

# **DIOCESE** *of* **LA CROSSE**



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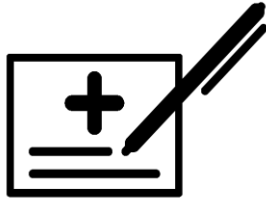
**EMPLOYEE MEDICAL BENEFIT PLAN GUIDE - Lay Group**

**Open Enrollment  
Plan Year 2024**

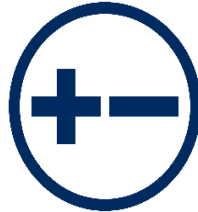
# OPEN ENROLLMENT

Open Enrollment is the annual event when benefit plans renew.

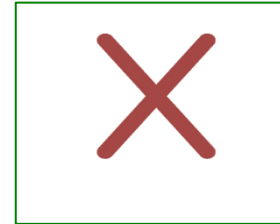
Things to consider during this time...



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

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# OVERVIEW

## ❑ Plan Year

- January 1 – December 31, 2024

## ❑ Premiums

- Health Plans
  - Traditional increase of 5%
  - HDHP/HSA increase of 5%
- Dental Plan increase of 5%

## ❑ Primary Medical Networks



- [www.anthem.com/contact-us/wisconsin/](http://www.anthem.com/contact-us/wisconsin/)
- 833.952.2061

## ❑ Prescription Drug / Pharmacy Benefit

- CVS caremark®
- [www.caremark.com/](http://www.caremark.com/)
- 800-565-7091

## ❑ VSP Vision Plan



- 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](http://www.vsp.com)

## ❑ Delta Dental Plan



- <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 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



DIocese of LA CROSSE LAY GROUP BENEFITS ENROLLMENT & CHANGE FORM

SAFSA Admin Use Only - Effective Date:

PARISH/INSTITUTION \_\_\_\_\_ City \_\_\_\_\_ # \_\_\_\_\_ Group # **1.06588**

**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 Disability \_\_\_\_\_ 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 \_\_\_\_\_

Address - provide new address under employee info

Name Change New Name \_\_\_\_\_ Former Name \_\_\_\_\_

Other - personal email, phone number, job title

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 - Select elections you are keeping or the elections you are changing to/or select WAIVE**

Medical  Employee Plan  TRADITIONAL DEDUCTIBLE  Vision  Employee  Employee & 1 dependent  
 Family & Deductible  HIGH DEDUCTIBLE/HSA  Included w/Medical if enrolled  Family  Family  Family  
 WAIVE  WAIVE  WAIVE

Dental  Employee  Employee & 1 dependent  
 Family  Family  Family  
 WAIVE  WAIVE  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 \_\_\_\_\_ Career \_\_\_\_\_ 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 benefits.

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				

**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.

**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 a 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) 793-2669 Fax: (608) 787-8068 <http://www.stambrosefinancial.com> Revised 08/2022

# Eligibility



## 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 – Nov. 27 – Dec. 14, 2023
- New employees – complete the **Enrollment Form** within 31 days of the employee's first day of work.

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# BENEFIT ELIGIBILITY



DIocese of LA CROSSE LAY GROUP BENEFITS ENROLLMENT & CHANGE FORM

SAFS Admin Use Only - Effective Date:

PARISH/INSTITUTION \_\_\_\_\_ City \_\_\_\_\_ # \_\_\_\_\_ Group # **1.06588**

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 \_\_\_\_\_  
 Address - provide new address under employee info  
 Name Change New Name \_\_\_\_\_ Former Name \_\_\_\_\_  
 Other - personal email, phone number, job title  
 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 - Select elections you are keeping or the elections you are changing to/or select WAIVE  
 Medical  Employee Plan  TRADITIONAL DEDUCTIBLE  Vision  Employee  Employee & 1 dependent  
 Family  Deductible  HIGH DEDUCTIBLE/HSA  Included w/Medical if Enrolled  Family  Family  WAIVE  
 WAIVE  WAIVE  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 \_\_\_\_\_ Career \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_  
 Dependents Covered Medical  Employee  Family Vision  Employee  Family Dental  Employee  Family

LIFE INSURANCE ELECTION  
 BASIC LIFE / ADB & D  \$50,000  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 benefits.  
 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			

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 a qualifying event or family status change.

Employee Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_  
 See Reverse Side for Additional Important Information

# Eligibility



## 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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# COVERAGE



## Benefits become effective:

### ❑ Open Enrollment

- ❖ Effective beginning of plan year – January 1, 2024

### ❑ 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
<b>Deductible</b>	Employee - \$2,200 Family - \$3,200 per individual \$4,200 per family	Employee - \$2,200 Family - \$3,200 per individual \$4,200 per family
<b>Co-Insurance</b>	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket
<b>Maximum Out of Pocket</b>	Employee - \$3,200 Family - \$6,200	Employee - \$5,200 Family - \$10,200
<b>Preventive / Wellness</b>	Covered at 100% not subject to deductible	<ul style="list-style-type: none"> <li>70% Insurance</li> <li>30% Insured to maximum out of pocket</li> </ul>
<b>Prescriptions / Pharmacy Plan</b>	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.	
<b>Pre-Certifications</b>	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 2024



**MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024**

**VISION COVERAGE INCLUDED IF ENROLLED IN HEALTH PLAN**

		<b>PREMIUM RATES</b>
		<b><u>HIGH DEDUCTIBLE / HSA ELIGIBLE PLAN</u></b>
Employee		\$ 975 / month
Family		\$ 2,480/ month

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# TRADITIONAL DEDUCTIBLE HEALTH PLAN



Benefit	PPO	Non-PPO
<b>Deductible</b>	Employee - \$1,000 Family - \$2,000	Employee - \$1,000 Family - \$2,000
<b>Co-Insurance</b>	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket
<b>Maximum Out of Pocket</b>	Employee - \$2,000 Family - \$4,000	Employee - \$4,000 Family - \$8,000
<b>Preventive / Wellness</b>	Covered at 100% not subject to deductible	<ul style="list-style-type: none"> <li>• 70% Insurance</li> <li>• 30% Insured to maximum out of pocket</li> </ul>
<b>Prescriptions / Pharmacy Plan</b>	Retail - 70% Insurance / 30% Insured to maximum out of pocket of \$1,000 per individual & \$3,000 per family	
<b>Pre-Certifications</b>	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 2024



**MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024**

**VISION COVERAGE INCLUDED IF ENROLLED IN HEALTH PLAN**

## **PREMIUM RATES** **TRADITIONAL PLAN DEDUCTIBLE**

Employee	\$ 1,406 / month
Family	\$ 3,573 / 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	<ul style="list-style-type: none"> <li>• Extractions &amp; other oral surgery</li> <li>• Restorations - amalgam, composite (front teeth), stainless steel prefabricated crowns (1 per tooth in a 3-year period)</li> <li>• Endodontics (root canal treatment &amp; therapy)</li> <li>• Periodontics (treatment of gum)</li> <li>• Repairs/adjustments to prosthetic appliances &amp; Dentures</li> <li>• Anesthesia and Injections</li> <li>• Emergency Palliative Treatment</li> </ul>	80%
Major Dental	<ul style="list-style-type: none"> <li>• Crowns, inlays or onlays</li> <li>• Prosthetics - fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth</li> <li>• Porcelain veneers on crowns on the six front teeth, bicuspids and upper first molars.</li> </ul>	50%

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# DENTAL PLAN PREMIUMS 2024



## MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

### PREMIUM RATES

Employee Only	\$ 39
Employee plus 1	\$ 76
Employee plus 2 or more (Family)	\$ 126

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# VISION PLAN



BENEFIT	DESCRIPTION	COPAY	FREQUENCY
<b>Your Coverage with a VSP Provider</b>			
<b>WELLVISION EXAM</b>	<ul style="list-style-type: none"> <li>• Focuses on your eyes and overall wellness</li> <li>• Routine retinal screening</li> </ul>	\$10 Up to \$39	Every 12 months
<b>ESSENTIAL MEDICAL EYE CARE</b>	<ul style="list-style-type: none"> <li>• Retinal imaging for members with diabetes covered-in-full</li> <li>• Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.</li> <li>• Coordination with your medical coverage may apply. Ask your VSP network doctor for details.</li> </ul>	\$20 per exam	Available as needed
<b>PRESCRIPTION GLASSES</b>		<b>\$25</b>	See frame and lenses
<b>FRAME*</b>	<ul style="list-style-type: none"> <li>• \$220 Featured Frame Brands allowance</li> <li>• \$200 frame allowance</li> <li>• 20% savings on the amount over your allowance</li> <li>• \$200 Walmart/Sam's Club frame allowance</li> <li>• \$110 Costco frame allowance</li> </ul>	Included in Prescription Glasses	Every 24 months
<b>LENSES</b>	<ul style="list-style-type: none"> <li>• Single vision, lined bifocal, and lined trifocal lenses</li> <li>• Impact-resistant lenses for dependent children</li> </ul>	Included in Prescription Glasses	Every 12 months
<b>LENS ENHANCEMENTS</b>	<ul style="list-style-type: none"> <li>• Standard progressive lenses</li> <li>• Premium progressive lenses</li> <li>• Custom progressive lenses</li> <li>• Average savings of 30% on other lens enhancements</li> </ul>	\$0 \$95 - \$105 \$150 - \$175	Every 12 months
<b>CONTACTS (INSTEAD OF GLASSES)</b>	<ul style="list-style-type: none"> <li>• \$130 allowance for contacts; copay does not apply</li> <li>• Contact lens exam (fitting and evaluation)</li> </ul>	Up to \$60	Every 12 months
<b>VSP LIGHTCARE**</b>	<ul style="list-style-type: none"> <li>• \$200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts</li> </ul>	\$25	Every 24 months
<b>ADDITIONAL SAVINGS</b>	<b>Glasses and Sunglasses</b> <ul style="list-style-type: none"> <li>• Extra \$20 to spend on Featured Frame Brands. Go to <a href="http://vsp.com/offers">vsp.com/offers</a> for details.</li> <li>• 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.</li> </ul>		
	<b>Laser Vision Correction</b> <ul style="list-style-type: none"> <li>• Average of 15% off the regular price; discounts available at contracted facilities.</li> </ul>		
	<b>Exclusive Member Extras for VSP Members</b> <ul style="list-style-type: none"> <li>• Contact lens rebates, lens satisfaction guarantees, and more offers at <a href="http://vsp.com/offers">vsp.com/offers</a>.</li> <li>• Save up to 60% on digital hearing aids with TruHearing®. Visit <a href="http://vsp.com/offers/special-offers/hearing-aids">vsp.com/offers/special-offers/hearing-aids</a> for details.</li> <li>• Enjoy everyday savings on health, wellness, and more with VSP Simple Values.</li> </ul>		
<b>YOUR COVERAGE GOES FURTHER IN-NETWORK</b>			
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to <a href="http://vsp.com">vsp.com</a> to find an in-network provider.			

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# VISION PLAN PREMIUMS 2024



## MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

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 2024

## SUMMARY



### MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2024

HDHP / HSA (VISION COVERAGE INCLUDED IN PLAN)		
	Employee	\$ 975
	Family	\$ 2,480

TRADITIONAL (VISION COVERAGE INCLUDED IN PLAN)		
	Employee	\$ 1,406
	Family	\$ 3,573

DENTAL		
	Employee	\$ 39
	Employee plus 1	\$ 76
	Family	\$ 126

VISION (VOLUNTARY)		
	Employee	\$ 4.95
	Family	\$ 11.82

The information provided is an outline of the benefits and guidelines of the Diocese of La Crosse Lay Group Employee Medical Benefit Plan and is not intended to be all inclusive. For more information, visit [www.StAmbroseFinancial.com](http://www.StAmbroseFinancial.com) – Health Plan - Lay Group.

# 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 - \$3.90 per month, typically paid by the employer.**

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# VOLUNTARY LIFE



<b>Eligibility</b>	Employees who work at least 20 hours per week
<b>Benefits</b>	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.
<b>Costs</b>	Monthly premium charges depend on age and benefit amount elected. Premiums are paid by the employee.
<b>Can I be turned down?</b>	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.
<b>When Can I Enroll?</b>	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.
<b>Coverage Effective Date</b>	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



<b>Eligibility</b>	Employees who work at least 20 hours per week
<b>Benefits</b>	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.
<b>Costs</b>	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.
<b>Can I be turned down?</b>	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.
<b>When Can I Enroll?</b>	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.
<b>Coverage Effective Date</b>	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

The information provided is an outline of the benefits and guidelines of the Diocese of La Crosse Lay Group Employee Medical Benefit Plan and is not intended to be all inclusive. For more information, visit [www.StAmbroseFinancial.com](http://www.StAmbroseFinancial.com) – Health Plan - Lay Group.

# RESOURCES

## ST. AMBROSE FINANCIAL SERVICES, INC.



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