DIOCESE OF SACRAMENTO

EMPLOYEE BENEFITS

JULY 1, 2019 - JUNE 30, 2020

OFFICE OF LAY PERSONNEL
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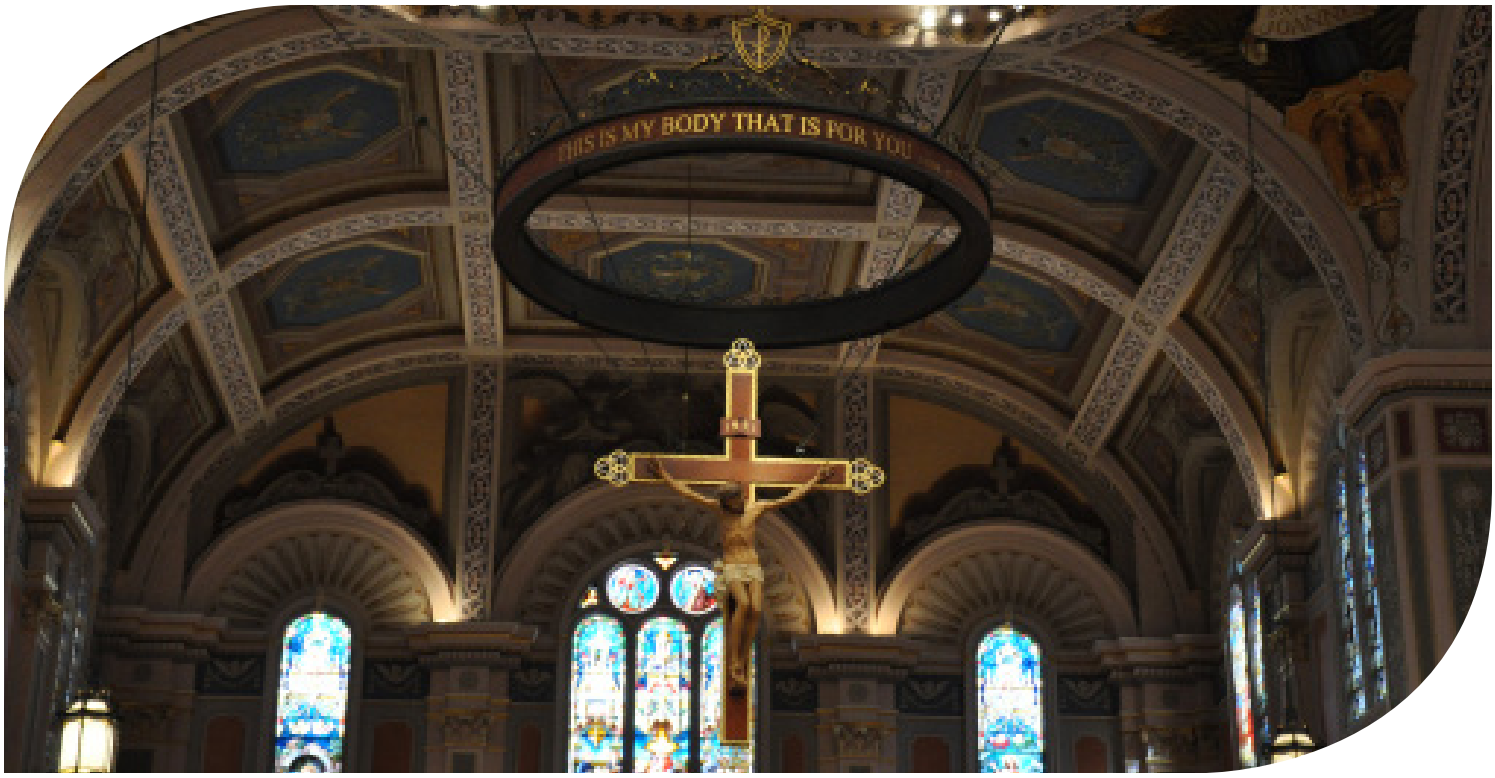


July 1, 2019 - June 30, 2020
Employee Benefits Guide

EFFECTIVE DATES OF BENEFITS

MEDICAL

1. Effective date of coverage is the date of hire.
2. Coverage always terminates at the end of the month.

DENTAL, VISION & LIFE

1. If your date of hire is on the 1st of the month, coverage will be effective immediately.
2. If your date of hire is on the 2nd through the end of the month, coverage will be effective the 1st of the following month.
3. Coverage always terminates at the end of the month.

YOUR RESPONSIBILITY

Before you enroll, make sure you understand the plans and ask questions if you don't. After you enroll, you should always check your first payroll stub to make sure that the correct amount is being deducted and that all the benefits you elected are included. Any corrections must be made within the first 31 days of enrollment. You should also verify that all beneficiary information is up to date.

ELIGIBLE DEPENDENT CHILD AGE LIMIT

	Age
Medical	26
Dental	26
Vision	26
Dependent Life	26

QUALIFYING EVENTS

Change must be made within 31 days of event and may require documentation.

Qualifying Event means a change in your family, employment or group coverage status which would affect your benefits due to one or more of the following:

1. Marriage

2. Birth, adoption or placement for adoption of a dependent child

3. Divorce, legal separation or annulment

4. Death of a dependent

5. A change in your or your dependent's employment status, such as ending employment; strike; lockout; taking or ending a leave of absence; changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage.

6. Increase/Decrease in hours significantly changing cost charged to employee.

7. Ineligible Dependent

VSP Vision Benefits

BENEFIT DESCRIPTION	IN-NETWORK	NON-NETWORK	FREQUENCY
Exam	$10 Copay	Up to $45	Every 12 Months
Lenses	See below		Every 24 Months*
Single Vision Lenses	Covered in Full	Up to $30	
Bifocal Lenses	Covered in Full	Up to $50	
Trifocal Lenses	Covered in Full	Up to $65	
Frames	$25 Copay $150 Allowance	Up to $70	Every 24 Months
Contact Lenses in Lieu of Glasses	$150 Allowance for Exam and Contacts	Up to $70	Every 24 Months
**Interim Benefits: Lenses provided every 12 months with an Rx change of .50 diopter or more			

VSP® Vision care for life

Delta Dental Benefits

BENEFIT DESCRIPTION	LOW OPTION		HIGH OPTION	
	PPO	NON-PPO	PPO	NON-PPO
Annual Deductible - Individual / Family Max.	$50 (x3)		$50 (x3)	
Deductible Waived for Preventive Services	Yes		Yes	
Preventive Services	100%	100%	100%	100%
Basic Services	90%	80%	90%	80%
Major Services (includes Implants)	60%	50%	60%	50%
Waiting Period for Major Services	None		None	
TMJ (Separate $1,000 Lifetime max)	60%	50%	60%	50%
Calendar Year Maximum Benefit	$1,500	$1,000	$2,500	$1,500
Orthodontia-Dependent Children	50%		50%	
Adult Benefit Ortho	50%		50%	
Orthodontia Deductible	N/A		N/A	
Orthodontia Lifetime Benefit	$1,000		$2,500	
Waiting Period for Orthodontia	None		None	
Coverage includes Brush Biopsies and 1 regular/1 periodontic cleaning every 6 months				

DELTA DENTAL®

Anthem® Blue Cross®

Anthem Blue Cross Medical Benefits

BENEFIT DESCRIPTION	ANTHEM PPO-1119		ANTHEM EPO-1139	
	In-Network	Out of Network	In-Network	Out of Network
Calendar Year Deductible	$750 / $1,500		$1,000 / $2,000	Not Covered
Out of Pocket Maximum: Single/Family	$3,000 / $6,000	$6,000 / $12,000	$5,000 / $10,000	Not Covered
Hospitalization	10% after Deductible	30% after Deductible	20% after Deductible	Not Covered
Outpatient Surgery	10% after Deductible	30% after Deductible	20% after Deductible	Not Covered
Emergency room	$100 + 10% *(Deductible Waived)*		$200 + 20% *(Deductible Waived)*	Same as In-Network
Office Visits	$20 Primary Care $35 Specialist	30% after Deductible	$25 Primary Care $40 Specialist	Not Covered
Routine Physicals	No Charge	30% after Deductible	No Charge	Not Covered
X-Ray/Lab	10% after Deductible	30% after Deductible	20% after Deductible	Not Covered
Chiropractic	$35 / visit *24 visits / calendar year*	30% after Deductible *24 visits / calendar year*	$40 / visit *24 visits / calendar year*	Not Covered
Ambulance	20% after Deductible		20% after Deductible	Same as In-Network
Prescriptions* Generic / Preferred Brand / Non-Preferred Brand / Specialty	$10 / $25 / $50 / $50 *30 day supply* $20 / $50 / $100 / $50 *mail order 90 day supply*	Not Covered	$10 / $30 / $50 / $50 *30 day supply* $20 / $60 / $100 / $50 *mail order 90 days supply*	Not Covered

*PPO and EPO Prescription Drugs are handled through EnvisionRx. You will receive a separate I.D. Card for prescriptions.

Anthem® Blue Cross®

More Anthem Blue Cross Medical Benefits

BENEFIT DESCRIPTION	ANTHEM HSA-1129	
	In-Network	**Out of Network**
Calendar Year Deductible	$2,500 / $5,000	
Out of Pocket Maximum: Single/Family	$5,000 / $10,000	$6,000 / $12,000
Hospitalization	20% after Deductible	40% after Deductible
Outpatient Surgery	20% after Deductible	40% after Deductible
Emergency room	20% after Deductible	
Office Visits	20% after Deductible	40% after Deductible
Routine Physicals	No Charge	40% after Deductible
X-Ray/Lab	20% after Deductible	40% after Deductible
Chiropractic	20% after Deductible *24 visits / calendar year*	40% after Deductible *24 visits / calendar year*
Ambulance	30% after Deductible	
Prescriptions Generic / Preferred Brand / Non-Preferred Brand / Specialty**	$10 / $20 / $40 *30 day supply* $20 / $40 / $80 *mail order 90 day supply*	$10 / $20 / $40 *30 day supply after Deductible*

**HSA Prescription Drugs are handled through Anthem Blue Cross. All HSA copays apply after the deductible is met. Out-of-network HSA plan Rx copay includes 50% of expense in excess of the maximum amount allowed.

KAISER PERMANENTE®

Kaiser Permanente Medical Benefits

BENEFIT DESCRIPTION	KAISER EPO-4063	KAISER HSA-4085
Calendar Year Deductible: Individual / Family	$1,000 / $2,000	$1,350 / $2,700
Out of Pocket Maximum: Individual / Family	$4,000 / $8,000	$3,000 / $6,000
Hospitalization	10% after Deductible	$250 after Deductible
Outpatient Surgery	10% after Deductible	$150 after Deductible
Emergency Room (waived if admitted)	10% after Deductible	$100 after Deductible
Office Visits	$25	$20 after Deductible
Routine Physicals	No Charge	No Charge
X-Ray/Lab	$10 after Deductible	$10 after Deductible
Chiropractic	$15 *(24 visits / calendar year)*	$15 after Deductible (20 visits / calendar year)
Ambulance	$150 after Deductible	$150 after Deductible
Routine Eye Care	No Charge *($175 allowance every 24 months)*	No Charge *($150 allowance every 24 months)*
Prescription Generic / Brand	Generic: $10 (retail) / $20 (mail order) Brand: $30 (retail) / $60 (mail order) 30 day supply at retail 100 days supply at mail order	After Deductible: Generic: $10 (retail) / $20 (mail order) Brand: $30 (retail) / $60 (mail order) 30 day supply at retail 100 days supply at mail order

Sutter Health | Aetna Medical Benefits

BENEFIT DESCRIPTION	SUTTER HEALTH | AETNA EPO-2122	
	In-Network	**Out of Network**
Calendar Year Deductible	$1,000 / $2,000	Not Covered
Out of Pocket Maximum: Single/Family	$5,000 / $10,000	Not Covered
Hospitalization	20% after Deductible	Not Covered
Outpatient Surgery	20% after Deductible	Not Covered
Emergency Room	$200	$200
Office Visits	$25	Not Covered
Routine Physicals	No Charge	Not Covered
X-Ray/Lab	20% after Deductible	Not Covered
Chiropractic	$40 / visit *24 visits / calendar year*	Not Covered
Emergency Ambulance	20% after Deductible	20% after Deductible
Prescriptions* Generic / Preferred Brand / Non-Preferred Brand / Standard Specialty**	$10 / $30 / $50 / $50 *30 day supply* $20 / $60 / $100 *mail order 90 days supply*	Not Covered

***Prescription Drugs are handled through Aetna.

Planning for the Unexpected

SUN LIFE FINANCIAL BENEFIT DESCRIPTION

Amount of Life/AD&D	$25,000
Guarantee Issue Amount	$25,000
Reduction Schedule	At age 70 reduces by 50%
Conversion	Yes
Portability	Yes
Waiver of Premium	Yes
Additional Dependent Life ($3 employee paid)	$10,000 Spouse $5,000 Each Child

Sun Life Financial

SUN LIFE FINANCIAL LONG TERM DISABILITY BENEFIT DESCRIPTION

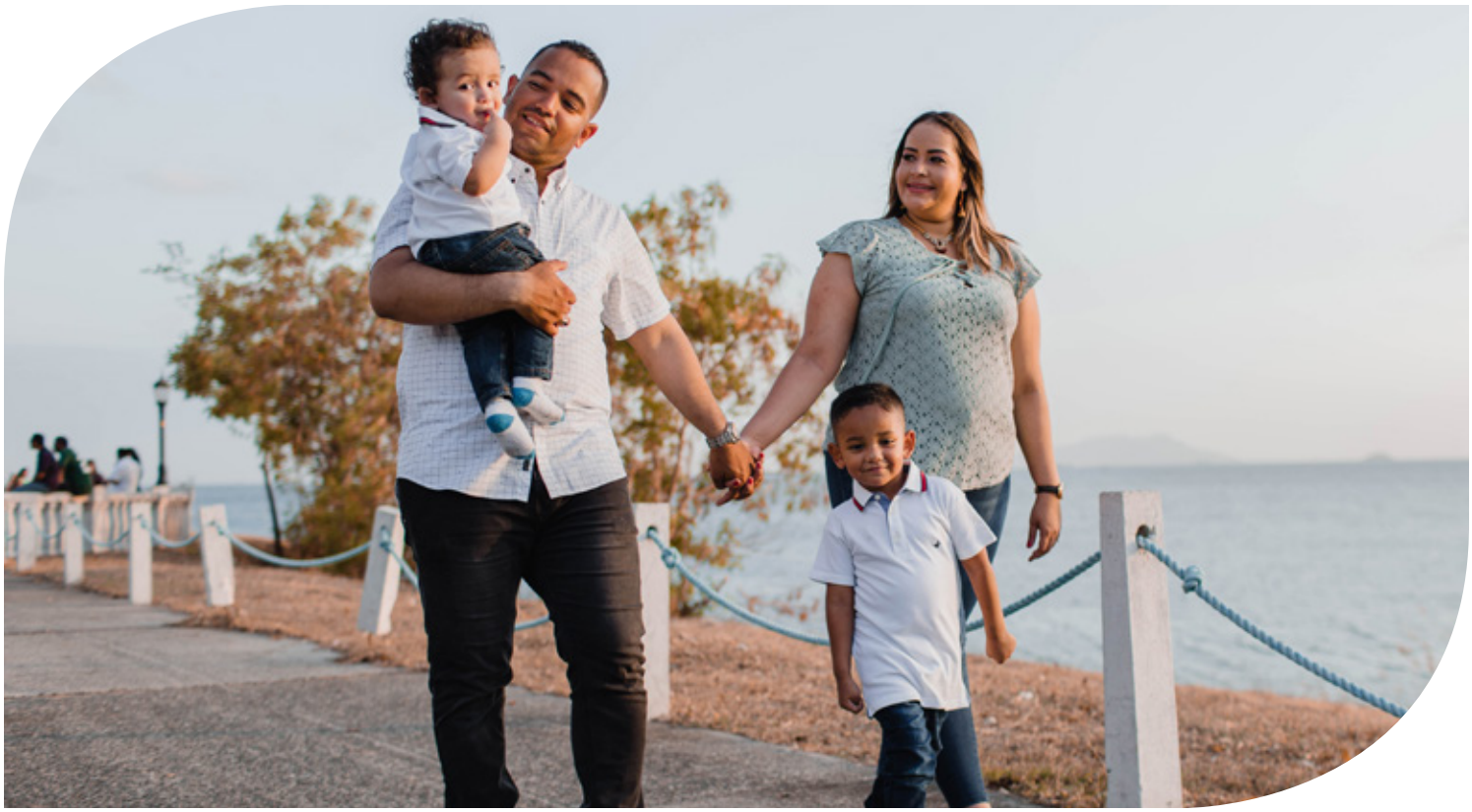
Monthly Benefit Percentage	60% of Covered Earnings
Maximum Monthly Benefit	$10,000
Elimination Period	6 months
Maximum Benefit Period	SSNRA
"Own Occ" Definition	36 Months
Pre-Existing Limitation	3/12
Survivor Benefit	3 Months
Waiver of Premium	Yes

COMPSYCH EMPLOYEE ASSISTANCE PROGRAM (EAP) SERVICES ADMINISTERED BY *SUN LIFE FINANCIAL*

Unlimited 24/7 Telephone Access to a Toll-Free Helpline
3 Face-to-Face Assessment and Counseling Sessions Per Issue

ComPsych® GuidanceResources® Worldwide

For exact details of plan benefits and limitations, please refer to your Policy Handbook. The Sun Life Financial plan documents are the final arbiter of coverage.



Voluntary Life & Dependent Life

The monthly cost for both you and your spouse varies by age of employee and spouse.

SUN LIFE FINANCIAL VOLUNTARY LIFE BENEFIT DESCRIPTION

Voluntary Life Amount	Employees may elect units of $10,000
Voluntary Life Maximum	$500,000 not to exceed 10 times your annual earnings
Reduction of Life & AD&D Insurance	Reduced by 33% at age 70 and an additional 22% at age 75, rounded to the next highest $1,000
Accidental Death & Dismemberment Benefit	If elected, coverage automatically doubles your benefit if death is due to an accident
Spouse Amount	Increments of $5,000, up to the lesser of 100% of the employee's amount or $250,000
Child Amount	Live birth to less than 26 years Increments of $1,000, up to $10,000 The dependent child amount cannot exceed 100% of the employee amount

Sun Life Financial

MONTHLY RATES PER $1,000 OF BENEFIT

Age	Employee	Spouse
<20	$0.026	$0.046
20-24	$0.038	$0.068
25-29	$0.045	$0.080
30-34	$0.062	$0.098
35-39	$0.083	$0.130
40-44	$0.139	$0.190
45-49	$0.192	$0.304
50-54	$0.350	$0.546
55-59	$0.718	$0.994
60-64	$1.044	$1.498
65-69	$1.800	$2.428
70-74	$3.718	$4.538
75+	$12.046	$14.928

Child Life Monthly Rates Per $1,000 of Benefit
$0.15

ACCIDENTAL DEATH & DISMEMBERMENT RATES

Employee Monthly Rates Per $1,000 of Benefit	$0.02

*GUARANTEE ISSUE AMOUNT

Employee	Spouse	Child
$200,000	$50,000	$10,000

If elected within first 31 days of hire or eligibility period.

Rate Sheet

	Monthly Premium	Employee Premium *(30hrs+)*	Employee Premium *(24hrs - 29hrs)*	Employee Premium *(20hrs - 23hrs)*
Kaiser EPO - 4063				
Employee only	$615.78	$85.78	$218.28	$297.78
Employee + 1	$1,224.36	$424.36	$624.36	$744.36
Family	$1,646.53	$726.53	$956.53	$1,094.53
Kaiser HSA - 4085				
Employee only	$564.71	$34.71	$167.21	$246.71
Employee + 1	$1,122.81	$322.81	$522.81	$642.81
Family	$1,509.96	$589.96	$819.96	$957.96
Anthem PPO - 1119				
Employee only	$900.32	$173.32	$355.07	$464.12
Employee + 1	$1,859.33	$772.33	$1,044.08	$1,207.13
Family	$2,345.41	$1,089.41	$1,403.41	$1,591.81
Anthem HSA - 1129				
Employee only	$783.12	$56.12	$237.87	$346.92
Employee + 1	$1,617.29	$530.29	$802.04	$965.09
Family	$2,040.09	$784.09	$1,098.09	$1,286.49
Anthem EPO - 1139				
Employee only	$819.24	$92.24	$273.99	$383.04
Employee + 1	$1,691.88	$604.88	$876.63	$1,039.68
Family	$2,134.19	$878.19	$1,192.19	$1,380.59
Aetna / Sutter EPO - 2122				
Employee only	$753.70	$77.70	$246.70	$348.10
Employee + 1	$1,556.53	$469.53	$741.28	$904.33
Family	$1,963.46	$707.46	$1,021.46	$1,209.86
VSP Vision				
Employee only	$5.19	$0.79	$1.89	$2.55
Employee + spouse	$9.80	$3.50	$5.08	$6.02
Employee + child(ren)	$10.45	$3.85	$5.50	$6.49
Employee + Family	$16.36	$7.66	$9.84	$11.14
Delta Dental - High				
Employee only	$60.34	$17.34	$28.09	$34.54
Employee + spouse	$108.61	$50.61	$65.11	$73.81
Employee + child(ren)	$132.74	$67.74	$83.99	$93.74
Employee + Family	$181.00	$102.00	$121.75	$133.60
Delta Dental - Low				
Employee only	$48.90	$5.90	$16.65	$23.10
Employee + spouse	$88.02	$30.02	$44.52	$53.22
Employee + child(ren)	$107.58	$42.58	$58.83	$68.58
Employee + Family	$146.70	$67.70	$87.45	$99.30

Who do I contact if I have questions?

CARRIER DIRECTORY

Anthem Blue Cross	www.anthem.com/ca (888) 722-1077
Kaiser	www.kp.org (800) 533-1833 | HSA (877) 750-3399
Sutter Health | AETNA	www.sutterhealthaetna.com (866) 243-9776
Health Equity HSA	www.healthequity.com/AnthemBCBS-HSA (877) 713-7712
EnvisionRX	www.envisionrx.com (844) 852-7437
Delta Dental	www.deltadentalins.com (800) 765-6003
VSP	www.vsp.com (800) 877-7195
Life Financial	www.sunlife.com (800) 247-6875
EAP services	www.guidanceresources.com (877) 595-5281
Reta Trust	www.retatrust.org (877) 303-7382

Reta
A Catholic Healthcare Trust
Over 40 years of dedicated service

This brochure contains a brief description of the benefits offered by Diocese of Sacramento. This brochure does not include the details relating to the terms and administration of the benefits offered. This brochure is not part of the plan document, summary plan description or provider contract for any of these benefits. For exact details of plan benefits & limitations please refer to your policy handbook. Diocese of Sacramento's plan documents are the final arbiter of coverage. Such documents, descriptions and contracts govern the interpretation and administration of the benefits. The benefits described herein are subject to amendment or termination by Diocese of Sacramento at any time. **Revised 4/8/2019**

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