



DIOCESE of
COLUMBUS

**Employee
Benefits Guide**



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The material contained in this guide are summaries. Please refer to your Certificate of Coverage for full plan details.





DIOCESE of COLUMBUS

A MESSAGE TO OUR EMPLOYEES

As we approach the 2026 Benefits Open Enrollment period, we want to keep you informed about important updates and changes to your healthcare coverage.

Due to rising healthcare costs driven by inflation, increased government regulation, and a higher volume and severity of claims, the cost to provide healthcare coverage has increased across the market. The Catholic Diocese of Columbus is not immune to these trends, but we remain committed to offering a comprehensive benefits package to support your health and well-being.

Help Is Here When You Need It

The USI Benefit Resource Center is a team of dedicated professionals available to assist you with any benefit or claim questions you may have. The team will provide you friendly, fast, and reliable service Monday through Friday from 8 a.m. to 5 p.m. Eastern Time.

To speak to a member of your Benefit Resource Center team:

CALL: 855-874-0829

EMAIL: BRCMidwest@usi.com



New for 2026 – Chubb Products:

- Hospitalization Insurance – Helps cover costs associated with hospital stays.
- Critical Illness Insurance – Provides financial support in the event of a serious diagnosis.
- Term Life Insurance with a Long-Term Care Rider – Offers life insurance coverage with added protection for long-term care needs.
- Accident Insurance - helps pay for medical expenses, lost income, or other costs resulting from accidental injuries—like fractures, burns, or hospital stays.

These voluntary benefits are designed to enhance your coverage and provide peace of mind for you and your family.

Enrollment Requirement for 2026 Benefits

We're partnering with Prepare Benefits to assist employees with benefit enrollment. **Every employee is required to meet with a Prepare Benefits representative to elect their benefits for 2026.**

Important: If you do not complete your enrollment meeting, your benefits will terminate effective 1/1/2026.



SCAN THE QR CODE OR USE THE LINK
TO VISIT THE BENEFITS HOMEPAGE

<https://DOC.benefitsinfo.com>

EMPLOYEE BENEFITS ENROLLMENT & ELIGIBILITY

Catholic Diocese of Columbus is pleased to announce our 2026 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are the Catholic Diocese of Columbus benefits available during open enrollment:

- Medical
- Dental
- Vision
- Group Term Life
- Voluntary Life, Critical Illness, Hospital Indemnity, Term Life with Long Term Care rider
- Short Term Disability
- Long Term Disability
- FSA Plan

Who is Eligible?

- Full time employees working 30 or more hours per week are eligible for all lines of coverage.
- Religious employees working full time are eligible for Medical, Dental, and Vision.
- Diocesan Priests are eligible for Medical, Dental, Vision, Priests Life Insurance, and Voluntary Life.
- Retired Diocesan Priests are eligible for Dental and Vision coverage.
- Working Spouse Eligibility: spouses are eligible to be covered under the health plan if they do NOT have medical coverage available to them through their employer.

Choose Carefully!

Due to IRS regulations, you cannot change your elections until the next Open Enrollment period, unless you have a Qualifying Event during the year. The following are examples of the most common qualifying events:

- Marriage, divorce, annulment, or permanent separation from spouse
- Birth of a child;
- Placement of a foster child or child for adoption with you, or assumption of legal guardianship of a child;
- Change in your spouse's or dependent's employment status that affects benefits eligibility, including termination or commencement of employment or change in worksite;

The change you request must be consistent with the qualifying event. You are required to provide supporting documentation within 30 days of the event.

How Do I Enroll?

Open enrollment will begin November 7, 2025, and end on November 18, 2025

When Does Coverage Begin?

Employees become eligible for benefits the 1st of the month following date of hire. You must complete the enrollment process within 30 days of your date of hire or within 30 days of the date of your qualifying event.



Important: To make changes to your benefit elections, you **MUST** notify HR within 30 days of the Qualifying Event (including newborns). Be prepared to show documentation of the event such as a marriage license, birth certificate, or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

MEDICAL PLANS

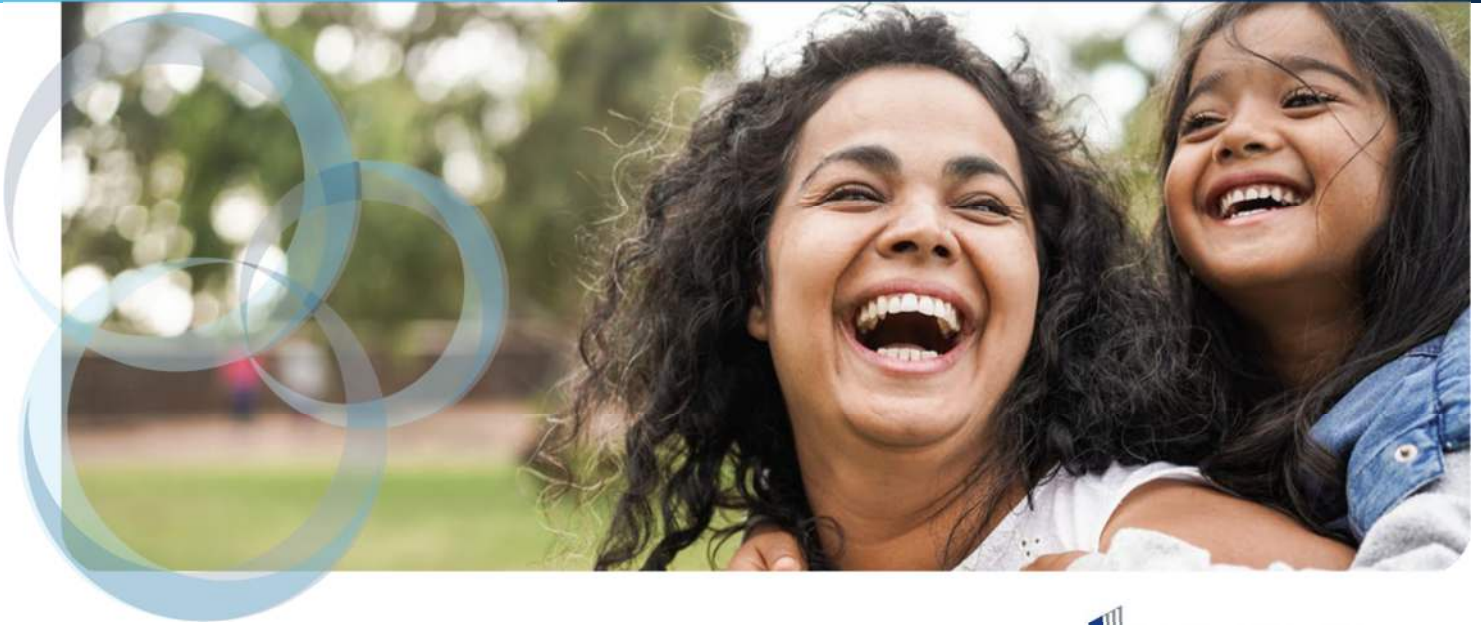
Diocese of Columbus is pleased to offer you a choice between two different medical plans from Surest. Coverage under both plans include comprehensive medical care and prescription drug coverage. This is a brief summary of the Base Plan.

Medical Base Plan			
Coverage Overview	In-Network Benefits		Out-of-Network Benefits
Routine Preventive Care	\$0 copay		\$195 copay
Deductible Individual / Family	\$0 / \$0		\$0 / \$0
Out-of-Pocket Maximum Individual / Family	\$5,500 / \$11,000		\$8,000 / \$16,000
Primary Physician Office Visit	\$25 - \$130 copay		\$215 copay
Specialist Office Visit	\$25 - \$130 copay		\$215 copay
Virtual Visit	\$0 - \$130 copay		Not Covered
Mental Health Virtual Visit	\$25 copay		Not Covered
Routine Diagnostic Lab/Radiology	\$0 copay		\$0 copay
Complex Radiology	\$150 to \$2,000		\$1,650 copay
Urgent Care	\$80 copay		\$200 copay
Emergency Room	\$500 copay		\$500 copay
Inpatient Hospital	\$40 to \$3,500 copay		\$195 - \$8,250 copay
Outpatient Surgery	\$40 to \$3,500 copay		\$195 - \$8,250 copay
Maternity Prenatal & Postnatal Care	\$0 copay		\$195 copay
Maternity Delivery	\$1,300 - \$2,750 copay		\$8,250 copay
Hospice Home Visits	\$70 copay		\$210 copay
Hospice Inpatient Care	\$2,750 copay		\$8,250 copay
Home Health Care	120 visit limit per person per plan year		
Skilled Nursing Facility	120 visit limit per person per plan year		
Physical Therapy	60 visit limit per person per plan year, not combined with other therapies		
Occupational Therapy	60 visit limit per person per plan year, combined with Cognitive therapy		
Speech Therapy	60 visit limit per person per plan year, not combined with other therapies		
Prescription Drug	Retail (30-day supply)	Retail (90-day supply)	Mail Order (90-day supply)
Preventive drugs	\$0		
Tier 1	\$10 copay	\$25 copay	\$25 copay
Tier 2	\$35 copay	\$88 copay	\$88 copay
Tier 3	\$70 copay	\$175 copay	\$175 copay
Specialty Tier 1	\$10 copay	Not Covered	Not Covered
Specialty Tier 2	\$100 copay	Not Covered	Not Covered
Specialty Tier 3	\$200 copay	Not Covered	Not Covered

MEDICAL PLANS

The second plan available from Surest is the Enhanced Plan. This plan has lower copays and out-of-pocket, but the contribution is more expensive when compared to the Base Plan. This is a brief summary of the Enhanced Plan.

Medical Enhanced Plan			
Coverage Overview	In-Network Benefits		Out-of-Network Benefits
Routine Preventive Care	\$0 copay		\$60 copay
Deductible Individual / Family	\$0 / \$0		\$0 / \$0
Out-of-Pocket Maximum Individual / Family	\$3,000 / \$6,000		\$8,000 / \$16,000
Primary Physician Office Visit	\$5 - \$40 copay		\$120 copay
Specialist Office Visit	\$5 - \$40 copay		\$120 copay
Virtual Visit	\$0 - \$40 copay		Not Covered
Mental Health Virtual Visit	\$5 copay		Not Covered
Routine Diagnostic Lab/Radiology	\$0 copay		\$0 copay
Complex Radiology	\$50 to \$550 copay		\$1,020 copay
Urgent Care	\$20 copay		\$60 copay
Emergency Room	\$200 copay		\$200 copay
Inpatient Hospital	\$10 to \$2,000 copay		\$60 - \$3,000 copay
Outpatient Surgery	\$10 to \$2,000 copay		\$60 - \$3,000 copay
Maternity Prenatal & Postnatal Care	\$0 copay		\$195 copay
Maternity Delivery	\$350 - \$1,025 copay		\$3,075 copay
Hospice Home Visits	\$20 copay		\$60 copay
Hospice Inpatient Care	\$20 to \$1,000 copay		\$3,000 copay
Home Health Care	120 visit limit per person per plan year		
Skilled Nursing Facility	120 visit limit per person per plan year		
Physical Therapy	60 visit limit per person per plan year, not combined with other therapies		
Occupational Therapy	60 visit limit per person per plan year, combined with Cognitive therapy		
Speech Therapy	60 visit limit per person per plan year, not combined with other therapies		
Prescription Drug	Retail (30-day supply)	Retail (90-day supply)	Mail Order (90-day supply)
Preventive drugs	\$0		
Tier 1	\$10 copay	\$25 copay	\$25 copay
Tier 2	\$35 copay	\$88 copay	\$88 copay
Tier 3	\$70 copay	\$175 copay	\$175 copay
Specialty Tier 1	\$10 copay	Not Covered	Not Covered
Specialty Tier 2	\$100 copay	Not Covered	Not Covered
Specialty Tier 3	\$200 copay	Not Covered	Not Covered



DENTAL

Catholic Diocese of Columbus offers two dental plans to choose from. Both dental plans allow you to seek treatment from the dentist of your choice, in or out-of-network.

You will get the most value out of your plan by using UHC's network providers, who cannot charge more than their negotiated, discounted rate. While the plan covers treatment from out-of-network providers, excess charges may not be covered. The chart below shows how the plan works and how each type of service is covered. This is a brief summary; please refer to your benefit booklet for complete details.

Dental Plans	Base Plan	Enhanced Plan
Coverage Overview	In / Out of Network	In / Out of Network
Deductible (Individual / Family)	\$0 / \$0	\$0 / \$0
Annual Maximum Per Person	\$1,500	\$2,000
Dental Coverage		
Preventive Services	100% / 100%	100% / 90%
Basic Services	50% / 50%	80% / 70%
Major Services	50% / 50%	50% / 50%
Orthodontia Coverage		
Orthodontia Eligibility (child to age 26)	Adults & Children	Adults & Children
Orthodontia Services (Adults & Children)	50% / 50%	60% / 50%
Orthodontia Lifetime Maximum	\$1,500	\$2,500



VOLUNTARY VISION

Catholic Diocese of Columbus will continue to offer the choice of two vision plans. Both vision plans include coverage for eye exams, lenses and frames, contact lenses and discounts for laser vision correction. With VSP, you can purchase lenses & frames from national vision retailers, as well as many other independent providers. You will receive a higher level of benefit if you utilize the services of an in-network. To find a provider, simply go to www.vsp.com and use the provider locator tool for a complete list of providers.

The chart below highlights the two plans and how each type of service is covered. This is a brief summary of the in-network benefits; please refer to your VSP benefit booklet for complete details, including out-of-network coverage.



Vision Plans	Base Plan	Enhanced Plan
Coverage Overview	In-Network Benefits	Out-of-Network Benefits
Eye Exam	\$15 copay	\$15 copay
Contact Lens Exam	\$60 copay	\$40 copay
Lenses		
Single Vision Bifocal Trifocal Lenticular	\$25 copay	\$25 copay
Allowances		
Frames Contacts	\$25 copay; \$150 allowance \$60 copay; \$150 allowance	\$25 copay; \$175 allowance \$60 copay; \$175 allowance
Benefit Frequency		
Exams Lenses Frames	Every calendar year Every calendar year Every other calendar year	Every calendar year Every calendar year Every calendar year

LIFE/ACCIDENTAL DEATH & DISMEMBERMENT

Catholic Dioceses of Columbus provides a life insurance and accidental death and dismemberment benefit (AD&D) for all full- time employees.

- The benefit is a flat \$50,000 of coverage.
- The benefit reduces by 15% at age 70, an additional 45% at age 75 and an additional 10% at age 80.
- The coverage terminates when you retire.

Voluntary Life/AD&D

You're able to purchase additional amounts of life/AD&D coverage to meet your individual needs. Voluntary Life/AD&D is available for employees, spouses and children. If voluntary life is elected, voluntary AD&D is automatically matched. The benefit reduces by 35% at age 70 and an additional 15% at age 75. The coverage may be continued or ported upon termination of active employment.

	Amount of coverage	Guarantee Issue Limit
Employee coverage	Increments of \$10,000 to a maximum the lessor of 7 times your salary or \$500,000	\$350,000
Spouse coverage (employee must elect in order to cover spouse)	Increments of \$5,000 to a maximum of \$250,000	\$100,000
Child coverage to age 26 (employee must elected in order to cover child)	Flat \$25,000 benefit	\$25,000

Age	Employee & Spouse Monthly Rate per \$1,000
Under age 24	\$ 0.090
25 – 29	\$ 0.090
30 – 34	\$ 0.100
35 – 39	\$ 0.120
40 – 44	\$ 0.180
45 – 49	\$ 0.230
50 – 54	\$ 0.420
55 – 59	\$ 0.620
60 – 64	\$ 0.640
65 – 69	\$ 1.100
70 – 74	\$ 2.840
75 +	\$ 11.390
Child Rate	\$ 0.225

Amounts over the guaranteed issue limit require Evidence of Insurability and approval before these amounts are effective.

Calculate Your Cost		Example	You
Step 1	Using the table, enter the rate that corresponds with your age.	\$0.090	
Step 2	Enter the desired coverage amount.	\$100,000	
Step 3	Divide Line 2 by \$1,000.	100	
Step 4	Multiply Line 1 times Line 3 to calculate your monthly cost.	\$9.00	

DISABILITY INSURANCE

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. This coverage is paid by the Diocese of Columbus. Disability benefits must be approved by a physician and the disability provider.

Short Term Disability

Short Term Disability (STD) is an employer paid benefit that provides partial income protection if you are unable to work due to an illness or injury. Your benefit covers a portion of your weekly salary up to 13 weeks. Benefits begin on the 8th day of disability.

Eligibility	Short-Term Disability
Eligibility	All active full-time employees working at least 30 hours per week
Benefits Begin	8th Day
Benefit Duration	13 Weeks
Weekly Benefit %	65% of Weekly Salary
Maximum Weekly Benefit	\$2,000

Long Term Disability

Long Term Disability (LTD) is an employer paid benefit that provides partial income protection if you are unable to work due to an illness or injury. Your benefit covers a portion of your monthly salary after 90 days and it can last up to Social Security normal retirement age.

Eligibility	Long Term Disability
Eligibility	All active full-time employees working at least 30 hours per week
Benefits Begin	After 90 days
Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Weekly Benefit %	40% of monthly base earnings
Maximum Monthly Benefit	\$5,000

Long Term Disability Buy Up

As an employee, you have the option to purchase additional Long Term Disability (LTD) coverage. The buy up plan would increase your benefit to 65% of your monthly base earnings up to a maximum of \$7,500 per month. For additional information, including the cost, speak with a benefit counselor or contact Human Resources.



Worksite Benefits

Catholic Diocese of Columbus is excited offer you some new exciting choices from Chubb in your benefits program. These plans are completely voluntary and are designed to help cover the out-of-pocket expenses not covered by your health insurance as well as paycheck protection if you can't work because of an injury or illness. When you meet with a benefit enroller through BAI, they will provide details on each benefit, including the monthly premium.

Accident Coverage

An accident or illness can take a toll on your income. If you are injured in an accident, Chubb's Accident Insurance offers benefits that cover catastrophic dismemberment and loss, and non-emergency initial care.

Common covered conditions include:

- Broken tooth
- Burns
- Coma
- Concussion
- Eye Injury
- Fractures
- Torn Ligaments

Critical Illness

A serious illness can take a toll on your health and financial wellness. Chubb's Critical Illness Insurance can provide protection to help lessen the burden of large out-of-pocket claims.

Critical Illness insurance can provide:

- A lump-sum payment directly to you
- Benefits paid, regardless what is covered by medical insurance

Examples of covered conditions include:

- Heart Attack
- Stroke
- Coronary Artery Bypass
- Kidney Failure
- Organ Transplant

Hospital Indemnity

Hospital stays resulting from an accident or illness can be unexpected and costly. Despite having medical coverage, many people are not adequately prepared for the out-of-pocket expenses associated with a hospital stay.

Hospital indemnity insurance through Chubb complements your existing medical coverage and helps narrow financial gaps caused by out-of-pocket expenses such as deductibles, copays, coinsurance, and non-covered services.

- Benefits are paid regardless of what is covered by your medical insurance
- Lump sum payments are made directly to you, to spend as you choose

Hospital indemnity covers a variety of benefits including:

- Hospital Admissions
- Hospital Confinement
- Inpatient Rehab
- ICU Confinement

Term Life with Long Term Care

LifeTime Benefit Term helps protect you and your family if you were no longer able to provide for them. Your family can receive cash benefits paid directly to them upon your death that they can use to help cover expenses like mortgage payments, credit card debt, childcare, college tuition and other household expenses. Cash benefits can also be paid directly to you while you are living for long term care expenses.

As Life Insurance, it protects your family with money that can be used any way they choose.

For Long Term Care (LTC) If you become chronically ill, the policy will pay you 4% of your death benefit each month you receive Long Term Care. Your death benefit will reduce proportionately each month as you receive benefit payments for Long Term Care. After 25 months of receiving Long Term Care Benefits, your death benefit will reduce to zero.

With Extension of Benefits, if you continue to need LTC after you have exhausted your Death Benefits, you can receive up to 25 more months of benefits, for a total of 50 months of LTC benefits.

Benefit Rates

January 1, 2026 – December 31, 2026

Medical – Surest Base Plan			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$931.58	\$793.58	\$138.00
Employee & Spouse	\$2,119.16	\$1,775.16	\$344.00
Employee & Child(ren)	\$1,826.86	\$1,526.86	\$300.00
Family	\$2,454.87	\$2,056.87	\$398.00

Medical – Surest Enhanced Plan			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$1,236.44	\$988.44	\$248.00
Employee & Spouse	\$2,782.00	\$2,227.00	\$555.00
Employee & Child(ren)	\$2,472.89	\$1,978.89	\$494.00
Family	\$3,214.75	\$2,572.75	\$642.00

Dental – United Healthcare Base Plan			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$28.00	\$22.00	\$6.00
Employee & Spouse	\$52.00	\$42.00	\$10.00
Employee & Child(ren)	\$58.00	\$47.00	\$11.00
Family	\$95.00	\$79.00	\$16.00

Dental – United Healthcare Enhanced Plan			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$49.00	\$29.00	\$20.00
Employee & Spouse	\$93.00	\$55.00	\$38.00
Employee & Child(ren)	\$103.00	\$63.00	\$40.00
Family	\$149.00	\$88.00	\$61.00

Benefit Rates

January 1, 2026 – December 31, 2026

Voluntary Vision – VSP Base Plan			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$6.12	\$0.00	\$6.12
Employee & Spouse	\$11.15	\$0.00	\$11.15
Employee & Child(ren)	\$11.49	\$0.00	\$11.49
Family	\$18.35	\$0.00	\$18.35

Voluntary Vision – VSP Enhanced Plan			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$11.05	\$0.00	\$11.05
Employee & Spouse	\$22.05	\$0.00	\$22.05
Employee & Child(ren)	\$23.85	\$0.00	\$23.85
Family	\$38.12	\$0.00	\$38.12

Lincoln Financial			
Benefit	Monthly Premium	Employer Cost Share	Employee Cost Share
Basic Life (\$50,000)	\$10.00	\$10.00	\$0.00
Voluntary Life	Based on amount elected and age	\$0.00	TBD
Short Term Disability	\$19.00	\$19.00	\$0.00
Long Term Disability	\$5.00	\$5.00	\$0.00
Voluntary Long Term Disability Buy Up	Based on earnings	\$0.00	TBD

Benefit Rates

January 1, 2026 – December 31, 2026

Accident – Chubb Plan 1			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$10.40	\$0.00	\$10.40
Employee & Spouse	\$19.24	\$0.00	\$19.24
Employee & Child(ren)	\$21.84	\$0.00	\$21.84
Family	\$30.68	\$0.00	\$30.68

Accident – Chubb Plan 2			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$5.20	\$0.00	\$5.20
Employee & Spouse	\$9.36	\$0.00	\$9.36
Employee & Child(ren)	\$10.92	\$0.00	\$10.92
Family	\$15.60	\$0.00	\$15.60

Hospital Indemnity – Chubb			
Coverage Level	Monthly Premium	Employer Cost Share	Employee Cost Share
Employee Only	\$24.18	\$0.00	\$24.18
Employee & Spouse	\$53.82	\$0.00	\$53.82
Employee & Child(ren)	\$44.98	\$0.00	\$44.98
Family	\$74.62	\$0.00	\$74.62

Additional Chubb Plans			
Benefit	Monthly Premium	Employer Cost Share	Employee Cost Share
Critical Illness	Based on amount elected and age	\$0.00	TBD
Term Life with Long Term Care	Based on amount elected and age	\$0.00	TBD

FLEXIBLE SPENDING ACCOUNTS (FSAs) & DEPENDENT CARE ACCOUNTS (DCAs)

Catholic Diocese of Columbus offers health care (FSA) and dependent care (DCA) accounts administered by Custom Design Benefits, which allows you to pay for eligible health and dependent care expenses with pre-tax dollars. The money contributed to your account is deducted from your paychecks before tax is taken out, so you end up with lower taxable income for the year.

Health Care FSA

You can use a Health Care FSA to pay for eligible medical, dental, vision and other out-of-pocket health care expenses that aren't covered by your health plan. You can contribute up to \$3,400 for 2026.

Dependent Care (DCA)

This account can be used to pay for eligible child or adult day care. To be considered an eligible expense, the care must be necessary to enable both you and your spouse, to work, look for work or attend school. Eligible dependents include: your children under age 13 or dependent of any age who resides in your home for at least eight hours each day who is physically or mentally incapable of self-care and is dependent on you for at least 50% of their financial support.

You will be able to contribute up to \$7,500 for 2026.

More About FSA & DCA

Once you have made your FSA election amounts, you cannot make changes during the plan year unless you experience a qualifying family status change. You cannot use money from your Health Care FSA to pay for dependent care expenses, or vice versa. The Dependent Care (DCA) is a "use it or lose it" account. **You must elect medical, dental or vision insurance with the Diocese to elect the FSA. You will be required to re-enroll in these accounts each year if you want to participate.**

Eligible Expenses

A list of eligible health care expenses can be found in Publication 502 on the IRS website at <https://www.irs.gov/pub/irs-pdf/p502.pdf>

Eligible dependent care expense information can be found in Publication 503 at <https://www.irs.gov/pub/irs-pdf/p503.pdf>



EMPLOYEE ASSISTANCE PROGRAM (EAP)

Catholic Diocese of Columbus understands that it can be difficult to juggle work responsibilities with personal matters you may be facing. For this reason, we have partnered with *EmployeeConnect* through Lincoln Financial to provide you with an Employee Assistance program at no cost to you!

The Employee Assistance Program helps you and your eligible dependents balance the demands of work, life, and personal issues. This confidential service provides access to professional counseling and guidance to address stressful life events. Employees and their eligible dependents can speak to a trained professional who will help assess their needs and provide referrals to local resources including psychologists, legal and financial consultants, marriage/family therapists, and substance abuse counselors.

Employees and their eligible dependents have unlimited telephonic access to the EAP and up to five face-to-face counseling sessions per issue.

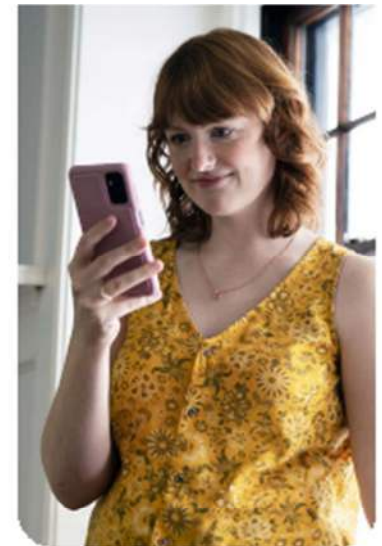
Access the website at www.guidanceresources.com or download the GuidanceNow mobile app.



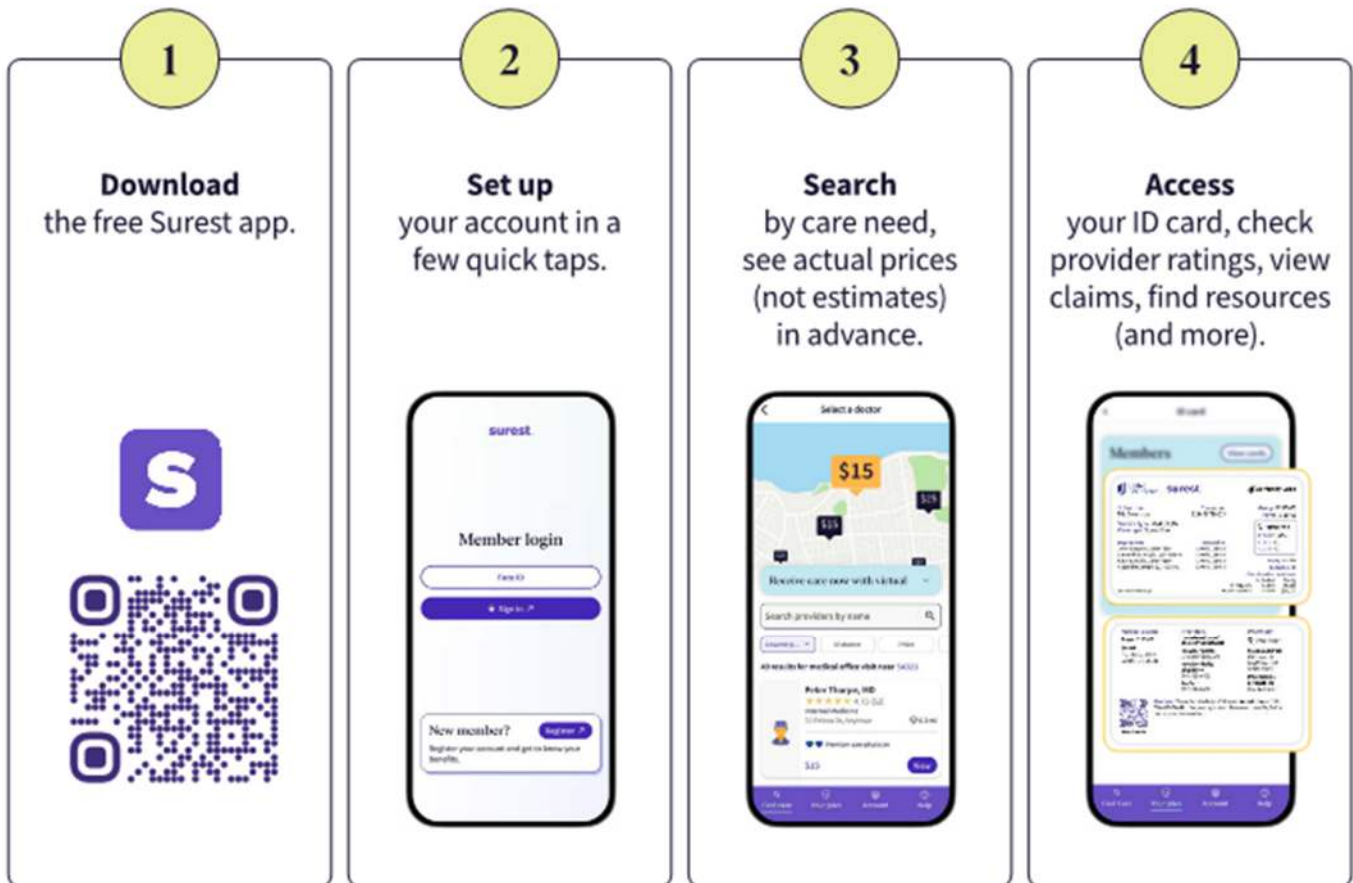
SAVE TIME, MONEY:

Get the Surest app.

The Surest health plan isn't "just another health plan," and the Surest app isn't "just another app." It's how you shop for care, compare prices, and access other helpful features.



Get started:



Illustrative example only. Costs and coverage may vary.



Have questions?

Member Services is available online via chat and email or by calling the number on the back of your Surest member ID card.

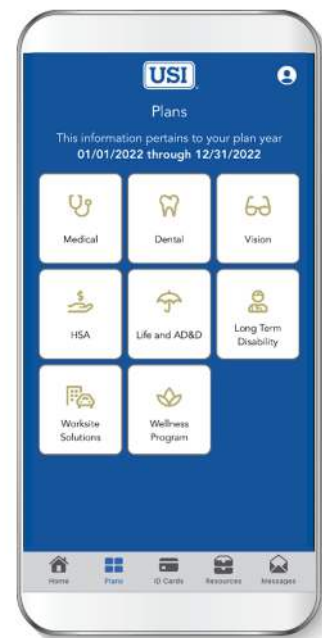


MyBenefits2GO: FREE MOBILE BENEFITS APP

The MyBenefits2GO app gives you on-the-go access to Catholic Diocese of Columbus benefit and insurance policy details, HR contact information and more!

The mobile benefits app provides a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. The app also offers the ability to take photos of ID cards to store on the phone, as well as a way to easily locate carrier and HR contact information—all in one place—24/7 and on the go. The MyBenefits2GO app is free and available for iPhone and Android platforms. App benefits include:

- **Staying Organized**
The app gives you access to benefit plan information and ID cards—all in one place.
- **Keeping Up-to-Date**
The app automatically connects you with the most updated plan information.
- **Lightening Wallets**
The app allows you to store and share images of your ID cards. Images are stored on the phone itself; no personal health information is transmitted or saved.
- **Getting In Touch**
The app provides you with a single location to find contact information for the Human Resources team and the Benefit Resource Center, as well as insurance carriers.



Check Out the App

Download the mobile app to your smartphone. Scroll through the intro pages and, when prompted, enter the code **T91798** to see your plan information.

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BENEFIT RESOURCE CENTER (BRC)

Access All Of Your Benefits Insurance Details While On The Go!

The Benefit Resource Center (BRC) is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time via phone 855-874-0835 or via email BRCSouth@usi.com. If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or email message by the end of the following business day.

CALL THE BENEFIT RESOURCE CENTER (“BRC”) WE’RE HERE TO HELP!

We speak insurance. Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution



Benefit Resource Center (BRC)

BRCMidwest@usi.com | Toll Free: 855-874-0829

Monday – Friday | 8:00am to 5:00pm EST

FREQUENTLY ASKED QUESTIONS

When Do I Pay A Copayment?

Expect to pay a copayment for doctor's visits, emergency room visits and urgent care center visits if you're on the PPO (Core) Plan. Most expenses on the HDHP (Base) Plan apply first to the deductible which is your financial responsibility.

How Do I Know When To Go To An Urgent Care Center Vs. The Emergency Room?

If you need medical care when your regular doctor is not available, think about going to an urgent care center. The urgent care center should be used for minor emergencies (fever, cough, pain, etc.), when your physician's office is closed and your symptoms are too severe to wait until the office reopens, or when you are out-of-town. The cost is less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for true emergencies such as broken bones, vigorous bleeding or severe pain.

The next time you are faced with deciding where to go, be sure to evaluate all your options and choose the setting that best suits your illness or injury. Of course, in a true emergency, seek the appropriate care without delay.

What Is An Explanation Of Benefits (EOB)?

An EOB is a description the insurance company sends to you explaining the health care charges that you incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the doctor. All data on your EOB should match the information that appears on the statements you receive from your doctor. If it doesn't, contact the doctor's office to discuss the discrepancy.

What Is Preventive Care?

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations, well woman and well man exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. Remember all preventive care benefits are covered 100% under your medical plan for the service deemed preventive by the Affordable Care Act.

What Is The Difference Between Generic And Brand Name Drugs?

The difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost much less than brand name drugs, save you and your employer money, and provide the same health benefits as brand name drugs.

What Is The Benefit Of Mail Order Drugs?

Mail order drugs are perfect for patients who take medication on an ongoing basis. Examples are high blood pressure medication, high cholesterol medication, and insulin. Mail Order drugs are convenient because they are delivered to your doorstep, which relieves the stress of standing in line at the pharmacy.

GLOSSARY

1095-C – The health care law outlining which employers must offer health insurance to their employees. The law refers to them as “applicable large employers,” or ALEs. A company or organization is an ALE if it has at least 50 full-time employees or full-time equivalents. It also provides information needed to do a federal tax return.

COINSURANCE – A type of health insurance in which the insured individual contributes a specified percentage of the total cost of the medical expense after the deductible has been reached.

COPAY – The fixed amount paid by the insured for health care services or prescriptions received.

DEDUCTIBLE – The amount the insurer pays for health care services before the health insurance begins to pay its portion. A deductible may not apply to all services such as preventive care.

EMPLOYEE CONTRIBUTION – The amount paid by an employee for insurance coverage.

EXPLANATION OF BENEFITS (EOB) – A statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf.

IN-NETWORK – Discounted rates for healthcare services provided by doctors, hospitals, and other providers that contract with the insurance company.

OUT-OF-NETWORK – Out-of-network providers are doctors, hospitals and other providers that do not offer their health services at a discounted rate because they are not contracted with the insurance company.

OUT-OF-POCKET MAXIMUM – The total you will pay for covered health care services during the plan year (typically a 12-month period) before the health insurance or plan starts to pay 100% of the allowed amount. This does not include the monthly premium or services not covered by the plan.

OVER-THE-COUNTER (OTC) MEDICATIONS – Medications available without a prescription.

PRESCRIPTION MEDICATIONS – Doctor-prescribed medications. The medications costs are determined by their specified tier: Generic, Preferred, Non-Preferred or Specialty.

SUMMARY OF BENEFITS AND COVERAGE (SBC) – Documents required through health care reform, an easy-to-follow summary of the insurance carrier or plan benefits and plan coverage offered.

Important Contacts

Benefit	Carrier	Phone / Website
Medical	Surest	866-683-6440 www.benefits.surest.com
Dental	United Healthcare	800-445-9090 www.myuhc.com
Vision	Vision Service Plan	800-877-7195 www.vsp.com
Life and AD&D Voluntary Life and AD&D Disability	Lincoln Financial	800-423-2765 www.lincoln-financial.com
Employee Assistance Program (EAP)	Lincoln Financial	888-628-4824 www.guidanceresources.com
Flexible Spending Accounts	Custom Design Benefits	800-598-2929 www.customdesignbenefits.com
Accident Insurance Hospital Indemnity Critical Illness Term Life with Long Term Care	Chubb	800-682-4822 www.chubb.com
Benefit Resource Center	USI	855-874-0829



Catholic Diocese of Columbus

Important Legal Notices



**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 8 for more details.**

***IMPORTANT NOTICE:** This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*



Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: \$0

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

HIPAA WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 614-224-1221 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Rhonda Frissora
197 E Gay St
Columbus, Ohio United States 43215-3229
614-224-1221 x 1632
rfrissora@columbuscatholic.org

Your Information. Your Rights. Our Responsibilities.

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.***

Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
Marketing purposes
Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- January 1, 2026
- Rhonda Frissora, Director of Insurance, rfrissora@columbuscatholic.org

Important Notice from Catholic Diocese of Columbus About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Catholic Diocese of Columbus and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Catholic Diocese of Columbus has determined that the prescription drug coverage offered by the Surest for the plan year 2026 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the Surest plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose Surest Plan creditable coverage.
- You may stay in the Surest plan and also enroll in a Medicare prescription drug plan. The Surest plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Surest Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Surest Plan you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Catholic Diocese of Columbus and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Catholic Diocese of Columbus changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2026
Name/Entity of Sender: Rhonda Frissora, Catholic Diocese of Columbus
Contact Position/Office: Director of Insurance
Address: 197 E. Gay Street, Columbus, OH 43215
Phone Number: 614-224-1221

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid

<p>Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>	<p>Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfir/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofr/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Catholic Diocese of Columbus
Contact--Position/Office:	Rhonda Frissora, Director of Insurance
Address:	197 E. Gay Street
Phone Number:	614-224-1221 x1632

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 All employees. Eligible employees are:

- Some employees. Eligible employees are:

- With respect to dependents:
 We do offer coverage. Eligible dependents are:

- We do not offer coverage.

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

- ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly