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: _____

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

Benefit Rates January 1, 2025 through December 31, 2025

Medical Insurance – Surest Base Plan	Monthly Premium	Employee Share	Employer Share
Employee	$792.00	$108.00	$684.00
Employee/Spouse	$1,705.00	$256.00	$1,449.00
Employee/Child(ren)	$1,705.00	$256.00	$1,449.00
Family	$1,950.00	$293.00	$1,657.00

Medical Insurance – Surest Enhanced Plan	Monthly Premium	Employee Share	Employer Share
Employee	$1,114.00	$223.00	$891.00
Employee/Spouse	$2,404.00	$480.00	$1,924.00
Employee/Child(ren)	$2,404.00	$480.00	$1,924.00
Family	$2,752.00	$550.00	$2,202.00

Dental – UHC Base Plan	Monthly Premium	Employee Share	Employer Share
Employee	$28.00	$4.00	$24.00
Employee/Spouse	$54.00	$8.00	$46.00
Employee/Child(ren)	$54.00	$8.00	$46.00
Family	$95.00	$12.00	$83.00

Dental – UHC Enhanced Plan	Monthly Premium	Employee Share	Employer Share
Employee	$49.00	$18.00	$31.00
Employee/Spouse	$97.00	$35.00	$62.00
Employee/Child(ren)	$97.00	$35.00	$62.00
Family	$149.00	$54.00	$95.00

Vision – VSP Base Plan - Voluntary	Monthly Premium	Employee Share	Employer Share
Single	$6.00	$6.00	None
Single + One	$11.00	$11.00	None
Family	$16.00	$16.00	None

Vision – VSP Enhanced Plan - Voluntary	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

Lincoln Benefits	Monthly Premium	Employee Share	Employer Share
Basic Life: $50,000	$10.00	$0	$10.00
Voluntary Life Buy-Up (Optional)	Based on Age Band	Payroll Deducted	$0
Short Term Disability	$19.00	$0	$19.00
Long Term Disability – Base	$5.00	$0	$5.00
Long Term Disability – Buy Up (Optional)	$21.00	$21.00	$0

Medical Insurance

Catholic Diocese of Columbus will continue to offer medical coverage. Coverage will be offered through Surest, which uses the United Healthcare Network. Verify your provider is part of the United Healthcare Network, https://connect.werally.com/plans/uhc, elect the Choice Plus Network. Below is an overview of the two plans offered.

Medical Benefits Overview – Base Plan

Benefit Coverage	surest A UnitedHealthcare Company	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$0	
Family	$0	
Maximum Out-of-Pocket*		
Individual	$5,500	$11,000
Family	$11,000	$22,000
Physician Office Visit		
Primary & Specialty Care	$25 to $130	$215
Mental Health Virtual	$25 to $90	Not covered
Virtual Health	$0 to $130	Not covered
Preventive Care		
Adult Periodic Exams	$0	$195
Well-Child Care	$0	$195
Diagnostic & Treatment Services		
Routine Diagnostic	$0	$0
Complex Radiology	$150 to $1,050	Up to $1,650
Urgent Care Facility	$80	$200
Emergency Room Observation Stay	$500	$500
Procedures	$40 to $3,500	Up to $10,000
Maternity	Prenatal & Postnatal Care: $0 Delivery: $1,300 to $2,750	Prenatal & Postnatal Care: $195 Delivery: $8,250
Mental Health & Susbstance Abuse		
Inpatient & Outpatient	$25 to $2,750	$195 to $8,250
Hospice		
Home Visits	$70	$210
Inpatient Care	$2,750	$8,250
Therapy Visit Limits		
Physical Therapy	60 visit limit per person per plan year, not combined with other therapies	
Occupational Therapy	60 visit limit per participant per plan year, combined with Cognitive Therapy	
Speech Therapy	60 visit limit per person per plan year, not combined with other therapies	

Benefit Coverage	surest. A UnitedHealthcare Company	
	In-Network Benefits	Out-of-Network Benefits
Home Health Care	120 visit limit per person per plan year	
Skilled Nursing Facility	120 visit limit per person per plan year	
Retail Pharmacy (30 Day Supply)		
Tier 1	$10	Not Covered
Tier 2	$35	Not Covered
Tier 3	$70	Not Covered
Retail Pharmacy (90 Day Supply)		
Tier 1	$25	Not Covered
Tier 2	$88	Not Covered
Tier 3	$175	Not Covered
Specialty Retail Pharmacy		
Tier 1	$10	Not Covered
Tier 2	$100	Not Covered
Tier 3	$200	Not Covered

Medical Benefits Overview – Enhanced Plan

Benefit Coverage	surest. A UnitedHealthcare Company	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$0	
Family	$0	
Maximum Out-of-Pocket*		
Individual	$3,000	$8,000
Family	$6,000	$16,000
Physician Office Visit		
Primary & Specialty Care	$5 to $40	$120
Mental Health Virtual	$5 to $30	Not covered
Virtual Health	$0 to $40	Not covered
Preventive Care		
Adult Periodic Exams	$0	$60
Well-Child Care	$0	$60
Diagnostic & Treatment Services		
Routine Diagnostic	$0	$0

Benefit Coverage	surest. A UnitedHealthcare Company	
	In-Network Benefits	Out-of-Network Benefits
Complex Radiology	$50 to $340	Up to $1,020
Urgent Care Facility	$20	$60
Emergency Room Observation Stay	$200	$200
Procedures	$10 to $2,000	Up to $6,000
Maternity	Prenatal & Postnatal Care: $0 Delivery: $350 to $1,025	Prenatal & Postnatal Care: $60 Delivery: $3,075
Mental Health & Susbstance Abuse		
Inpatient & Outpatient	$5 to $1,000	$60 to $3,000
Hospice		
Home Visits	$20	$60
Inpatient Care	$1,000	$3,000
Therapy Visit Limits		
Physical Therapy	60 visit limit per person per plan year, not combined with other therapies	
Occupational Therapy	60 visit limit per participant per plan year, combined with Cognitive Therapy	
Speech Therapy	60 visit limit per person per plan year, not combined with other therapies	
Home Health Care	120 visit limit per person per plan year	
Skilled Nursing Facility	120 visit limit per person per plan year	
Retail Pharmacy (30 Day Supply)		
Tier 1	$10	Not Covered
Tier 2	$35	Not Covered
Tier 3	$70	Not Covered
Retail Pharmacy (90 Day Supply)		
Tier 1	$25	Not Covered
Tier 2	$88	Not Covered
Tier 3	$175	Not Covered
Specialty Retail Pharmacy		
Tier 1	$10	Not Covered
Tier 2	$100	Not Covered
Tier 3	$200	Not Covered

Dental Insurance

Catholic Diocese of Columbus will continue to offer a dental program. Dental will now be provided through United Healthcare. Verify your provider is part of the United Healthcare network, https://connect.werally.com/plans/uhc/375, select National Options PPO 30.

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Benefit Coverage	Base Plan In/Out Network	Enhanced Plan In/Out Network
Annual Deductible		
Individual	n/a	n/a
Family	n/a	n/a
Waived for Preventive Care?	n/a	n/a
Annual Maximum		
Per Person	$1,500	$2,000
Preventive	100%	100% | 90%
Basic	50%	80% | 70%
Major	50%	50%
Orthodontia		
Benefit Percentage	50%	60% | 50%
Adults (and Covered Full-Time Students, if Eligible)	Yes	Yes
Dependent Child(ren)	Yes	Yes
Lifetime Maximum	$1,500	$2,500

Vision Insurance

Catholic Diocese of Columbus provides Vision Insurance through VSP.

Benefit Coverage	VSP	
	Base Plan	**Enhanced Plan**
Copay		
Routine Exams (Annual)	$15 copay, every 12 months	$15 copay, every 12 months
Vision Materials		
Materials Copay	$25	$25
Material Frequency	Lenses: 12 months Frames: 24 months	Lenses: 12 months Frames: 12 months
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	$150 allowance (after up to a $60 copay for fitting & evaluation)	$175 allowance (after up to a $40 copay for fitting and evaluation)