Diocese of La Crosse

& Its Affiliates

Employee Medical Benefit Plan Guide - Lay Group

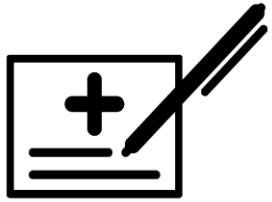
Open Enrollment 2023

St. Ambrose
Financial Services, Inc.

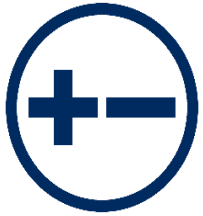
OPEN ENROLLMENT

Open Enrollment is the annual event when benefit plans renew.

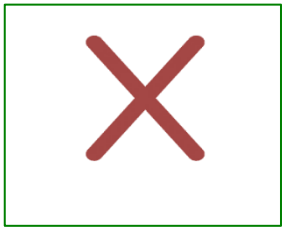
Things to consider during this time…



Enroll in a New Plan



Add or Drop Dependent



Waive Coverage

This is the only time that changes can be made to your plan…

- Unless you experience a Qualifying Life Event, changes to the plan cannot be made until the next open enrollment. When a qualifying event happens, you have 31 days from the date of the event to make changes to your benefits. Changes are made via the **Change Form**.
- Qualifying events include:
  - Change with child's dependent status
  - Employment change
  - Change in coverage or eligibility under another plan

Marriage

Birth

Adoption

Divorce

Loss of Coverage

Death

The information provided is an outline of the benefits and guidelines of the Diocese of La Crosse and its affiliates Health Plan and is not intended to be all inclusive. For more information, visit **StAmbroseFinancial – Health Plan - Lay Group**.

OVERVIEW

- **Plan Year**
  - January 1 – December 31, 2023
- **Premiums**
  - Health Plans
    - Traditional increase of 2%
    - HDHP/HSA increase of 3%
  - Dental Plan increase of 10%
- **Primary Medical Networks**

  Anthem
  - www.anthem.com/contact-us/wisconsin/
  - 833.952.2061 (*available January 1, 2023*)
- **Prescription Drug / Pharmacy Benefit**
  - CVS caremark
  - www.caremark.com/
  - 800-565-7091 (*available January 1, 2023*)
- **VSP Vision Plan**

  vsp vision care
  - Coverage included if enrolled in Health Plan
  - Can be added as a separate benefit if not enrolled in a Health Plan
  - Member Services - - **800-877-7195** or www.vsp.com
- **Delta Dental Plan**

  DELTA DENTAL
  - https://www.deltadentalwi.com/DDWI/s/

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BENEFIT ELIGIBILITY

Eligible Employee:

- Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours).
- Full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours)
- A non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours)

Additional family members eligible:

- Spouse
- Children, including stepchildren and children placed for adoption with the covered employee, who are up to 26 years old, regardless of student or marital status
- Dependent Children of any age who are disabled or incapable of self support due to physical or mental disability

PLEASE NOTE: If you and your spouse are employed within the Diocese of La Crosse and Its Affiliates and are eligible for the **Diocese of La Crosse Lay Group Employee Medical Benefit Plan**, you can be covered as an employee or as a dependent, but not both. Only one of you can cover your dependents.

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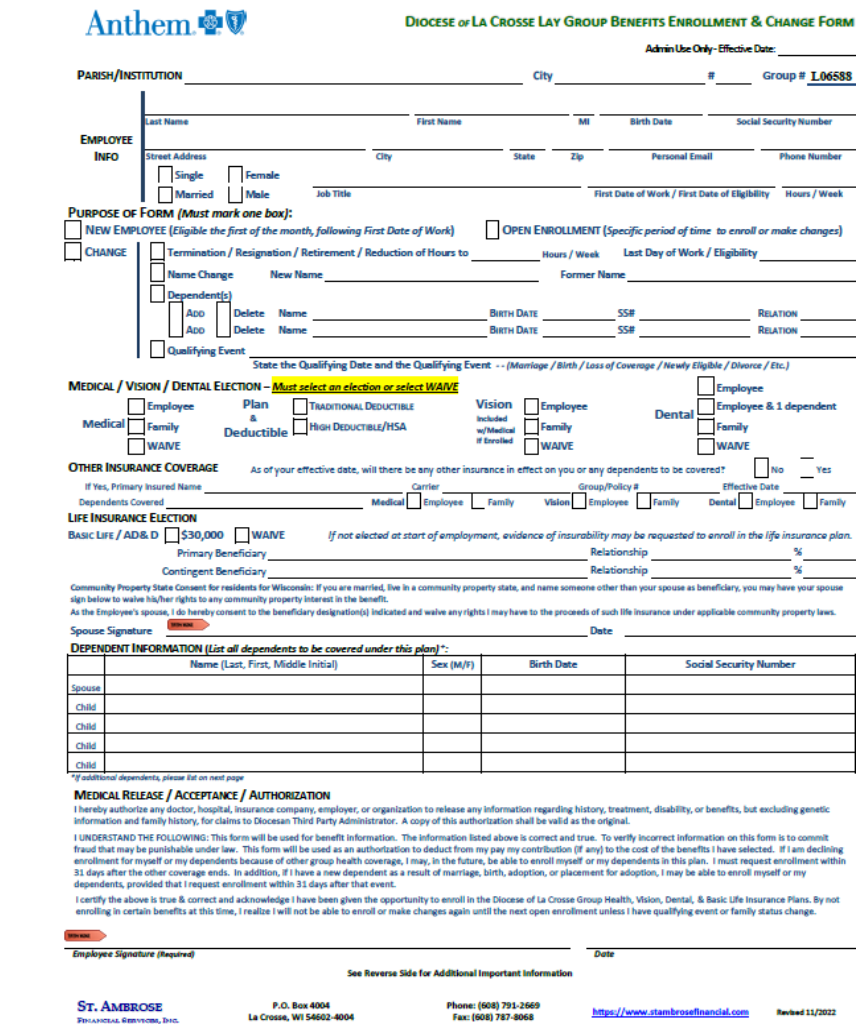
BENEFIT ELIGIBILITY



Anthem

DIOCESE OF LA CROSSE LAY GROUP BENEFITS ENROLLMENT & CHANGE FORM

Admin Use Only - Effective Date: _____

PARISH/INSTITUTION _____ City _____ # ____ Group # L06588

EMPLOYEE INFO

Last Name | First Name | MI | Birth Date | Social Security Number

Street Address | City | State | Zip | Personal Email | Phone Number

☐ Single ☐ Female ☐ Married ☐ Male

Job Title | First Date of Work / First Date of Eligibility | Hours / Week

PURPOSE OF FORM (Must mark one box):

☐ NEW EMPLOYEE (Eligible the first of the month, following First Date of Work) ☐ OPEN ENROLLMENT (Specific period of time to enroll or make changes)

☐ CHANGE

☐ Termination / Resignation / Retirement / Reduction of Hours to _____ Hours / Week Last Day of Work / Eligibility _____

☐ Name Change New Name _____ Former Name _____

☐ Dependent(s)

☐ ADD ☐ Delete Name _____ BIRTH DATE _____ SS# _____ RELATION _____

☐ ADD ☐ Delete Name _____ BIRTH DATE _____ SS# _____ RELATION _____

☐ Qualifying Event _____

State the Qualifying Date and the Qualifying Event -- (Marriage / Birth / Loss of Coverage / Newly Eligible / Divorce / Etc.)

MEDICAL / VISION / DENTAL ELECTION – Must select an election or select WAIVE

Medical: ☐ Employee ☐ Family ☐ WAIVE

Plan & Deductible: ☐ TRADITIONAL DEDUCTIBLE ☐ HIGH DEDUCTIBLE/HSA

Vision (Included w/Medical if Enrolled): ☐ Employee ☐ Family ☐ WAIVE

Dental: ☐ Employee ☐ Employee & 1 dependent ☐ Family ☐ WAIVE

OTHER INSURANCE COVERAGE As of your effective date, will there be any other insurance in effect on you or any dependents to be covered? ☐ No ☐ Yes

If Yes, Primary Insured Name _____ Carrier _____ Group/Policy # _____ Effective Date _____

Dependents Covered _____ Medical ☐ Employee ☐ Family Vision ☐ Employee ☐ Family Dental ☐ Employee ☐ Family

LIFE INSURANCE ELECTION

BASIC LIFE / AD&D ☐ $30,000 ☐ WAIVE *If not elected at start of employment, evidence of insurability may be requested to enroll in the life insurance plan.*

Primary Beneficiary _____ Relationship _____ % _____

Contingent Beneficiary _____ Relationship _____ % _____

Community Property State Consent for residents for Wisconsin: If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in the benefit.

As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated and waive any rights I may have to the proceeds of such life insurance under applicable community property laws.

Spouse Signature _____ Date _____

DEPENDENT INFORMATION (List all dependents to be covered under this plan)*:

	Name (Last, First, Middle Initial)	Sex (M/F)	Birth Date	Social Security Number
Spouse				
Child				
Child				
Child				
Child				

*If additional dependents, please list on next page

MEDICAL RELEASE / ACCEPTANCE / AUTHORIZATION

I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original.

I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution (if any) to the cost of the benefits I have selected. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after that event.

I certify the above is true & correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans. By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have qualifying event or family status change.

Employee Signature (Required) _____ *Date* _____

See Reverse Side for Additional Important Information

ST. AMBROSE FINANCIAL SERVICES, INC. P.O. Box 4004 La Crosse, WI 54602-4004 Phone: (608) 791-2669 Fax: (608) 787-8068 https://www.stambrosefinancial.com Revised 11/2022

To Enroll

The decisions you make at this time can impact your life and finances. It is important to take the time to review and evaluate your options, then complete the **Enrollment - Change Form**.

When To Enroll

- Open Enrollment - November 9 – 23, 2022
- New employees – complete the **Enrollment Form** within 31 days of the employee's first day of work.

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BENEFIT ELIGIBILITY

Anthem

DIOCESE OF LA CROSSE LAY GROUP BENEFITS ENROLLMENT & CHANGE FORM

Admin Use Only - Effective Date: _____

PARISH/INSTITUTION _____ City _____ # ____ Group # L06588

EMPLOYEE INFO

Last Name | First Name | MI | Birth Date | Social Security Number

Street Address | City | State | Zip | Personal Email | Phone Number

☐ Single ☐ Female ☐ Married ☐ Male

Job Title | First Date of Work / First Date of Eligibility | Hours / Week

PURPOSE OF FORM *(Must mark one box)*:

☐ NEW EMPLOYEE *(Eligible the first of the month, following First Date of Work)* ☐ OPEN ENROLLMENT *(Specific period of time to enroll or make changes)*

☐ CHANGE
- ☐ Termination / Resignation / Retirement / Reduction of Hours to _____ Hours / Week Last Day of Work / Eligibility _____
- ☐ Name Change New Name _____ Former Name _____
- ☐ Dependent(s)
  - ☐ ADD ☐ DELETE Name _____ BIRTH DATE _____ SS# _____ RELATION _____
  - ☐ ADD ☐ DELETE Name _____ BIRTH DATE _____ SS# _____ RELATION _____
- ☐ Qualifying Event _____

State the Qualifying Date and the Qualifying Event - *(Marriage / Birth / Loss of Coverage / Newly Eligible / Divorce / Etc.)*

MEDICAL / VISION / DENTAL ELECTION – *Must select an election or select WAIVE*

Medical: ☐ Employee ☐ Family ☐ WAIVE
Plan & Deductible: ☐ TRADITIONAL DEDUCTIBLE ☐ HIGH DEDUCTIBLE/HSA
Vision (Included w/Medical if Enrolled): ☐ Employee ☐ Family ☐ WAIVE
Dental: ☐ Employee ☐ Employee & 1 dependent ☐ Family ☐ WAIVE

OTHER INSURANCE COVERAGE As of your effective date, will there be any other insurance in effect on you or any dependents to be covered? ☐ No ☐ Yes

If Yes, Primary Insured Name _____ Carrier _____ Group/Policy # _____ Effective Date _____

Dependents Covered _____ Medical ☐ Employee ☐ Family Vision ☐ Employee ☐ Family Dental ☐ Employee ☐ Family

LIFE INSURANCE ELECTION

BASIC LIFE / AD&D ☐ $30,000 ☐ WAIVE *If not elected at start of employment, evidence of insurability may be requested to enroll in the life insurance plan.*

Primary Beneficiary _____ Relationship _____ % _____

Contingent Beneficiary _____ Relationship _____ % _____

Community Property State Consent for residents for Wisconsin: If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his/her rights to any community property interest in the benefit.
As the Employee's spouse, I do hereby consent to the beneficiary designation(s) indicated and waive any rights I may have to the proceeds of such life insurance under applicable community property laws.

Spouse Signature _____ Date _____

DEPENDENT INFORMATION *(List all dependents to be covered under this plan)*:*

	Name (Last, First, Middle Initial)	Sex (M/F)	Birth Date	Social Security Number
Spouse				
Child				
Child				
Child				
Child				

**If additional dependents, please list on next page*

MEDICAL RELEASE / ACCEPTANCE / AUTHORIZATION

I hereby authorize any doctor, hospital, insurance company, employer, or organization to release any information regarding history, treatment, disability, or benefits, but excluding genetic information and family history, for claims to Diocesan Third Party Administrator. A copy of this authorization shall be valid as the original.

I UNDERSTAND THE FOLLOWING: This form will be used for benefit information. The information listed above is correct and true. To verify incorrect information on this form is to commit fraud that may be punishable under law. This form will be used as an authorization to deduct from my pay my contribution (if any) to the cost of the benefits I have selected. If I am declining enrollment for myself or my dependents because of other group health coverage, I may, in the future, be able to enroll myself or my dependents in this plan. I must request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself or my dependents, provided that I request enrollment within 31 days after that event.

I certify the above is true & correct and acknowledge I have been given the opportunity to enroll in the Diocese of La Crosse Group Health, Vision, Dental, & Basic Life Insurance Plans. By not enrolling in certain benefits at this time, I realize I will not be able to enroll or make changes again until the next open enrollment unless I have qualifying event or family status change.

Employee Signature (Required) _____ *Date* _____

See Reverse Side for Additional Important Information

ST. AMBROSE FINANCIAL SERVICES, INC. | P.O. Box 4004, La Crosse, WI 54602-4004 | Phone: (608) 791-2669, Fax: (608) 787-8068 | https://www.stambrosefinancial.com | Revised 11/2022

How To Make Changes

- Unless you experience a Qualifying Event, changes to the plan cannot be made until the next open enrollment. If you experience a qualifying event, you have 31 days from the date of the event to make benefit changes. Changes are made via the **Enrollment - Change Form.**
- Qualifying events include:
  - Change with child's dependent status
  - Employment change
  - Change in coverage or eligibility under another plan


Marriage


Birth


Adoption


Divorce


Loss of Coverage


Death

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ST. AMBROSE FINANCIAL SERVICES, INC.

COVERAGE

Benefits become effective:

- Open Enrollment
  - Effective beginning of plan year – January 1, 2023
- New Employee
  - First day of the month following the first day of employment
- Qualifying Event
  - Either the first day of the event or the first day of the month following the qualifying event, depending on termination date of coverage previously provided
- Terminated employees
  - May continue coverage on a self pay basis as outlined in the ***Continuation of Coverage*** section of the Summary of Plan Description

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High Deductible Health Plan / HSA

Benefit	PPO	Non-PPO
Deductible	Employee - $2,000 Family - $3,000 per individual $4,000 per family	Employee - $2,000 Family - $3,000 per individual $4,000 per family
Co-Insurance	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket
Maximum Out of Pocket	Employee - $3,000 Family - $6,000	Employee - $5,000 Family - $10,000
Preventive / Wellness	Covered at 100% not subject to deductible	• 70% Insurance • 30% Insured to maximum out of pocket
Prescriptions / Pharmacy Plan	Insured pays 20% after deductible to Maximum Out-of-Pocket	Insured pays 30% after deductible to Maximum Out-of-Pocket
	Insured pays full discounted price.	
Pre-Certifications	Authorization required to cover hospitalization and other certain medical procedures at least 72 hours prior for nonemergency admissions	

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High Deductible Health Plan / HSA

Premiums 2023

Monthly premium effective January 1, 2023

Vision coverage included if enrolled in Health Plan

	Premium Rates High Deductible / HSA Eligible Plan
Employee	$ 929 / month
Family	$ 2,362 / month
Medicare - Individual (Retiree w/ Continuation Coverage)	$ 293 / month
Medicare - Husband & Wife (Retiree w/ Continuation Coverage)	$ 586 / month

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TRADITIONAL DEDUCTIBLE HEALTH PLAN

Benefit	PPO	Non-PPO
Deductible	Employee - $1,000 Family - $2,000	Employee - $1,000 Family - $2,000
Co-Insurance	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket
Maximum Out of Pocket	Employee - $2,000 Family - $4,000	Employee - $4,000 Family - $8,000
Preventive / Wellness	Covered at 100% not subject to deductible	• 70% Insurance • 30% Insured to maximum out of pocket
Prescriptions / Pharmacy Plan	Retail - 70% Insurance / 30% Insured to maximum out of pocket of $1,000 per individual & $3,000 per family	
Pre-Certifications	Authorization required to cover hospitalization and other certain medical procedures at least 72 hours prior for nonemergency admissions	

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Traditional Deductible Health Plan

Premiums 2023

Monthly premium effective January 1, 2023

Vision coverage included if enrolled in Health Plan

	Premium Rates Traditional Plan Deductible
Employee	$ 1,339 / month
Family	$ 3,403 / month
Medicare - Individual (Retiree w/ Continuation Coverage)	$ 335 / month
Medicare - Husband & Wife (Retiree w/ Continuation Coverage)	$ 670 / month

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PRESCRIPTIONS (PHARMACY BENEFIT)

Provider – **CVS caremark**

Listed on the Medical ID card which is presented when purchasing prescription drugs at participating pharmacies in your area. The Pharmacy Benefit is as follows:

- **Traditional Health Plan**
  - Retail purchases at a pharmacy for generic prescriptions - 30% copayment of the total drug cost, with a minimum payment of $10 per prescription, or actual total cost if less than $10.
  - Brand name prescriptions - 30% copayment of the total drug cost.
  - Prescription drug copayments are not applied to the plan deductible or coinsurance
  - Maximum out of pocket of $1,000 per person, up to $3,000 per family, each plan year for copays
- **HDHP/HSA Plan**
  - Prescription drug copayments are applied to the plan deductible or coinsurance.
- **Mail Order option**
  - Approximately 80% of the prescription drugs currently used are maintenance drugs and typically can be purchased via the mail order option - saves time and money.
- Check with provider to see if a generic equivalent is available for brand name/non-generic drugs.

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DENTAL PLAN

COVERAGE SUMMARY – Delta Dental

Deductible	Employee - Deductible = $0 Employee + 1 dependent = $0	$1,500 - Maximum Benefit per participant per plan year	
	Family - Deductible = $0	$ 3,000 - Maximum Benefit per plan year	
Diagnostic & Preventative	Examinations, Bitewing X-rays, Teeth Cleaning **2 times per benefit year**		100%
Preventive Charges			100%
Basic Dental	• Extractions & other oral surgery • Restorations - amalgam, composite (front teeth), stainless steel prefabricated crowns (1 per tooth in a 3-year period) • Endodontics (root canal treatment & therapy) • Periodontics (treatment of gum) • Repairs/adjustments to prosthetic appliances & Dentures • Anesthesia and Injections • Emergency Palliative Treatment		80%
Major Dental	• Crowns, inlays or onlays • Prosthetics - fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth • Porcelain veneers on crowns on the six front teeth, bicuspids and upper first molars.		50%

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DENTAL PLAN
PREMIUMS 2023

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2023

PREMIUM RATES	
Employee Only	$ 37
Employee plus 1	$ 72
Employee plus 2 or more (Family)	$ 120

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ST. AMBROSE
FINANCIAL SERVICES, INC.

VISION PLAN

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
WellVision Exam	Focuses on your eyes and overall wellness	$ 10	Every 12 months
Prescription Glasses		$ 25	See frame/lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® or Walmart frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children		Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$ 0 $ 95 - $ 105 $ 150 - $ 175	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)		Every 12 months
Primary EyeCare	• Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Visit your VSP doctor for medical and urgent eyecare.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

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VISION PLAN
PREMIUMS 2023

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2023

PREMIUM RATES	
Employee Only	$ 4.95
Family	$ 11.82

NOTE:

- The Vision Insurance premium is included at no added cost for employees enrolled in the Diocese of La Crosse Lay Group Employee Health Plan
- Family Vision is available as a stand-alone benefit. You can elect Employee Only Health and Family Vision, or you can elect Vision without any Health benefit.

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PREMIUMS 2023

SUMMARY

MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2023

HDHP / HSA (VISION COVERAGE INCLUDED IN PLAN)	
Employee	$ 929
Family	$ 2,362
Medicare (Individual Retiree)	$ 293
Medicare (Married Retiree)	$ 586

TRADITIONAL (VISION COVERAGE INCLUDED IN PLAN)	
Employee	$ 1,339
Family	$ 3,403
Medicare (Individual Retiree)	$ 335
Medicare (Married Retiree)	$ 670

DENTAL	
Employee	$ 37
Employee plus 1	$ 72
Family	$ 120

VISION (VOLUNTARY)	
Employee	$ 4.95
Family	$ 11.82

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BASIC LIFE

Group Life	
Eligibility	• Enrollment must take place within 31 days following the first day of work with employer within the Diocese of La Crosse • Full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours) • A non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours) • All other Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours) • Late Enrollees must complete Evidence of Insurability and are subject to approval. Coverage is effective upon approval.
Death Benefit	$30,000
Accidental Death and Dismemberment Benefit	$30,000

Basic Life monthly premium - $3.00 per month, typically paid by the employer.

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VOLUNTARY LIFE

Eligibility	Employees who work at least 20 hours per week
Benefits	Life insurance in $10,000 increments up to $500,000 (not to exceed 5 times annual income). Non-medical maximum of$150,000. If coverage is selected, employee can choose coverage for spouse and/or dependent child(ren) up to age 18 (23 if a full-time student). Coverage for spouses is in $5,000 increments up to $100,000 (not to exceed 50% of the employee election), non-medical maximum of $25,000. Coverage for dependent child(ren) is in increments of $2,500, $5,000, $7,500, or $10,000, without medical underwriting.
Costs	Monthly premium charges depend on age and benefit amount elected. Premiums are paid by the employee.
Can I be turned down?	If enrolled when first eligible, employee and dependents can be covered for up to the non-medical (guarantee issue) maximum listed without medical questions, provided the eligibility requirements listed above are met.
When Can I Enroll?	Enrollment must take place within 31 days following the first day of work in a position which meets the eligibility requirements. This includes a change in scheduled hours to a position that would meet eligibility requirements. Late enrollees will be required to wait until the next annual enrollment to apply and will be subject to medical review and could be turned down by the insurance company.
Coverage Effective Date	Coverage will be effective the first of the month following the first day of work. Late enrollees will be effective on the first of the month following approval by the carrier's underwriting department

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VOLUNTARY LONG-TERM DISABILITY

Eligibility	Employees who work at least 20 hours per week
Benefits	You can receive up to 60% of your gross income if you become disabled due to a sickness or injury, on or off the job. Benefits begin after 90 days of disability and can last until age 65 or beyond.
Costs	Monthly premium charges vary depending on your age and income. Premiums are paid entirely by the employee. You will receive a summary of benefits with information on rates and how to calculate monthly premiums.
Can I be turned down?	If you enroll when first eligible, you cannot be turned down regardless of your health, as long as you meet the eligibility requirements listed above.
When Can I Enroll?	Enrollment for the voluntary long term disability insurance must take place within 31 days following the first day of work in a position which meets the eligibility requirements. This includes a change in scheduled hours to a position that would meet eligibility requirements. Late enrollees will need to wait until the next open enrollment to apply and will be subject to medical review and could be turned down by the insurance company.
Coverage Effective Date	Coverage will be effective the first of the month following the first day of work. Late enrollees will be effective on the first of the month following approval by the carrier's underwriting department

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RESOURCES

ST. AMBROSE
FINANCIAL SERVICES, INC.

Website: **www.StAmbroseFinancial.com**

Email: **SAFS@StAmbroseFinancial.com**

Phone #: **608.791.2669**

- **Dennis Herricks,** Executive Director
  608-519-9893
- **Rachel Melde**, Benefits Coordinator
  608-519-9895
- **Cheryl Cummings,** Accounting Manager
  608-519-9894