August 4, 2010

Dear Members of the Lay Employee Benefit Plan,

On behalf of Bishop Robert W. Finn, I would like to introduce you to our 2010-11 Lay Employee Benefit Plans. We are extremely pleased that we can continue to offer a comprehensive fringe benefit program for our dedicated employees, and we are committed to enhancing the programs when it is appropriate and possible.

This Highlights booklet includes a general outline of the major parts of our benefits program. It will answer most of your questions. This booklet includes an overview of each benefit plan, premium rates and application forms.

You'll see coded in red the four plans provided at no cost to you; those coded in blue are your health insurance options in which you share the cost with your employer; and those coded in green are paid entirely by employees who choose to participate. They include the dental and supplementary life plans; the tax-saving flexible benefit plans, the health savings account, accident and cancer policies, and a tax deferred annuity plan. (All employees, full and part-time, may participate in the annuity plan.)

Note: The "Open Enrollment" period, during which you may change from one health or dental insurance plan to another, is in September. To make a change in your current dental or health insurance plan, complete the appropriate application form found in the back of this booklet. You may make application to change the current amount of your supplementary life insurance.

If you wish to continue in the Flexible Benefits Plan – Healthcare Reimbursement Savings Plan and/or Dependent Care Savings Plans, you MUST re-enroll for the new plan year.

All changes will be effective October 1st. Please give all your completed forms to your supervisor no later the September 24, 2010. Please feel free to call Anne Marie Stueve in our Benefits Office at (816) 714-2318, if you have any questions regarding your benefits. Completed forms can be faxed to 816-756-2685.

Sincerely,

Rhonda Stucinski

Rhonda Stucinski
Director of Human Resources

Diocese of Kansas City – St. Joseph
Department of Human Resources
300 East 36th Street
Kansas City, MO. 64141
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100% Employer Paid Benefits

Cost Shared Benefits: Employer/Employee

100% Voluntary Benefits

Other Important Information

Good News!

This has been an exciting year for our benefit program with the continuation of free health screenings and Health Risk Assessments (HRA). Many participants won gift cards through participation in a variety of valuable wellness activities and informational programs such as Nutri-Wise Food Labeling Eduation, Tobacco Cessation, and Weigh To Go. Overall, over 167 of you participated in at least one wellness initiative and the Diocese was pleased to give away more than $4,200 in gift cards to participants.

Thanks to your collective efforts we have again held down our health care claim costs, and therefore our premiums, to substantially less than industry average!

The "A Healthier You" program continues to be a success and we are pleased to be able to expand this wellness initiative for the benefit of our employees covered under the health plan and their covered dependents. This year we are adding a "Points to Blue" program. The features of the Diocesan "Points to Blue" program are:

- Members can earn points for taking HRA, screenings, classes, calling the health coach, etc.
- Earn up to 250,000 points per year or a cash equivalent of $250
- Redeem points for gift cards from more than 350 merchants including retailers, sports and fitness goods, restaurants, travel, entertainment providers or debit card

More Good News!

In addition the Diocese has contracted with Saint Luke's Health System to provide a part-time wellness coordinator! The wellness coordinator is located in the Chancery office and can assist you with the following:

- Respond to any health or fitness related inquiries, in person, via telephone or email, from employees for lifestyle coaching
- Refer requests/needs to appropriate resources or interventions based on their health risks and interests
- Provide onsite programs including seminars, book studies, and other programs that support employee health and wellness

Better Health = Better Premium Rates

Still More Good News – New Diocesan Benefits!

Blue Saver PPO Option – a New Lower Cost Health Plan Better

Features of this additional option include:

- Lower cost – AND the Diocese is passing all of the premium savings to you
- Same network of physicians and hospitals as the Preferred-Care Blue PPO – available to all Diocesan locations
- Same pharmacy network
- Same contracted provider discounts
- Same list of covered services
- Most employees will be able to contribute to a tax sheltered Health Savings Account (HSA)
- Annual routine/preventive services are covered at 100% - not subject to the deductible

Delta Dental – a New Dental Plan!

Access to far more dentists – over 97% of all Missouri dentists

- All Diocesan locations have good access to the broad selection of participating dentists
- Even greater benefits if you choose to utilize a smaller selection of dentists (at any time)
- Two plan options from which to annually choose
- A $10 per month employer premium contribution towards the option of your choice

And the employee survey said…..more dentists and an employer premium contribution – we heard you!

Short-Term Disability Insurance

All full-time, non-temporary lay and religious employees will be eligible for the following Short-Term Disability coverage provided through Assurant Employee Benefits.

- Non-occupational coverage only.
- Weekly benefits are equal to 70% of weekly pre-disability pay, to a maximum of $500 per week; minimum weekly benefit greater of $25 or 15% of the scheduled amount.
- Benefits begin on the eighth day of disability due to accident, sickness or pregnancy.
- Benefit duration is 16 weeks (120 calendar days).

100% EMPLOYER PAID

- **Maternity:** According to Assurant's medically-accepted guidelines, 6 weeks is allowed for vaginal and cesarean delivery for a sedentary position (office/desk work). For any occupation greater than sedentary, the guidelines allow up to 8 weeks for cesarean. Since pregnancy is treated as any other illness, if there are complications in recovery that impact the ability to perform the job/occupation, Assurant will consider benefit payment beyond these time periods.
- During the period of disability, the employee has the option to trade their Diocesan benefits of accrued sick leave or vacation for an additional 30% of weekly salary or the percent necessary for the employee to receive 100% of pre-disability salary.
- Includes a Dual Definition of Disability*, which allows you to qualify for disability benefits by meeting either an occupation or an earnings test, not both.

In order to assist employees who may be faced with financial hardship due to disabling conditions, Long-Term Disability coverage is provided through Assurant Employee Benefits.

- Provided for all full-time, non-temporary lay employees.
- Benefits commence after the later of the maximum benefit period of your STD plan or 120 calendar days of disability.
- Benefits are payable to age 65 (longer if disability occurs after age 60, per ADEA).

100% EMPLOYER PAID

- Monthly benefits are payable equal to 60% of monthly pre-disability pay, to a maximum of $5,000 per month; minimum monthly benefit the greater of $100 or 15% of the scheduled amount.
- Includes a Dual Definition of Disability*, which allows you to qualify for disability benefits by meeting either an own occupation or an earnings test, not both.
- Pre-existing condition exclusions apply.
- Limitations apply to mental illness, drugs, alcohol and chemical dependency.
- Coverage includes partial disability benefit.
- 3 month survivor benefit in the event of employee's death.

Products marketed by Assurant Employee Benefits are underwritten by Union Security Insurance Company.

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* **Occupation Test - 24 month regular occupation test (LTD ONLY)**
You can qualify for the occupation test if you are under the regular care and attendance of a doctor and an injury, sickness or pregnancy prevents you from performing at least one of the material duties of your occupation; the ability to work full-time is considered a material duty of an occupation.

Earnings Test (LTD and STD)
You qualify for the earnings test if an injury, sickness or pregnancy prevents you from earning more than 80% of your pre-disability pay, even if you are working full-time and performing all of the material duties of your occupation.

Offsets (LTD and STD)
Offsets may include, but are not limited to, retirement or government plans, other group disability plans, no-fault benefits, and return-to-work earnings.

New full-time employees must complete the Employee Information Sheet in order to be enrolled in the Group Term Life, AD&D, Short-Term Disability, Long-Term Disability and Pension Plans. Eligibility for the benefits described in this booklet commence on the first day of the month following the starting date of full-time employment. Full details regarding the above are available upon request. See group policy or certificate booklet for details of coverage, limitations and exclusions.

Life & AD&D Insurance

100% EMPLOYER PAID

To provide a measure of protection to your beneficiaries in the event of your death, the Diocese provides Group Term Life Insurance and Accidental Death and Dismemberment coverage.

- Provided through Assurant Employee Benefits and UsAble for all full-time, non-temporary lay employees.
- Amount of Life Insurance: One times annual earnings to a maximum of $50,000. Benefit reduced by 50% at age 70.
- You may change your beneficiary at any time by making a written request to the Diocese.
- If you become disabled before your 60th birthday, your insurance will continue as long as you are disabled, but not past the earlier of age 65, or the date you retire. If you become disabled on or after your 60th birthday, but before age 65, your insurance may continue for up to one year, but not past the earlier of age 65, or the date you retire.
- You may request that coverage be converted upon termination without evidence of insurability.
- Accidental Death: An additional amount equal to the amount of Life Insurance will be paid to your beneficiary if death is due to an accident. Lesser benefits are payable for specified disabilities resulting from an accident. Limitations and exclusions apply.
- Accelerated Death Benefit: If you have a qualifying medical condition and meet certain specifications, you have the right to receive a portion of your life benefit. Limitations and exclusions apply.

Products marketed by Assurant Employee Benefits are underwritten by Union Security Insurance Company.

100% EMPLOYER PAID

The Lay Pension Plan provides a retirement benefit to eligible retired lay employees based on salary and the number of years of credited service in the Diocese. The plan is designed to help employees prepare for retirement, even though it may now seem a long time away. Combined with Social Security benefits and savings or investments, the Plan will help to meet personal living expenses during retirement.

- Covers all full-time, non-temporary lay employees of the parishes and participating institutions in the Diocese. Ordained priests and religiously professed Brothers and Sisters are not eligible for the Lay Employee Pension Plan.
- Monthly benefit for employees who retire at age 65 is 1.25% of participant's average monthly compensation, times the number of years of credited service, up to a maximum of 40 years. Employees may apply for a reduced pension after age 62.
- Average Monthly Compensation is the average of the highest consecutive 60 months' salary the employee received during the 15 years prior to retirement.
- Credited Service means continuous full-time employment from the employee's latest date of hire. A retiree must have at least five years of credited service to be eligible for a pension benefit.
- Transferring from one participating employer to another within the Diocese does not change an employee's "Date of Hire", as long as there is no break in service.
- An employee may leave the Diocese with a "Vested Pension" - the right to future benefits - after 5 years of continuous full-time service.
- The spouse of a deceased, vested employee may apply for a surviving spouse benefit on the deceased employee's normal retirement date, age 65. A surviving spouse benefit is the amount that would have been paid (based on service to the date of death) if the employee had elected a 50% survivor annuity on the employee's normal retirement date.
- As of July 1, 1998, a participating employee, prior to completing 5 years of continuous service, may incur a break in service up to 36 months without the loss of credited service.
- The retirement benefit for an employee who continues to work after age 65 will be based on compensation and service to the date of actual retirement but credited service may not exceed 40 years.
- Retiring employees may elect to receive their earned benefit under one of several irrevocable options.
- The Diocese administers the plan. All contributions to the plan are held in a Trust Fund and are not eligible for distribution until age 62. Additional details can be found in the Summary Plan Description.
- Please contact the Employee Benefits Office two months prior to commencement of pension.

Health Insurance

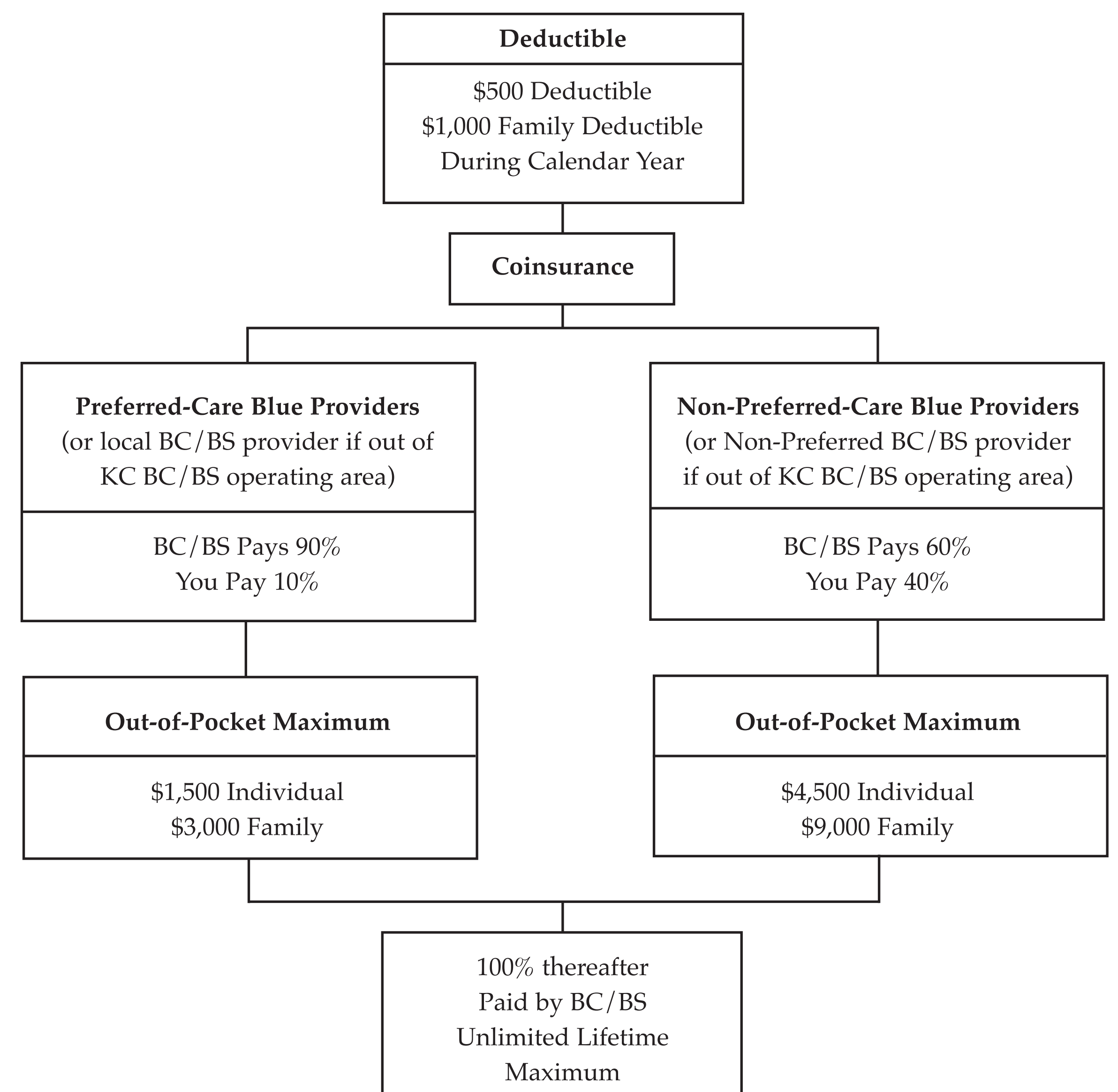
The Diocesan Group Health Insurance Plan contains three options through Blue Cross/Blue Shield of Kansas City (BC/BS).

1. Preferred-Care Blue Preferred Provider Organization (PPO)

The first option is Preferred-Care Blue, which is a Preferred Provider Organization (PPO). In the Preferred-Care Blue area, listed in your Preferred-Care Blue Directory, the plan includes a network of hospitals and physicians who have agreed to allow substantially greater discounts to BC/BS Preferred-Care Blue subscribers. Plan subscribers from any area who choose these providers will pay only 10% of the discounted costs. You have the option to use other providers in the area, but 40% coinsurance payments will apply.

Through the Blue Card system, if you receive services outside of the Kansas City BC/BS Preferred-Care Blue area, eligible expenses will be paid at the 90%/10% coinsurance level for services provided by a local BC/BS provider. Subscribers may use any Non-Preferred-Care Blue provider inside or outside the local Kansas City BC/BS area, including specialized services in other parts of the country, and the 60%/40% coinsurance applies.

A common deductible applies to Preferred-Care Blue and Non-Preferred-Care Blue. See diagram for out-of-pocket expenses.



MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT

Limitations apply to outpatient and inpatient mental illness, alcoholism and drug abuse benefits. Inpatient benefits will be payable only if pre-authorized and approved by BC/BS prior to any inpatient treatment for drug addiction, alcoholism, and chemical dependency or nervous and mental illness. You can obtain authorization by calling 913-982-8400 locally or toll free at 800-528-5763. Pre-authorization is not required for outpatient treatment.

HOSPITAL PRIOR AUTHORIZATION

Prior authorization is required for all Non-Preferred-Care Blue hospital admissions or out-of-area hospital admissions. The member is responsible for the cost of services received at non-network or out-of-area hospitals if the services received require prior authorization and prior authorization was not obtained. In case of an emergency, admissions must be authorized within 48 hours of the admission, or as soon as reasonably possible.

OTHER BENEFITS

- **Allergy Testing:** Deductible & Coinsurance.
- **Allergy Treatment:** Deductible & Coinsurance.
- **Ambulatory Surgical Center:** Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside our service area are limited to a $200 calendar year maximum.
- **Chiropractic Services:** In-network services are covered 100% after a $35 copay. Out-of-network services are subject to deductible and coinsurance, and requires prior authorization. Includes office visit, lab and x-ray (excluding MRI, MRA, CT and ultra-sound) performed and billed in a chiropractor's office. Other services/procedures including skeletal manipulations performed in a chiropractor's office are subject to the Preferred Deductible and Coinsurance level.
- **Outpatient Therapy:** Combined maximum 40 visits per calendar year (physical and occupational). Combined maximum 20 visits per calendar year (speech and hearing).
- **Prosthetics:** Coverage when medically necessary.
- **Durable Medical Equipment:** Benefit subject to Deductible and Coinsurance and payable up to $5,000 per calendar year.
- **Hospice Care:** Hospice Care benefits are available for patients who are considered to be terminally ill. Services must be authorized by BC/BS's Case Management program by calling 816-395-3989.
- **Home Health Care:** Home Health Care services are available for patients to receive care in the home as an alternative to services in the hospital. Benefits are subject to Deductible and Coinsurance and will be payable up to 60 visits per member per calendar year. Services must be approved and provided by a home health agency contracted with BC/BS's Case Management program by calling 816-395-3989.
- **Little Stars:** The Little Stars program helps expectant mothers reduce the risk of delivering early and prepares them for handling the unexpected. The plan is confidential and free to employees and covered spouses covered under the Diocesan medical plan. To register for the program, call 816-395-3964 or toll-free at 800-892-6116, ext. 3964.
- **Maternity Benefits:** Maternity benefits for subscribers and covered spouses are covered the same as any illness. Hospital prior authorization is necessary for Non-Preferred-Care Blue admission. Room charges for newborns are covered under family coverage; but only if BC/BS is notified of birth and individual coverage is changed to family coverage within 30 days of birth date, on a prescribed change form.
- **Skilled Nursing Facilities:** Deductible and Coinsurance. Covered up to 30 days per calendar year. Some limitations may apply.

DEPENDENT AGE LIMITATION

Children who are dependent on their parents are covered until the end of the calendar year in which they turn 26 or the end of the month they are no longer dependent, whichever is first. It is your responsibility to contact the Employee Benefits Office when your dependent is no longer eligible.

PRE-EXISTING CONDITIONS

Your Employer's group contract provides coverage that contains limitations based on whether a condition is considered pre-existing. Any condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the **90 day** period from the enrollment date, is considered a pre-existing condition (pregnancy is not considered a pre-existing condition). Your Employer's group contract excludes coverage for these specific pre-existing conditions for **12 months** beginning on the first day of the waiting period (or the date coverage is effe ctive if there is no waiting period). However, your Employer's group contract will provide credit for pre-existing conditions if you were previously covered under creditable coverage. The period of any pre-

existing condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the pre-existing condition exclusion period, you must provide **copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s)** for the verification of prior creditable medical coverage you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any pre-existing condition exclusion, please contact BC/BS's Member Services Department at (816) 395-2950. Note - The pre-existing exclusion period does not apply to dependents under age 19.

EXCLUSIONS

- Any injury or sickness covered under Worker's Compensation, Employer Liability or similar law or act.
- Any injury or sickness resulting from an act of war.
- Dental surgery, treatment or hospitalization related to dental services.
- Custodial care or rest cures.
- Cosmetic surgery.
- Physical examinations for, or in conjunction with insurance, employment or any recreational activities.
- Payment for health services in conjunction with motor vehicle accidents when the services are covered under the Personal Injury Protection segment of any automobile insurance policy, including no-fault automobile insurance.
- Services not specifically mentioned as covered under your group contract.
- Treatment of temporomandibular joint dysfunction.
- Penile prosthesis and implantation of penile prosthesis.
- Infertility studies and treatment (including prescription drugs).

OTHER HIGHLIGHTS

- **Claims:** For Preferred-Care Blue members, your participating Preferred-Care Blue physician, laboratory or hospital, will file your claim for you for most services. Please advise them of your correct address.

  For those charges not filed by the provider, complete the appropriate Claim Form for your plan and attach an itemized billing from the provider. The itemized billing statement must be on the letterhead of the provider and must include: date and type of service; charge for each service rendered and total claim amount; diagnosis/symptomatic complaint (reason these services were performed); date of accident, if the services are related to an accident (i.e., follow-up care for accident). (More detailed filing instructions are located on the back of the claim form.) Claim forms are available at your location or the Diocesan Benefits Office.

- **Flexible Benefits Plan/Premium Savings Plan:** You will automatically be enrolled in the Premium Savings Plan to pay your share of the premium with pre-tax dollars. See page 23 for more information.

- **Continuation of Benefits:** After termination, you may be eligible to continue your group medical benefits at your own expense for up to 18 months, if you are not eligible for other coverage and if the Diocesan Benefits Office receives your premium and signed agreement within 31 days of termination.

- **Converting Coverage:** You are entitled to convert your insurance to a non-group policy after coverage terminates, if BC/BS receives your application within 31 days of termination.

For enrollment information, see page 13.
For monthly cost information, see page 28.
For enrollment form, see page 29.

Provider Directories are available by calling BC/BS customer service or you can visit the BC/BS website at www.bluekc.com. To find a provider on the website, please choose the provider directory option located on the left side of the webpage. The website has the most updated information regarding provider participation and availability.

2. BC/BS Blue-Care HMO

The second option to the Diocesan Group Health Insurance Plan is Blue-Care, a Health Maintenance Organization (HMO). Your Blue-Care HMO is an "open access" plan. This means Blue-Care members will be able to schedule visits directly with physician specialists in the plan network without having to receive a referral from their Primary Care Physician (PCP). Members who choose self-referral will be required to pay the specialist co-pay, which is twice the PCP copay. Blue-Care is available in several counties in Missouri and Kansas. These are your Blue-Care Benefits when using Blue-Care providers. Benefits will not be payable if using non-Blue-Care providers.

Blue-Care Benefits

LIFETIME MAXIMUM: Unlimited

HOSPITAL BENEFIT PAYMENT LEVEL:

Inpatient

- Unlimited number of days in a semi-private room: 100% after $200 copay per day (maximum 5 copays)
- Hospice: $100 copay per admission, then 100% (maximum $1,000/calendar year)

Outpatient

- Outpatient Surgery: 100% after $200 copay per day (max 5 copays)
- Diagnostic procedures, laboratory, radiology: 100%
- Emergency Room: $100 copay, then 100%
- Urgent Care: $40 copay, then 100%

Note: Approval for any non-life threatening emergencies in the service area must be pre-authorized by your PCP. Emergency treatment outside of the service area must be authorized within 48 hours of treatment.

PHYSICIAN SERVICES - PRIMARY CARE PHYSICIAN: *100% after $20 copay*

- Office Visits
- Routine Physicals
- Well Baby Care
- Immunizations and Inoculations
- Ear Examinations for children through age 19

PHYSICIAN SERVICES - SPECIALISTS:

100% after $40 copay

- Surgery
- Consultations
- Hospital treatment
- OB Care
- X-rays
- Eye Examinations

OTHER PHYSICIAN SERVICES:

- Allergy Testing: $100 copay
- Allergy Treatment: 100%

PRESCRIPTION DRUGS:

- Purchased at a network pharmacy (BCBSKCRx)
  - Tier 1: $8 copay
  - Tier 2: $35 copay
  - Tier 3: $60 copay
- Mail Order (Express Scripts) (102-Day Supply)
  - Tier 1: $16 copay
  - Tier 2: $70 copay
  - Tier 3: $120 copay
- Annual Maximum: None

MENTAL HEALTH /SUBSTANCE ABUSE:

- *Inpatient:* 100% after $200 copay per day (maximum 5 copays)
- *Outpatient Therapy:* 100%
- *Outpatient Office Visits:* $20 copay, then 100%

Note: Prior authorization must be obtained through New Directions, prior to any treatment for drug addiction, alcoholism, chemical dependency, or nervous or mental illness. You can obtain services by calling the New Directions Hotline 24 hours a day, seven days a week at 913-982-8400 locally or toll-free at 800-528-5763.

For enrollment information, see page 13.
For monthly cost information, see page 28.
For enrollment form, see page 29.

Provider Directories are available by calling BC/BS customer service or you can visit the BC/BS website at www.bcbskc.com. To find a provider on the website, please choose the provider directory option located on the left side of the webpage. The website has the most updated information regarding provider participation and availability.

OTHER BENEFITS

- **Outpatient Therapy**: 100% (Combined maximum 40 visits per calendar year including physical and occupational); (Combined maximum 20 visits per calendar year including speech and hearing).

- **Chiropractic Services**: 100%

- **Prosthetics:** Coverage when medically necessary.

- **Durable Medical Equipment:** Paid at the same benefit level as other services, but is subject to a $5,000 maximum per calendar year. Specific limitations may apply. Please consult your Benefit Schedule.

- **Hospice Care:** Your group program will pay for Hospice Care when approved and services are provided by BC/BS Case Management program by calling 816-395-3989.

- **Home Health Care:** Your group program will pay Home Health Care up to a maximum of 60 visits per calendar year, when benefits are approved and services provided by BC/BS's Case Management program by calling 816-395-3989.

- **Vision Care:** Your group program will pay for one routine vision exam per year after a $40 copay through BCBSKC. Refer to your HMO directory for a complete list of the BCBSKC network. To make an appointment you will need to call the provider of your choice. For questions about your vision benefit call 816-395-3558. For service issues call the BC/BS customer service phone number on the front of your ID card.

- **Little Stars:** The Little Stars program helps expectant mothers reduce the risk of delivering early and prepares them for handling the unexpected. The plan is confidential and free to employees and covered spouses covered under the Diocesan medical plan. To register for the program, call 816-395-3964 or toll-free at 800-892-6116, ext. 3964.

- **Skilled Nursing Facilities:** Covered up to 30 days per calendar year. Some limitations may apply.

DEPENDENT AGE LIMITATION

Children who are dependent on their parents are covered until the end of the calendar year in which they turn 26 or the end of the month they are no longer dependent. Dependent daughters are covered for maternity. It is your responsibility to contact the Diocesan Benefits Office when your dependent is no longer eligible.

PRE-EXISTING CONDITION

There are no pre-existing condition exclusions on the Blue-Care HMO plan.

EXCLUSIONS

- Non-emergency services that are not authorized by a Blue-Care Provider.
- Any injury or sickness covered under Worker's Compensation, Employer Liability or similar law or act.
- Any injury or sickness resulting from an act of war.
- Dental surgery, treatment or hospitalization related to dental services.
- Custodial care or rest cures.
- Cosmetic surgery.
- Physical examinations for, or in conjunction with insurance, employment or any recreational activities.
- Out-of-area non-emergency services.
- Payment for health services in conjunction with motor vehicle accidents when the services are covered under the Personal Injury Protection segment of any automobile insurance policy, including no-fault automobile insurance.
- Services not specifically mentioned as covered under your group contract, even if authorized by your PCP.
- Treatment of temporomandibular joint dysfunction.
- Penile prosthesis and implantation of penile prosthesis.
- Infertility studies and treatment (including prescription drugs).

OTHER HIGHLIGHTS

- **Claims**: Blue-Care Primary Care Physicians and authorized specialists and consultants will file claims for you.

- **Flexible Benefits Plan/Premium Savings Plan:** You will automatically be enrolled in the Premium Savings Plan to pay your share of the premium with pre-tax dollars. See page 23 for more information.

- **Continuation of Benefits:** After termination, you may be eligible to continue your group medical benefits at your own expense for up to 18 months, if you are not eligible for other coverage and if the Diocesan Benefits Office receives your premium and signed agreement within 31 days of termination.

- **Converting Coverage:** You are entitled to convert your insurance to a non-group policy after coverage terminates, if BC/BS receives your application within 31 days of termination.

- **Away From Home Care:** Guest Memberships offer the full range of coverage to members living or traveling away from home for at least 90 days. Call (800) 892-6048 and your Blue Cross and Blue Shield of Kansas City Away From Home Care Coordinator will find an HMO near your travel destination and have you complete a Guest Membership application.

3. Blue Saver Preferred Provider Organization (PPO)

The third option is Blue Saver, which is a Preferred Provider Organization (PPO). Coupled with Blue Saver, we are also offering you the opportunity to enroll in a Health Savings Account (HSA). This is a tax-advantaged, individually-owned account. Please see the Important Contact Information located on the inside back cover of this booklet, for additional information.

In the Blue Saver area, listed in your Preferred-Care Blue Directory, the plan includes a network of hospitals and physicians who have agreed to allow substantially greater discounts to BC/BS Blue Saver subscribers. Plan subscribers from any area who choose these providers will pay 0% of the discounted costs after the calendar year deductible. You have the option to use other providers in the area, but 20% coinsurance payments will apply.

Through the Blue Card system, if you receive services outside of the Kansas City BC/BS Blue Saver area, eligible expenses will be paid at the 100%/0% coinsurance level for services provided by a local BC/BS provider. Subscribers may use any Non-Preferred-Care Blue provider inside or outside the local Kansas City BC/BS area, including specialized services in other parts of the country, and the 80%/20% coinsurance applies.

A common deductible applies to Blue Saver and Non-Blue Saver. See diagram for out-of-pocket expenses.

Deductible

$2,500 Deductible
$5,000 Family Deductible
During Calendar Year

Coinsurance

Preferred Blue Saver Providers (or local BC/BS provider if out of KC BC/BS operating area)	**Non-Blue Saver Providers** (or Non-Preferred BC/BS provider if out of KC BC/BS operating area)
BC/BS Pays 100% You Pay 0%	BC/BS Pays 80% You Pay 20%
Out-of-Pocket Maximum	**Out-of-Pocket Maximum**
$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family

100% thereafter
Paid by BC/BS
Unlimited Lifetime
Maximum

MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT
Limitations apply to outpatient and inpatient mental illness, alcoholism and drug abuse benefits. Inpatient benefits will be payable only if pre-authorized and approved by BC/BS prior to any inpatient treatment for drug addiction, alcoholism, and chemical dependency or nervous and mental illness. You can obtain authorization by calling 913-982-8400 locally or toll free at 800-528-5763. Pre-authorization is not required for outpatient treatment.

HOSPITAL PRIOR AUTHORIZATION
Prior authorization is required for all Non-Blue Saver hospital admissions or out-of-area hospital admissions. The member is responsible for the cost of services received at non-network or out-of-area hospitals if the services received require prior authorization and prior authorization was not obtained. In case of an emergency, admissions must be authorized within 48 hours of the admission, or as soon as reasonably possible.

OTHER BENEFITS
- **Allergy Testing:** Deductible & Coinsurance.
- **Allergy Treatment:** Deductible & Coinsurance.
- **Ambulatory Surgical Center:** Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility inside our service area are limited to a $200 calendar year maximum.
- **Chiropractic Services:** In-network services are subject to deductible and coinsurance. Out-of-network services are subject to deductible and coinsurance, and requires prior authorization. Includes office visit, lab and x-ray (excluding MRI, MRA, CT and ultra-sound) performed and billed in a chiropractor's office. Other services/procedures including skeletal manipulations performed in a chiropractor's office are subject to the Blue Saver and Coinsurance level.
- **Outpatient Therapy:** Combined maximum 40 visits per calendar year (physical and occupational). Combined maximum 20 visits per calendar year (speech and hearing).
- **Prosthetics:** Coverage when medically necessary.
- **Durable Medical Equipment:** Benefit subject to Deductible and Coinsurance and payable up to $5,000 per calendar year.
- **Hospice Care:** Hospice Care benefits are available for patients who are considered to be terminally ill. Services must be authorized by BC/BS's Case Management program by calling 816-395-3989.
- **Home Health Care:** Home Health Care services are available for patients to receive care in the home as an alternative to services in the hospital. Benefits are subject to Deductible and Coinsurance and will be payable up to 60 visits per member per calendar year. Services must be approved and provided by a home health agency contracted with BC/BS's Case Management program by calling 816-395-3989.
- **Little Stars:** The Little Stars program helps expectant mothers reduce the risk of delivering early and prepares them for handling the unexpected. The plan is confidential and free to employees and covered spouses covered under the Diocesan medical plan. To register for the program, call 816-395-3964 or toll-free at 800-892-6116, ext. 3964.
- **Maternity Benefits:** Maternity benefits for subscribers and covered spouses are covered the same as any illness. Hospital prior authorization is necessary for Non-Blue Saver admission. Room charges for newborns are covered under family coverage; but only if BC/BS is notified of birth and individual coverage is changed to family coverage within 30 days of birth date, on a prescribed change form.
- **Skilled Nursing Facilities:** Deductible and Coinsurance. Covered up to 30 days per calendar year. Some limitations may apply.

DEPENDENT AGE LIMITATION
Children who are dependent on their parents are covered until the end of the calendar year in which they turn 26 or the end of the month they are no longer dependent, whichever is first. It is your responsibility to contact the Employee Benefits Office when your dependent is no longer eligible.

PRE-EXISTING CONDITIONS
Your Employer's group contract provides coverage that contains limitations based on whether a condition is considered pre-existing. Any condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the **90 day** period from the enrollment date, is considered a pre-existing condition (pregnancy is not considered a pre-existing condition). Your Employer's group contract excludes coverage for these specific pre-existing conditions for **12 months** beginning on the first day of the waiting period (or the date coverage is effe ctive if there is no waiting period). However, your Employer's group contract will provide credit for pre-existing conditions if you were previously covered under creditable coverage. The period of any pre-

existing condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the pre-existing condition exclusion period, you must provide **copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s)** for the verification of prior creditable medical coverage you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any pre-existing condition exclusion, please contact BC/BS's Member Services Department at (816) 395-2950. Note - The pre-existing exclusion period does not apply to dependents under age 19.

EXCLUSIONS

- Any injury or sickness covered under Worker's Compensation, Employer Liability or similar law or act.
- Any injury or sickness resulting from an act of war.
- Dental surgery, treatment or hospitalization related to dental services.
- Custodial care or rest cures.
- Cosmetic surgery.
- Physical examinations for, or in conjunction with insurance, employment or any recreational activities.
- Payment for health services in conjunction with motor vehicle accidents when the services are covered under the Personal Injury Protection segment of any automobile insurance policy, including no-fault automobile insurance.
- Services not specifically mentioned as covered under your group contract.
- Treatment of temporomandibular joint dysfunction.
- Penile prosthesis and implantation of penile prosthesis.
- Infertility studies and treatment (including prescription drugs).

OTHER HIGHLIGHTS

- **Claims:** For Preferred-Care Blue members, your participating Preferred-Care Blue physician, laboratory or hospital, will file your claim for you for most services. Please advise them of your correct address.

  For those charges not filed by the provider, complete the appropriate Claim Form for your plan and attach an itemized billing from the provider. The itemized billing statement must be on the letterhead of the provider and must include: date and type of service; charge for each service rendered and total claim amount; diagnosis/symptomatic complaint (reason these services were performed); date of accident, if the services are related to an accident (i.e., follow-up care for accident). (More detailed filing instructions are located on the back of the claim form.) Claim forms are available at your location or the Diocesan Benefits Office.

- **Flexible Benefits Plan/Premium Savings Plan:** You will automatically be enrolled in the Premium Savings Plan to pay your share of the premium with pre-tax dollars. See page 23 for more information.

- **Continuation of Benefits:** After termination, you may be eligible to continue your group medical benefits at your own expense for up to 18 months, if you are not eligible for other coverage and if the Diocesan Benefits Office receives your premium and signed agreement within 31 days of termination.

- **Converting Coverage:** You are entitled to convert your insurance to a non-group policy after coverage terminates, if BC/BS receives your application within 31 days of termination.

For enrollment information, see page 13.
For monthly cost information, see page 28.
For enrollment form, see page 29.

Provider Directories are available by calling BC/BS customer service or you can visit the BC/BS website at www.bluekc.com. To find a provider on the website, please choose the provider directory option located on the left side of the webpage. The website has the most updated information regarding provider participation and availability.

Preferred-Care Blue, Blue-Care & Blue Saver Enrollment

- All non-temporary, full-time employees are eligible to participate in one of the Diocesan health insurance plans.
- To enroll in Preferred-Care Blue, Blue-Care, or Blue Saver employees must complete an enrollment application. Enrollment applications can be found in the forms section of this book on page 29. If you enroll in Blue Saver you will be sent a Health Savings Account enrollment kit which describes the eligibility requirements and other pertinent information.
- Employees and/or dependents who decline coverage in writing when first eligible because of other insurance (group or individual), and subsequently lose that coverage due to termination of eligibility, such as legal separation, divorce, death, termination of employment, employer contribution, or reduction of hours are entitled to a Special Enrollment Period and may request enrollment in the Diocesan program without penalty within 31 days of losing coverage.
- Other employees and/or dependents who do not enroll within 31 days of employment or during a Special Enrollment Period may be considered late enrollees. All late enrollees who request enrollment will be accepted and their coverage will become effective on the next Anniversary Date, October 1st.
- A 90-day waiting period applies to pre-existing conditions for all new Preferred-Care Blue and Blue Saver subscribers; but all or part of the waiting period may be satisfied by proof of prior insurance as long as there has been no gap in coverage of more than 62 days. Your employer can furnish you a sample request for certification of prior insurance from your former plan administrator or carrier. Dependents under age 19 do not have a pre-existing condition exclusion.
- Once you have enrolled, you may not change the plan you select until the next open enrollment period in September.

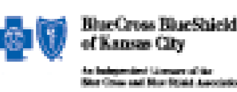
Please note: When enrolling in Blue-Care (HMO), you must specify on your application a Primary Care Physician for each family member you are enrolling.

IMPORTANT: Applications are available from your employer if you wish to change your medically covered dependents, marital status, name, address, etc.

Special forms are available from your employer or the Diocesan Benefits Office if you qualify to continue benefits up to 18 months after termination. Certain provisions apply, under the Missouri Health Continuation Law, to some surviving spouses and their covered dependents, and to some divorced and legally separated spouses and their covered dependents. Call the Diocesan Benefits Office for details.

ANY CHANGES AFFECTING COVERAGE AND REQUESTS FOR CONTINUATION AFTER TERMINATION MUST BE RECEIVED BY THE DIOCESAN BENEFITS OFFICE WITHIN 30 DAYS OF THE CHANGE.

For more complete information on these plans, please call the Diocesan Benefits Office at 816-756-1850 or Blue Cross/Blue Shield's Customer Service at 816-395-3558 or toll-free at 800-892-6048.



Diocese of Kansas City – St. Joseph
Health Benefit Plan Summary

Effective Date: 10/1/10

This Benefit Summary provides only a highlight of the services covered by Blue Cross and Blue Shield of Kansas City. *www.bluekc.com*

	Blue-Care	Preferred-Care Blue
Plan Type	A Health Maintenance Organization (HMO)	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	Members choose a primary care physician. Members may self-refer to physician specialists in the Blue-Care network. Urgent care and an exclusive network of specialists are also covered; **other services must be ordered by an HMO Physician.**	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
Deductible	N/A	$500 per individual/$1,000 per family
Coinsurance *(1)*	N/A	Network: 90%; Non-network: 60%
Out-of-Pocket Maximum	NA	Network: $1,500 individual/$3,000 family; *(2)* Non-network: $4,500 individual/$9,000 family
Physician Office Visits	PCP office visits: $20 copay Specialists: $40 copay	Network: $35 copay (office visit only) *(3)* Non-network: Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Applicable copay+	Network Routine Services: 100% Office Visit/Wellness Exam: $35 copay+ Non-network: Deductible then 60% No calendar year maximum
Lab Performed in Physician's Office/Independent Lab	No copay	Network: No copay Non-network: Deductible then 60%
Lab Performed in Hospital/Outpatient Facility	No copay	Network: Deductible then 90% Non-network: Deductible then 60%
X-ray and Other Radiology Procedures	No copay	Network: Deductible then 90% *(4)* Non-network: Deductible then 60%
Mammograms, Pap Smears and PSA Tests	Applicable copay+	Network: 100% after office visit copay+ Non-network: Deductible then 60%
Routine Vision Care	100% (less appropriate copays) *(5)*	None
Childhood Immunizations	100% (less appropriate copays)+	100% (office visit charges apply)+
Inpatient Hospital Services/Outpatient Surgery*	$200 copay per day up to $1,000 per calendar year	Deductible then 90%/60% *(4)*
MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)	$100 copay Only one copay will apply for each provider on a specified date of service even if multiple scans are performed	Deductible then 90% / 60%
Emergency Room *(Copay waived if admitted to a network hospital)*	$100 copay then 100%	$100 copay then Deductible then 90%
Urgent Care	$40 copay if services are received in an **urgent care center**.	Network: $35 copay (office visit and lab only) Non-network: Deductible then 90%/60%
Electronic Physician Visit (e-visit)	PCP: $10 copay Specialist: $10 copay	Network: $10 copay Non-network: No Benefit
Ambulance	No copay Ground ambulance limited to $500 benefit maximum per use.	Deductible then 90% Ground ambulance limited to $500 benefit maximum per use.

[1]Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.
[2]Total of deductible and coinsurance members pay each year toward covered charges before BCBSKC pays 100% of benefits.
[3]Other services/procedures not specified on this benefit schedule that are performed in a physician's office are subject to the Network Deductible and Coinsurance level.
[4]Diagnostic services performed at a Non-Participating Imaging Center inside Our Service Area are limited to a $200 calendar year maximum. Inpatient hospital services in a Non-Participating Hospital inside our service area are limited to a $200 maximum per day and are limited to 30 days per calendar year. Outpatient services at a Non-Participating Provider Hospital or at a Non-Participating Provider outpatient facility (including an ambulatory surgical

	Blue-Care	Preferred-Care Blue
Durable Medical Equipment*	No copay; $5,000 calendar year maximum	Deductible then 90%/60%; $5,000 calendar year maximum
Allergy Testing, Treatment, Injections	No copay for injections; $100 copay for testing	Deductible then 90%/60%
Home Health Services*	No copay; 60 visit calendar year maximum	Deductible then 90%/60%; 60 visit calendar year maximum
Skilled Nursing Facility*	No copay; 30 day calendar year maximum	Deductible then 90%/60%; 30 day calendar year maximum
Outpatient Therapy *(Speech, Hearing, Physical and Occupational Therapy)**	No copay Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum	Deductible then 90%/60% Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services*	No copay	Office Visit Network Providers: $35 copay All other services: Deductible then 90%/60% *
Inpatient Mental Illness & Substance Abuse*	$200 copay per day up to $1,000 per calendar year	Deductible then 90%/60%
Outpatient Mental Illness & Substance Abuse*	Office Visit:$20 copay Therapy: 100%	Office Visit Network Providers: $35 Copay Therapy: Deductible then 90%/60%
Inpatient Hospice Facility*	$100 copay per day up to $1,000 per calendar year Copayments paid for Inpatient Hospice apply to the maximum amount you pay for inpatient services and outpatient surgery in any calendar year 14 day lifetime maximum	Deductible then 90%/60% 14 day lifetime maximum
Organ Transplant*	Applicable copays $500,000 Organ Transplant lifetime maximum	Deductible then 90%/60% Network: $500,000 Organ Transplant lifetime maximum Non-Network: $100,000 Organ Transplant lifetime maximum
Prescription Drugs	**BCBSKC Rx Network:** $8 copay for Tier 1 drug $35 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug.	**BCBSKC Rx Network:** $8 copay for Tier 1 drug $35 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug. Non-Network: 50% after copay
Express Scripts (Mail order drug program 102 day supply)	$16 copay for Tier 1drug; $70 copay for Tier 2 brand drug; $120 copay for Tier 3 brand drug.	$16 copay for Tier 1drug; $70 copay for Tier 2 brand drug; $120 copay for Tier 3 brand drug.
Annual Drug Maximum	None	None
Lifetime Maximum	Unlimited	Unlimited
Dependent Coverage Missouri Mandate: Dependent daughters covered for maternity on Blue-Care only.	End of calendar year the children reach age 26 or the month they are no longer dependent, whichever is first.	End of calendar year the children reach age 26 or the month they are no longer dependent, whichever is first.
Prior Authorization Penalty (Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).	Prior authorization is the responsibility of the network provider.	You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!

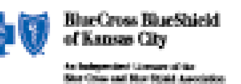
	Blue-Care	Preferred-Care Blue
Pre-existing Exclusion Period (does not apply to children under age 19)	Your Employer's group contract provides coverage that contains limitations based on whether a condition is considered preexisting. Any condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 90 day period from the enrollment date, is considered a preexisting condition (pregnancy is not considered a pre-existing condition). Your Employer's group contract excludes coverage for these specific preexisting conditions for 12 months beginning on the first day of the waiting period (or the date coverage is effective if there is no waiting period). However, your Employer's group contract will provide credit for preexisting conditions if you were previously covered under creditable coverage. The period of any preexisting condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the preexisting condition exclusion period, you must provide **copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s)** for the verification of prior creditable medical coverage you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any preexisting condition exclusion, please contact our Member Services Department at (816) 395-2950. **There is no exclusion period for the HMO plan.**	
Portability	The exclusion period for pre-existing conditions may be reduced by the length of time a person had prior creditable coverage, provided the member does not have a gap in coverage of more than 62 days.	
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.	
Detailed Benefit Information	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.	
Exclusions and Limitations	**Customer Service 816-395-3558 or *www.bluekc.com***	**Customer Service 816-395-3558 or *www.bluekc.com***
Other Changes Required by Federal Health Care Reform	Changes are coming for the following benefits: preventive care, emergency care, lifetime dollar limits and annual dollar limits. As soon as the regulations are received and the needed changes to those benefits are determined, you will be notified.	

*Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, speech and hearing therapy (including home health for speech therapy), prosthetics and appliances, mental health and chemical dependency, some outpatient prescriptions, skilled nursing facility, dental implants and bone grafts, and (for Preferred-Care Blue only) chiropractic services received from a non-network chiropractor. This list of services is subject to change. Please refer to your contract for the current list of services, which require Prior Authorization.

**Use of in-network benefits reduces out-of-network benefits and use of out-of-network benefits reduces in-network benefits where applicable.

The covered services described in the Benefit Schedule are subject to the conditions, limitations and exclusions of the contract.

Log on to *www.bluekc.com* for Provider Directories, claims status and much more!



Diocese of Kansas City – St. Joseph
Health Benefit Plan Summary

Effective Date: 10/1/10

This Benefit Summary provides only a highlight of the services covered by Blue Cross and Blue Shield of Kansas City.

www.bluekc.com

	BlueSaver Plan
Plan Type	A Preferred Provider Organization (PPO)
Plan Description *(Visit our website at www.bluekc.com to receive a complete listing of network hospitals and physicians)*	Members can receive services from any hospital or physician but receive greater benefits when they use the Preferred-Care Blue network.
Deductible	$2,500 per individual/$5,000 per family
Coinsurance *(1)*	Network: 100%; Non-network: 80%
Out-of-Pocket Maximum	Network: $2,500 individual/$5,000 family; *(2)* Non-network: $5,000 individual/$10,000 family
Physician Office Visits	Deductible then coinsurance
Routine Preventive Care *(Contract lists covered services)*	Network Routine Services: 100% Non-network: Deductible then 80% No calendar year maximum
Lab Performed in Physician's Office/Independent Lab	Network: Deductible then 100% Non-network: Deductible then 80%
Lab Performed in Hospital/Outpatient Facility	Network: Deductible then 100% Non-network: Deductible then 80%
X-ray and Other Radiology Procedures	Network: Deductible then 100% *(4)* Non-network: Deductible then 80%
Mammograms, Pap Smears and PSA Tests	Network: 100% Non-network: Deductible then 80%
Routine Vision Care	None
Childhood Immunizations	100%
Inpatient Hospital Services/Outpatient Surgery*	Deductible then 100%/80% *(4)*
MRI, MRA, CT and PET scans performed in a Physician's Office, Imaging Center or Other Outpatient Setting (including a hospital)	Deductible then 100%/80%
Emergency Room	Deductible then 100%
Urgent Care	Deductible then 100%/80%
Ambulance	Deductible then 100% Ground ambulance limited to $500 benefit maximum per use.
Durable Medical Equipment*	Deductible then 100%/80%; $5,000 calendar year maximum
Allergy Testing, Treatment, Injections	Deductible then 100%/80%
Home Health Services*	Deductible then 100%/80%; 60 visit calendar year maximum
Skilled Nursing Facility*	Deductible then 100%/80%; 30 day calendar year maximum
Outpatient Therapy (Speech, Hearing, Physical and Occupational Therapy)*	Deductible then 100%/80% Physical and Occupational: Combined 40 visit calendar year maximum Speech and Hearing: Combined 20 visit calendar year maximum
Chiropractic Services*	Deductible then 100%/80% *

[1] Portion of covered charges paid by BCBSKC after you satisfy your deductible and required copayments.

	BlueSaver Plan
Inpatient Mental Illness & Substance Abuse*	Deductible then 100%/80%
Outpatient Mental Illness & Substance Abuse*	Deductible then 100%/80%
Inpatient Hospice Facility*	Deductible then 100%/80% 14 day lifetime maximum
Organ Transplant*	Deductible then 100%/80% Network: $500,000 Organ Transplant lifetime maximum Non-Network: $100,000 Organ Transplant lifetime maximum
Prescription Drugs	**BCBSKC Rx Network:** Network: Deductible then 100% Non-Network: Deductible then 50% after $8 copay for Tier 1 drug $35 copay for Tier 2 brand drug; $60 copay for Tier 3 brand drug. (copays apply to out-of-pocket maximum)
Express Scripts (Mail order drug program 102 day supply)	Deductible then 100%
Annual Drug Maximum	None
Lifetime Maximum	Unlimited
Dependent Coverage	End of calendar year the children reach age 26 or the month they are no longer dependent, whichever is first.
Prior Authorization Penalty (Prior Authorization is required for selected services. See your certificate for a listing of services requiring Prior Authorization).	You are responsible for prior authorization for services received from non-network and out-of-area providers. If prior authorization is not obtained for services which require prior authorization, you are responsible for the cost of the services.
Pre-existing Exclusion Period (does not apply to children under age 19)	Your Employer's group contract provides coverage that contains limitations based on whether a condition is considered preexisting. Any condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 90 day period from the enrollment date, is considered a preexisting condition (pregnancy is not considered a pre-existing condition). Your Employer's group contract excludes coverage for these specific preexisting conditions for 12 months beginning on the first day of the waiting period (or the date coverage is effective if there is no waiting period). However, your Employer's group contract will provide credit for preexisting conditions if you were previously covered under creditable coverage. The period of any preexisting condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the preexisting condition exclusion period, you must provide copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s) for the verification of prior creditable medical coverage you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any preexisting condition exclusion, please contact our Member Services Department at (816) 395-2950.
Portability	The exclusion period for pre-existing conditions may be reduced by the length of time a person had prior creditable coverage, provided the member does not have a gap in coverage of more than 62 days.
Late Enrollees	For employees or dependents applying after the eligibility period and not within a special enrollment period, coverage will become effective only on the group's anniversary date.
Detailed Benefit Information	Call a Customer Service Representative or consult your booklet/certificate. The certificate will govern in all cases.
Exclusions and Limitations	Customer Service 816-395-3558 or www.bluekc.com
Other Changes Requires by Federal Health Care Reform	Changes are coming for the following benefits: preventive care, emergency care, lifetime dollar limits and annual dollar limits. As soon as the regulations are received and the needed changes to those benefits are determined, you will be notified.

*Prior Authorization will be required for elective inpatient admissions, durable medical equipment (DME), infusion therapy and self injectables, organ and tissue transplants, some outpatient surgeries and services, speech and

Two Dental Plans are available through the Diocese. Employees, spouses and eligible dependent children may participate in one of two dental plans. The employer will provide a $10.00 monthly contribution toward the cost of the plan you choose. You may elect to pay your portion of the premium with pre-tax dollars through the Flexible Benefits Plan. See page 23 for more information.

Both plans are PPO programs offered by Delta Dental of Missouri and give you the freedom to visit the dentist of your choice and to select any dentist on a treatment by treatment basis. It is not necessary to pre-select a dentist.

1. **Delta Dental PPO – Core Plan** is intended to provide employees and covered family members with dental benefits for preventive and basic restorative services such as fillings and simple extractions.

2. **Delta Dental PPO – Enhanced Plan** is a more comprehensive dental program that provides coverage for preventive, basic restorative and major restorative services such as root canals, crowns, bridges, dentures and orthodontic services for dependent children.

A side by side comparison of the plans are included on page 15 to assist you in selecting the plan that best suits the needs of your family.

About Delta Dental

Delta Dental provides coverage through two national networks of participating dentists, Delta Dental PPO and Delta Dental Premier. PPO and Premier network dentists agree to special provisions that save you time and money. If your dentist participates in both networks you will receive the best level of coverage available which is typically found in the PPO network. You can verify which network(s) your dentist participates in by visiting Delta Dental's website at www.deltadentalmo.com and clicking on "Looking for a Dentist?" or by calling Delta's Customer Service Team at 1-800-335-8266.

COST SHARED BY EMPLOYER AND EMPLOYEE

Delta Dental PPO Network

A subset of the Delta Dental Premier Network, over 138,000 dental offices participate in the Delta Dental PPO program. Delta Dental will provide the highest level of benefits (see schedule of benefits on page 22) for plan coverage when care is received from a Delta Dental PPO dentist. These dentists agree to:

- **Accept payment based on a reduced fee schedule –** which means fewer dollars accumulate towards your annual benefit maximum, your out-of-pocket expenses are typically less and you are protected from balance billing.
- Submit dental claims for members and abide by Delta's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

Your out-of-pocket expenses are typically lowest when you see a Delta Dental PPO dentist.

Delta Dental Premier Network

Comprised of over 181,000 participating dental offices, Delta Dental Premier offers you greater access to dentists while still offering the advantages of a network. These dentists have contractual agreements with Delta Dental which require them to:

- **Accept payment based on Delta's maximum plan allowance –** which means no balance billing.
- Submit dental claims for members and abide by Delta's policies.
- Charge members only their deductible, co-insurance, and costs for non-covered services at the time of visit because Delta Dental pays the dentist directly.

Non-Network Dentist

If you receive services from a non-network dentist (does not participate in either Delta Dental network):

- You may be responsible for filing your own claim forms.
- Delta Dental's benefit payment will be made directly to you.
- Benefit payments will be based on Delta's maximum plan allowance.
- You may be balance billed if there is a difference between the dentist's charge and Delta's maximum plan allowance.

Your out-of-pocket expenses may be more when you use a non-network dentist.

To enroll in one of the dental plans, you must complete the appropriate application located in the Forms section of this book, which starts on page 29. For a listing of numbers, please see inside back cover.

Delta Dental PPO Plan Comparison

Delta Dental PPO Plan Comparison

Delta Dental PPO Schedule of Benefits	Core Plan		Enhanced Plan	
	Delta Dental PPO Network	Delta Dental Premier Network or Non-Network	Delta Dental PPO Network	Delta Dental Premier Network or Non-Network
Diagnostic and Preventive Services Oral exams (all types), once per benefit period Bitewing x-rays, one set per benefit period Periapical x-rays, up to four x-rays per benefit period Full-mouth x-rays once in any 60 consecutive months Cleanings (all types), twice per benefit period Fluoride, once per benefit period for dependents under age 14 Emergency palliative treatment Sealants for dependent children under 16, once per tooth per lifetime, limited to non-decayed 1st and 2nd permanent molars Space maintainers, once in 5 years , to age 16	**100%**	**90%**	**100%**	**100%**
Basic Restorative Services Restorative services using synthetic porcelain and plastic material (white) on front teeth and amalgam (silver) on molar teeth Simple extractions	**80%**	**70%**	**85%**	**80%**
Major Restorative Services Surgical Extractions and other Oral Surgery Periodontics: treatment for diseases of gums and bone supporting the teeth Endodontics: root canal filling and pulpal therapy Prosthetics: bridges and dentures; a replacement will be covered only once in 5 years, but not during the first 12 months of coverage[1] Crowns, jackets, labial veneers, inlays and onlays when required for restorative purposes, once in 5 years	**Not Covered**	**Not Covered**	**55%**	**50%**
Orthodontic Services For eligible dependents to age 19. A 24 month waiting period applies.[2]	**Not Covered**	**Not Covered**	**50%**	**50%**
Deductible **(applies to Basic and Major Services only)**	**$50 per person**		**$50 per person**	
Policy Year Benefit Maximum A new policy year begins each year on October 1st.	**$1,000 per person**		**$1,000 per person**	
Separate Lifetime Orthodontic Maximum	**Not Covered**		**$1,000 per child to age 19**	
Dependent Age Limit: End of the calendar year in which your dependent turns 26.				

- **Delta Dental PPO Network Dentists:** Accept payment based on a fee schedule and will not balance bill you for charges above the schedule.
- **Delta Dental Premier Network Dentists:** Accept payment based on a contractual agreement and will not balance bill you for charges above the contract.
- **Non-Network Dentists:** Payment is made up to Delta's maximum plan allowance; balance billing is possible.

To find a Network Dentist in your area go to www.deltadentalmo.com or call 1-800-335-8266.

This is intended to be a summary only. Please refer to your Summary Plan Description (SPD) for a more complete listing of services including plan limitations and exclusions. If discrepancies arise the SPD will govern.

Sometimes referred to as a cafeteria plan, flex plan, or a Section 125 plan - a Flexible Benefits Plan lets you set aside a certain amount of your paycheck into an account - before paying income taxes. During the year you have access to this account for reimbursement of expenses you regularly pay for, such as health care and day care. When you use tax-free dollars to pay for certain expenses, such as Health and other insurance premiums, prescription drugs, eyeglasses and day care expenses, you realize an increase in your spending power, and substantial tax savings.

There are three parts to the Flexible Benefits Plan in which you can enroll:

1. Premium Savings Plan;
2. Health Care Reimbursement Savings Plan;
3. Dependent Care Savings Plan.

Note: By Federal Law, you may not contribute to a Health Care Reimbursement Savings Plan and a Health Savings Account simultaneously.

1. Premium Savings Plan

The Section 125 of the IRS Code allows employees to deduct these premiums before taxes are calculated, and save the Federal, FICA, State and City income taxes which would apply - a total of 25% - 30% of the premiums. The Diocese has filed the required plan documents so that our employees can take advantage of this tax savings.

Important notes regarding the Premium Savings Plan:

• There are virtually no disadvantages to participating. Your pension and long term disability benefits will not be affected. The reduction in your Social Security Tax may have a slight effect on your Social Security benefit, but our accountants advise that the effect, if any, will be negligible.

• **Beginning October 1, 2010 through September 30, 2011, you will automatically be enrolled in the Premium Savings Plan if you are having premiums deducted from your paycheck.** These premiums will be deducted before taxes are calculated (pre-tax basis). You may elect to waive out of the Premium Savings Plan by completing a form requesting your premium contributions be taken out on a post-tax salary reduction basis.

When your premium contributions are deducted before taxes are calculated, you may not change your mind until the end of the plan year, September 30th. You may not cancel your health or dental coverage nor change coverage levels (even if you transfer from one school or parish to another), unless there is a significant change in your family status - marriage, divorce, death of spouse, birth of child, termination of spouse's employment, or changes in cost or coverage, such as a significant change in your spouse's health coverage. If a change in status occurs, you may make changes consistent with the qualifying event.

• All employee-paid Diocesan health, dental and the voluntary Aflac insurance premiums are eligible.

• Your W-2 form will reflect your reduced taxable income, because your health/dental contributions are treated as employer expenses under the tax code. You will not be required to report these contributions as income at a later date.

• Because these premiums are not treated as income, you may not claim them as deductions when you file your annual income tax.

• We believe the Premium Savings Plan is another valuable component of the fringe benefit program for our employees in the Diocese of Kansas City-St. Joseph. We will continue to search for opportunities to improve fringe benefits and assist you in obtaining the most benefit from each benefit dollar.

For enrollment information, see page 29.

2. Health Care Reimbursement Savings Plan

If you are a **full-time, non-temporary Diocesan employee** you may save additional taxes under Section 125 of the IRS code by redirecting, or "banking", a portion of your salary in a TAX FREE Diocesan account, to be used as needed for out-of-pocket medical expenses incurred by you, your spouse, or your dependents.

Redirected salary will not appear on your W-2 and will be exempt from federal, state and local taxes. Only expense NOT reimbursed by insurance can be claimed. These expenses can include, but are not limited to:

- Acupuncture (excluding remedies and treatments prescribed by acupuncturist)
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth
- Chiropractors
- Contact lenses and solutions
- Copayments
- Costs for physical or mental illness confinement
- Crutches
- Deductibles
- Dental fees
- Dentures
- Diagnostic fees
- Drug and medical supplies (i.e syringes, needles, etc.) prescribed by a physician
- Eyeglasses prescribed by your doctor
- Eye examination fees
- Eye surgery (cataracts, lasik, etc.)
- Hearing devices and batteries
- Hospital bills
- Insulin
- Laboratory fees
- Laser eye surgery
- Obstetrical expenses
- Oral surgery
- Orthodontic fees
- Orthopedic shoes
- Over-the-counter drugs and medications (except for vitamins and supplements)
- Oxygen
- Physician fees
- Prescribed medicines
- Psychiatric care
- Psychologist's fees
- Routine physicals and other non-diagnostic services or treatments
- Smoking cessation programs (including over-the-counter patches, medications and gums)
- Surgical fees
- Weight loss programs for obesity when prescribed by a physician
- Wheelchair
- X-Rays

The following expenses are typically not eligible for reimbursement:
- Cosmetic surgery and procedures
- Dental bleaching
- Marriage and family counseling
- Premiums you or your spouse pay for insurance coverage

(Payroll-deducted premiums sponsored by your employer are eligible under the Premium Savings Plan).

Important Notes Regarding the Health Care Reimbursement Savings Plan:

- You may set aside a maximum of $2,500 in this account each plan year.

- If you have elected to have money set aside in this account before taxes are calculated, you may not change your plan elections until the end of the plan year, September 30th, unless there is a significant change in your family status - marriage, divorce, death of spouse, birth of child, termination of spouse's employment, or a significant change in your spouse's health coverage. If a change in status occurs you may make changes consistent with the qualifying event.

- Participants may pay for covered expenses using their Aflac FSA Debit Card. If other means of payments are used, a Claim Form must be submitted along with copies of receipts. Claim Forms may be obtained by calling Aflac at 1-877-353-9487, Option 2., or at www.aflac.com.

- **You must request reimbursement of expenses incurred during the plan year within 60 days of the plan year end or 60 days of your termination date. The IRS requires that any funds left in the account be forfeited.**

3. Dependent Care Savings Plan

All full-time, non-temporary employees may also be eligible to save the taxes on their dependent care expenses.

A portion of salary may be redirected, or "banked" in a TAX FREE Diocesan account, and used to reimburse expenses necessary for you and your spouse (if married) to be gainfully employed. Eligible expenses include:

- Expenses paid to a dependent care center or care provider for care of dependent under age 13.
- Expenses paid for care of an older dependent who is physically or mentally incapable of caring for himself.

Important notes regarding the Dependent Care Savings Plan:

- The following maximums apply to the amount of money you may set aside for this plan:

1. $5,000 for single individuals or married individuals who are filing joint tax returns, or

2. $2,500 for married individuals filing individual tax returns.

- If you have elected to have money set aside in this account before taxes are calculated, you may not change your election until the end of the plan year, September 30th, unless there is a significant change in your family status - marriage, divorce, death of spouse, birth of child, termination of spouse's employment, or changes in cost or coverage.

- Participants may pay for covered expenses using their Aflac FSA Debit Card. If other means of payments are used, a Claim Form must be submitted along with copies of receipts. Claim Forms may be obtained by calling Aflac at 1-877-353-9487, Option 2.

- **You must request reimbursement of expenses incurred during the plan year within 60 days of the plan yearend or 60 days of your termination date. The IRS requires that any funds left in the account be forfeited.**

Here's how it works. . .

Example: An employee makes $2,000 each month and decides to participate in her employer's Flexible Benefits Plan. As a result, her insurance premiums and health and day care expenses are paid with tax-free dollars, giving her an additional $100 each month!

Without the Plan	
Gross Earnings	$2,000
FICA, Federal, State Taxes	-$500
Insurance Premium	-$100
Health and Day Care Expenses	-$300
Net Earnings	**$1,100**

With the Plan	
Gross Earnings	$2,000
Insurance Premium	-$100
Health and Day Care Expenses	-$300
Adjusted Gross Earnings	$1,600
FICA, Federal, State Taxes	-$400
Net Earnings	**$1,200**

Voluntary Life & AD&D Insurance

100% EMPLOYEE PAID

Voluntary Life Insurance for Employees and Dependents is provided through Assurant Employee Benefits. Today, many people need additional financial protection. As your life style, your family, and your income change, so can your need for life insurance.

Now is a good time to review your life protection and make sure it has kept pace with your changing needs. In the event of your death, life insurance benefits can help:

- Pay for your children's higher education
- Pay off the mortgage on your home
- Settle outstanding personal and business debts
- Pay for final expenses
- Pass on a certain standard of living

Non-temporary, full-time lay employees are eligible at employment. You will find an enrollment form on page 21 or you can ask your local administrator for a brochure and application.

Employee Schedule of Benefits: Voluntary Life is available in $10,000 units from a minimum of $20,000 to a maximum of $500,000 not to exceed five times your basic annual earnings. Matching Accidental Death and Dismemberment (AD&D) is an option that can be elected for the employee. AD&D has limitations and exclusions. If you are a newly eligible employee and are within 31 days of hire, you may elect coverage up to $150,000 without health questions, elections over this amount will require completion of "health statement" located in the Form Section of this booklet.

Spouse Schedule of Benefits: If you elect coverage for yourself, you may choose $5,000 units for your spouse limited to 50% of the employee's amount. If you are a newly eligible employee and are within 31 days of hire, you may elect coverage up to $75,000 without health questions for your spouse. Elections over this amount will require completion of health statement. Any increases to spouse coverage at anniversary will require completion of health statement.

If you and your spouse work for the same employer and are both eligible for this insurance as employees, you cannot cover each other as dependents, and only one of you may insure any dependent children.

Child(ren) Schedule of Benefits: Choose $1,000, $5,000 or $10,000 per child. If you are a newly eligible employee and are within 31 days of hire, you may elect coverage up to $10,000 without health questions for your children. *For late entrants, please fill out the health statement in the forms section for your children as well.**

****Where italicized, please refer to the application in the forms section for eligibility requirements regarding required health statement.***

Premiums increase incrementally every five years per age bands.

This Voluntary Life coverage offers the following advantages to you:

- Affordable group rates.
- Convenience of payroll deduction.
- Large amounts issued without Evidence of Insurability.
- Waiver of premium provision.
- Portability - allows you to take coverage with you should you leave the employment of the Diocese of Kansas City - St. Joseph. You will go into a separate pool and the rates will differ from the group rates.
- Dependent coverage is available. Children are covered up to the age of 19 or 25 if a full-time student.
- Living Benefits Option - allows you to receive a portion of your life proceeds in advance, if diagnosed terminally ill. Limitations and exclusions apply.

Products marketed by Assurant Employee Benefits are underwritten by Union Security Insurance Company.

100% EMPLOYEE PAID

In addition to the tax savings available through the Flexible Benefits Plan (see pages 23-25) our employees may choose to invest funds in a 403(b) program. 403(b) programs are the mirror image of a 401(k) plan. Employee contributions are deducted before federal and state income taxes are computed, but Social Security and Medicare taxes do apply.

All full-time and part-time employees, lay and religious, are eligible and strongly encouraged to take advantage of the tax savings by participating in this retirement savings plan. Contributions are invested through AIG VALIC, under a contract approved by the Diocese. Many investment options are available through AIG VALIC, from little or no risk to those with more growth potential, and more risk.

AIG VALIC will advise your employer the amount you wish deducted each month by a copy of a salary reduction agreement you and your employer sign.

New for 2006 – ROTH 403(b) You may contribute after-tax money to this retirement program, then tax-free withdrawals of interest and earnings. Please contact your AIG Valic representative for more information or to enroll in this program.

You may change the amount you invest up to once each quarter, by completing a new salary reduction form. This agreement is kept in your payroll file.

Interested employees should contact Michael Bauer, AIG VALIC District Manager, at: (913) 402-5000.

Voluntary Accidental Indemnity Advantage Insurance

Voluntary Accident Indemnity Advantage Insurance for Employees and Dependents is provided through Aflac. It is a 24-hour accident-only insurance, which pays cash benefits directly to you. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose.

Under the Accident Indemnity Advantage Insurance Policy there are no deductibles and no copayments; no lifetime limits; no network restrictions – you choose your own medical treatment provider; and no coordination of benefits – Aflac pays regardless of any other insurance.

Schedule of Benefits: Aflac will pay the following benefits as applicable if a Covered Person's Accidental Death, dismemberment, or Injury is caused by a covered accident that occurs on or off the job. Please Note: this is just a partial listing of the benefits. For a full listing of all of the covered benefits, please see the Aflac policy at www.aflac.com. Click on "Individuals" then "Policies." Accidental Death, dismemberment, or injury must be independent of sickness or the medical or surgical treatment of sickness, or of any cause other than a covered accident and must also occur while coverage is in force and is subject to the limitations and exclusions of the policy.

- **Wellness:** $60 once per policy per 12-month period, payable after the policy has been in force for 12 months.
- **Accident Emergency Treatment:** $120 once per 24-hour period and once per covered accident, per Covered Person.
- **X-Ray:** $25 once per covered accident, per Covered Person.
- **Initial Accident Hospitalization:** $1,000 once per period of hospital confinement or $2,000 once when a Covered Person is admitted directly to an intensive care unit.
- **Accident Hospital Confinement:** $250 per day up to 365 days per covered accident, per Covered Person.

If you are interested in enrolling in the Aflac Accident Plan, please contact Barbara O'Neil with Aflac at 913-322-1473 or barbara.oneil@us.aflac.com and she will coordinate getting you enrolled.

Voluntary Cancer Indemnity Insurance

Voluntary Cancer Indemnity Insurance for Employees and Dependents is provided through Aflac. Although major medical insurance can help with the costs of cancer treatment, you still may have to cover deductibles and copayments on your own. Additionally, cancer treatment can necessitate out-of-pocket expenses that are not covered by major medical insurance, including travel, food, lodging, long-distance calls, child care, and household help. By paying cash benefits directly to you, Aflac's Cancer Indemnity Insurance policy allows you the freedom to use those funds as you see fit, helping you with the financial consequences of cancer that may not be covered by major medical insurance.

Schedule of Benefits: You will receive cash benefits based on a schedule (please see the Aflac policy for details at www.aflac.com. Click on "Individuals" then "Policies.") Benefits are paid only for covered Persons who receive Physician-prescribed treatment approved by the National Cancer Institute (NCI) or the Food and Drug Administration for Cancer (unless stated otherwise) or an Associated Cancerous Condition, as applicable. Covered Benefits include:

- **Direct Nonsurgical Treatment:** Initial Treatment, Injected Chemotherapy, Oral Chemotherapy, Radiation Therapy, Experimental Treatment

- **Indirect/Additional Therapy Benefits:** Immunotherapy, Anti-Nausea, Stem Cell Transplantation, Bone Marrow Transplantation, Blood and Plasma

- **Surgical Treatment Benefits:** Surgical/Anesthesia, Skin Cancer Surgery, Hospital Confinement, Outpatient Hospital Surgical Room Charge

- **Continuing Care Benefits:** Extended-Care Facility, Home Health Care, Hospice Care, Nursing Services, Surgical Prosthesis, Prosthesis Nonsurgical Reconstructive Surgery

- **Ambulance, Transportation, and Lodging Benefits:** Ambulance, Transportation, Lodging.

If you are interested in enrolling in the Aflac Cancer Plan, please contact Barbara O'Neil with Aflac at 913-322-1473 or barbara.oneil@us.aflac.com and she will coordinate getting you enrolled.

Your Aflac Representative is ready to be of assistance. Call Barbara O'Neil at 913-322-1473; Regional Office, 816-786 3585; Mobile 913-322-3698; email barbara_oneil@us.aflac.com

Monthly Cost for Each Plan

MEDICAL PLAN OPTIONS:	Total Premium	Employer Pays	Employee Pays
Preferred-Care Blue (PPO)			
Individual	$497	$248.50	$248.50
Family	$1,197	$598.50	$598.50
Blue-Care (HMO)			
Individual	$490	$245	$245
Family	$1,161	$580.50	$580.50
Blue Saver (PPO)			
Individual	$400	$245	$155
Individual +1	$800	$490	$310
Family	$1,020	$580.50	$439.50

DENTAL PLAN OPTIONS:	Total Premium	Employer Pays	Employee Pays
Delta Core			
Individual	$18.19	$10.00	$ 8.19
Individual +1	$32.35	$10.00	$22.35
Individual + Family	$58.92	$10.00	$49.82
Delta Enhanced			
Individual	$29.91	$10.00	$19.90
Individual +1	$53.00	$10.00	$43.00
Individual + Family	$90.22	$10.00	$80.22

VOLUNTARY LIFE INSURANCE:

YOU PAY:	*Employee Per $1,000*	*Spouse Per $1,000*
Under Age 20	.032	.052
20-24	.048	.068
25-29	.058	.092
30-34	.086	.10
35-39	.116	.13
40-44	.196	.228
45-49	.304	.346
50-54	.494	.576
55-59	.900	1.126
60-64	1.152	1.624
65-69	1.872	2.286
70-74	3.348	4.606
75+	5.892	7.942

Dependent Child Rates:. **$.18 per $1,000 for all children**

VOLUNTARY AD&D INSURANCE:

YOU PAY:	*Employee Per $1,000*
Under Age 30	.03
30-39	.04
40-49	.05
50-64	.06
65+	.07

Forms

The following forms are included for your convenience. You may either cut out or photocopy the forms. All forms need to be returned to your Payroll Department unless otherwise indicated.

Medical

Form 1 - Enrollment/Change Form

> **Note:** If enrolling in the **Blue-Care HMO**, please check the "Blue-Care (HMO) Option 1" box.
>
> **Note**: If enrolling in the **Preferred-Care Blue PPO**, please check the "Preferred-Care Blue (PPO) Option 1" box.
>
> **Note**: If enrolling in the **Blue Saver PPO**, please check the "Preferred-Care Blue (PPO) Blue Saver" box in Section II. If you are enrolling in Blue Saver PPO and wish to establish an HSA with your Employer's preferred Banking Institution, UMB, please complete Section VIII. You will also need to complete the following three forms if you would like to open up a Health Savings Account through UMB and have your contributions payroll deducted: (1) UMB Bank Health Savings Account Election Form (Form 1a); Enrollment Agreement for Health Savings Account (Form 1b); Health Savings Account Beneficiary Designation Form (Form 1c). Please Note: Forms 1b and 1c to be faxed directly to UMB at 816-843-2247.

Dental

Form 2 - Delta Dental Plan Enrollment Form

Flexible Benefits Plan

Form 3 - Election Form and Premium Savings Waiver Form

Voluntary Life Insurance

Form 4 - Employee Application and Health Statement

Form 1

EMPLOYER USE ONLY: BCBSKC GROUP NO. 10262000 SUBGROUP NO. ______________ CLASS NO. ______________

Employee Application and Change Form

GROUPS WITH 100+ FULL TIME EMPLOYEES
Please Complete All Boxes LEGIBLY (Print) IN BLUE OR BLACK INK and Sign.

Preferred-Care Blue PPO | Preferred-Care PPO | Blue-Care HMO

If application is to be used as a Change Form, please specify event below. DATE OF EVENT: ______________ PROPOSED EFFECTIVE DATE: ______________

☐ Birth ☐ Change of Address ☐ Divorce ☐ Marriage ☐ Death ☐ Change of Beneficiary ☐ Adoption/Placement ☐ Loss of Other Group Coverage ☐ Reaching Lifetime Benefit Maximum

I Employee Information Only

LAST NAME	FIRST NAME	M.I.	STREET ADDRESS

CITY	STATE	ZIP CODE	HOME PHONE NO. ( ) WORK PHONE NO. ( )

E-MAIL ADDRESS	BIRTH DATE	GENDER	SOCIAL SECURITY NO.
	/ /	☐ Male ☐ Female	– –

HIRE DATE	MARITAL STATUS	EMPLOYER	POSITION	NO. OF HRS WORKED PER WK
/ /	☐ Married ☐ Single	Diocese of Kansas City-St.Joseph		

II Medical Coverage Selection

I Elect Coverage For: (select only one)

☐ Blue-Care (HMO) Option 1
~~☐ Blue-Care (HMO) Option 2~~
~~☐ Blue-Care (HMO) Option 3~~
~~☐ Preferred-Care (PPO)~~
~~☐ PersonalBlue (PPO)~~
~~(Personal Care Account + PPO)~~

☐ Preferred-Care Blue (PPO) Option 1
~~☐ Preferred-Care Blue (PPO) Option 2~~
~~☐ Preferred-Care Blue (PPO) Option 3~~
☐ Preferred-Care Blue (PPO) BlueSaver ‡
(High deductible health plan (HDHP) for use with an HSA)
‡ *Would you like to set up an HSA with your Employer's preferred bank?*

~~**Medical Plan Design Choice** (select only one - if no selection is made, employee will be enrolled in Base Plan)~~
~~☐ Base Plan ☐ Buy-Up Plan (I understand this election may increase my employee contributions)~~

III Ancillary Coverage Selection

Dental (If offered)
~~☐ Preferred-Care Dental PPO~~
~~☐ Traditional~~

Life (If offered, through USAble Life)
~~Life/AD&D ☐ Self~~
Please See Section IX
~~Dependent Life (Dep Life) ☐ Dependent(s)~~
Dependent life benefits are payable to employee only
~~Short Term Disability (STD) ☐ Self~~
~~Long Term Disability (LTD) ☐ Self~~
~~Supplemental Life (Supp Life) ☐ Self~~

Not Applicable ☑

IV Family Information - Employee and Employee's Dependents to be Enrolled or Changed: (Attach Sheet if Necessary)

CHECK APPROPRIATE BOX	SOCIAL SECURITY NO.	LAST NAME FIRST NAME M.I.	DATE OF BIRTH	[illegible]	GENDER	PRIMARY CARE PHYSICIAN (Complete Only if Applying for HMO Coverage)	CURRENT PATIENT
☐ New ☐ Change	Employee – –		/ /	☐ Medical ☐ Dental	☐ Male ☐ Female	PCP Name: PCP NO.	☐ YES ☐ NO
☐ New ☐ Change	Spouse – –		/ /	☐ Medical ☐ Dental	☐ Male ☐ Female	PCP Name: PCP NO.	☐ YES ☐ NO
☐ New ☐ Change	Child – –		/ /	☐ Medical ☐ Dental	☐ Male ☐ Female	PCP Name: PCP NO.	☐ YES ☐ NO
☐ New ☐ Change	Child – –		/ /	☐ Medical ☐ Dental	☐ Male ☐ Female	PCP Name: PCP NO.	☐ YES ☐ NO

If Dependent Child(ren) are full-time Students in College, Vocational or Trade School, please indicate name of school & dependent Child's Name (Full-time students may not be eligible Dependents under your group coverage).

1. 2.

V Waiver of Coverage Selection

I Decline Coverage For:

Medical ☐ Self ☐ My Spouse ☐ My Dependent Child(ren)
~~Dental ☐ Self ☐ My Spouse ☐ My Dependent Child(ren)~~
~~Life/AD&D ☐ Self~~
~~Dep Life ☐ Dependent(s)~~
~~STD ☐ Self~~
~~LTD ☐ Self~~
~~Supp Life ☐ Self~~

Due To:
☐ Existence of Other Group Health Coverage ☐ Medicare or Medicaid
☐ Existence of Other Individual Health Coverage
☐ Other Reason (Explain) ______________________________

If you are declining medical coverage for yourself or your dependents (including your spouse) because of other group coverage, you or your dependents may in the future be able to enroll in this plan, provided that you request enrollment within 31 days after your other group coverage ends. In addition, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within 31 days after a marriage, birth, adoption or placement for adoption. If you are declining medical and/or dental coverage for any other reason, or if you fail to complete this form, you may be limited to enrolling only during the annual enrollment period and a preexisting condition exclusion period may apply. If you decline the life, dependent life, short term disability, long term disability or supplemental life coverage and elect to enroll for coverage at a later date, you may be required to submit, at your own expense, evidence of insurability to USAble Life. To request a special enrollment for medical and/or dental coverage, please contact our Member Services Department at (816) 395-2950.

LAST NAME ______________________ FIRST NAME ______________________

VI Other Health Insurance Carrier (For Coordination of Benefits)

1. On the day the coverage begins will any family members be covered by other health or dental insurance or Medicare, including continuation of coverage?
☐ YES ☐ NO If yes, answer all questions below. Attach sheet if more than one additional policy will be in force.

COVERAGE TYPE: ☐ Medical Insurance ☐ Dental Insurance	INSURANCE COMPANY NAME	(AREA CODE) PHONE NO. ( )	POLICY NO.

NAME OF INSURED	INSURED'S EMPLOYER NAME	EFFECTIVE DATE / /	TERMINATION DATE / /

FAMILY MEMBERS COVERED
1. 2. 3.

2. Are any of your dependent children subject to a divorce decree or court order? ☐ YES ☐ NO
If yes, whose coverage is primary? ☐ Yours ☐ The Other Parent's

3. If you or your dependent(s) have Medicare, include a copy of your Medicare card(s) with this Application.
Do you or your dependent(s) have Medicare? ☐ YES ☐ NO If yes, are you actively working? ☐ YES ☐ NO
Are you retired? ☐ YES ☐ NO If yes, please provide date of retirement: / /

4. Are you or any of your dependent(s) covered under COBRA or State Continuation? ☐ YES ☐ NO
If yes, please provide the effective date and future termination date of coverage. Effective Date: / / Future Termination Date: / /

VII Pre-Existing Conditions: If you are enrolling in the PPO product, please complete the following to receive Creditable Coverage

Your Employer's group contract provides coverage that may contain limitations based on whether a condition is considered preexisting. Please consult the Health Benefit Plan Summary provided to you for specific information on preexisting conditions and the length any preexisting condition exclusion period. However, your Employer's group contract will provide credit for preexisting conditions if you were previously covered under creditable coverage. The period of any preexisting condition exclusion that would otherwise apply to a person will be reduced by the number of days of creditable coverage the person has as of the enrollment date. In order to receive credit toward the preexisting condition exclusion period, you must provide copies of the Certificates of Creditable Coverage or other acceptable proof of coverage from the prior plan(s) or the following information for the verification of prior creditable medical coverage you or any listed dependents currently have, or previously had, including continuation of coverage. You have the right to request a Certificate of Creditable Coverage from your prior plan or insurer. To request assistance in obtaining a Certificate of Creditable Coverage from a prior plan or insurer, please contact Blue Cross and Blue Shield of Kansas City. Should you need additional information or assistance regarding any preexisting condition exclusion, please contact our Member Services Department at (816) 395-2950.

Insurance Company Name	Name as Listed on Policy	Name(s) of Person(s) Covered in Prior Plan	Effective Date	Termination Date
			/ /	/ /

VIII If you are enrolling in a BlueSaver PPO & plan to establish an HSA with your Employer's Preferred Banking Institution, please complete the following:

EMPLOYEE'S SOCIAL SECURITY NUMBER *(UNDER FEDERAL RULES, YOUR SOCIAL SECURITY NUMBER IS REQUIRED TO ESTABLISH AN HSA ACCOUNT.)*
___ – __ – ____

PHYSICAL ADDRESS *(IF YOU PROVIDED A POST OFFICE BOX IN SECTION I, A PHYSICAL ADDRESS IS REQUIRED UNDER FEDERAL RULES TO ESTABLISH AN HSA ACCOUNT.)*

IX If you are enrolling in Life Insurance, please complete the following: (Attach Sheet if Necessary)

For new coverage with USAble Life, or when changing a beneficiary under existing coverage, this designation revokes any existing beneficiary designation you have made.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

Employee's Earnings Hourly ________ Monthly ________ Yearly ________

LAST NAME ______________________ FIRST NAME ______________________

X Agreement & Acknowledgment

I request coverage under the Group Contract(s) ("Contract") issued by Blue Cross and Blue Shield of Kansas City ("BCBSKC") and Subsidiaries and coverage under the Group Life Policy ("Policy") issued by USAble Life as may from time to time be amended. I authorize my Employer to deduct from my earnings any required contributions. I understand coverage under the Contract and coverage under the Group Life Policy issued by USAble Life will be available subject to the exclusions, limitations and benefits described in, as applicable, the Contract and the Group Life Policy issued by USAble Life and the USAble Life certificate. I authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance. I authorize all said sources, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission. I agree that this authorization shall be valid for two (2) years from the application date. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request. I represent that the statements and answers in this application are true, complete and correctly recorded. I understand that the statements and answers provided by me in this application shall be a basis of any coverage issued and the coverage is conditioned upon its truth.

With respect to my request for coverage under the Contract:
I understand that if at any time it is determined by BCBSKC or USAble Life that a person listed on this application did not meet the Contract's or Policy's definition of dependent, BCBSKC and/or USAble Life has the right to terminate or rescind coverage for that person or for all ineligible persons under the application, and to recover any benefit payments made for such ineligible person or persons. Furthermore, I understand that if I misrepresented any of the information on the application, BCBSKC and/or USAble Life have the right to terminate or rescind coverage for that person or for all persons under the application; however no statement I make voids my coverage unless my statements are material to the risk assumed and contained in my written application. After my coverage has been in force for two (2) years from the effective date, no statement except fraudulent statements I make voids my medical or dental coverage or reduces my benefits. I understand that my medical records will be maintained with strict confidentiality by BCBSKC and USAble Life in accordance with applicable federal and state laws.

I authorize the bank selected by my Employer and BCBSKC as the insurer of my high deductible health plan, and my Employer, if applicable, to exchange my enrollment status and other information necessary to establish my account, facilitate direct deposits to my account and accomplish other purposes related to payment for my healthcare, including complying with the terms of my depository agreement. I hold harmless and will indemnify the bank selected by my Employer and BCBSKC for any claims against or losses the bank selected by my Employer and BCBSKC may suffer arising out of the bank selected by my Employer and BCBSKC's reliance on this authorization and release the bank selected by my Employer and BCBSKC from all liability arising from such reliance.

EMPLOYEE'S SIGNATURE: ______________________ SPOUSE'S SIGNATURE: ______________________

PRINTED NAME: ______________________ PRINTED NAME: ______________________

DATE: ____________ DATE: ____________

NOTICE OF WOMEN'S HEALTH AND CANCER RIGHTS ACT : Along with benefits detailed in your Certificate of Coverage, your benefits include coverage for: (1) breast reconstruction in connection with a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance; (2) prosthesis; and (3) treatment of physical complications from all stages of mastectomy, including lymphedemas. This coverage is subject to copayments, coinsurance and deductibles consistent with other benefits under your plan. This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998, a federal law.

Form 1a

UMB BANK HEALTH SAVINGS ACCOUNT (HSA)

Payroll Election Form

Name: Last, First, Middle Initial SSN DOB

Street Address City State Zip Code

FIRST TIME ELECTIONS: Complete this form to establish your first contribution.
- You will receive account information from UMB Bank in the mail.
- This will include your UMB Bank Account Number. **

Per Pay Period Deferral: ____________ Effective Date __________ Annual Goal Amount: __________ (optional)

CHANGE ELECTIONS: You may change your current payroll deduction once per month.
UMB Account Number: ____________ Per Pay Period Deferral: __________

Annual Goal Amount: _________ (optional) Effective Date for this election __________

STOP ELECTIONS: You may stop your current payroll deduction at any time.
UMB Bank Account Number: ___________ Per Pay Period Deferral: _______________

I want to stop my current payroll deduction effective on this date: __________________

Note: This change will be reflected in Payroll as soon as administratively possible.

Please read, sign and date this form:

I authorize the pre-tax reduction of my salary, or the discontinuation of my pre-tax reduction of my salary, on a per paycheck basis as designated above. I understand that this election takes the place of any current elections in force on my HSA deferral.

I understand that any withdrawals/distributions made from my HSA for health care expenses incurred prior to the establishment of my HSA or for other non-qualified types of expenses will be **taxable** and may be subject to additional penalties in accordance with IRS regulations. I further understand that it is solely my responsibility to report these withdrawals/distributions to the IRS.

Signature: ____ Signature Date: _______________

Please Read Important Information:

**Eligibility for a Health Savings Account is based on when you are enrolled in a Qualified High Deductible health plan and have no other medical coverage (ex: Medicare, Tricare, Medical Flexible Spending Accounts, etc.) Determining eligibility is your obligation. Do not submit this form until you are eligible to contribute to an HSA.*

***Read any information you receive from UMB Bank carefully. Opening an UMB Bank account is an agreement you are making with the bank.*

There are fees associated with this account that are the responsibility of the accountholder. You may elect to make after-tax contributions to your account but this is not required. Your first payroll deduction, established by completing and submitting this form, can be your first contribution to the account.

If eligible for the HSA, the maximum contribution you may make to your HSA is $3,050/individual coverage and $6,150 if have a family coverage. The maximum contribution is allowed regardless of when you are eligible for, or open, the Health Savings Account. Catch up contributions are allowed for individual's age 55 (or who turn age 55 during the calendar year, regardless of your actual birth date) and older. You may make the maximum catch up contributions regardless of when you are eligible for, or open, the HSA. Catch up contributions are limited to a maximum of $1,000 for 2010.

Since your contribution limits may be specific to your circumstances, we recommend you contact a Tax Advisor to verify your limits. As an accountholder you may contribute to your health savings accounts through gifts and other after tax contributions. You should consider the total of other contributions to your account before electing an Annual Goal Amount. Refunds from UMB Bank are the responsibility of the participant and may include fees.

Return this completed form to your Payroll Department

Form 1b

Enrollment Agreement for Health Savings Account at UMB Bank, N.A.

Only complete and sign this form if you are enrolled in, or are enrolling in, the Blue Cross Blue Shield of Kansas City BlueSaver PPO plan and want to enroll in a Health Savings Account at UMB Bank, N.A.

This Enrollment Agreement is used in conjunction with a Blue Cross Blue Shield of Kansas City ("BCBSKC") Employee Application Form by which the undersigned Employee is applying to BCBSKC for the BlueSaver PPO.

In connection with that application, Employee is electing to apply to UMB Bank, N.A., a national banking association located in Kansas City, Missouri, as Employer's Preferred Banking Institution, to open a health savings account ("**HSA**") at UMB.

In connection with the Employee's application to open an HSA at UMB, Employee agrees as follows:

1. Your HSA will be governed by UMB's Custodial Agreement and the HSA Deposit Account Terms and Conditions (the "**UMB HSA Documents**"). Your Employer has agreed to provide the HSA Documents to you in connection with your application. Please make sure that you get those documents from your Employer's Benefits Department. If you do not receive the documents from your Employer's Benefit Department, please call UMB at 1-866-520-4472. We will be happy to mail the HSA Documents to you free of charge.
2. The UMB HSA Documents also include UMB's Q&A on the Federal Tax Aspects of Health Savings Accounts, which provide certain basic information on HSAs under Federal law, and the UMB Privacy Policy.
3. You acknowledge that you have not relied on UMB for personal tax advice related to the HSA, but will rely on your own personal tax advisor for such advice.
4. Your HSA at UMB is governed by the UMB HSA Documents, and you will be bound by all the terms and conditions stated in the UMB HSA Documents, as they may be amended by Bank from time to time.
5. You request UMB to send you a Visa® HSA Debit Card that will access the HSA after your account has been opened. Use of the Card is governed by a Cardholder Agreement that will be sent with the Card. UMB may obtain a personal credit report on you and on each authorized user of the Card as a condition to opening the HSA and issuing the Card.
6. You understand that upon your death, all funds remaining in the HSA will be paid to your estate, unless you have on file with UMB a designation of beneficiary form in form acceptable to UMB that designates a different beneficiary.
7. You may be required to pay certain fees associated with opening or maintaining my HSA, as are disclosed in the HSA Documents. You authorize the Bank to deduct those fees from your HSA.

By signing below, you agree that BCBSKC is authorized to provide your name, address, social security number, birth date, and other information necessary to establish your HSA at UMB to UMB. You also agree that your HSA at UMB will be governed by the UMB HSA Documents.

W-9 Certification. Under the penalties of perjury, I certify that (1) the social security number provided below is my correct taxpayer identification number (interest paid, if any, on my HSA will be reported under this number); and (2) that I am exempt from backup withholding, or I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding; and (3) that I am a U.S. person (including a U.S. resident alien).

Certification Instructions. Cross out item (2) above if you have been notified that you are subject to backup withholding because of under reporting of interest or dividends on your tax return.

Note: The Internal Revenue Service does not require your consent to any provision of this document other than the certification to avoid backup withholding.

Signature ____ Date ______________

Printed Name ____ SSN ______--____--______

FAX COMPLETED FORM TO UMB at 816-843-2247

UMB i9350009 (09/06)

Health Savings Account (HSA)
Beneficiary Designation Form

UMB Health Savings Account Number
(found on your monthly bank statement)

A. Individual HSA Owner Information.

FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER
ADDRESS LINE 1 – STREET ADDRESS (NO POST OFFICE BOX)			TELEPHONE NUMBER (DAY) ( )
ADDRESS LINE 2 – PO BOX, APARTMENT OR LOT NO.	CITY		STATE / ZIP CODE

B. Beneficiary Designation. As the named Account Owner of the above-referenced Health Savings Account ("HSA"), I have the right to designate the beneficiary or beneficiaries to whom any funds remaining in my HSA upon my death are to be paid and, at any time and from time to time prior to my death, to revoke, alter or amend any such designation previously made. Any such designation must be on a form provided by or acceptable to the Custodian and must be filed with the Custodian prior to my death. I hereby revoke completely every such designation previously made by me and I direct that, if I die before distribution of my HSA has been completed, the value of my Account shall be distributed to the Primary Beneficiary (ies) named below in the percentage(s) indicated, or in the absence of any percentages, in equal shares. The interest of any Primary Beneficiary who predeceases me shall terminate and the percentage shares of all surviving Primary Beneficiaries shall increase ratably in proportion to the relative sizes of the percentages of such surviving Beneficiaries as originally set forth herein.

PRIMARY BENEFICIARY S NAME	ADDRESS	SSN	DATE OF BIRTH	PERCENTAGE

If none of the persons listed above as Primary Beneficiaries are living at my death, I designate the following Secondary Beneficiary(ies) for my HSA, subject to the same distribution rules as are set forth above with respect to Primary Beneficiaries.

SECONDARY BENEFICIARY SNAME	ADDRESS	SSN	DATE OF BIRTH	PERCENTAGE

C. Other Provisions. If no Beneficiaries are named on this form or if all the named Beneficiaries predecease me, the HSA funds will be paid to my estate. If my spouse receives the HSA as a result of being named as Beneficiary, my spouse may choose to continue the HSA in his or her name, subject to Custodian's consent, by providing a written election to the Custodian and by signing the forms and providing the information the Custodian requires. For any non-spouse Beneficiary, the HSA terminates as of my date of death and becomes payable. I understand that in certain states, my spouse's consent may be necessary if I wish to name a person other than or in addition to my spouse as Beneficiary, and that I should consult with my attorney before making such a Beneficiary Designation. By making the foregoing Beneficiary Designation, I represent and warrant to the Custodian that this Beneficiary Designation satisfies all legal requirements under applicable law and, on behalf of myself, the Beneficiary(ies), my heirs and my estate, I hereby indemnify and hold the Custodian harmless from and against any and all claims, damages, liabilities, and costs (including attorney's fees) arising as a result of the Custodian's payment of my HSA in accordance with this Beneficiary Designation. Custodian may condition payment to any Beneficiary on satisfactory proof of identity and entitlement to payment.

Signature of Account Owner x	Date:

D. Spousal Consent (If Applicable) Note: The following section should be signed in the event your state requires the consent of your spouse to the designation of a beneficiary other than such spouse with respect to the HSA. This could apply, for example, if you live in a community or marital property state and you designate someone other than or in addition to your spouse as a beneficiary. Consult your attorney or tax advisor for further information.

The undersigned spouse of the Account Owner in whose name the Health Savings Account identified above is opened hereby consents to and joins in the designation of the beneficiary(ies) identified above. To the extent the undersigned spouse is not named as Beneficiary, such spouse relinquishes any interest such spouse may have in the funds contained in the Health Savings Account.

Name of Spouse	Date:
Signature of Spouse x	Date:

FAX COMPLETED FORM TO UMB at (816) 843-2247.

Form 2

DELTA DENTAL

P.O. Box 8690; St. Louis, MO 63126
314-656-3000 or 800-392-1167

☐ New Application for Coverage Complete Section 1, 2, and 4.

☐ COBRA - Complete Sections 1, 2, 4 and the COBRA item in Section 3 if applicable.

☐ I do not wish to enroll.

☐ Change/Subscriber Authorization Form Section 1 and 4 must be completed. Section 2 and 3, complete as applicable for change requested.

Group Name

Catholic Diocese of Kansas City-St. Joseph

Group#/Sublocation# ☐☐☐☐ - ☐☐☐☐
Division/Sublocation ______

If applicable:
☐ **Core Plan**
☐ **Enhanced Plan**

SECTION 1 EMPLOYEE INFORMATION

Employee Last Name: ______ First Name: ______ Sex: ☐ M ☐ F

Social Security No. ☐☐☐☐☐☐☐☐☐ Alternate ID Number * ☐☐☐☐ ☐☐☐☐☐☐☐☐☐ Birth Date (mm/dd/yyyy): ___ / ___ / ______

Street Address: ______ Coverage Effective Date: ___ / ___ / ______

City: ______ State: ______ Zip Code: ______ ☐ Check here if this is a new address.

Employee Hire Date: ___ / ___ / ______ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

A. Does your spouse have any other group dental coverage? ☐ Yes ☐ No
B. If yes to A, are you covered by your spouse's plan? ☐ Yes ☐ No
C. If yes to A, are your dependents covered by your spouse's plan? ☐ Yes ☐ No
D. If yes to A, is the other group dental coverage through a retiree plan? ☐ Yes ☐ No
E. If yes to B or C, provide the name of your spouse's dental plan ______

* For employer groups who utilize Alternate ID numbers, the assigned group number is the first four digits of the Alternate ID. You are still required to submit your SSN on the application for claims processing purposes.

SECTION 2 SPOUSE AND DEPENDENT INFORMATION

Please complete for spouse/dependents to be enrolled or cancelled. Use a 2nd form for additional dependents if needed.

			Sex
☐ Enroll ☐ Cancel	**Spouse** - Last Name ______ Birth Date (mm/dd/yyyy): ___ / ___ / ______	First Name ______	M F ☐☐
☐ Enroll ☐ Cancel	**Dependent #1** - Last Name ______ Birth Date (mm/dd/yyyy): ___ / ___ / ______	First Name ______ Relationship: ☐ Child ☐ Other ______	M F ☐☐
☐ Enroll ☐ Cancel	**Dependent #1** - Last Name ______ Birth Date (mm/dd/yyyy): ___ / ___ / ______	First Name ______ Relationship: ☐ Child ☐ Other ______	M F ☐☐
☐ Enroll ☐ Cancel	**Dependent #3** - Last Name ______ Birth Date (mm/dd/yyyy): ___ / ___ / ______	First Name ______ Relationship: ☐ Child ☐ Other ______	M F ☐☐
☐ Enroll ☐ Cancel	**Dependent #4** - Last Name ______ Birth Date (mm/dd/yyyy): ___ / ___ / ______	First Name ______ Relationship: ☐ Child ☐ Other ______	M F ☐☐

IMPORTANT: For court ordered dependents, legal documentation must be attached. If your dependent meets the qualifications for full-time student status, necessary documentation is required.

DDPM E/C 08-05

CONTINUED ON NEXT PAGE. **No action requested can be taken without your signature.**

SECTION 3 COVERAGE TYPE SELECTION/REASON FOR CHANGE

Select appropriate coverage type:

☐ Employee Only Coverage ☐ Employee and Spouse ☐ Family ☐ Employee and Child/Children

Name Change:

From: Last Name: ____________________ First Name: ____________________

To: Last Name: ____________________ First Name: ____________________

Reason for Change: *All changes must be made within 31 days of the qualifying event.*

Additions:

Effective Date of Addition: ___ / ___ / _____

☐ Birth
☐ Marriage
☐ Adoption (attach legal documentation)
☐ Court ordered dependent (attach documentation)
☐ Annual Open Enrollment
☐ Other (describe)____________________

Cancellations:

Effective Date of Cancellation: ___ / ___ / _____

☐ Death
☐ Employee terminated on ___ / ___ / _____
☐ Divorce
☐ Dependent reached student/dependent maximum age
☐ Retired

Transfer Membership: Effective Date of Transfer ___ / ___ / _____

From:
Group#/Sublocation# ☐☐☐☐-☐☐☐☐
Division/Sublocation ____________

To:
Group#/Sublocation# ☐☐☐☐-☐☐☐☐
Division/Sublocation ____________

COBRA Membership: If new COBRA participant was previously covered as a dependent of another membership, please list that covered employee's social security number and name:

Social Security No. ☐☐☐☐☐☐☐☐☐ Last Name: ____________________ First Name: ____________________

SECTION 4

I represent that the information I have provided on this form is complete and accurate. I request the group coverage to which I am entitled, or may become entitled, under the provision of the Membership Certificate/Master Policy issued by Delta Dental of Missouri. I authorize the proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this membership. I understand that I cannot transfer my or my dependents' right to receive benefit payments, and I agree to repay promptly any benefit payments to which I or my dependents were not entitled. I also authorize any dentist or other provider of care to furnish Delta Dental of Missouri any necessary information regarding care or treatment of myself or any covered dependents. I understand that courses of dental treatment which began before my effective date may not be covered. Please note that coverage is subject to the limitations, exclusions, and waiting periods contained in the group contract.

Employee's Signature: ____________________ Date: ____________

No action requested can be taken without your signature above.

Form 3

SALARY REDIRECTION AGREEMENT

EMPLOYER: Diocese of Kansas City-St. Joseph

EMPLOYER TAX ID NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

AFFILIATE NAME / LOCATION: ______________________

AFFILIATE TAX ID NUMBER: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Flex One® FSA? ☐ Yes ☐ No CAFETERIA PLAN YEAR: 10 / 01 / 10 - 09 / 30 / 11

(CHECK ONE) ☐ OPEN ENROLLMENT OR ☐ NEWLY ELIGIBLE EMPLOYEE, ELIGIBILITY DATE: ___ / ___ / ___

SOCIAL SECURITY NO.: ______ DATE OF BIRTH: ___/___/___ PHONE: (___) ______

NAME: (Last) ______ (First) ______ (Middle Initial) ___

STREET ADDRESS: ______

CITY: ______ STATE: ___ ZIP: ___

E-MAIL: ______

No. of Payroll Cycles in Plan Year: ___ Date of first deduction: ___/___/___ Payroll Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly

On a separate benefit enrollment form(s), I have enrolled for certain benefit or insurance coverage(s) and understand that my required contribution and/or Flexible Spending Account(s) (FSA) election amounts will be deducted from my paycheck by my employer or Third Party Payroll Administrator. Unless this agreement is amended or terminated, these deductions will be continuous and in an amount equal to my required contribution for my elected coverage and/or FSA account election amount as prorated for each payroll period throughout the plan year. The amount of my required contribution has been provided to me. In the event of a rate change, I authorize a corresponding change in the amount deducted from my salary without signing a new Salary Redirection Agreement. Amounts corresponding to "employer-provided" non-elective benefits (if any) will not be deducted from my paycheck. In addition, pre-tax contributions reduce my compensation for Social Security tax purposes; therefore, my Social Security benefits could be decreased. I elect to receive the following coverage(s) under the Flexible Benefits Plan as elected in the pre-tax column. Any previous election and Salary Redirection Agreement under the Flexible Benefits Plan relating to the same benefits as selected below are hereby revoked. My employer's deduction of any premium/contribution amounts hereunder shall evidence acceptance of this Agreement.

Check the desired coverage(s) below. (Note: If this is an annual enrollment, your existing coverage elections will remain the same (as adjusted for any increase/decrease in premium or required contribution) except as indicated below.)

	Pre-Tax	After-Tax		Pre-Tax	After-Tax
Medical Coverage			Accident Insurance		
Dental Insurance			~~Short-Term Disability Insurance~~		
~~Vision Care Insurance~~			~~Long-Term Disability Insurance~~		
Cancer Insurance			~~Hospital Indemnity Insurance~~		
~~Intensive Care Insurance~~			~~Personal Sickness Indemnity~~		
~~Specified Health Event~~			~~Health Savings Account (HSA) §223~~		
~~Group Term Life Insurance (If family, must be after-tax)~~			Other accident or health plan(s) under section 106 of the Internal Revenue Code List: ______		

Complete the following section *only* if participating in a Medical or Dependent Care Reimbursement Plan:

Medical Care FSA Plan: ($ ______ per pay period) X (___ number of deductions) = $ ______ Annual Election

Dependent Care FSA Plan: ($ ______ per pay period) X (___ number of deductions) = $ ______ Annual Election

Required acknowledgement to participate in Flexible Benefits Plans:

I certify that the features and benefits under the Flexible Benefits Plan have been explained to me completely. By initialing, I acknowledge that I understand the Important Information Regarding Participation in the Flexible Benefits Plan on the back of this form and agree to be bound by those requirements and any other requirements of the Flexible Benefits Plan.

INITIAL

WAIVER OF PRE-TAX BENEFITS UNDER THE FLEXIBLE BENEFITS PLAN:

I elect to waive all pre-tax benefits under the Flexible Benefits Plan. Except for a change in status, I understand that I cannot elect pre-tax benefits until the next anniversary date, and that any after-tax coverage shall be outside the plan.

INITIAL

EMPLOYEE SIGNATURE: ______ **DATE:** ______

IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE FLEXIBLE BENEFITS PLAN

I understand and agree to the following:

- **Restrictions on Election Changes:** On or after the first day of the plan year, I cannot change or revoke this Salary Redirection Agreement with respect to pre-tax premiums before the next anniversary date of the plan unless a "change in status" occurs (as defined under the Plan and the Internal Revenue Code), and the change is caused by and consistent with the "change in status." I understand that I cannot revoke any pre-tax election based on a Right to Examine provision as may be contained in any insurance plan or policy issued to me.

- **Commencement of Coverage and Status of Prior Elections:** Execution of this Salary Redirection Agreement does not begin coverage under the component benefit plans or insurance policies. The terms and conditions and actual coverage effective date of the underlying coverage will be determined under the separate benefit plans or insurance policies. Prior to the anniversary date each year, I will be offered the opportunity to add, drop or change coverage for the following plan year. If I do not complete and return a new Salary Redirection Agreement form at that time, benefit plans or policies currently in effect will continue. Elections under the Medical and Department Care FSA plans will not continue without my completing and submitting a new Salary Redirection Agreement prior to the beginning of each plan year.

- **Use of Personal Information:** In addition to and without limiting in any way the rights my employer, the Plan, their service provider (Aflac and Flex One®) and their respective agents, employees, subcontractors and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider (Aflac and Flex One) and their respective agents, employees, subcontractors and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

- **Effect of Pre-Tax Contributions on Benefit Payments:** Paying for coverage on a pre-tax basis may cause insurance claim payments under health and medical coverage to be subject to federal and state taxes if claim payments (combining the total from all health and medical policies/plans) are in excess of medical expenses. Paying for disability income policies with pre-tax premiums will cause the benefits payable thereunder to be taxable. Such coverages may be funded on an after-tax basis to preserve the excludability of policy benefits.

- **FOR MEDICAL AND DEPENDENT CARE FSA PARTICIPANT:** I verify that I have received a summary of the tax rules, operational guidelines and reimbursement procedures for use in Medical and Dependent Care FSA plans. I understand the plan document will control notwithstanding any contrary oral representation by any person. I understand that reimbursement will be available only for eligible expenses, and I agree to notify the employer if I receive reimbursement for an expense that does not qualify. I also agree, upon demand, to indemnify and reimburse my employer for any liability it may incur for failure to withhold taxes from any reimbursement I receive for non-qualified expenses, up to the amount of additional tax owed by me. Furthermore, I understand that any account surplus at the end of the plan year shall be retained by my employer and such amounts may (but are not required to) be used to offset administrative expenses or future costs, and that the obligation to make reimbursements is the responsibility of my employer and not any service provider hired by my employer to assist in processing claims. I understand that I may be responsible for a monthly service fee for Medical and Dependent Care FSA plans and authorize my employer to payroll deduct any required service fee amount. I acknowledge that in some cases reimbursement for eligible Medical and Dependent Care FSA expenses may be administered through an electronic payment card ("the Card") and agree to abide by the terms and conditions of the Plan with regard to such card usage and the electronic payment cardholder agreement, including any fees applicable to the Card, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. I also agree to use the Card exclusively for Medical and/or Dependent Care FSA expenses and to retain paper documentation for any claims adjudicated by the Card.

Employee Application

Please print clearly in blue or black ink.

RENEWAL

Check one – Employer Use

☐ Initial Employee ☐ New Employee ☐ Change

EMPLOYEE INFORMATION -Failure to accurately complete the questions on this application may affect the existence or amount of coverage. Please correct any errors in the information listed below

Employee name *(last, first, initial)*	Employer **Catholic Diocese of Kansas City**	Employment location

Group policy/participant # **4006407 - 0**	Account # or Bill Group Name **2**	Cert. #	Employee SSN	Employee birthdate

Sex ☐ M ☐ F	Job title or position	Employee hire date	# hours Per week	Earnings $ ____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other	Married ☐ Yes ☐ No	Children ☐ Yes ☐ No

Address	City	State	Zip

ELECTIONS ARE NOT VALID WITHOUT A SIGNATURE AT THE END OF THIS APPLICATION.

DEPENDENT INFORMATION—Required if Dependent coverage applies

Name (Last Name, First Name)	Date of Birth	Gender	Relationship

NOTE — Coverage not elected will be assumed refused even if not specifically refused

Employee Choice Life Benefits – You may select the benefit(s) below. If you enroll, you will pay all or a portion of the premium.

Accept	Refuse	Coverage
☐	☐	Employee Voluntary Life - Amount ________
☐	☐	Employee Matching Voluntary AD&D
☐	☐	Spouse Life - Amount ________
☐	☐	Child Voluntary Life - Amount ________

BENEFICIARIES

Last name First MI	Relationship*	
		☐ Primary ☐ Secondary
		☐ Primary ☐ Secondary

If beneficiary is not related to you, please provide Date of Birth, Social Security Number, and full address.
1) Give FULL names and relationships of each beneficiary. 2) Beneficiaries elected will apply to all employee Life coverages. 3) If primary/secondary election is not noted, the beneficiary will be considered primary. 4) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 5) If your designation does not fit in the above arrangement, please contact Union Security Insurance Company for the appropriate forms.

Union Security Insurance Company

Mail to: Assurant Employee Benefits P.O. BOX 2909 Clinton IA 52733-2909

RENEWAL

Employee name	Employer **Catholic Diocese of Kansas City**

Group policy/participant no. **4006407 - 0**	Account no. **2**	Cert. no.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:
(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee's signature Date

Employee Health Statement

Employee name *(last, first, initial)*		Employer **Catholic Diocese of Kansas City**		
Group policy/participant no. **4006407 - 0**	Account no. **2**	Cert. no.	Employee SSN	Employee birthdate

☐ New Enrollee ☐ Annual Enrollment ☐ Life Event-Type/Date ______________________

Please answer the following questions. If you are applying for dependent coverage, please answer all questions for your eligible dependents. Applicant's Height ________ Weight ________ Spouse's Height ________ Weight ________

	YES	NO
1. Have you or your dependents gained or lost 10 or more pounds in the past 12 months? If yes, how much ______	☐	☐
2. Have you or your dependents within the past 5 years: a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?	☐	☐
b) Used any illegal drug?	☐	☐
3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection?	☐	☐
4. Are you or your dependents pregnant?	☐	☐
5. Have you or your dependents used tobacco, in any form in the past 12 months?	☐	☐
6. Have you or your dependents ever had, been medically diagnosed, or treated for: arthritis, back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years or immune system disorder? "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.	☐	☐

Name, address and telephone number of personal physician ______________________________

Employee's address ______________________________ Daytime phone (______) ____________

If you answered "YES" to any questions, please provide details in REMARKS below.
Elections are not valid without a signature at the end of this application.

REMARKS

If you answered "Yes" to any medical questions above, please provide details below:

Question no.	First name	Description of illness injury or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects	Name and address of attending physician or hospital (including zip)

Employee name		Employer **Catholic Diocese of Kansas City**
Group policy/participant no. **4006407 - 0**	Account no. 2	Cert. no.

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

To properly underwrite applications and RENEWAL insurance policies on an equitable basis, we must obtain information about our proposed insured. The nature of the information we seek includes age, occupation, physical condition, health history, habits, avocations and other personal characteristics and information. This information will be collected from you and various sources, including health professionals and health facilities. Information regarding factors affecting insurability will be treated as confidential.

The information which we collect may, under certain circumstances, be disclosed to third parties without your specific authorization. However, be assured that disclosure will be strictly limited to that which is reasonably required.

You have the right to gain access to and request correction of information contained in our files. However, we will not disclose information which relates to a claim or to a civil or criminal proceeding. If you wish to receive a more detailed explanation of our information practices, including a description of access and correction rights as well as circumstances under which non-authorized disclosures of personal information may be made, please contact Senior Vice-President, Underwriting and Administration, 2323 Grand Boulevard, Kansas City, Missouri 64108.

AUTHORIZATION TO RELEASE INFORMATION: For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer or any other organization to give UNION SECURITY INSURANCE COMPANY or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to UNION SECURITY INSURANCE COMPANY or its reinsurers to release any information to other life insurance companies as I may come in contact with. I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for two and one half years from the date shown below. This authorization is not governed by HIPAA, however, when necessary, I may be asked to execute a HIPAA authorization form, allowing Union Security Insurance Company to use and disclose protected health information.

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

(1) Apply for the coverages designated for which I am eligible under my employer's plan with Union Security Insurance Company. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Union Security Insurance Company. (3) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (4) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

This will certify that I HAVE read and understand the above important notice.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee's signature ______________________________ Date ______________

Spouse's signature (if spouse coverage elected) ______________________ Date ______________

Important Contact Information

CARRIER	CUSTOMER SERVICE	GROUP NUMBER
Health Insurance		
Blue Cross Blue Shield **www.bcbskc.com**	**(816) 395-3558**	**10262000**
UMB **Customer Service for HSAs**	**1-866-520-4472**	**n/a**
Flexible Benefits		
Aflac **https://www.aflac.com**	**(877) 353-9487**	**n/a**
Tax Deferred Annuity 403(b) Plan		
VALIC **www.valic.com**	**(913) 402-5000**	**n/a**
Dental		
Delta Dental of Missouri **www.deltadentalmo.com**	**(800) 335-8266**	**Core - 9182** **Enhanced - 9183**
Life & AD&D, Voluntary Life & AD&D, STD, LTD		
Assurant Employee Benefits **www.assurantemployeebenefits.com**	**General Info** **(800) 733-7879**	**select applicable group number below**
	LTD & STD Claims **Life & Voluntary Life Claims**	**4033501** **4006407**
Aflac Voluntary Cancer and Accident Insurance		
	913-322-1473, x 305 **Customer Service**	**n/a**
	913-322-1473, x 100 **Claims**	

Additional Contact Information

Diocesan Employee Benefits Coordinator:

Anne Marie Stueve

Diocese of Kansas City-St. Joseph
300 E. 36th St.
Kansas City, MO 64111

(816) 756-1850 x 235
(800) 246-1850 x 235
Fax: (816) 756-2685
stueve@diocesekcsj.org

Employee Benefits Broker Consultant:

Michelle Conn

CBIZ Benefits & Insurance Services
11440 Tomahawk Creek Parkway
Leawood, Kansas 66211-9955

(913) 234-1777
(800) 530-5866
Fax: (913) 458-5270
mconn@cbiz.com

Short-Term Disability Insurance

Long-Term Disability Insurance

Life & AD&D Insurance

Pension

Health Insurance

Dental Insurance

Voluntary Life & AD&D Insurance

Tax Deferred Annuity 403(b) Plan

Flexible Benefits Plan

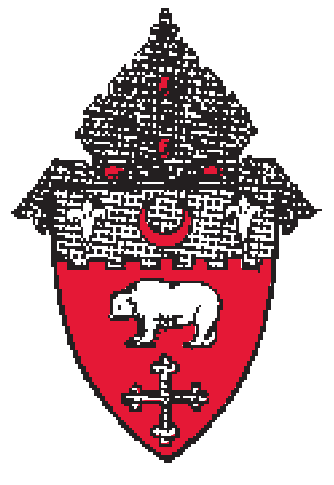
Voluntary Accident Insurance

Voluntary Cancer Insurance

Costs, Forms & Important Contact Information

This booklet provides brief summaries only of the various lay benefits programs. Each program is described in greater detail in the summary plan description available to our employees. It must be understood that each benefit program is subject in every respect to the provisions of the actual policies or legal plan documents.

of your
Lay Employee Benefits
October 1, 2010 - September 30, 2011



Diocese of Kansas City-St. Joseph

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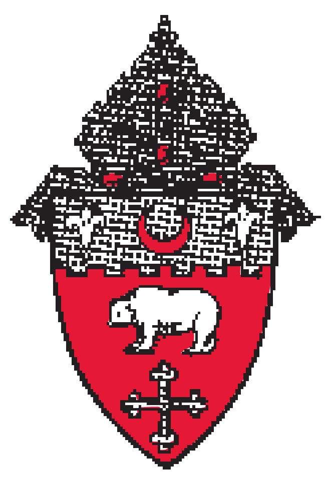

Diocese of Kansas City-St. Joseph