ROMAN CATHOLIC
DIOCESE OF BURLINGTON

2024 Benefits Enrollment Guide

Health and Welfare Benefits

Open Enrollment

Welcome to your 2024 Benefits Enrollment Guide! We are excited to present our benefit plan offerings for 2024. We sincerely hope that you take time to learn as much as possible about what is available for you and your family.

All employees eligible for benefits (those who consistently work 30 hours or more per week) are required to participate in Annual Open Enrollment, irrespective of whether you plan to modify your benefits for the year 2024.

- **If you want to keep the same benefits for 2024,** you must complete the Declaration of Health Care form as well as section 1 of the Health and Welfare Benefit Plan Enrollment Form.

- **If you are making changes to your benefits for 2024,** you must complete the Declaration of Health Care form and the Health and Welfare Benefit Plan Enrollment form.

Annual Open Enrollment will take place November 1, 2023 through November 17, 2023. All benefit elections will become effective January 1, 2024.

2024 Open Enrollment Meeting

There will be one benefit informational meeting:

Wednesday November 1st, 2023

3:30pm-4:30pm

The Roman Catholic Diocese

Degoesbriand Conference Room

55 Joy Drive, S. Burlington

Virtual Meeting Option via

Teams

Meeting ID: 250 308 596 401

Passcode: 7P3YKr

For the meeting link or questions about Open Enrollment,
please contact HR at HumanResources@vermontcatholic.org

Open Enrollment

This benefits enrollment guide is your manual to the resources, key updates, changes and answers to your common questions about the health plans available to you. Reviewing the guide and its resources will inform your choices for this fall's Open Enrollment period.

MY OPEN ENROLLMENT CHECKLIST

- ❑ READ Benefits Enrollment Guide
- ❑ ATTEND the Open Enrollment Meeting
- ❑ COMPARE Plans
- ❑ REVIEW FAQs and other resources
- ❑ If you are not making any changes, COMPLETE, sign and return:
  - Declaration of Health Care form
  - Benefit Plan Enrollment Form section 1
- ❑ If you are making changes to your benefit selections, COMPLETE, sign and return:
  - Declaration of Health Care form
  - Benefit Plan Enrollment form

Benefit Basics

ELIGIBILITY

Employees are eligible to enroll in health and welfare benefits--medical, dental, and vision- during Open Enrollment if the employee works at least 30 hours per week and according to company policy. Seasonal and temporary employees are not eligible.

Dependents are your legally married spouse and/or any biological, adopted, foster or stepchildren, or any child for whom you are court appointed as legal guardian (up to age 26).

KEY TERMS TO KNOW

Deductibles are the amount you pay for covered health care services before your insurance plan starts to pay.

Copayments (copays) are the fixed dollar amounts (for example, $15) you pay for covered health care, typically at the time of service.

Coinsurance is the percentage of costs of a covered health care service that you pay (20%, for example) after you've paid your deductible.

Generic drugs contain the same active ingredients as brand-name drugs, but generally are less expensive.

Preferred brand drugs are brand-name drugs that are listed on the plan's preferred list of prescription drugs.

Non-preferred brand drugs are brand-name drugs that are not included on the plan's preferred list of prescription drugs. These may not be covered under the plan.

Specialty drugs are used to treat certain complex health problems. These drugs tend to be very expensive.

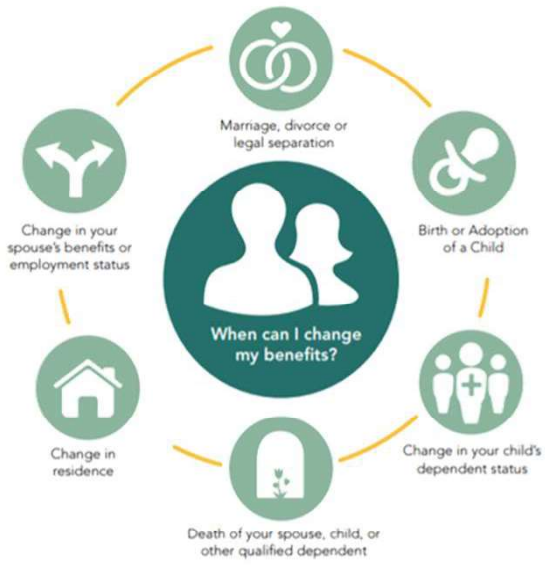
An **Exclusive Provider Organization (EPO)** plan provides coverage to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network but would incur larger costs.

WHEN CAN I MAKE CHANGES TO BENEFITS?

Generally, changes are only allowed under the following circumstances.

Annual Open Enrollment Period
Once a year we conduct an Annual Open Enrollment (usually in the fall). During this time, you can add or drop benefit plans, and add or remove dependents from your coverage for the coming plan year.

Qualifying Life Events (QLEs) / Change in Family Status
Outside of Annual Open Enrollment, you may change your benefit elections during the year only if you experience a Qualifying Life Event. Below are examples of life events that may allow you to make a change.



Medical | MVP Health Care

The premiums listed at the bottom of the page are total monthly premiums for MVP PLATINUM, GOLD and SIVLER plans. Your employer contributes toward each employee's monthly premium based on: employer/location, the number of regular scheduled hours worked each week, and the type of coverage. You will pay a share of this premium, per pay period. The administration office at your location will distribute a Benefit Rate Sheet. The Benefit Rate Sheet will show your cost per pay period. If you do not receive one, please see your administration office for a copy.

MVP HEALTH CARE	Standard **PLATINUM**	Standard **GOLD**	Standard **SILVER**
Preventive Care	Covered 100%	Covered 100%	Covered 100%
Telemedicine Services *Gia*	$0 for all emergency, urgent and primary care, as well as nutrition, mental health and psychiatry		
Physician Services Primary Care Office Visit * Chiropractic & PT Office Visit Specialist Office Visit Urgent Care Emergency Room	3 visits per member at no cost share, then $15 $20 Copay $40 Copay $50 Copay Deductible, then $100	3 visits per member at no cost share, then $20 $35 Copay $55 Copay $65 Copay Deductible, then $150	$40 Copay $50 Copay $90 Copay $100 Copay Deductible, then $500
Medical Deductible Individual/Family **Rx Deductible** Individual/Family	$450/ $900 N/A	$1,400/ $2,800 $200/ $400	$4,000/ $8,000 $500/ $1,000
Medical Out-of-pocket Max Individual/Family **Rx Out-of-pocket Max** Individual/Family	$1,500/ $3,000 $1,500/ $3,000	$5,600/ $11,200 $1,500/ $3,000	$9,100/ $18,200 $1,500/ $3,000
Hospital Services Inpatient/Outpatient Imaging (CT/PET/MRI) Lab & X-Ray	Deductible, then plan pays 90%	Deductible, then plan pays 70%	Deductible, then plan pays 50%
Prescriptions Retail 30-day Supply	Generic: $10 Preferred Brand: $50 Non-Preferred Brand: 50%	Generic: $15 Preferred Brand: Deductible, then $60 Non-Preferred Brand: Deductible, then 50%	Generic: $20 Preferred Brand: Deductible, then $70 Non-Preferred Brand: Deductible, then 50%
Total MONTHLY Premium			
Employee Employee + Spouse Employee + Child(ren) Family	$1,094.86 $2,189.72 $2,113.08 $3,076.56	$912.32 $1.824.64 $1.760.78 $2,563.62	$720.03 $1,440.06 $1,389.66 $2,023.28

The text contained in this Guide was taken from various summary plan descriptions and benefit information. In the case of a discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you have any questions about your Guide, contact Human Resources.

Dental | Northeast Delta Dental

We offer two dental plans through Northeast Delta Dental. You'll see from the chart below, there are differences in coverage, so it's important you choose the plan that is right for your needs. Look at the factors such as the amount you pay for coverage, annual deductible, annual maximum, and your out-of-pocket costs on services.

SAVE MONEY IN THE NETWORK. Although Northeast Delta Dental allows you to visit any provider you would like, staying in the Delta Dental network will provide you with the highest level of benefits. Non-network providers can balance bill you for any amount above what Northeast Delta Dental considers "Usual and Customary." Visit nedelta.com to see who is in the network.

Employees pay the full cost for this coverage and pay period deductions are shown in your Benefits Rate Sheet. Premiums will be deducted bi-weekly or semi-monthly from your paycheck on a pre-tax basis.

DELTA DENTAL	**HIGH** OPTION	**LOW** OPTION
Office Visit Copay	$20	$20
Diagnostic/Preventive (Coverage A) No waiting period	You pay 0%	You pay 0%
Basic Services (Coverage B) No waiting period	You Pay 20%	You Pay 30%
Major Services (Coverage C) 6-month waiting period	You pay 50%	You pay 50%
Orthodontia Services (Coverage D) 6-month waiting period	You pay 50%	You pay 50%
One-time Deductible Individual/Family **(Coverages B & C Only)**	$100/$300	$75/$225
Calendar Year Maximum (Coverages A, B, C)	$2,000	$1,500
Lifetime Orthodontics Maximum (Coverage D)	$1,500	$1,250
Double-up Max	Yes	Yes
Total MONTHLY Premium		
Employee *Employee + 1* *Family*	$40.59 $74.43 $130.71	$35.26 $64.62 $113.20

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Vision | VSP

Vison coverage is available to all eligible employees through Vision Service Provider (VSP). Remember, you'll save on eyewear and eye care when you visit a VSP network doctor. To learn what doctors are in your network, call 800.877.7195 or visit vsp.com.

Employees pay the full cost for this coverage. Refer to your Benefits Rate Sheet for your pay period deduction amount. Premiums will be deducted bi-weekly or semi-monthly from your paycheck on a pre-tax basis.

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Well Vision Exam	Focuses on your eyes and overall wellness	**$20**	Every calendar year
Prescription Glasses		**$20**	See below for frame and lenses
Frame	$180 allowance for a wide selection of frames 20% savings on the amount over your allowance $80 Walmart frame allowance	Included in Prescription Glasses	Every other calendar year
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 35-40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every calendar year
Contacts	$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Get the most out of your benefits and greater savings with a VSP network doctor.			

Total MONTHLY Premium	
Employee	$9.40
Employee + Spouse	$13.63
Employee + Family	$24.43

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Frequently Asked Questions

Q: I'm not planning on making any changes to my benefits, do I need to do anything?

A: Yes, all employees are required to complete the Declaration of Health Care Coverage form as well as section 1 of the Health and Welfare Benefit Plan Enrollment Form.

Q: I need to make a change to one or more of my benefits. What forms do I need to complete?

A: You will need to complete the Declaration of Health Care form and the Benefit Plan Enrollment form.

Q: Why are the premium/paycheck deductions increasing for the medical plans?

A: Managing healthcare costs is a continuing challenge. National health care spending costs continue to climb and, according to recent reports, are expected to grow an estimate of 5.8% annually through 2024. Contributing factors for costs increases are driven mainly by rising medical and pharmaceutical costs, particularly specialty drug costs.

Q: What are some things I can do to help me save on health care costs?

A: Some actions you can take to help reduce costs are:

Preventive Care
To stay on the healthy track, be sure to take advantage of preventive care, such as annual exams. Preventive care is free under all the plans as long as you stay in network.

Choose Generic vs. Brand Name Prescriptions
Save money on prescriptions by requesting generic or lower-cost versions of the medicine you need (approved by your doctor) and take advantage of mail-order programs.

Using Urgent Care Facilities and limit Emergency Room Visits
Don't run to the emergency room for needs that are better suited to a doctor's office or an urgent care clinic.

Participate in MVP Health Care Wellness
Enrolled employees have access to a wide variety of online tools, activities, and education designed to support their health and wellness. From free wellness classes to exclusive discounts on wellness products and services, MVP is available to help you succeed at reaching your health improvement goal.

Annual Notices & Disclosures

COBRA Information:
COBRA continuation coverage is a temporary extension of coverage under the group health plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Benefits Coordinator in Human Resources.

Health Insurance Marketplace:
You may have other options available to you when you lose group health coverage. You may be eligible to buy an individual plan through the Health Insurance Marketplace (www.healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30- day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

HIPAA Information:
Special Enrollment Right Mandated by the Health Insurance Portability and Accountability Act of 1996
Group health plans and health insurance insurers are required to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll without having to wait for the plan's next open enrollment period. A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption. If you refuse enrollment for yourself or your dependents for medical coverage, you may later enroll within 30 days of a change in family status or loss of health coverage.

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals based on these specific health factors.

Effective April 1, 2009, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) created a new 60-day special enrollment period for eligible Team Members and dependents to immediately enroll in the plan if they become ineligible for Medicaid or any state's Children's Health Insurance Program (CHIP) and lose coverage or become eligible for that state's premium assistance program. The Team Member must request coverage within 60 days after the termination of coverage or the determination of subsidy eligibility.

Women's Health and Cancer Rights Act of 1998 (WHCRA):
WHCRA requires a group health plan to notify you, as a participant or a beneficiary, of your potential rights related to coverage in connection with a mastectomy. Your plan may provide medical and surgical benefits in connection with a mastectomy and reconstructive surgery. If it does, coverage will be provided in a manner determined in consultation with your attending physician and the patient for a) all stages of reconstruction on the breast on which the mastectomy was performed; b) surgery and reconstruction of the other breast to produce a symmetrical appearance; c) prostheses; and d) treatment of physical complications of the mastectomy, including lymphedema. The coverage, if available under your group health plan, is subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under the plan. For specific information, please refer to your summary plan description or benefits booklet, or contact Human Resources.

Contact Information

Please refer to the list below when contacting one of the benefit vendors. For general information contact Human Resources.

PLAN	VENDOR	CONTACT
Open Enrollment and General Benefits Inquiries	Human Resources	HumanResources@vermontcatholic.org
Medical Coverage	MVP Health Care	www.mvphealthcare.com 888-687-6277
Dental Coverage	Northeast Delta Dental	www.nedelta.com 800-832-5700
Vision Coverage	VSP	www.vsp.com 800-877-7195

Notes