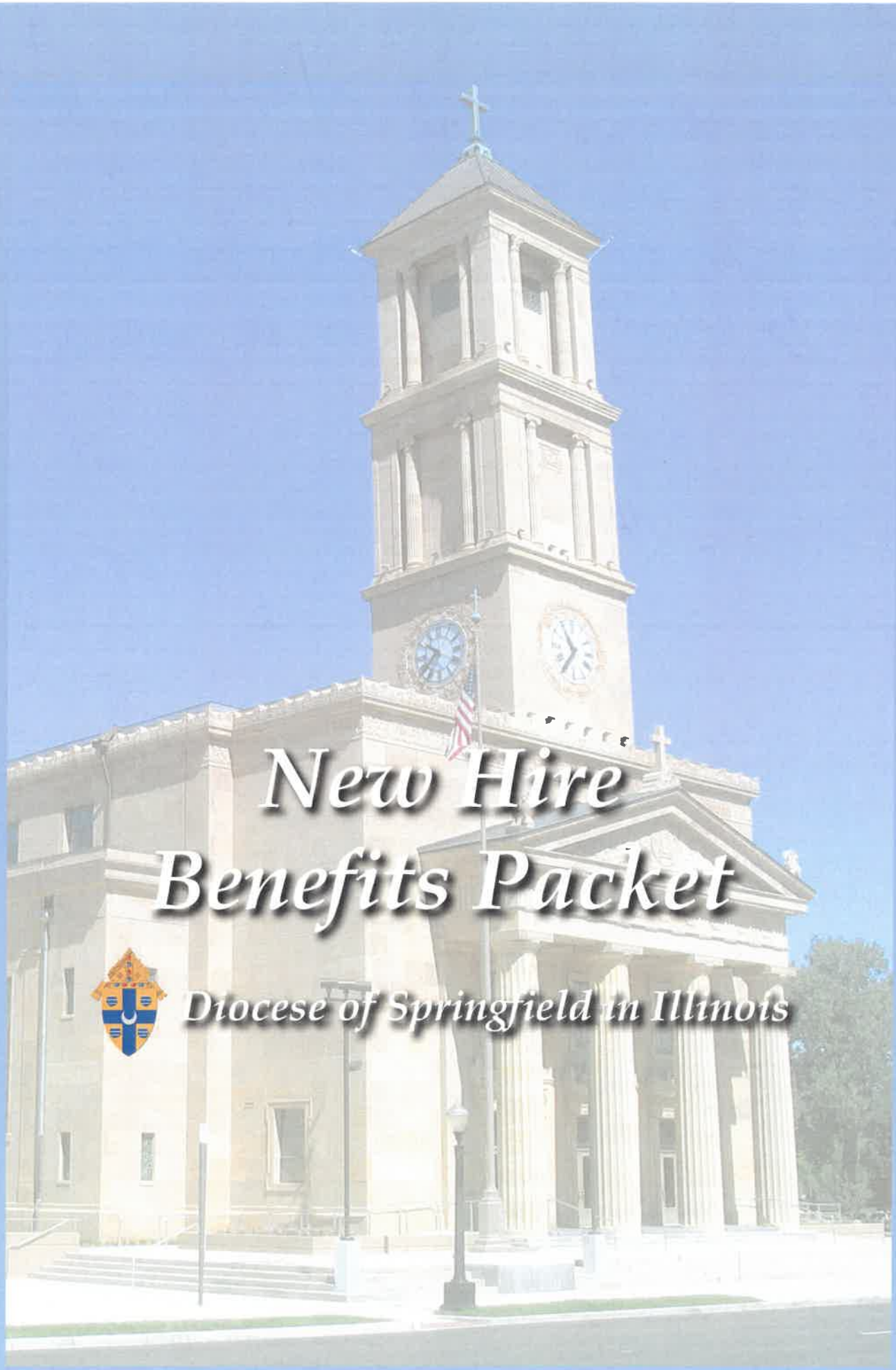


New Hire Benefits Packet

Diocese of Springfield in Illinois

BAS

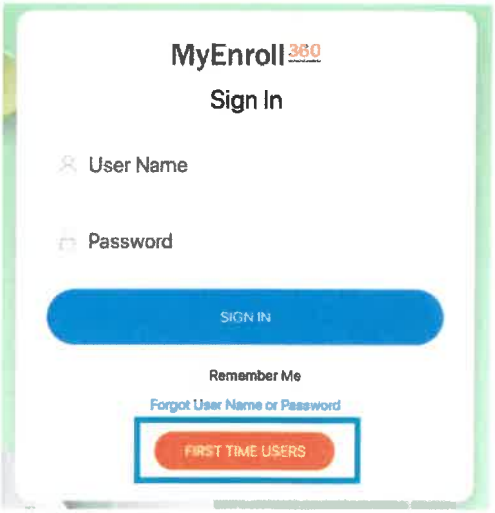
MyEnroll[360] User Guide

How to obtain your User Name & Password

How to Obtain your User Name & Password

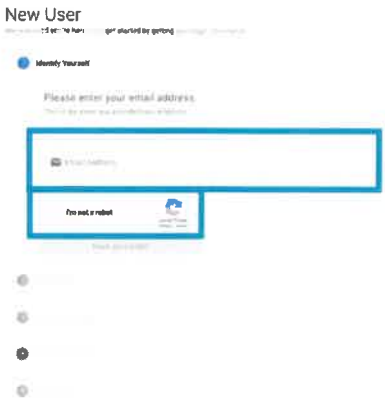
First Time Users

Click "**First Time User**".



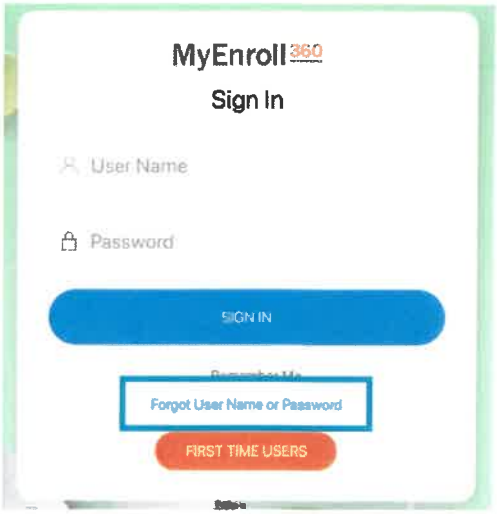
Enter your email address & Click **"I'm not a robot"**.

Your User Name and Password will be sent to you via email.

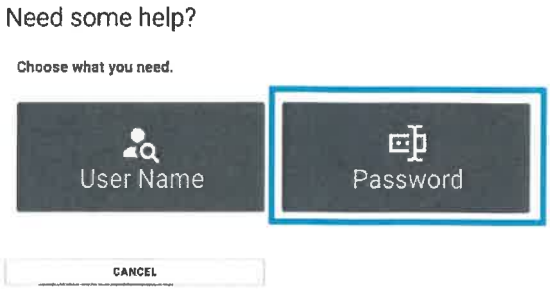


How to Reset Your Password

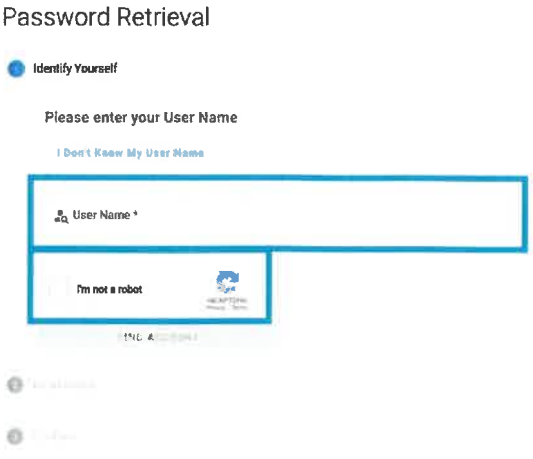
Click "**Forgot User Name or Password**" on the MyEnroll[360] login page.



Click "**Password**".



Enter your User Name & Click "**I'm not a robot**".



Click "**Find Account**".

Copy the temporary password from your email account.

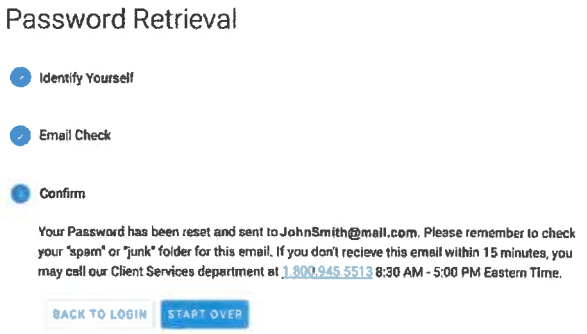
Click the "**Click Here to Login**" button in the password reset email.

Enter your temporary password.

Click "**Next**".

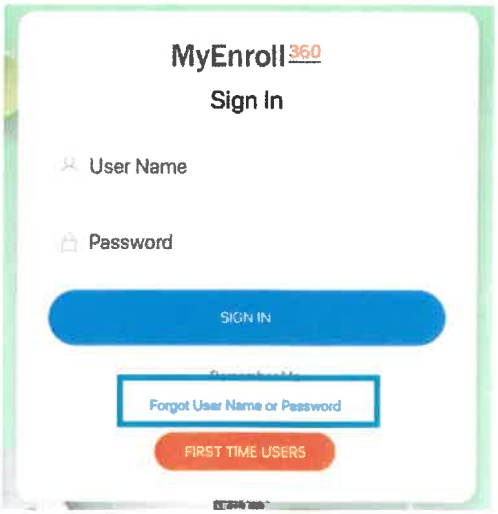
Enter your new password twice.

Click "**Finish**".

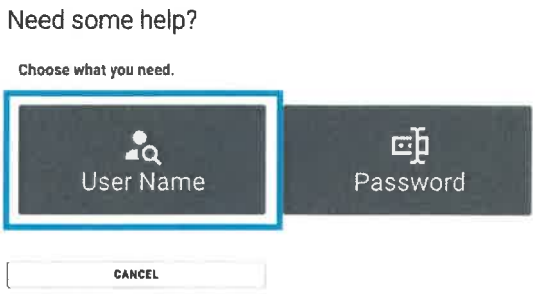


How to Reset Your User Name

Click "**Forgot User Name or Password**" on the MyEnroll[360] login page.

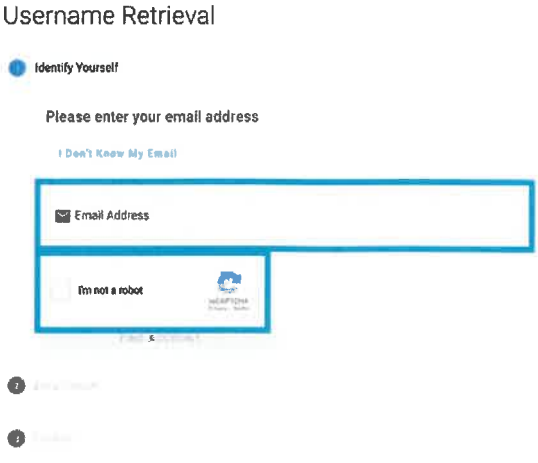


Click "**User Name**".

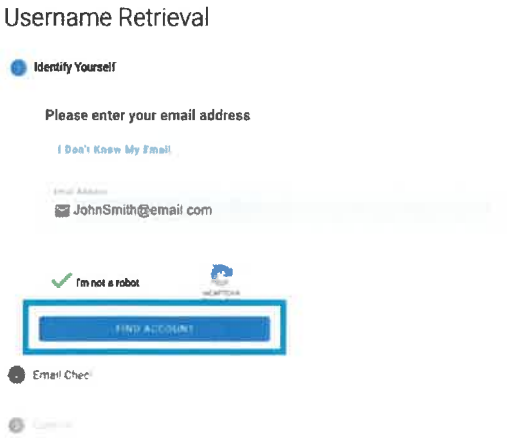


Enter your email address and click "**I'm not a robot**".

If you don't know which email address is associated with your user account, click "**I Don't Know My Email**".



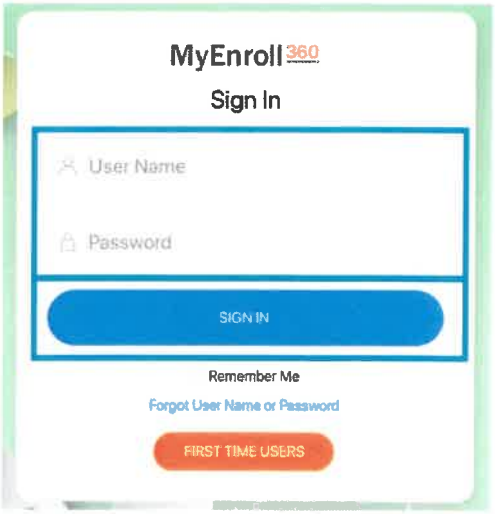
Click "**Find Account**".



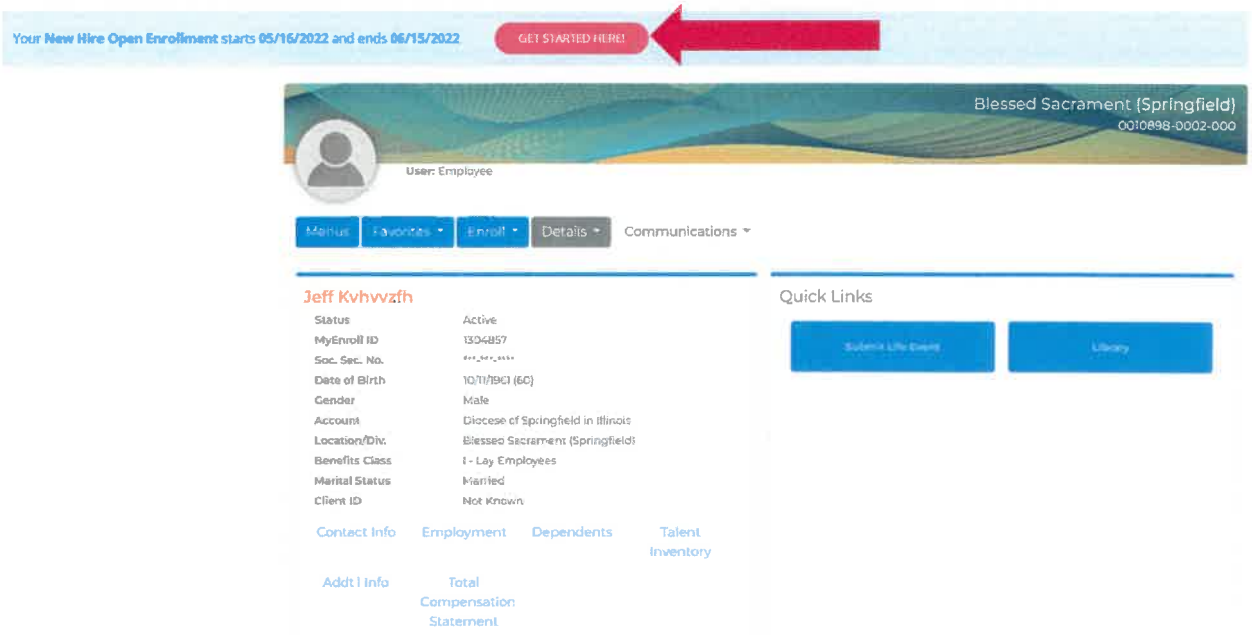
Your email will be delivered to the email address associated with your user record.

Return to the MyEnroll[360] login page and enter your User Name and Password.

Click "**Sign In**".



To begin your New Hire election, click the "**GET STARTED HERE**" button. This will take you into the enrollment wizard.



AETNA

aetna

The Roman Catholic Diocese of Springfield in Illinois
Effective Date: 07-01-2022
Aetna Choice® POS II -- ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$400 Individual $1,200 Family	$400 Individual $1,200 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	10%	40%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$1,500 Individual $4,500 Family	$2,500 Individual $7,500 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	40%; after deductible
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40%; after deductible
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40%; after deductible
1 exam and pap smear per year, includes related fees.		
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Women's Health	Covered 100%; deductible waived	40%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	40%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	10%; after deductible	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Telemedicine Consultation with Non-Specialist	Covered 100%; after deductible	40%; after deductible
Specialist Office Visits	10%; after deductible	40%; after deductible
Telemedicine Consultation with Specialist	Covered 100%; after deductible	40%; after deductible
Hearing Exams	10%; after deductible	40%; after deductible
1 routine exam per 24 months.		
Pre-Natal Maternity	Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics	10%; after deductible **Designated Walk-in Clinics** Covered 100%; deductible waived	40%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Telemedicine Consultations for Non-Emergency Services through a Walk-in Clinic	Your cost sharing is based on the type of service and where it is performed **Designated Walk-in Clinics** Covered 100%; deductible waived	40%; after deductible
If telemedicine preventive screening and counseling services are provided through a walk-in clinic, these services are paid under the preventive care benefit.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (other than Complex Imaging Services)	10%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	10%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Complex Imaging	10%; after deductible	40%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	10%; after deductible	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	10%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Mental Health Telemedicine Consultations	Covered 100%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	10%; after deductible	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	10%; after deductible	40%; after deductible
Substance Abuse Office Visits	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Substance Abuse Telemedicine Consultations	Covered 100%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	10%; after deductible	40%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	10%; after deductible	40%; after deductible
Limited to 40 visits per year. Home health care services include private duty nursing Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Private Duty Nursing	Covered as part of Home Health Care	Covered as part of Home Health Care
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy	10%; after deductible	40%; after deductible
Outpatient Short-Term Rehabilitation	10%; after deductible	40%; after deductible
Includes speech, physical, occupational therapy		
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit		
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	10%; after deductible	40%; after deductible
Hearing Aids Limited to $2,500 every 5 years.	10%; after deductible	40%; after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

Diabetic Supplies – (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	10%; after deductible	40%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	10%; after deductible	40%; after deductible
Acupuncture	Not Covered	Not Covered
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing is based on the type of service and where it is performed 10%: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Vision Eyewear	Not Covered	Not Covered
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	10%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Not Covered	Not Covered
Tubal Ligation	Not Covered	Not Covered
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to end of the month they turn 26 regardless of student status.	

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.
The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

Illinois

All contract state benefits shown above will match for this ancillary state.

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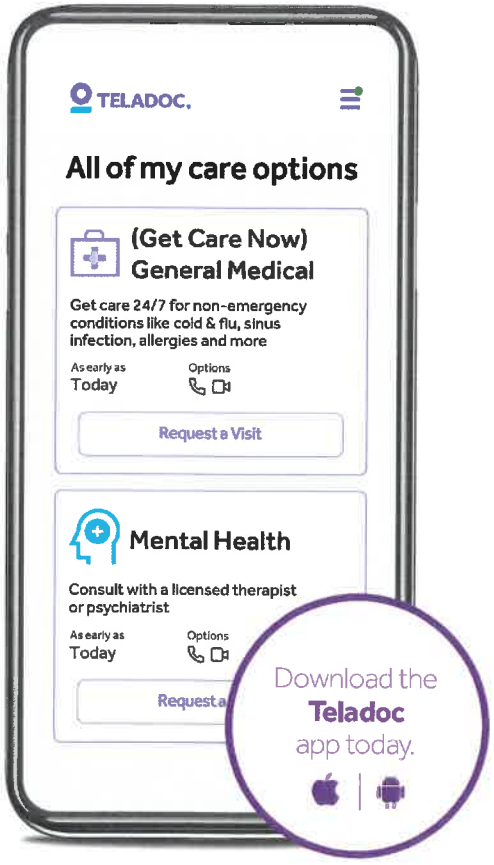
Access to quality care at your fingertips

General Medical
free/visit

Talk to a licensed doctor for non-emergency conditions 24/7
Flu • Sinus infections • Sore throats • And more

Mental Health
free/ therapist visit
free/ psychiatrist first visit
free/ psychiatrist ongoing visit

Talk to a therapist 7 days a week (7 a,m, to 9 p.m. local time)



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Visit Teladoc.com/Aetna

Call 1-855-TELADOC (835-2362) | Download the app

10E-196_411295158_12042019

Group ID: 449978

Take charge of your benefits.

Discover a seamless way to connect to care and get support on your path to better health with these digital tools.

Aetna.com

95.03.392.1-NMEP A (3/20)

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Helping you take charge.

Stay healthy. Keep track of your benefits. Stay on top of it all with two easy-to-use tools — the Aetna Health℠ app and your Aetna® member website.

Set up your account today to manage your benefits and more.

AT HOME

Visit your member website at **Aetna.com** to create an account and log in.

ON THE GO

Get the **Aetna Health app** by texting "**AETNA**" to **90156** for a link to download the app.
Message and data rates may apply.*

Manage benefits

- View your health plan summary and get information about what's covered.
- Track spending and progress toward meeting your deductibles for you and your family.
- Access your ID card whenever you need it.
- View claims details and pay your claims.

Connect to care

- Search for facilities, procedures and medications.
- Find in-network providers accepting new patients.
- Estimate and compare costs.

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*Terms and Conditions: bit.ly/2nlJFYG Privacy Policy: aetna.com/legal-notices/privacy.html By texting 90156, you consent to receive a one-time marketing automated text message from Aetna with a link to download the Aetna Health℠ app. Consent is not required to download the app. You can also download by going to the App Store or Google Play.

Aetna.com

95.03.392.1-NMEP A (3/20)

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Right there with you

Aetna One® Flex

Ongoing nurse support when you need it most

Aetna.com

45.03.918.1 (8/20)

aetna™

Supporting you on your path to better health

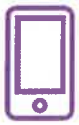
Your health — both physical and mental — is everything. Whether you're managing a chronic condition or dealing with other complex health challenges, our nurses can help. If you're identified for care management, a nurse can work with you to put together a plan, help you understand your benefits offerings and answer your health-related questions.

One-on-one personalized nurse support

If you're identified for care, our clinical nurses can collaborate with service teams to help you achieve your health goals. Whether you're struggling with emotional issues or an advanced illness, we'll work with you and your family to provide guidance and support.

Tools, tips and support centers

Through your Aetna® member website, you'll be able to locate a doctor, review your personal health record and watch informational health videos. And for specific health needs, you can explore member resources like the Cancer Support Center, the Maternity Support Center and the Joint Pain Support Center.



Access to information — whenever, wherever

Always on the go? No problem. Your member website is fully mobile. Remember, this is your one-stop shop for getting the help you need. And when you download the Aetna Health℠ app, you can access it all from the palm of your hand.

Get started with these resources today.

Go to **Aetna.com** to log in to your member website.

Aetna.com

Understanding your Explanation of Benefits (EOB) statement

What information will be on your EOB statement

- Your name and address
- Your member ID
- The group number — this identifies your plan
- The group name — typically, this is your employer
- Customer service contact information

It's easy to track your spending and savings

We make it easy to understand what you owe.*

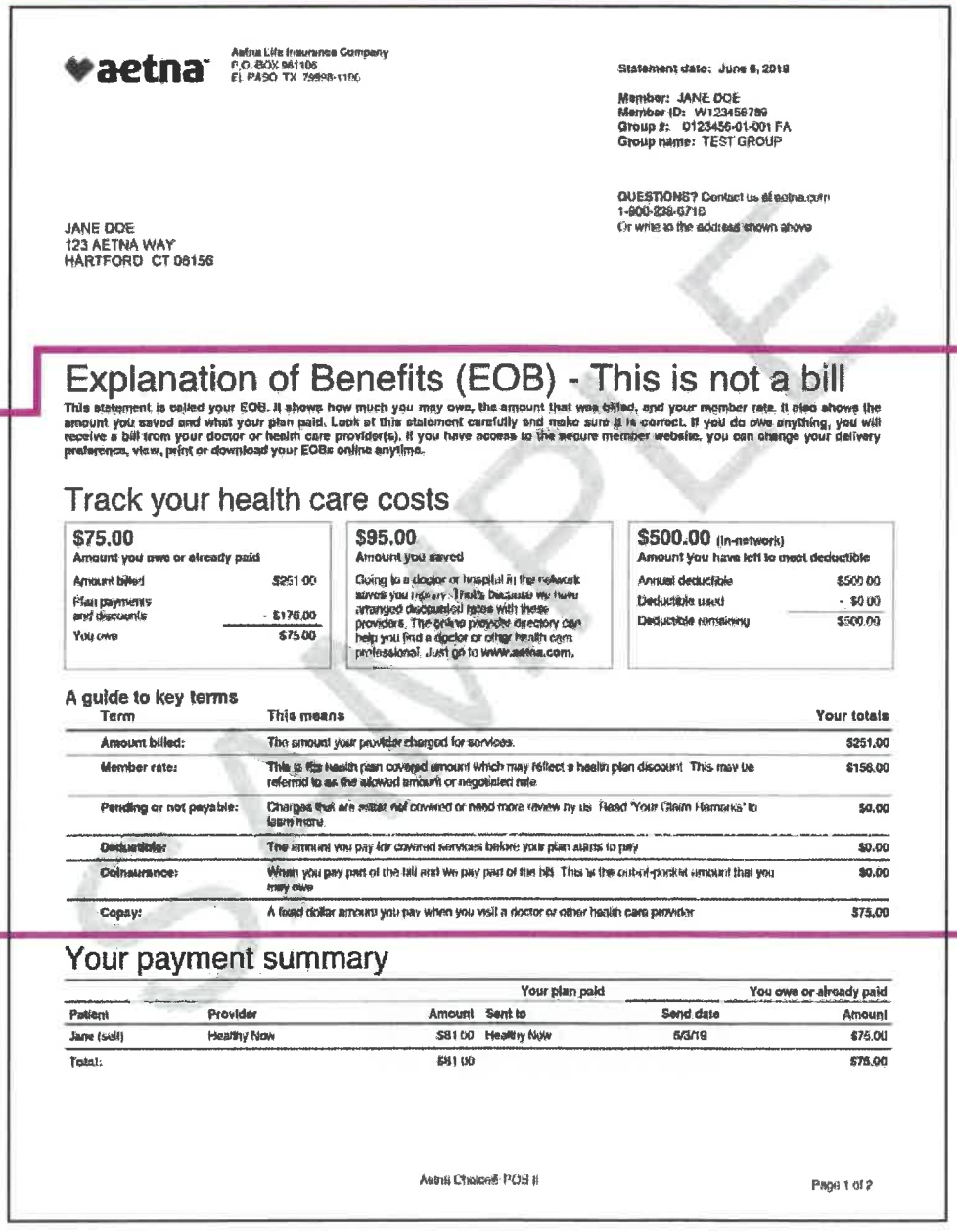
We tell you what you've saved by using an in-network provider.*

We also clearly show the remaining amount you have to pay in order to meet your yearly in-network family or individual deductible.*

Your payment summary

This includes a summary about any payments made and what you owe for the claims listed on the EOB statement.

*This section may not always be included. The sections are based on your benefits.



aetna

Aetna Life Insurance Company
P.O. BOX 981106
EL PASO TX 79998-1106

Statement date: June 6, 2019

Member: JANE DOE
Member ID: W123456789
Group #: 0123456-01-001 FA
Group name: TEST GROUP

QUESTIONS? Contact us at aetna.com
1-800-238-6716
Or write to the address shown above

JANE DOE
123 AETNA WAY
HARTFORD CT 06156

Explanation of Benefits (EOB) - This is not a bill

This statement is called your EOB. It shows how much you may owe, the amount that was billed, and your member rate. It also shows the amount you saved and what your plan paid. Look at this statement carefully and make sure it is correct. If you do owe anything, you will receive a bill from your doctor or health care provider(s). If you have access to the secure member website, you can change your delivery preferences, view, print or download your EOBs online anytime.

Track your health care costs

$75.00
Amount you owe or already paid

Amount billed	$251.00
Plan payments and discounts	- $176.00
You owe	$75.00

$95.00
Amount you saved

Going to a doctor or hospital in the network saves you money. That's because we have arranged discounted rates with these providers. The online provider directory can help you find a doctor or other health care professional. Just go to www.aetna.com.

$500.00 (In-network)
Amount you have left to meet deductible

Annual deductible	$500.00
Deductible used	- $0.00
Deductible remaining	$500.00

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your provider charged for services.	$251.00
Member rate:	This is the health plan covered amount which may reflect a health plan discount. This may be referred to as the allowed amount or negotiated rate.	$156.00
Pending or not payable:	Charges that are either not covered or need more review by us. Read "Your Claim Remarks" to learn more.	$0.00
Deductible:	The amount you pay for covered services before your plan starts to pay.	$0.00
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is the out-of-pocket amount that you may owe.	$0.00
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	$75.00

Your payment summary

			Your plan paid		You owe or already paid
Patient	Provider	Amount	Sent to	Send date	Amount
Jane (self)	Healthy Now	$81.00	Healthy Now	6/3/19	$75.00
Total:		$81.00			$75.00

Aetna Choice® POS II

Page 1 of 2

Your claims up close

We provide detailed information for each claim shown on your EOB statement.

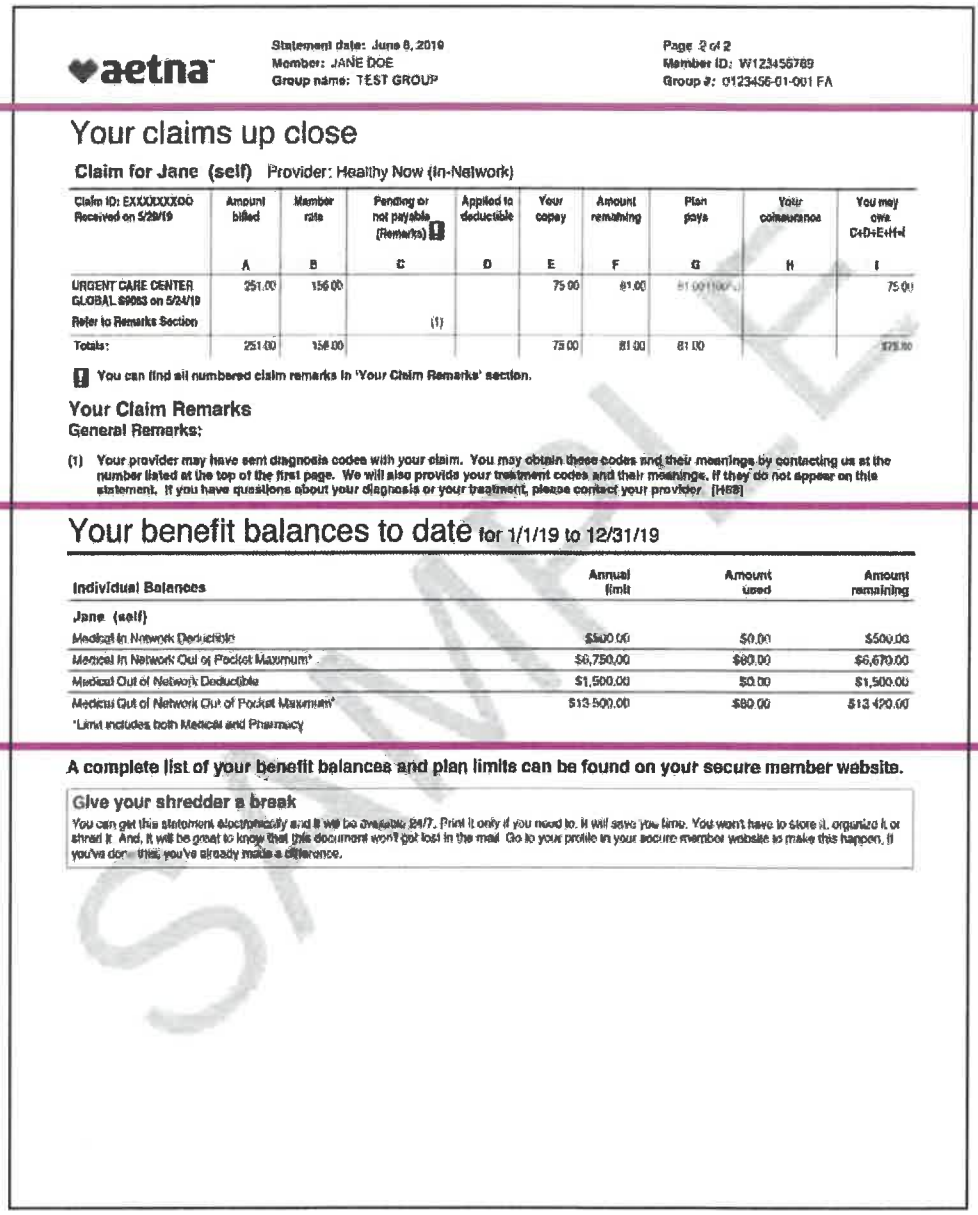
We break down each charge to show how your benefits were applied, what the plan paid and the amount you owe.

Your benefit balances

This provides a summary of financial limits for the benefit year listed.

Messages

In the last section, find helpful messages from us or your employer.



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Statement date: June 8, 2019
Member: JANE DOE
Group name: TEST GROUP

Page 2 of 2
Member ID: W123456789
Group #: 0123456-01-001 FA

Your claims up close

Claim for Jane (self) Provider: Healthy Now (In-Network)

Claim ID: EXXXXXXXX0 Received on 5/29/19	Amount billed	Member rate	Pending or not payable (Remarks)	Applied to deductible	Your copay	Amount remaining	Plan pays	Your coinsurance	You may owe C+D+E+H=I
	A	B	C	D	E	F	G	H	I
URGENT CARE CENTER GLOBAL 69983 on 5/24/19	251.00	156.00			75.00	81.00	81.00		75.00
Refer to Remarks Section			(1)						
Totals:	251.00	156.00			75.00	81.00	81.00		75.00

You can find all numbered claim remarks in 'Your Claim Remarks' section.

Your Claim Remarks
General Remarks:

(1) Your provider may have sent diagnosis codes with your claim. You may obtain these codes and their meanings by contacting us at the number listed at the top of the first page. We will also provide your treatment codes and their meanings, if they do not appear on this statement. If you have questions about your diagnosis or your treatment, please contact your provider. [H68]

Your benefit balances to date for 1/1/19 to 12/31/19

Individual Balances	Annual limit	Amount used	Amount remaining
Jane (self)			
Medical In Network Deductible	$500.00	$0.00	$500.00
Medical In Network Out of Pocket Maximum*	$6,750.00	$80.00	$6,670.00
Medical Out of Network Deductible	$1,500.00	$0.00	$1,500.00
Medical Out of Network Out of Pocket Maximum*	$13,500.00	$80.00	$13,420.00

*Limit includes both Medical and Pharmacy

A complete list of your benefit balances and plan limits can be found on your secure member website.

Give your shredder a break

You can get this statement electronically and it will be available 24/7. Print it only if you need to. It will save you time. You won't have to store it, organize it or shred it. And, it will be great to know that this document won't get lost in the mail. Go to your profile in your secure member website to make this happen. If you've done that, you've already made a difference.

SAMPLE

On Aetna.com, you can view, print or download your EOB statement and other documents, anytime.

Want to stop paper? It's easy. Go to **Aetna.com** to log in to your member website. Go to your account settings, provide a current email address and select your paper-saving preferences.

Aetna.com

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At your fingertips

Find in-network doctors and hospitals with our convenient provider search tool

The help you need to pick your plan

We're here to help you stress less — and save more — when choosing your health plan. It's simple with our provider search tool. You'll be able to check plans to see if the doctors and sites of services you use are in network for our plans.

The tool lets you search for and learn more about doctors, hospitals, walk-in clinics, labs and other health providers in your area.

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90.03.568.1 (8/20)

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More helpful details

Use your custom provider search tool — in English or Spanish — to find doctors, hospitals and other health care providers that participate in the Aetna network. You'll also find useful information, such as:

- Whether your plan is accepted
- Office locations and directions
- Provider's gender, where they went to school, hospital affiliations and languages spoken
- Whether providers are accepting new patients

Because staying in network helps you keep your medical costs lower.

Multiple ways to search

You can search using a doctor or facility's name, or by:

- City, state, ZIP code
- Specialty
- Common procedure types, such as flu/vaccine shots or back care

You can even search for doctors who treat specific conditions.

Visit Aetna.com

Go to
Aetna.com/individuals-families/find-a-doctor.html
to find a doctor or hospital now.

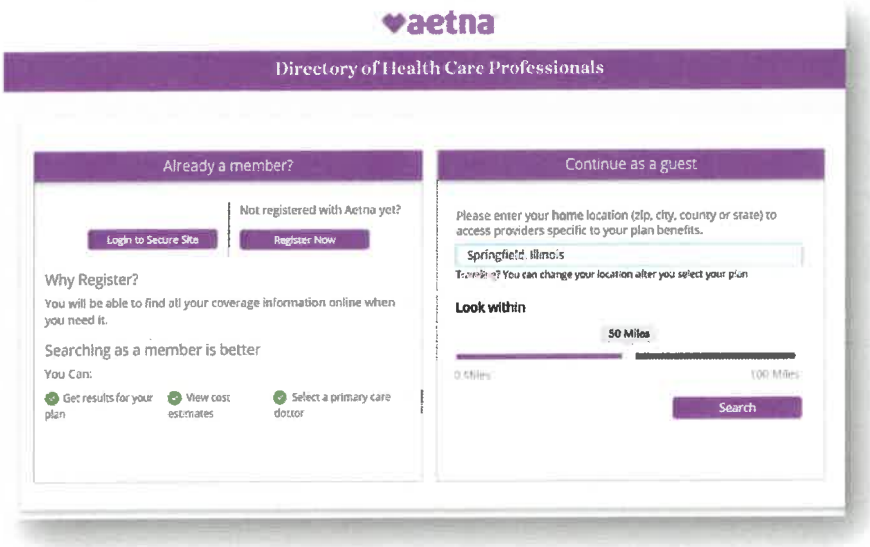
Here's how it works:

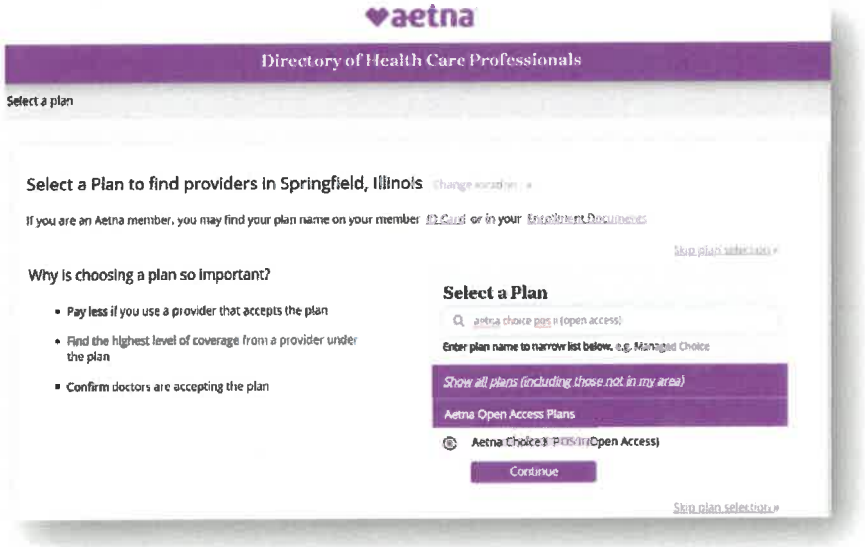
1. Visit" **Find a doctor**" on **Aetna.com**, and under "Guests," choose "Plan from an employer."
2. Enter your home location (ZIP, city, county or state) to access providers specific to plan benefits.
3. Set range of miles around home location (up to 100-mile radius).
4. You can enter the name of the plan and search or you can scroll and pick the plan. Make sure your employer's plan name matches the Aetna plan name. If you do not know your potential plan offering, select "Skip Plan Selection."
5. Search by provider name or provider type. You'll also have the option to search by category: *Medical Doctors & Specialists, Hospitals & Facilities, Urgent Care, Walk-In Clinics, Pharmacies, Behavioral Health, Dental Care, Vision, Labs & Testing, Alternative Medicine, Durable Medical Equipment, Common Procedures & Conditions, Institutes of Quality/Institutes of Excellence.*
6. Explore providers in list view or map view.
7. If you can't find your provider, please call Member Services for assistance.

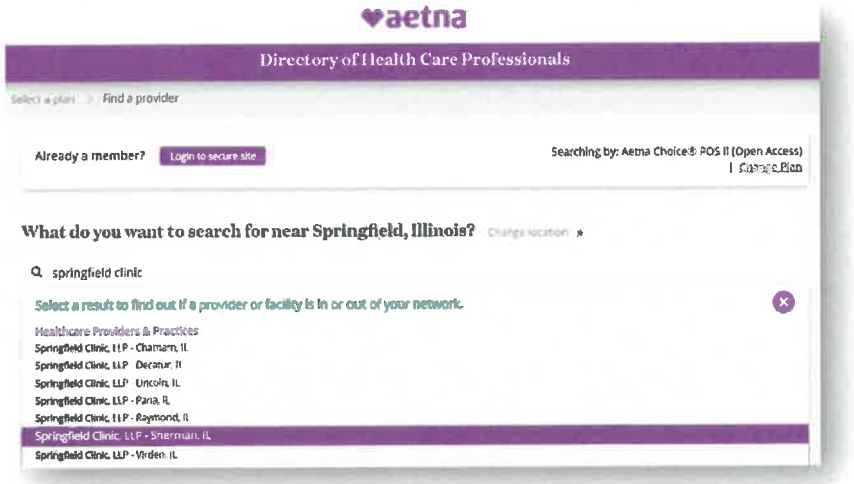
Aetna.com

90.03.568.1 (8/20)

aetna provider search instructions







Step 1

Navigate to the following URL: https://www.aetna.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=dse&language=en

Step 2

Under 'Continue as a guest', type the zip code or city you'd like to search within. Then select a distance for the search radius.

Step 3

Under "Select a Plan", type Aetna Choice POS II (Open Access).

Step 4

Search for your provider by typing in their name or searching by category.

24-Hour Nurse Line

Information and support for your health questions

Talk to a registered nurse anytime

With the 24-Hour Nurse Line, you can speak to a registered nurse about health issues — whenever you need to.*

Plus —

- It's toll-free.
- You can call as many times as you need — at no extra cost.
- Your covered family members can use it, too.

You could save time, money and a trip to the doctor

The 24-Hour Nurse Line can provide helpful information and possibly prevent an unneeded trip to the doctor's office. That can be a money-saver.

Plus, you'll be able to make smarter health decisions. You'll have reliable information you can trust — and it's only a phone call or click away.

*While only your doctor can diagnose, prescribe or give medical advice, the 24-Hour Nurse Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

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20.03.309.1 H (11/19)

More reasons to use the 24-Hour Nurse Line

You can:

- Get information on a wide range of health and wellness topics
- Make better health care decisions
- Find out more about a medical test or procedure
- Get help preparing for a visit to your doctor
- Receive emails with links to videos that relate to your question or topic

Your online source for health information

Prefer to go online for health information? Check out the 24-Hour Nurse Line page on your member website.

Here's what you can do:

- Send us an email.
- Use our symptom checker.
- Learn about treatment options and health risks.
- Research a medicine, and more.

It explains things in terms that are easy to understand. And it's easy to get to — once you're a member, just go to **Aetna.com** and log in.

Members like you get the information they need

We asked our members what they liked about the 24-Hour Nurse Line.[1] Here's what they said:

- 93 percent felt it helped them better manage their health.
- 96 percent said this program was an important part of their health plan benefits.

Two ways to get health information fast

1. Call a registered nurse anytime toll-free.
2. Go to **Aetna.com** and log in.

Get health information — when and where you need it.
Just call **1-800-556-1555 (TTY: 711)*** or go to **Aetna.com** to log in.

THIS IS NOT INSURANCE. THIS IS A PROGRAM AVAILABLE WITH THE MEDICAL PLAN.

[1]24-Hour Nurse Line Member Satisfaction Survey. October 2017.

*Ask the relay operator to dial **1-800-556-1555 (TTY: 711)** and select the option to speak to a nurse.

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20.03.309.1 H (11/19)

Notice of Privacy Practices

Para recibir esta notificación en español por favor llamar al número gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificación.

To receive this Notice in Spanish, please call the toll-free number on your member ID card.

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.

This Notice of Privacy Practices (Notice) describes the privacy practices of Aetna Life Insurance Company (In this Notice, we may also refer to *Aetna*, *we*, *us* or *our*). It also applies to the members of its Affiliated Covered Entity ("Aetna ACE"). This is a group of covered entities and health care providers we own or control. They designate themselves as a single entity to comply with the Health Insurance Portability and Accountability Act (HIPAA).

The members of the Aetna ACE can share Protected Health Information (PHI) with each other. We do this for the treatment, payment and health care operations of the Aetna ACE and as allowed by HIPAA and this Notice.

The Aetna ACE includes Aetna Life Insurance Company, and its health plan entity affiliates and subsidiaries. For a full list of the members of the Aetna ACE, contact the Aetna Privacy Office at **Privacy.Officer@cvshealth.com**.

This Notice applies to insured plans

This Notice of Privacy Practices is for Aetna insured health benefit plans. It does not apply to any plans that are self-funded by an employer. If you have coverage where you work, ask your employer if your plan is insured or self-funded. If it's self-funded, ask for a copy of your employer's Privacy Notice.

Effective date

This Notice took effect on February 10, 2022.

In this Notice, we describe:

- Information we collect about you
- How we use and share your information
- Times when we must share your information
- When we may share your information with those involved in your care
- When we need your okay to use or share your information
- Your rights under the law
- How we keep your information safe
- How we comply with the law
- When this Notice may change

Information we collect about you

We get information about you from many sources, including from you. But we also can get it from your employer or benefits plan sponsor (if applicable), other insurers, HMOs or third-party administrators, and health care providers such as doctors.

This is called Protected Health Information (PHI). It includes personal information that may identify you that is not public information. And it includes information about your health, medical conditions, prescriptions, and payment for health care products or services.

It may include:

- Demographic data (like your name or address)
- Health details (like a medical history)
- Test results (like a lab test)
- Insurance information (like your member ID)
- Other information used to identify you or that's linked to your health care or health care coverage

How we use and share your information without your authorization

In providing your health benefits, we may use and share PHI about you in varied ways. For instance:

Health care operations: We may use and share your PHI for our health care operations. Those are actions we need to do to run our health business, including:

- Quality assessment and improvement
- Licensing
- Accreditation by independent organizations
- Performance measurement and outcomes assessment
- Health services planning and development activities
- Preventive health, disease and case management, and care coordination

For example, we may use your PHI to offer programs for certain conditions, such as diabetes, asthma, or heart failure. We may also use it for other operations requiring use and disclosure, such as:

- Administering reinsurance and stop loss
- Underwriting and rating
- Investigating fraud
- Running pharmaceutical programs and payments
- Moving policies or contracts from and to other health plans
- Facilitating a sale, transfer, merger or consolidation of all or part of Aetna with another entity (including related due diligence)
- Performing other general administrative activities (including data and information systems management and customer service)
- Creating de-identified data (this is data that no longer identifies you. We may use it or share it for analytics, business planning or other reasons).

Payment: We may use and disclose PHI to help pay for your covered services when:

- Doing utilization and medical necessity reviews
- Coordinating care
- Deciding eligibility
- Deciding on drug list (formulary) compliance
- Getting premium payments from you
- Calculating cost-sharing amounts
- Responding to complaints, appeals and requests for external reviews

We carry out these tasks to make sure we pay for your care the right way.

We may use your health history and other PHI to decide whether a treatment is medically necessary and what the payment should be. During this process, we may share information with your health care provider.

We may also mail Explanation of Benefits forms and other information to the address we have on file for the subscriber (i.e., the primary insured). We also make claims information on our secure member website and telephonic claims status sites available to the subscriber and all covered dependents. We also use PHI to get payment for any mail-order pharmacy services you get.

Treatment: We may share your PHI with the health care providers who take care of you like your doctors, dentists, pharmacies and hospitals. Sometimes doctors may ask for your medical information from us to put in their own records.

We may also use your information to offer you mail-order pharmacy services. And we may also share certain information for patient safety or other reasons linked to your treatment.

Disclosures to other covered entities: We may share your PHI with other covered entities or their business associates. This may be for treatment, payment, or for certain health care operations.

For example, you may get your health benefits through an employer. If so, we may share your PHI with other health plans your employer offers. We do this to make sure we pay your claims the right way.

Additional Reasons for Use and Disclosure without Your Authorization

We may use or share PHI about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may use or share your PHI without your authorization in support of:

- **Plan Administration** (Group Plans) – to your employer, as applicable, when we have been informed that appropriate language has been included in your plan documents, or when summary data is disclosed to assist in bidding or amending a group health plan.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Associates** – to persons who provide services to us and assure us they will protect the information.
- **Health Oversight** – to health oversight agencies (e.g., agencies that oversee the healthcare system and government benefit programs) for purposes of oversight activities authorized by law (e.g., investigations, audits, and licensure or disciplinary actions).

Continued on next page.

- **Workers' Compensation** – to comply with workers' compensation laws.
- **Law Enforcement** – to Government law enforcement officials as permitted or required by law.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, public health surveillance and investigations, controlling disease, product recalls).
- **As Required by Law** – to comply with legal obligations and requirements.
- **Decedents** – to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or as authorized by law; and to funeral directors as necessary to carry out their duties.
- **Organ Procurement** – to respond to organ donation groups for the purpose of facilitating donation and transplantation.
- **Abuse, Neglect, or Domestic Violence** – to government authorities, including social service or protective service agencies, authorized to receive such reports, if we believe that you are a victim of abuse, neglect, or domestic violence. We will inform you of such a disclosure, unless doing so would place you at risk of serious harm or not be in your best interests.
- **Specialized Government Functions, Military, and Correctional Institutions** – to authorized government officials for purposes of national security and intelligence activities, protective services for the President, and medical suitability determinations. If you are a member of the U.S. armed forces or the foreign military, we may disclose your PHI for activities deemed necessary by appropriate command authorities or under the law. If you are under the custody of a correctional institution or a law enforcement official, we may disclose your PHI to such parties if certain representations are made (e.g., the information is necessary to provide you with health care or the health and safety of others).

Times when we must share your information

There are times when we must share your PHI. When required, we must release it to:

- You, or someone who has the legal right to act for you. This person is your personal representative. We do this to help manage your rights, as spelled out in this Notice.
- The Department of Health and Human Services. We may do this to comply with the Health Insurance Portability and Accountability Act (HIPAA). They may collect this information to enforce HIPAA.
- Other government authorities as required by applicable law.

When we may share your information with those involved in your care

We may share your PHI with people involved in your health care. We may also share with those involved in paying for your care. For example, if a family member or a caregiver calls us about a claim, we may tell them what stage it's in. You have the right to stop or limit this kind of sharing (disclosure). To do so, just call the toll-free number on your member ID card.

If you're a minor, you may have the right to block parental views of your health information in certain cases. But you can only do so if state law allows it. You can call us at the toll-free number on your ID card. Or have your provider talk to us.

We may use or share your PHI to notify or to help to notify a family member or any other person responsible for your care about your location, general condition or death. We may also disclose your PHI to disaster relief groups so that your family or others responsible for your care can learn of your location, general condition or death.

When we need your okay to use or share your information

If we have not described a use or disclosure above, we will need you to say it's okay in writing to use or disclose your PHI. For example, we will get your okay:

- For marketing purposes unrelated to your benefit plan(s)
- Before sharing any psychotherapy notes
- When linked to the sale of your PHI
- For other reasons as required by law

Even if you gave us your okay, you can withdraw it anytime. You just need to let us know in writing. If we haven't already acted on it, we'll stop using or sharing your information for that purpose. If you have questions about written permission, just call the toll-free number on your ID card.

We must also follow state privacy laws that are stricter (or more protective of your PHI) than federal law.

Your rights under the law

Under federal privacy laws, you have rights when it comes to your PHI. You have the right to:

- Ask us to communicate with you how or where you choose. For example, if you're covered as an adult dependent, you might want us to send health information, like your Explanation of Benefits, to another address than that of your subscriber. If it's a reasonable request, we will make this happen.
- Ask us to limit the way we use or share your information when it comes to health care operations, payment and treatment. We will consider, but may not agree to, such requests. You also have the right to ask us to restrict sharing with people involved in your health care.
- Ask us for a copy of PHI that's part of a "designated record set". This may include medical records. It may also include other records we keep and use for:
  - Enrollment
  - Payment
  - Claims processing
  - Medical management
  - Other decisions

  We may ask you to request this in writing. And we may charge a reasonable fee for making and mailing the copies. Sometimes, we may deny the request.
- Ask us to fix your PHI. You need to ask this in writing. And you must include the reason for the request. If we deny it, you may write us, to let us know you disagree.
- Ask us to give you a list of certain disclosures we have made about you, such as PHI we've shared with government agencies that license us. (This is called an "accounting.") You need to ask this in writing. If you ask for this kind of list more than once in 12 months, we may charge a reasonable fee.
- Be notified after a breach of your PHI.
- Know the reasons for denying an insurance policy or other unfavorable underwriting decision. If you've been denied a policy in the past, we can't use that information in our decision process. We must review the facts on our own. Also, we can't use your genetic information to decide if we should issue you a policy or for other underwriting purposes.
- Insurers aren't allowed to take part in pretext interviews, except in some cases, such as suspected fraud or criminal activity. We don't take part in these.

You may make any of the above requests (if they apply), ask for a paper copy of this Notice, or ask questions about this Notice. You can do this by calling the toll-free number on your member ID card.

You also have the right to file a complaint if you think someone has violated your privacy rights. To do so, just send a letter to:

Aetna HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079
Fax: 859-280-1272

You may stop the paper mailing of your EOB and other claim information by visiting **Aetna.com**. Choose **"Log In/Register."** Follow the prompts to complete the one-time registration. Then you can log in anytime to view your EOBs and other claim information.

You also may write to the Secretary of the U.S. Department of Health and Human Services. There are no penalties for filing a complaint.

How we keep your information safe

We use administrative, technical and physical safeguards to keep your information from unauthorized access, and other threats and hazards to its security and integrity. We comply with all state and federal laws that apply related to the security and confidentiality of your PHI.

We don't destroy your PHI even when you end your coverage with us. We may need to use and share it even after your coverage terminates. (We describe the reasons for using or sharing in this Notice). We will continue to protect your information against inappropriate use or disclosure.

How we comply with the law

Federal privacy law requires us to keep your PHI private. And we must tell you about our legal duties and privacy practices. We must also follow the terms of the Notice in effect.

When this Notice may change

We may change the terms of this Notice and our privacy policies anytime. If we do, the new terms and policies will be effective for all the information we now have about you. And they'll apply to any information that we may get or hold in the future.

If we make material or important changes to our privacy policies, we will promptly revise our Notice.

We will also post the revised Notice on our website, and if you are enrolled in an Aetna insurance plan at that time we will send you a new notice, as required.

You can ask for a copy of the revised Notice, just ask the Aetna Privacy Office at the email above.

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512
(CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),
CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

CVS-
CAREMARK

Register at Caremark.com

When you register at Caremark.com, you'll get access to tools and resources that make managing your pharmacy benefits easier and more convenient.

There are three easy ways to register:

- Go to Caremark.com, click the ***Register*** button, and follow the instructions to sign up
- Download the CVS Caremark® mobile app from Google Play or the App Store to register your account
- Call the number on the back of your prescription ID card and a representative will get you started with a personalized registration email or text

Register to:

- Refill your prescriptions
- Check the status of your order
- Review your coverage and track annual spending
- Locate network pharmacies near you
- Check medication costs and find opportunities to save money
- Log into Caremark.com from your desktop to access these additional features: manage your profile information, including shipping addresses, payment methods and notifications

Visit Caremark.com/GetStarted or scan the QR code to download the CVS Caremark mobile app and register today.

GET IT ON Google Play

Download on the App Store

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

CVS caremark®

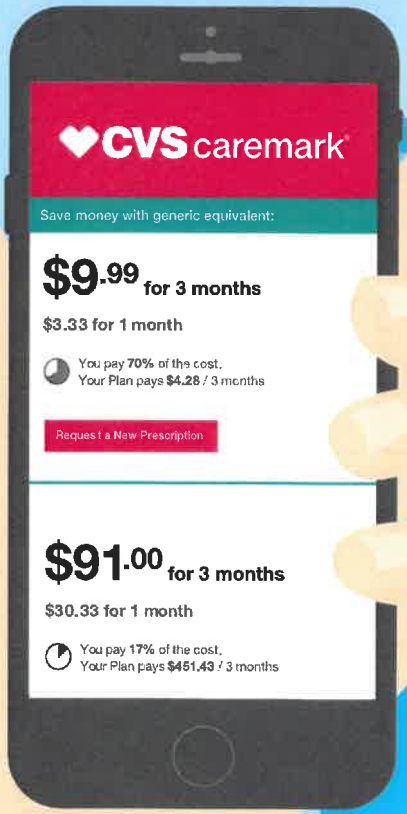
CVS caremark®

Manage your medications anytime, anywhere.

Download the CVS Caremark app and manage your prescription medications from wherever you are.

You can order refills, check drug costs, view your prescription ID card and locate a pharmacy – anytime, anywhere.

Download our app today.



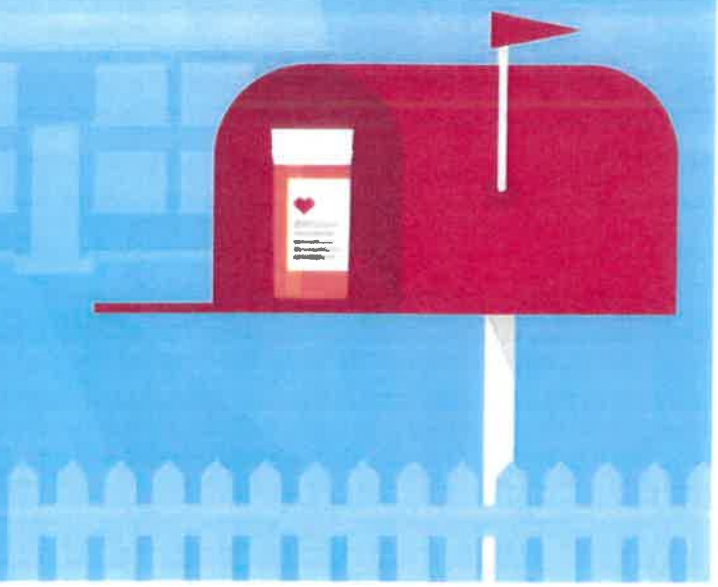
Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

6527-40692Q 071018

CVS caremark

Mail Service Pharmacy

Rx delivered to your door



Save on medications you take regularly (such as high blood pressure or diabetes medicine) when you have them delivered by mail, in 90-day supplies, from CVS Caremark Mail Service Pharmacy. It's an easy way to make sure you have the medication you need, when you need it, with one less thing to worry about.

Savings

One 90-day supply typically costs less than three 30-day supplies, so you can be sure you're paying a lower price. And we deliver by mail, anywhere you choose, with no-cost shipping.

Convenience

Mail delivery means no more monthly trips to the pharmacy, and with automatic refills, you won't need to keep track of refill schedules either. We alert you 10 days before a refill in case you need to change the delivery date or location.

Safety

Every order is filled by a licensed pharmacist, then quality checked before shipping. Our discreet packages are tamper-proof, weather-proof and temperature controlled. Plus, we'll send status alerts by email, phone or text – so there's nothing to worry about.

Two easy ways to get started

Online
Visit **Caremark.com/mailservice**

- OR -

By phone
Call the number on your member ID card for live help getting set up

Be sure to have a prescription bottle in hand, all the information needed to get started is on the label.

Download the CVS Caremark mobile app to manage mail orders anytime, anywhere.

106-42431D 063017

TDD: 1-800-863-5488

DELTA DENTAL

Welcome to Delta Dental

Diocese of Springfield

Group #11390

DELTA DENTAL

Delta Dental of Illinois

DELTA DENTAL

Delta Dental of Illinois
Dental Benefit Highlight Sheet
Diocese of Springfield, Group #11390

Delta Dental of Illinois is pleased to be your dental benefits carrier. Your group plan offers you the dental benefits program: Delta Dental PPO Plus Delta Dental Premier.

Delta Dental PPO Plus Premier

On the reverse side of this sheet is a summary of your plan coverage*. Please also see the enclosed sheet, "How You Can Save with a Delta Dental Network Dentist," which provides an example of your out-of-pockets costs with network dentists and a non-network dentist.

With Delta Dental PPO Plus Premier:

- You can go to any licensed general or specialty dentist.
- **You will maximize your benefits by receiving care from a Delta Dental PPO or Delta Dental Premier network dentist.**
- Delta Dental's network dentists have agreed to reduced fees as payment in full, which means you will likely save money by going to a Delta Dental PPO or Delta Dental Premier network dentist. Non-network dentists have not agreed to accept our reduced fees as payment in full, which means they may bill you for any charges over our allowed fees.
- You are charged only the patient's share** at the time of treatment. Delta Dental pays its portion directly to network dentists.

Finding a Dentist

Visit our web site at www.deltadentalil.com and click on Provider Search. Please see the enclosed "How to Find a Network Dentist" sheet for more details.

Example of Your Copayment with Delta Dental Network Dentists and Non-Network Dentists

- Delta Dental PPO: Lowest out-of-pocket costs and network protection.
- Delta Dental Premier: Higher out-of-pocket costs than PPO, but may be lower than non-network and network protection.
- Non-network: You may have the highest out-of-pocket costs.

Delta Dental PPO Plus Premier Plan Features

Your Delta Dental PPO Plus Premier plan includes the following features (please see enclosed pieces for more information):

- ToGo℠, a feature that allows you to carryover qualified unused portions of your annual maximum to the next year.
- **Enhanced Benefit Program** offers additional coverage for individuals who have specific health conditions (including pregnancy, diabetes, high-risk cardiac conditions, suppressed immune systems, and special needs) that can be positively affected by additional oral health care.

Customer Service

The enclosed Member Connection sheet explains how to register on Delta Dental of Illinois' website, www.deltadentalil.com. Once registered, you can **get real time benefit information, check claim status, sign up for electronic Explanation of Benefits and print a temporary ID card.**

Call 1-800-323-1743 to access our automated phone system or speak to a customer service representative from 7 am to 7 pm Monday through Thursday and 7 am to 6 pm Friday, Central Time. Our automated phone system is available 24 hours a day, seven days a week, and offers dentist listings and claim information.

You can also connect with us through our mobile app, Facebook, Twitter, our blog and more. See the enclosed sheets on connecting with us.

Learn More

You can learn more about your Delta Dental of Illinois dental plan by reading the information included in your enrollment kit.

***The information on the reverse side of this sheet is a brief summary of your dental plan and the services it covers. There are some limitations on the expenses for which your dental plan pays If you have specific questions regarding benefit coverage, limitations, exclusions, or non-covered services, please refer to your certificate of coverage/dental benefit booklet or contact Delta Dental of Illinois.

**Patient's share is the coinsurance/copayment, any remaining deductible any amount over the annual maximum and any services your plan does not cover.

Note: Delta Dental imposes no restrictions on the method of diagnosis or treatment by a treating dentist. A benefit determination relates only to the level of payment that your group dental plan is required to make.

PPOPREF

DELTA DENTAL

Dental Benefit Highlight Sheet

Diocese of Springfield, Group #11390

Eligible Dependents	**Spouse/and dependent children to age 26**
Annual Deductible (applies to Basic and Major Services Only)	**$50/person; $150/family**
Annual Maximum	**$1,000/person**
ToGo℠ Carryover Feature	**Your plan allows you and your covered dependents to carry over qualified unused portions of your annual maximum from one year to the next.**
Enhanced Benefit Program	**Your plan provides additional cleanings and/or applications of topical fluoride to people with specific health conditions that put them at risk for oral health disease. The costs of the additional cleanings and fluoride treatments will be applied to your annual maximum.**

	Delta Dental PPO Network Dentist	Delta Dental Premier® Network Dentist	Non-Network Dentist
PREVENTIVE/DIAGNOSTIC SERVICES • Routine exams (two per benefit year) • Cleanings (two per benefit year) • X-rays (bitewings – two per benefit year; full mouth - every three years) • Fluoride treatments (once per benefit year to age 19) • Space maintainers • Emergency exams & palliative (pain relief) treatment • Sealants (to age 16)	**100%***	**100%****	**90%*****
BASIC SERVICES • Fillings • Posterior composites (tooth colored fillings on back teeth) • Periodontics • Endodontics • Oral surgery • General anesthesia (in conjunction with surgical extractions)	**80%***	**80%****	**70%*****
MAJOR RESTORATIVE SERVICES • Implants • Crowns, jackets, and other cast restorations to permanent teeth • Partial/full dentures • Denture (repair, reline, rebase and adjustments) • Fixed/removable bridges	**50%***	**50%****	**50%*****

***Delta Dental PPO dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's allowed PPO fee. PPO network dentists cannot charge you for costs exceeding the PPO fee.**

****Delta Dental Premier dentists accept payment based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. Premier dentists may not charge you for costs exceeding the maximum plan allowance.**

*****Non-network dentists (non-Delta Dental PPO/non-Delta Dental Premier) do not agree to accept Delta Dental's allowed fees as payment in full; payment is based on the lesser of the submitted fee (their usual fee) or Delta Dental's maximum plan allowance. These dentists can charge you for costs exceeding the maximum plan allowance.**

DELTA DENTAL

Save More by Going PPO

When it comes to pearly whites, everyone wants to save a little green. With the Delta Dental PPO™ network, you'll get the coverage you need at a lower out-of-pocket cost.

Here's why: When general and specialty dentists participate in the Delta Dental PPO network, they agree to accept Delta Dental's PPO fees for services as payment in full. On average, **patients save 30%** on the fee a Delta Dental PPO dentist would submit for a claim versus their regular fee. Delta Dental PPO network dentists have also agreed **not to "balance bill" patients**. This means they can't bill you the difference between the Delta Dental PPO fee and their regular fee.

Delta Dental Premier® is a safety net for our Delta Dental PPO network. You will pay more out-of-pocket with a Delta Dental Premier Dentist compared to a Delta Dental PPO Dentist. However, you may save more with a Delta Dental Premier Dentist compared to a non-network Dentist. Delta Dental Premier Dentists agree to our maximum plan allowances as payment in full, which may be lower than the dentist's regular fee.

	Amount Billed	Delta Dental of Illinois' Allowed Amount	Coverage Percentage Paid by Delta Dental of Illinois	Amount Delta Dental of Illinois Pays*	Amount Dentist Can Bill You Over the Allowed Amount	Total Amount You Pay	Your Total Cost Savings
Procedure 1							
Delta Dental PPO™ Network	$80	$57	100%	$57	$0	$0	$23
Delta Dental Premier® Network	$80	$70	100%	$70	$0	$0	$10
Out-of-Network	$80	$70	100%	$70	$10	$10	$0
Procedure 2							
Delta Dental PPO™ Network	$1,200	$850	50%	$425	$0	$425	$350
Delta Dental Premier® Network	$1,200	$995	50%	$497.50	$0	$497.50	$205
Out-of-Network	$1,200	$995	50%	$497.50	$205	$702.50	$0

Whether you see a general dentist or visit a specialist, it pays to use a Delta Dental PPO dentist. Visit deltadentalil.com today to find participating dentists in your area.

You can also download our free Delta Dental mobile app to search dentists and gauge the cost of common dental treatments using the Dental Care Cost Estimator tool.

** The example chart is relative to plans where Delta Dental Premier network and out-of-network services are paid off of the maximum plan allowance. This information is for illustrative purposes only and assumes the deductible has been met and the annual maximum has not been reached. There are some limitations on the expenses for which your dental plan pays. If you have specific questions regarding benefit coverage, limitations, exclusions or non-covered services, please refer to your policy or certificate of coverage, or contact Delta Dental of Illinois. For specific fees and costs for a certain procedure, you can request a pre-estimate from your dentist.*

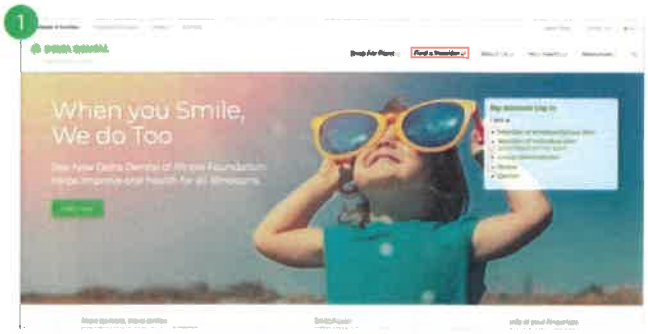
DELTA DENTAL

Finding a Delta Dental PPO™ or Delta Dental Premier® Dentist

Finding a Delta Dental network dentist is easy. More than 3 out of every 4 dentists nationwide participate in a Delta Dental network. In Illinois, more than 75 percent of dentists participate in a Delta Dental network. You can find a network dentist today by using the Dentist Search on our website or calling our automated phone system.

Provider Search

1. Go to deltadentalil.com, and select "Find a Provider." On the following page, select "Dental."



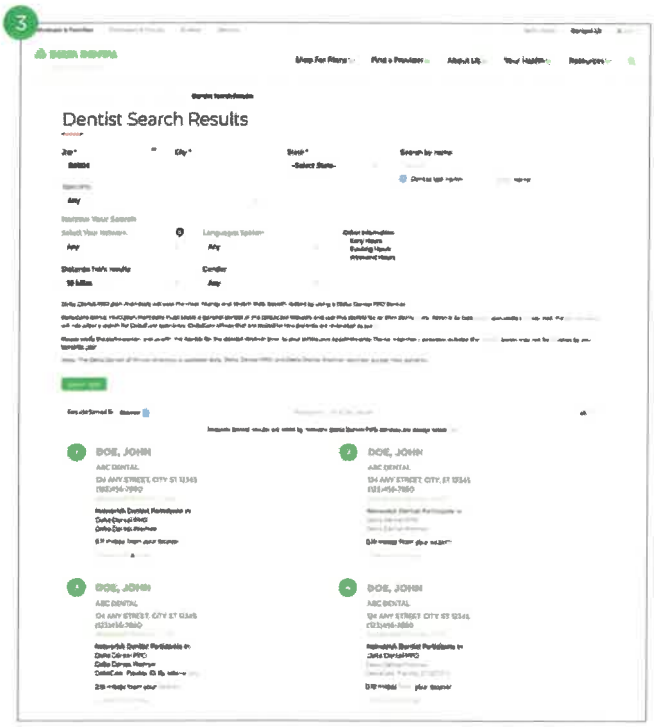
2. To start your search, you can either enter the location where you want to locate network dentists (search by city/state or ZIP code), or search for a particular dentist or practice by name and ZIP code.

3. Results will automatically display by proximity (within 10 miles from city or ZIP code) and all Delta Dental networks the dentist participates in will be listed. You can change the distance by selecting a new option under the "Distance from results" dropdown menu and clicking "Search Again."

4. You have the option to narrow your search based on the Delta Dental network a dentist participates in. You will save the most if you use a Delta Dental PPO network dentist.

   Any field marked with a red asterisk is a required field.

5. You can further narrow your search by selecting a specialty (such as orthodontist), languages spoken and gender.



Automated Phone System

You can also find a dentist through our automated phone system. Delta Dental PPO and Delta Dental Premier members can call 800-323-1743, say "Dentist Directory" and follow the automated instructions.

DELTA DENTAL

Member Connection

Connecting with Delta Dental of Illinois is easy!

Get real-time benefit and claim information 24 hours a day, seven days a week through the Member Connection at deltadentalil.com or through our automated phone system at 800-323-1743.

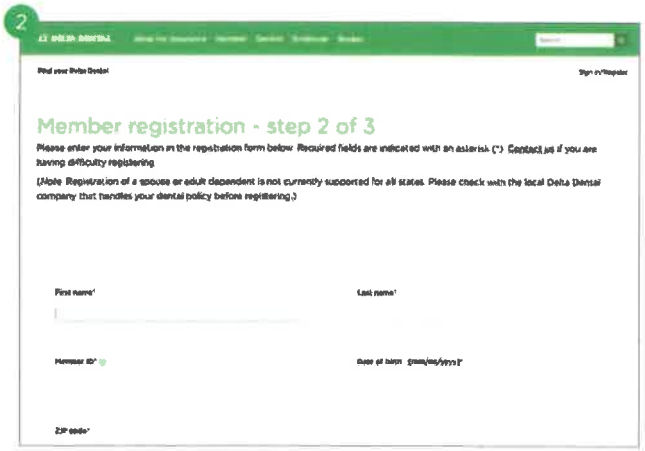
With the Member Connection, you can find everything you need to know about your and your covered dependents' benefits, including:

- Claim status
- Eligibility information
- Maximum and deductibles used to date
- Benefit levels
- Frequency and age limits
- Waiting periods
- Preventive history
- Explanation of Benefits (EOBs)

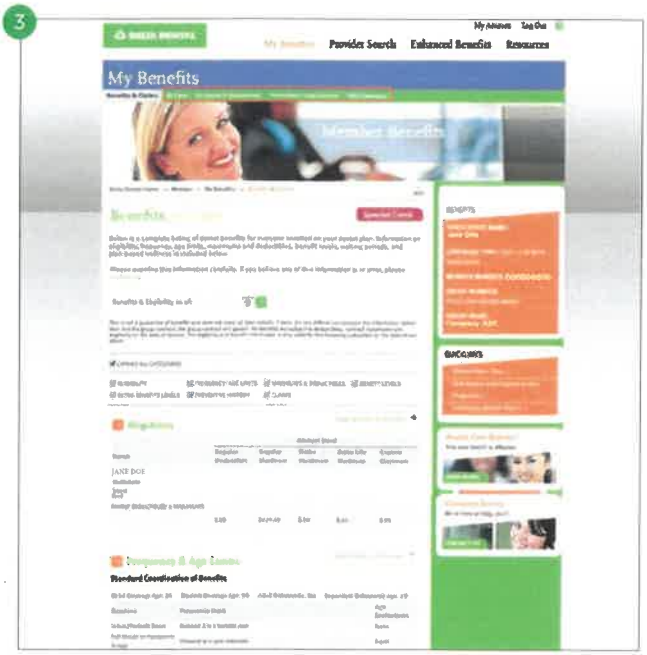
How to Register:

1. Go to deltadentalil.com, select "Member of employer/group plan" in the "My Account Log In" box located on the right side of the homepage. On the next page, click "Don't have an account? Create an account." Select "I am a member or adult dependent and have coverage with Delta Dental" on the next screen.

2. Enter the primary member's first and last name (the name must appear exactly as what your employer entered during enrollment; for example, "Bob" may be "Robert"). Please note there is a 10-character limit for first name and a 15-character limit for last name. For example, if your first name is Christopher, you are limited to Christophe for first name. You will also need to enter the primary member's assigned member ID (if your member ID is less than 9 digits, you need to enter zero's in front of the number; for example, 001234567) or Social Security number and date of birth (enter two-digit month, two-digit day and four-digit year with dividers; for example, 03/15/1984).



3 Once registered, you can easily access your and your covered dependents' benefits and claims information, print a temporary ID card, sign up to receive electronic EOBs (Go Green E-Statements), conduct a procedure code search and access EOB history.



Automated Phone System. Faster service for you.

You can also call 800-323-1743 to access our automated phone system 24 hours a day, seven days a week or to speak to a customer service representative during normal business hours (7 a.m. to 7 p.m. Monday through Thursday, 7 a.m. to 6 p.m. Friday, Central Time.).

DELTA DENTAL

Use it or lose it?

Not with To Go℠ from Delta Dental of Illinois

In traditional PPO dental plans, the annual maximum is a "use it or lose it" benefit. With Delta Dental of Illinois' To Go feature, members don't have to leave unused annual maximum dollars behind.* They can carry over the unused portion of their annual maximum to the next benefit year and use it later.

To Go allows members more flexibility and can help them plan for more costly dental treatments down the road.

Visiting the dentist is doubly important.

It pays to go to the dentist for routine visits to keep oral health in check and maximize dental benefit plans. If members have a dental service that applies to their annual maximum** during their benefit year, To Go allows unused annual maximum dollars to be applied to their dental plan for the next year — up to twice the amount of their plan's annual maximum. Plus, their To Go carryover balance never expires, so they keep the additional dollars until they need them.***

How To Go annual maximum carryover works:

YEAR 1	**Annual Maximum**	**$1,500**
	Eligible Benefits Received	− $500
	Unused Annual Maximum	$1,000
	To Go Balance / Carryover to Year 2	**$1,000**
YEAR 2	**Annual Maximum**	**$1,500**
	Eligible Benefits Received	− $400
	Unused Annual Maximum	$1,100
	To Go Balance	+ $1,000
	To Go Balance / Carryover to Year 3	$2,100
	The To Go balance cannot exceed the total annual maximum amount ($1,500) so only $500 of the $1,100 unused annual maximum can be applied to the To Go balance.	
	Adjusted To Go Balance / Carryover to Year 3	**$1,500**
YEAR 3	**Annual Maximum**	**$1,500**
	Eligible Benefits Received	− $2,000
	Balance Due	$500
	Unused Annual Maximum	$0
	To Go Balance	$1,500
	To Go Balance Applied	$500
	To Go Balance / Carryover to Year 4	**$1,000**

deltadentalil.com

* The To Go feature may not be available with all Delta Dental PPO™ and Delta Dental Premier® plans. Review your plan documents to see if To Go is included in your plan.

** Any preventive/diagnostic, basic or major dental services apply to the annual maximum. Carryover amounts for unused annual maximum dollars are subject to plan design and cannot exceed twice the plan's annual maximum.

*** Members cannot take unused maximums with them upon termination of employment or the dental plan, nor can they apply the unused annual maximum to another dental plan.

4331 (06/20)

UNUM

unum sm

Term Life Insurance
Coverage Highlights

Diocese of Springfield in Illinois
Policy # 94537

Please read carefully the following description of your Unum Term Life insurance plan.

Your Plan

Eligibility

-All Full-Time Employees in active employment in the United States with the Employer

Coverage Amounts

Basic Benefit - $15,000 if you have reached age 65, but not age 70, your amount of life insurance will be:

-$11,000;or

-$11,000 if you become insured on or after age of 65 but before age 70.

There will be no further increases in your amount of life insurance.

If you have reached age 70 or more, your amount of life insurance will be:

-$8,000;or

-$8,000 if you become insured on or after age 70.

There will be no further increase in your amount of life insurance.

Additional Benefit Options:

*Employee: $10,000; $20,000; $30,000; $40,000; $60,000; $80,000; $100,000

*Spouse: $5000; $10,000; $15,000; $20,000; $30,000; $40,000; $60,000
*Not to exceed **100%** of employee coverage amount.*
***Coverage AND premium** reduce to 67% at age 70 and then down to 45% at age 75. These percentages are of the original coverage/premium amount.

Child: $1000; $5,000; $10,000

The maximum death benefit for a child between the ages of live birth and 6 months is $1000. Benefits will be paid to the employee.

In order to purchase Life coverage for your spouse and/or child, you must purchase Life coverage for yourself.

Enrollment Information

If you enroll within 31 days of your eligibility date, you may apply for any amount of Life insurance coverage up to $100,000 for yourself, up to $60,000 for your spouse and up to $10,000 of children. If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during an annual enrollment period and will be required to furnish evidence of insurability for the entire amount of coverage.

If you are currently enrolled in the buy-up plan, you can increase your coverage by one level at annual enrollment period or within 31 days of a change in status. Evidence of insurability is required if you increase your coverage by more than one level.

Term Life Coverage Rates

Rates shown are your Monthly deduction:

Age Band	Employee per $10,000	Spouse per $5,000	Child per $1,000
			$.180
- 24	$.63	$.32	
25-29	$.63	$.32	NOTE: The
30-34	$.84	$.42	premium paid for
35-39	$1.01	$.51	child coverage is
40-44	$1.57	$.79	based on the cost of
45-49	$2.56	$1.28	coverage for one
50-54	$4.13	$2.07	child, regardless of
55-59	$7.14	$3.57	how many children
60-64	$10.30	$5.15	you have.
65-69	$15.24	$7.62	
70-74	$29.62	$14.81	
75+	$50.67	$25.34	

NOTE: Your rate will increase as you age and move to the next age band.

Insurance Age

Your rate is based on your insurance age, which is your age immediately prior to and including the anniversary/effective date.

To calculate your cost, complete the following by selecting your coverage amount and rate (based on your insurance age).

Term Life Calculation Worksheet

Coverage Amount		Increment	Rate		Monthly Cost
Employee	$_____	÷ $10,000 x	$_____	=	$_____
Spouse	$_____	÷ $ 5,000 x	$_____	=	$_____
Children	$_____	÷ $ 1,000 x	$_____	=	$_____
		Total Monthly Cost		=	$_____

Additional Benefits

Life Planning Financial & Legal Resources

This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to you. This service is also extended to you upon the death or terminal illness of your covered spouse. The financial consultants are master level consultants. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security. At no time will the consultants offer or sell any product or service.

Portability

If you reduce your hours below 20 hours per week or leave your employer, you can take your employer funded Basic Life and your VTL coverage with you according to the terms outlined in the contract. The rates are the same as the current VTL rates, please see your Portability form.

Accelerated Benefit

If you become terminally ill and are not expected to live beyond a certain time period as stated in your certificate booklet, you may request up to 50% of your life insurance amount up to $750,000, without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your

death, the remaining benefit will be paid to your designated beneficiary(ies). This feature also applies to your covered dependents.

Waiver of Premium

If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived during the period of disability.

Limitations/Exclusions/ Termination of Coverage

Suicide Exclusion

Life benefits will not be paid for deaths caused by suicide in the first twenty-four months after your effective date of coverage.

No increased or additional benefits will be payable for deaths caused by suicide occurring within 24 months after the day such increased or additional insurance is effective.

Termination of Coverage

Your coverage and your dependents' coverage under the Summary of Benefits ends on the earliest of:

- The date the policy or plan is cancelled;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The last day of the period for which you made any required contributions;
- The last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage; or an eligible retiree as defined by the company;
- For dependent's coverage, the date of your death.

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends;
- The date your dependent ceases to be an eligible dependent;
- For a spouse, the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while you and your dependents are covered under the policy or plan.

Next Steps

How to Apply

To apply for coverage, complete your enrollment form within 31 days of your eligibility date.

All employees: If you apply for coverage after your effective date, or if you choose coverage over the guarantee issue amount, you will need to complete a medical questionnaire which you can get from your Plan Administrator. You may also be required to take certain medical tests at Unum's expense.

Delayed Effective Date of Coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date

that insurance would otherwise become effective.

Dependent: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"Totally disabled" means that, as a result of an injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

Changes to Coverage

Each year you and your spouse will be given the opportunity to change your Life coverage. You and your spouse may purchase additional Life coverage up to the Guarantee Issue amounts without evidence of insurability if you are already enrolled in the plan. Life coverage over the Guarantee Issue amounts will be medically underwritten and will require evidence of insurability and approval by Unum's Medical Underwriters. The suicide exclusion will apply to any increase in coverage.

Questions

If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.

This plan highlight is a summary provided to help you understand your insurance coverage from Unum. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern. For complete details of coverage, please refer to policy form number C.FP-1, et al.

Life Planning is provided by Ceridian Incorporated. The services are subject to availability and may be withdrawn by Unum without prior notice.

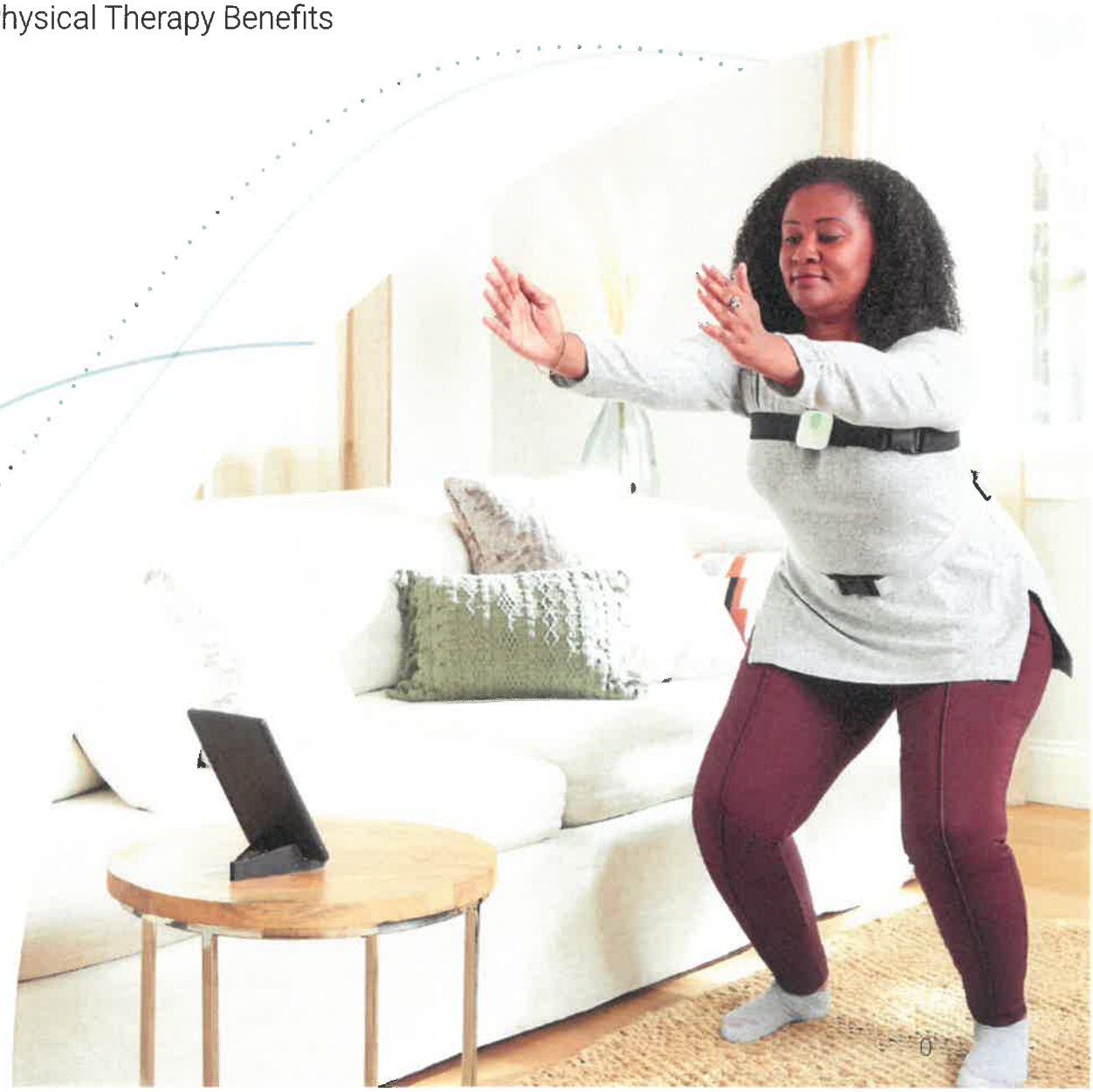
Underwritten by: **Unum Life Insurance Company of America,** 2211 Congress Street, Portland, Maine 04122, www.unum.com

HINGE HEALTH

Hinge Health

New Hire Booklet Information

Digital Physical Therapy Benefits



Benefits Info

What is Hinge Health? (~10 seconds)

Hinge Health is an at-home, virtual physical therapy program that targets back and joint pain. As a Diocese of Springfield employee, 100% of your costs are covered. hingehealth.com/aetna-em

What is Hinge Health? (~35 seconds)

Hinge Health is an at-home, virtual physical therapy program that targets back, knee, neck, and other joint pain. You're guided through stretches and exercises via an app. These sessions take around 15 minutes and can be done whenever it fits into your schedule.You also get connected with your own personal health coach who'll help guide you through the program and make sure it's tailored to your exact needs. On average, participants see close to a 70% reduction in pain. It's a totally free program available through our Aetna health plan. hingehealth.com/aetna-em

Whole-body wellness, personalized care

Hinge Health virtual programs connect you with your own health coach and physical therapist so you'll get all the support you need to reduce your pain and reach your wellness goals.

Mental health is important

Hinge Health programs also tackle the mental strain which often goes hand in hand with long-term pain. By reducing your physical pain, you're also improving your emotional wellbeing. On average, participants see a 58% reduction in anxiety and depression.

Reduction in surgery

Two out of three participants in Hinge Health avoid surgery and reduce their pain by close to 70%. If you've been thinking about surgery to treat your pain, these programs may be a much better solution for you.

At-home care, no office visits

If you're suffering from back or joint pain, but don't feel you have time to visit a physical therapist in person, Hinge Health is for you. You'll receive wearable sensors to guide you through virtual exercise sessions that take just 10-15 minutes and can be done at home, on your schedule. hingehealth.com/aetna-em

Zero-cost care

Your wellbeing is our priority which is why we've partnered with Hinge Health, a totally free virtual physical therapy program, available through our Aetna health plan. hingehealth.com/aetna-em

FAQs

How do I enroll?

You can sign up at hingehealth.com/aetna-em

Who is eligible?

Employees and dependents 18+ enrolled on an Aetna® medical plan are eligible.

How much does the program cost?

The program is provided at no cost for employees and dependents 18+ enrolled in an Aetna® medical plan.

Can I join the program if I don't have any pain?

Yes, we have a Wellness program for participants who aren't currently suffering from any pain. The program includes a customized exercise plan.

What is a health coach and how can they help me?

In some of our programs, you will receive 1:1 health coaching. A health coach is an accountability partner. They will work 1:1 with you throughout the program to help you create and stick with your goals. You will have a monthly call with them and they will check-in with you each week.

Can I do more than one program at the same time?

Participants are unable to do multiple programs simultaneously. We recommend selecting the part of the body you would like to work on first. Once you complete the first 12-weeks, we will be happy to have you on another program.

What if my doctor has told me that I can't do specific movements?

The program is designed to meet you where you are, we provide modifications and education on how to pace yourself during your activities so you can succeed.

AFLAC

Aflac.

Scan the QR Code below to see the Aflac Insurance Products

Aflac helps with expenses health insurance doesn't cover, so you can care about everything else.*

Or, visit your benefits page at:
aflacenrollment.com/DioceseofSpringfield/A7920

Get help with expenses health insurance doesn't cover

Health insurance pays doctors and hospitals if you're sick or hurt. Aflac pays benefits directly to you* — often in just one day. And you can use the money your way, whether to help with medical bills or any other expense you may have.**

Here are some of the insurance policies Aflac offers:

Accident

Accidents happen. When a covered accident happens to you, our accident insurance policy pays you cash benefits to help with the unexpected medical and everyday expenses that begin to add up

Cancer/Specified-Disease

Aflac's cancer/specified-disease insurance policy can help you and your family better cope financially if a positive diagnosis of cancer ever occurs.

Critical Illness (Specified Health Event)

An Aflac specified health event insurance policy is designed to help with the costs of treatment if you experience a covered health event.

Hospital Confinement Indemnity

Hospital stays are expensive. An Aflac hospital confinement indemnity insurance policy can help ease the financial burden of hospital stays by providing cash benefits.

Short-Term Disability

How would you pay your bills if you're disabled and can't work? An Aflac short-term disability insurance policy can help provide you with a source of income while you concentrate on getting better.

Give Aflac a look— or a second one

We're excited to talk about your coverage options. Fill out the form below and return it to your agent.

Name Date Email

Phone and best time to contact

Aflac.

Aflac agen
Coverage is In New Yor coverage is underwritten by WWHQ | 1932 Wynnto

EYEMED

Diocese of Springfield in Illinois

Additional discounts

40% OFF Complete pair of prescription eyeglasses

20% OFF Non-prescription sunglasses

20% OFF Remaining balance beyond plan coverage

These discounts are for in-network providers only

Take a sneak peek before enrolling

- You're on the INSIGHT Network
- For a complete list of **in-network** providers near you, use our **Enhanced** Provider Locator on www.eyemed.com or call **1-866-804-0982**.
- For Lasik providers, call 1-877-5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $35
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay; $150 allowance; 20% off balance over $150	Up to $75
Standard Plastic Lenses		
Single Vision	$10 Co-pay	Up to $25
Bifocal	$10 Co-pay	Up to $40
Trifocal	$10 Co-pay	Up to $55
Standard Progressive Lens	$75 Co-pay	Up to $40
Premium Progressive Lens[A]	$95 Co-pay - $120 Co-pay	
Tier 1	$95 Co-pay	Up to $40
Tier 2	$105 Co-pay	Up to $40
Tier 3	$120 Co-pay	Up to $40
Tier 4	$75 Co-pay, 20% off Retail Price less $120 allowance	Up to $40
Lenticular	$10 Co-pay	Up to $55
Lens Options (paid by the member and added to the base price of the lens)		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$15	N/A
Standard Polycarbonate	$40	N/A
Standard Polycarbonate - Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Premium Anti-Reflective Coating[A]	$57 - $68	N/A
Tier 1	$57	N/A
Tier 2	$68	N/A
Tier 3	20% off Retail Price	N/A
Photochromic/Transitions	$75	N/A
Polarized	20% off retail price	N/A
Other Add-Ons and Services	20% off retail price	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and two follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
Contact Lenses		
Conventional	$0 Co-pay; $130 allowance; 15% off balance over $130	Up to $105
Disposable	$0 Co-pay; $130 allowance; plus balance over $130	Up to $105
Medically Necessary	$0 Co-pay, Paid-in-Full	Up to $210
Laser Vision Correction		
Lasik or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	

[A]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level . All providers are not required to carry all brands at all levels. Benefits are not provided from services or materials arising from: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services or materials provided by any other group benefit plan providing vision care 9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order. 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered-fund as a Bifocal lens. Standard Progressive lens covered-fund Premium Progressive as a Standard. Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri, except in New York. The Certificate of Insurance is on file with your employer. Benefit allowance provides no remaining balance for future use within the same benefit year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

EyeMed

Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam with dilation as necessary (Once every 12 months)	**$10 Co-pay**	Up to $35
Frames (Once every 24 months)	**$0 Co-pay; $150 allowance; 20% off balance over $150**	Up to $75
Single Vision Lenses (Once every 12 months)	**$10 Co-pay**	Up to $25
Or		
Contacts (Once every 12 months)	**$0 Co-pay; $130 allowance; plus balance over $130**	Up to $105

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

85%

SAVINGS with us*

With EyeMed	Without Insurance**
Exam $10 Co-pay	Exam $106
Frame $163 **-$150 allowance** **$13** **-$2.60 (20% discount off balance)** **$10.40**	Frame $163
Lens $10 Co-pay **$15 UV treatment add-on** **+$15 Scratch coating add-on** **$40**	Lens $78 $23 UV treatment add-on +$25 Scratch coating add-on $126
Total $60.40	Total $395

Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

eyed INDEPENDENT PROVIDER NETWORK + LensCrafters PEARLE VISION OPTICAL

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.

MEMBERSHIP PERKS: MEMBER WEB

Fresh look. Same great benefits.

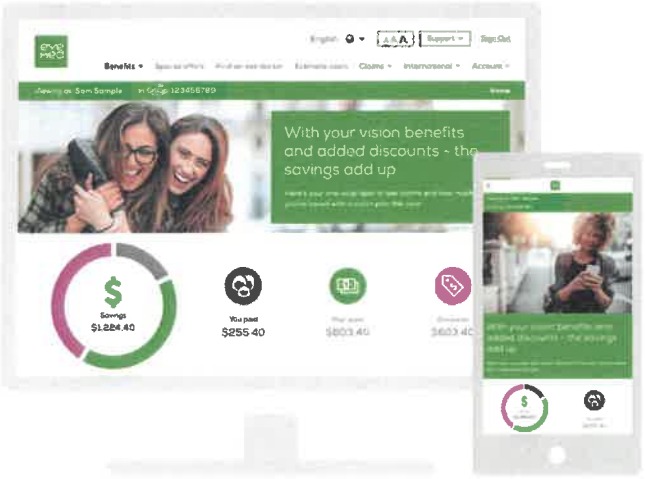
GET THE WHOLE PICTURE

Our revamped Member Web is the place for all things vision–a one-stop shop where you can manage your benefits whenever you want. And now, it's got an all-new look designed to make things easier, faster and more convenient for you.

YOU'LL LIKE WHAT YOU SEE

What can you do with the new Member Web? Simple: just about everything, all in one place.

- Find an in-network eye doctor with our refreshed Provider Locator
- View your Savings Dashboard to see how much you've saved with your benefits
- Estimate out-of-pocket costs before your visit
- Browse your vision benefits and view claims
- Grab special offers curated just for you
- Take a look at your ID card
- Discover helpful guides, resources and FAQs – even while traveling abroad



SEE FOR YOURSELF

Log in or create a new Member Web account at eyemed.com/member

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

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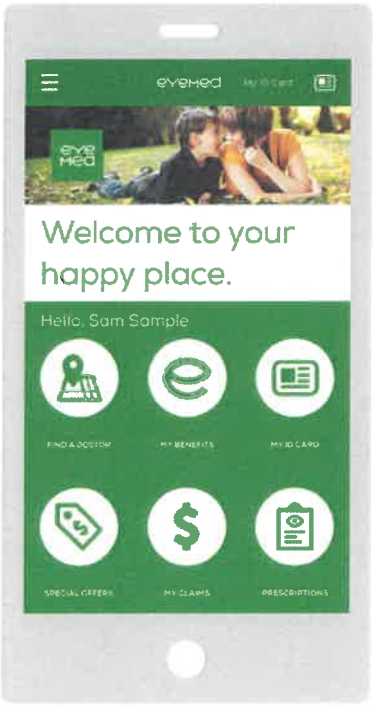
EYEMED MOBILE APP

On the go? Now your benefits are, too.

NEW LOOK. FRESH FEATURES. SAME GREAT BENEFITS. WHENEVER YOU NEED THEM.

Our revamped EyeMed Mobile App brings you fresh new features to help you get the most from your EyeMed experience – anytime, anywhere.



The features you love plus new features to explore

- See benefits and eligibility at-a-glance
- Track your claims
- Grab special offers to help you save more
- Find an in-network eye doctor with the Provider Locator
- View your ID card at-a-shake
- Set upcoming exam and contact lens replacement reminders
- Get answers to your FAQs
- Access interactive vision guides to help you see and live your best
- Use Facial recognition, Touch ID and Apple Wallet for Apple users

USING THE OLD APP?

Make sure you download the newest version of the app to keep up with our latest features, as older versions will no longer be supported. Download the new app, enter your existing login info (no need to re-register) and you're all set.

Check out the App Store or Google Play to download the new app

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL

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BRINGING IT ALL INTO FOCUS

Time for a little Q&A

A LOOK AT THE BENEFITS

What exactly do my EyeMed benefits cover?

If you're thinking about EyeMed, you'll want to connect with your employer to learn about the benefit options. Already a member? The easiest way to find your benefit information is to create a member account on eyemed.com or grab the EyeMed Members App (App Store or Google Play).

Does EyeMed offer any extra discounts?

We sure do. At participating in-network providers, members get 40% off an extra pair of eyeglasses or 20% off a partial pair (lenses only or frames only).* You also get 20% off non-prescription sunglasses and accessories, and discounts on LASIK laser vision correction. Call 1.800.988.4221 to find a LASIK location near you.

Can I use EyeMed benefits online?

Instantly apply your in-network benefits at checkout, with free shipping, free returns and no paperwork at these participating providers: lenscrafters.com, targetoptical.com, ray-ban.com, glasses.com and contactsdirect.com.

Can I get the same kind of care with a retail provider as I can with an independent doctor?

Many optometrists share space with a retail optical store, but operate a separate practice. All of them, wherever they practice, must meet the same state licensing and credentialing requirements. One advantage of using a vision carrier, like EyeMed, is that credentials of every in-network eye doctor are thoroughly examined and verified, so you can feel confident you're getting access to qualified eye doctors.

MEMBER HOW-TO TIPS

How do I use my benefits?

At EyeMed, we're all about easy. Just choose an in-network eye doctor from our Enhanced Provider Search, schedule your visit and go in for care or eyewear. You don't even need your ID card – just give them your name and birthday. When you stay in-network, we'll handle all the paperwork.

How do I find an eye doctor in my network?

The Enhanced Provider Search on Member Portal and the EyeMed Members App has thousands of in-network eye doctors to choose from. Filter your search to find ones near you with the brands, hours and services you most want.

How do I get on-the-go access?

The EyeMed Members App can do almost everything that Member Portal can. Find an eye doctor, set an appointment, review your benefits, check claims, find special offers, show your ID card—even store your vision prescriptions and set exam reminders. Download it through the App Store or Google Play.

How do I submit a claim?

When you see one of our in-network eye doctors, you won't have to; we take care of all the paperwork. By the way, you'll save money by staying in-network, too. If you need an out-of-network claim form, log into your member account to find one.

How do I get an ID card replacement or extra cards?

If you lose your card or need extras for your family, log into eyemed.com to print a replacement, or use your digital ID on the app. Here's a tip: you don't even need the card when you visit your eye doctor.

VISION AND YOUR HEALTH

I don't wear glasses and can see fine. Do I still need an eye exam?

Getting an eye exam isn't just about needing glasses. It's also about your health. An eye exam can detect eye health problems like glaucoma or cataracts, but it can also help identify early signs of serious diseases, like high blood pressure, diabetes and high cholesterol—just to name a few.[1]

How often should I get an eye exam?

Vision changes can happen slowly—you may not even notice it. Annual eye exams are a good rule of thumb unless your doctor suggests more frequent checks; we suggest making it part of your regular preventive care routine.

At what age should my child first visit the eye doctor?

The American Optometric Association recommends a first eye exam between 6 months and 1 year of age.2The doctor may check for nearsightedness, farsightedness, astigmatism, amblyopia (or "lazy eye"), proper eye movement and eye alignment, and how the eye reacts to light and darkness. They also recommend an exam between the ages of 3 and 5, and every year after that.

My child gets a vision screening at school, so there's no need for an eye exam, right?

A vision screening does not take the place of a comprehensive eye exam. School screenings generally check for color blindness and your child's ability to see far away. A comprehensive exam will evaluate the entire structure of the eye.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

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EyeMed

Thinking of becoming a member? Learn more at **enroll.eyemed.com**

Looking to stay healthy with vision? Learn how at **eyesiteonwellness.com**

Already a member? Manage benefits at **eyemed.com**

*Discounts are for in-network providers only. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Additional limitations and exclusions may apply. Log into your member account for full details. [1] "5 Health Problems Eye Exams Can Detect," YourSightMatters.com, March, 2016. 2"Comprehensive pediatric eye and vision examination"; (2017 guideline brief); American Optometric Association; https://www.aoa.org/Documents/AOA%20Executive%20Summary%20Pediatric%20Eye%20Exam%20Guidelines%20Revised%2003.05.18.pdf

NOTICES

HIPAA Special Enrollment Rights Notice

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about very important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" without being considered a late enrollee if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Special Enrollment Provisions

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)

If you are declining enrollment for yourself or your eligible 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. However, you must request enrollment within 30 days after your or your dependents other coverage ends.

Loss of Coverage for Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after your or your dependents coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

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 in this plan. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 30 days after your or your dependents determination of eligibility for such assistance.

WOMEN'S HEALTH AND CANCER RIGHTS ACT
ANNUAL NOTICE

On October 21, 1998 the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you with this annual notice outlining the coverage that this law requires our plan to provide.

Our group health plan has always provided coverage for medically-necessary mastectomies. This coverage includes procedures to reconstruct the breast on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance and any complications that could result from that surgery.

The following benefits must be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting from any stage of the mastectomy, including lymphedemas.

These benefits are subject to the same deductible, copays and coinsurance that apply to mastectomy benefits under the plan.

Model Newborns' Act Disclosure

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 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 Grandfathered Status

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator Mike Kelly in the insurance office. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

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.

[1] An employer-sponsored 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.

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)
Diocese of Springfield in Illinois		37-0661201
5. Employer address		6. Employer phone number
1615 West Washington		217-698-8500
7. City	8. State	9. ZIP code
Springfield	IL	62702
10. Who can we contact at this job?		
Mike Kelly		
11. Phone number (if different from above)	12. Email address	
	mkelly@dio.org	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

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 January 31, 2018. Contact your State for more information on eligibility -

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	**Website:** http://flmedicaidtplrecovery.com/hipp/ **Phone:** 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program **Website:** http://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**Website:** http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) **Phone:** 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)	**Healthy Indiana Plan for low-income adults 19-64** **Website:** http://www.in.gov/fssa/hip/ **Phone:** 1-877-438-4479 **All other Medicaid** **Website:** http://www.indianamedicaid.com **Phone** 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/ State Relay 711 **CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus** **CHP+ Customer Service: 1-800-359-1991/** **State Relay 711**	**Website:** http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp **Phone:** 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website:
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/ombp/nhhpp/
Phone: 603-271-5218
Hotline: NH Medicaid Service Center at 1-888-901-4999

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

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

PENNSYLVANIA – Medicaid

Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthipprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov **Phone: 1-888-828-0059**	**Website:** http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program **Phone: 1-800-562-3022 ext. 15473**
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ **Phone: 1-800-440-0493**	**Website:** http://mywvhipp.com/ **Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)**
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ **CHIP Website:** http://health.utah.gov/chip **Phone: 1-877-543-7669**	**Website:** https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf **Phone: 1-800-362-3002**
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ **Phone: 1-800-250-8427**	**Website:** https://wyequalitycare.acs-inc.com/ **Phone: 307-777-7531**
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm **Medicaid Phone: 1-800-432-5924** **CHIP Website:** http://www.coverva.org/programs_premium_assistance.cfm **CHIP Phone: 1-855-242-8282**	

To see if any other states have added a premium assistance program since January 31, 2018, 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