

### Symetra Basic Life and AD&D Plans (Company-paid)

Coverage	Basic Life	Basic AD&D
Employee Benefit Amount	\$20,000	\$20,000
Conversion/Portability	Both	Both
Age Reduction	65% at age 70; 50% at age 75	

### Symetra Voluntary Life and AD&D Plans

Coverage	Vol. Life	Vol. AD&D
Employee Benefit Amount (employee must be enrolled in AD&D Plan for spouse to elect AD&D coverage)	Choice of \$10,000; \$25,000; \$50,000; \$75,000; \$100,000; \$125,000; \$150,000 or \$175,000	Choice of \$10,000; \$25,000; \$50,000; \$75,000; \$100,000; \$125,000; \$150,000 or \$175,000
Maximum Amount for Spouse (spouse amount cannot be higher than employee amount)	100% of employee amount	100% of employee amount
Dependent Child(ren): (Live Birth to 6 mo)	\$1,000	\$1,000
Dependent Child(ren): (6 months to age 26)	\$10,000	\$10,000
Guarantee Issue for Voluntary Life (Employee/Spouse)	\$175,000/\$25,000	
AD&D Seatbelt and Airbag Benefit (Employee/Dependent)	\$10%/\$25,000 Seatbelt 5%/\$5,000 Airbag	
Accelerated Death Benefit	Included to a maximum of \$15,000 not to exceed 15% of in force amount	
Conversion/Portability	Both	
Annual Enrollment Period	Included	
Age Reduction	65% at age 70; 50% at age 75	
Annual Open Enrollment	\$25,000 for existing employee to \$175k max-no EOI	

### Monthly Rates per \$1,000 Benefit by Age – Voluntary Life/AD&D

Vol. Life	Employee	Spouse	Child
Child			\$2.937/\$10,000
Age 15-24	\$0.055	\$0.067	
Age 25-29	\$0.063	\$0.076	
Age 30-34	\$0.080	\$0.097	
Age 35-39	\$0.110	\$0.140	
Age 40-44	\$0.158	\$0.201	
Age 45-49	\$0.252	\$0.315	
Age 50-54	\$0.400	\$0.490	
Age 55-59	\$0.615	\$0.752	
Age 60-64	\$0.960	\$1.286	
Age 65-69	\$1.666	\$2.196	
Age 70-74	\$2.974	\$3.913	
Age 75 +	\$5.827	\$7.837	
Vol. AD&D	Employee	Spouse	Child
All Ages	\$0.027	\$0.028	\$0.300/\$10,000

### Premier Access PPO Dental Plan

Coverage	PCN/PPO/Out of Network
Plan Year Deductible	
Individual	\$0/\$0/\$ 50
Family	\$0/\$0/\$150
Coinsurance	
Preventive	100%/100%/100%
Basic	100%/90%/80%
Major	70%/60%/50%
Plan Year Maximum	\$2,000
Orthodontia	
Adult & Children Benefit	50%
Lifetime Maximum	\$1,500
Percentile	50 <sup>th</sup>
Late Entrant:	6 months wait Basic/12 months Major
<b>Missing Tooth Exclusion applies/No implant coverage</b>	

Dental: Dependent children to age 19; 25 if full time student.  
Includes Annual Open Enrollment. [www.premierlife.com](http://www.premierlife.com) (register to get full list of dentist)

### Symetra LTD Plan

Coverage	Priests	Lay Employee
Benefit Percent	66 2/3%	60%
Benefit Maximum	\$3,000	\$5,000
Elimination Period	180 days	180 days
Duration	To age 70 –Extended Own Occ	To SSNRA
Definition of Disability	Extended Own occ	24 months own occ
Pre-Existing	3/12	3/12
Survivor Benefit	Yes	Yes

### Monthly Rates – Medical/Vision and Dental

Anthem BC PPO	Employer Share	Employee Cost
Employee	\$ 845	\$ 93
Employee + Spouse	\$1300	\$662
Employee + Children	\$1041	\$549
Employee + Family	\$1620	\$993
Dental – PPO	Employer Share	Employee Cost
Employee	\$ 51	\$3
Employee + Spouse	\$ 77	\$35
Employee + Children	\$ 73	\$29
Employee + Family	\$104	\$57

*This is an illustrative overview to briefly summarize the benefit plans offered by your employer. Please see the actual plan documents for complete benefit descriptions including limitations, exclusions and other requirements.*



## Employee Benefits July 1, 2020 / June 30, 2021

For Benefit Questions regarding coverage, eligibility, help with claims, etc., you or your covered dependents can contact BRCCA at 888-336-7463 or email them at [BRCCA@usi.com](mailto:BRCCA@usi.com). They are available Mon-Fri 8am – 5pm PST. Bilingual services are also available.

You can also call Delta Health Systems at 888-212-1231 for questions about your medical plan or IPM Rx 877-860-8846.

24/7 Nurseline 800-700-9184

Anthem LiveHealthOnline – Telemedicine visit \$10 copay for visits including applicable mental health. Register before you need services by calling 888 548 3432 or go to [www.livehealthonline.com](http://www.livehealthonline.com)

Delta Team Care – Wellness Vendor 866-724-0032 or email [TeamCare@delapro.com](mailto:TeamCare@delapro.com)

Employee Benefits Brokered by



**Medical Plan Comparison – Anthem Blue Cross PPO** [www.anthem.com/ca](http://www.anthem.com/ca)

Coverage	Anthem BC Preferred Provider <sup>1</sup>	Anthem BC Non Preferred Provider
<b>Medical Plan Deductible Per Plan Year</b> (Plan Year is July 1 <sup>st</sup> – June 30 <sup>th</sup> each year)	\$500 per individual \$1,000 per family	\$1,500 per individual \$3,000 per family
	Deductible \$0 for wellness participant <sup>5</sup>	
<b>Maximum Copayment Per Plan Year</b>	\$2,500 per individual \$7,500 per family	\$10,000 per individual <sup>2</sup> \$20,000 per family <sup>2</sup>
<b>Lifetime Benefit Maximum</b>	None	None
<b>Professional Services (office visits)</b>		
Most primary and specialty care consultations and exams	\$25 per visit <sup>3</sup>	50%
Telemedicine Doctor Visit (see LiveHealthOnline flyer)	\$10 per visit <sup>3</sup>	N/A
Annual Routine Preventive Health Benefits	No Charge <sup>3</sup>	Not covered
Well-child preventive exams (through age 23 months)	No Charge <sup>3</sup>	Not covered
Pregnancy and maternity care	20%	50%
Physical, occupational and speech therapy	\$25 per visit	50%
Acupuncture and Chiropractic Services (12 visits per plan year Chiro/20 visits plan year Acupuncture) deductible applies	\$25 copay	50% Chiropractic \$25 copay - Acupuncture
<b>Outpatient Services</b>		
Outpatient Surgery and certain other outpatient procedures	20%	50% to \$600/dy max
Allergy injections (including allergy serum)	20%	50%
Most routine immunizations (including vaccines)	No Charge <sup>3</sup>	Not covered
Most X-rays and laboratory tests	20%	50%
<b>Hospitalization Services</b>		
Inpatient Physician Services	20%	50%
Room and Board, surgery, anesthesia, X-ray, laboratory tests and drugs	\$250 per admit + 20%	50% to \$600/dy max
<b>Emergency Health Coverage (Urgent Care \$25 copay<sup>3</sup>)</b>		
Emergency room visits not resulting in admission	\$200 <sup>3</sup> per visit	\$200 <sup>3</sup> per visit
Emergency room visits resulting in admission	\$250 per admit + 20%	\$250 per admit + 20%
Emergency room physician services	20%	20%
Ambulance Services	20%	20%
<b>Mental Health &amp; Chemical Dependency Services</b>		
Inpatient hospital services	\$250 per admit + 20%	50% to \$600/dy max
Outpatient mental health evaluation and treatment	\$25 per visit <sup>3</sup>	50%
LiveHealth Online virtual mental health visits	\$10 copay per call	Not covered
Outpatient chemical dependency consultations and treatment	\$25 per visit <sup>3</sup>	50%
<b>Home Health Services (up to 100 visits per plan year)</b>	20%	Not covered
<b>Skilled Nursing Facility Care</b>		
Free-standing skilled nursing facility (up to 100 days per benefit period)	20%	50% to \$600/dy max
Skilled nursing unit of a hospital *up to 100 days per plan year)	20%	50% to \$600/dy max
<b>Hospice Care</b>		
Routine home care or inpatient respite care	No Charge	Not covered
24-Hour continuous home care or general inpatient care	20%	Not covered
<b>Durable Medical Equipment</b>	20%	50%
<b>Prescription Drug Coverage</b>		
Prescription Drug Deductible per Plan Year	\$150 per member <sup>4</sup>	\$150 per member <sup>4</sup>
Retail formulary generic drugs	\$10	Member pays 25% of allowable amount plus a copay of \$10
Retail formulary brand name drugs	\$25	Member pays 25% of allowable amount plus a copay of \$25
Retail non formulary brand name drugs	\$40	Member pays 25% of allowable amount plus a \$40 copay
Mail-order formulary generic drugs	\$20 up to 90 day supply	Not covered
Mail-order formulary brand name drugs	\$50 up to 90 day supply	Not covered
Mail order non-formulary brand name drugs	\$80 up to 90 day supply	Not covered
Specialty drugs-all refills must go through Walgreen's Specialty	20% (up to \$150 copayment maximum per prescription)	Not Covered (unless Medically Necessary for a covered emergency)

1. Benefits provided through BlueCard Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross /Blue Shield provider. 2. Charges which exceed Anthem Blue Cross' allowable amount is the Member's responsibility and do not count towards the deductible or copayment maximum. 3. Not subject to Medical Plan Deductible. 4. Pharmacy Deductible is plan year - July 1<sup>st</sup> to June 30<sup>th</sup> each year & applies to covered brand-name and specialty drugs. 5. If Emp/Spouse both complete wellness, the In-Network deductible is \$0. Wellness credit doesn't apply to Out of Network. For E+C, only parent completes wellness. Please refer to the Diocesan website for all annual legal notices, SBC's, Summary of Benefits and all other plan documents. The above is just a brief summary. Refer to your plan documents for complete details.

**Superior Vision Care** [www.superiorvision.com](http://www.superiorvision.com)

Vision Care Services	In Network	Non-Network
<b>Exam with Dilation as Necessary</b>	\$10 Copay	Up to \$30
<b>Contact Lens Fit and Follow-up</b> (after exam)		
Standard	100% after \$25 copay	N/A
Specialty	\$50 retail allowance	N/A
<b>Frames</b>	\$0 Copay, \$150 allowance; 20% off balance over \$150	
<b>Standard Plastic Lenses</b>		
Single Vision	\$0 Copay	Up to \$25
Bifocal	\$0 Copay	Up to \$40
Trifocal	\$0 Copay	Up to \$63
Progressive	Covered up to cost of lined trifocal minus 20% of the difference	Up to \$40
<b>Lens Options</b> (maximum paid by the member):		
Tints, solids or gradients	Max of \$25	N/A
UV Treatment	Max of \$15	N/A
Standard Plastic Scratch Coating	Max of \$13	N/A
Standard Polycarbonate	Max of \$40	N/A
Standard Anti-Reflective Coating	Max of \$50	N/A
Polarized/Other Add-Ons and Services	20% off retail price	N/A
<b>Contact Lenses</b>		
Conventional	\$0 Copay, \$150 allowance	Up to \$100
Disposables	\$0 Copay, \$150 allowance	Up to \$100
Medically Necessary	\$0 Copay	Up to \$210
<b>Eye Care Supplies</b> (ie., cleaning solutions)	10-20% discount @ some provider's office	NA
<b>LASIK and PRK Vision Correction Procedures</b>	5-50% discount with Superior's nationwide network-call Customer Service	N/A
<b>Frequency</b>		
Exam		Once every 12 months
Frames		Once every 24 months
Standard Plastic Lenses or Contact Lenses		Once every 12 months
Discounts of up to 20-30% on an unlimited number of extra pairs of glasses/contact lenses.		

**Additional Vision Purchase and Out of Pocket Discount:** 20% discount on Transitions lens and other covered lens options and 20% for allowance overages. For Costco, check first as not all Costco physicians are contracted.

Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Other restrictions apply. Vision: Dependent children to age 19; or to age 25 if full time student.

Visit [www.svcontacts.com](http://www.svcontacts.com) to order replacement contact lens for shipment to your home at less than the retail price.

Anthem LiveHealth Online Telemedicine visits. \$10 copay. Be sure to register before your first use to save time. Call 888 548 3432 or visit [www.livehealthonline.com](http://www.livehealthonline.com) This options saves you time and money for simple things like cold, bronchitis, pink eye, rash, etc. The visit is virtual and done from your home or anyone you can login to your laptop or phone for a virtual visit.