Benefit
Urgent Care Services	Subject to deductible then coinsurance of 30% until O-P-M reached	Deductible then coinsurance of 50%
CVS Minute Clinics	100% paid by Plan 10%;after deductible is met	Deductible then coinsurance of 30%
Non-CVS Minute Clinics	100% paid by Plan 30%;after deductible is met	Deductible then coinsurance of 50%
Outpatient Hospital & Alternate Facility Services	Subject to deductible then coinsurance of 30%	Deductible then coinsurance of 50%
Outpatient Mental Health & Substance Abuse Services	Subject to deductible then coinsurance of 30%	Deductible then coinsurance of 50%
Inpatient Mental Health & Substance Abuse	Subject to deductible then coinsurance of 30%	Deductible then coinsurance of 50%

Prosthetic Devices & Durable Medical Equipment	Deductible then coinsurance of 30%; **over $1,000 requires prior approval**; Maximum $2,500 (except diabetic DME items)	Deductible then coinsurance of 50%; **over $1,000 requires prior approval**; Maximum
Outpatient Rehabilitation Services (Limitations Apply)	Subject to deductible then coinsurance of 30% until O-P-M reached	Deductible then coinsurance of 30% until O-P-M reached
Prescription Benefit – Retail Pharmacy	Tier I - $10 Tier II – 25% (min $50 – max $100) Tier III – 40% (min $100 – max $150)**	Deductible then coinsurance of 50%
Prescription Benefit – Mail Order 90-Day Supply	Tier I - $25 (includes CVS retail stores) Tier II – 25% (min $125 – max $225) Tier III –40% (min $225 – max $325)**	Not Covered

Specialty Drugs involves process through the Prudent Rx Copay Program

What is PrudentRx Copay Program?
PrudentRx Copay program combines an innovative specialty copay plan design strategy and improved member experience to help optimize savings from non-needs-based manufacturer copay cards and reduce member costs. The program allows members to pay $0 Out of pocket for all specialty medications on the plan's Exclusive Specialty drug list dispensed by CVS Specialty, regardless if a copay card is available.

DENTAL PLANS:

ADMINISTERED BY AETNA | P. O. Box 14094, Lexington, KY 40512-4094 | 1-877-238-6200 | www.aetna.com

The **Base Plan** reimburses non-network claims based on a Maximum Allowable Charge fee schedule (MAC), meaning Aetna will not reimburse any amount charged over this set fee schedule. Any amount charged by a provider over this fee schedule will be the responsibility of the member—this is referred to as balance billing.

The **Enhanced (Buy-Up) Plan** reimburses non-network claims based on Usual, Customary, and Reasonable amounts (UCR), reimbursing claims up to 90% UCR. This often results in a higher non-network reimbursement and less out-of-pocket cost for the member if they choose to go out of network.

Neither plan balance bills a member if services are received at a network provider. In addition, neither plan requires a deductible for any services received. Premium rate information will be available on the online Paycor system when completing your benefit elections. NOTE: AETNA does not issue dental cards but one can be printed once you register on their website.

Please note that dependents are covered until the end of the month in which they turn 26.

	ENHANCED PLAN		BASE PLAN
	Plan Pays		Plan Pays
Non-Network Benefits – Dentist can balance bill	Benefits are based on 90th percentile of UCR (usual, customary & reasonable)		Benefits are based on **Network** allowable
Dental Benefits	**Plan Pays**		**Plan Pays**
Annual Deductible	No Deductible		No Deductible
Calendar Year Maximum	$2,000 per person		$1,500 per person
Lifetime Ortho Maximum	$2,500 per person		$1,500 per person
Preventative Services	**In Network**	**Out of Network**	**Network Allowable**
Oral Examination (2x per Year)	100%	90%	100%
Dental Prophylaxis (2x per Year)	100%	90%	100%
Bitewing X-rays (2x per Year)	100%	90%	100%
Full Mouth X-rays (1x per 3 years)	100%	90%	100%
Fluoride Treatments (2x per Year)	100%	90%	100%
Sealants (1x per 3 years – under 16)	80%	70%	50%
Basic Services			
Amalgam Restorations (Fillings)	80%	70%	50%
Composite Resin Restorations			
(Fillings) – Anterior Teeth	80%	70%	50%
Space Maintainers	80%	70%	50%
Root Canal Treatment	80%	70%	50%
Periodontal Surgery	80%	70%	50%
Root Planing	80%	70%	50%
Simple Extractions	80%	70%	50%
Surgical Extractions – Impacted			
Wisdom Teeth	80%	70%	50%
Necessary General Anesthesia	80%	70%	50%
Palliative Treatment (Relief of Pain)	80%	70%	50%

Preventative Services	In Network	Out of Network	Network Allowable
Major Services			
Crowns, Inlays, Onlays	50%	50%	50%
Fixed Bridges	50%	50%	50%
Partial Dentures	50%	50%	50%
Full Dentures	50%	50%	50%
Orthodontic Services (up to 19)	60%	50%	50%

VISION PLAN:
ADMINISTERED BY Vision Service Plan (VSP)

Vision Benefits	Base Plan (VSP Provider)	Enhanced Plan (VSP Provider)
Vision Exam	$15 Co-Pay	$15 Co-Pay
Vision Exam Frequency	**Exam: 12 Months**	**Exam: 12 Months**
Materials	$25 Co-Pay	$25 Co-Pay
Diabetic EyeCare	$20 per visit	$20 per visit
Materials Frequency: Lenses/Frames	Lenses: 12 months Frames: 24 months	Lenses: 12 months Frames: 12 months
Lenses		
Single Vision	Covered after co-pay	Covered after co-pay
Lined Bifocal	Covered after co-pay	Covered after co-pay
Lined Trifocal	Covered after co-pay	Covered after co-pay
Lenticular	Covered after co-pay	Covered after co-pay
Scratch Resistant Coating	No co-pay	No co-pay
Progressive Lenses	Single – N/A Multifocal - $55	Single – N/A Multifocal - $50*
Polycarbonate Lenses for children	No co-pay	No co-pay
Polycarbonate Lenses for adults	Single - $31 Multifocal - $35	Single - $31 Multifocal - $35
Photochromic – Transition Lenses	Single - $70 Multifocal - $82	Single - $20 Multifocal - $20
Anti-Reflective Coating	$41	$41
Frames		
Frame Allowance	$150 ($170 on featured frame brands)	$175 ($195 on featured frame brands)
Contacts		
Elective Contact Lenses (in lieu of spectacles/frames every 12 months)	$150 (after up to $60 co-pay for fitting & evaluation)	$175 (after up to a $40 co-pay for fitting & evaluation)
Medically Necessary Contact Lenses	Covered after co-pay	Covered after co-pay
Other Services		
Lasik Surgery	15% off regular or 5% off	

Additional Glasses/Contacts: 20% off unlimited pairs of prescription glasses and/or non-prescription sunglasses. Mail-in rebates savings up to $110 on eligible Bausch+Lomb contacts and up to $125 on eligible ACUVUE Brand contacts.

Vision Benefits	Base Plan (VSP Provider)	Enhanced Plan (VSP Provider)
Examination	$45 Co-Pay	$45 Co-Pay
Single Vision lenses	$30	$30
Bifocal Lenses	$50	$50
Trifocal lenses	$65	$65
Lenticular	$100	$100
Frames	$70	$70
Elective Contact Lenses*	$105	$105
Necessary Contact Lenses	$210	$210

* Contact lenses are in lieu of spectacle lenses and frames once every 12 months

CATHOLIC DIOCESE OF COLUMBUS

Change Enrollment Form

Employee's Full Name | Location

Job Title | Effective Date

Address:

City | State | Zip Code

Email Address

Reason for Change

Please indicate below the insurance coverage you wish to select:

Medical Benefits (Base): ______ Employee ______ Emp. + 1 ______ Family ______ I decline
Medical Benefits (Enhanced): ______ Employee ______ Emp. + 1 ______ Family ______ I decline
Dental Benefits (Base): ______ Employee ______ Emp. + 1 ______ Family ______ I decline
Dental Benefits (Enhanced): ______ Employee ______ Emp. + 1 ______ Family ______ I decline
Vision Benefits (Base): ______ Employee ______ Emp. + 1 ______ Family ______ I decline
Vision Benefits (Enhanced): ______ Employee ______ Emp. + 1 ______ Family ______ I decline

Please indicate below the dependent(s) you are adding or deleting. If adding a dependent(s) for Health, please **include verifying documentation** (recent tax return - black-out confidential information, birth certificate for children, marriage certificate for recent marriages, etc.). Please note that dependents will **not** be covered without their social security number.

Name	Gender	SSN	DOB	Add	Delete

Flexible Spending Account (FSA): ________________________ Amount per pay
Maximum annual amount is $2,500; $10 per pay minimum

Dependent Care Account (DCA): ________________________Amount per pay
Maximum annual amount is $5,000; $10 per pay minimum

By my signature below, I hereby authorize the Diocese of Columbus to deduct from my pay the established employee premium for the benefits changes I indicated above.

I understand these rates will remain in effect throughout the calendar year unless I experience a lifechanging event or my employment is terminated with the Diocese of Columbus.

Employee Signature: ____

Date: ________________________