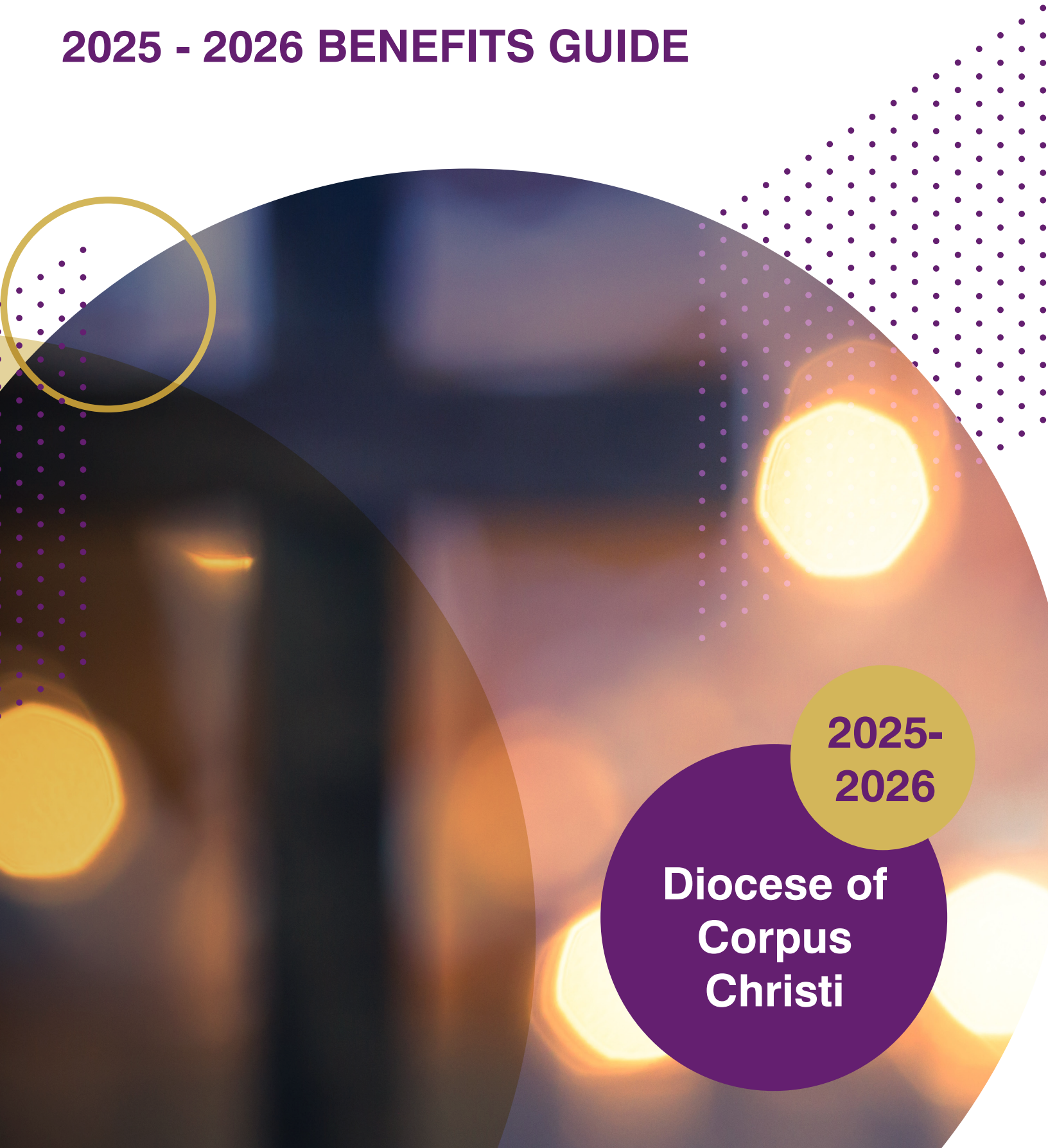
Catholic Employee Benefit Group

2025 - 2026 BENEFITS GUIDE



2025-2026

Diocese of Corpus Christi

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Benefits Overview

Catholic Employee Benefit Group is proud to offer a comprehensive benefits package to eligible, full-time employees who work a minimum of 30 hours. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

Benefit Plans Offered

- Medical
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Enrollment and Eligibility

Catholic Employee Benefit Group offers a comprehensive, cost-effective benefit package to help protect you and your family, but it only works if you make thoughtful decisions about your benefits. In other words, you need to take an active role in choosing your benefit coverage. This way, your benefits will line up with your needs and goals.

To help you make your benefit choices, Catholic Employee Benefit Group has provided this Benefit Guide. Enroll before the deadline so you can get the maximum value from these benefit plans.

To review/elect benefits, follow the below steps.

1. Go to **myenroll.com**
2. Select first time user. This will prompt you to create a user name and password to review/elect benefits.

Using Your Enrollment Guide

Review Your Benefits— Read this guide thoroughly as it describes your options in detail.

Review Your Enrollment Information— All employees will submit benefit elections in BAS (Benefit Allocation Systems). If you have not logged into BAS, your Payroll Administrator will give you a login and password.

Current Benefit Elections— Current benefit elections should carry forward but will require employee review and confirmation. Benefit changes must be submitted during the Annual Enrollment period.

When Can I Change My Benefit Elections During the Year?

The benefits you choose will remain in effect until June 30, 2026, as IRS rules do not allow benefit changes during the plan year unless you have a qualifying event (change in family or employment status). Qualifying Event changes must be submitted in BAS within 30 days of the event date.

Types of Qualifying Events Include:

- Change in marital status (marriage, divorce)
- Change in number of dependents (birth of child, adoption)
- Death (legal dependent)
- Change in employment that results in loss of benefits
- Loss of coverage
- Obtain other coverage
- HIPAA Special Enrollment, Court Judgment or Decree
- Medicare or Medicaid enrollment, or loss of coverage
- Loss of eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)*
- Determination of eligibility for a premium assistance subsidy under Medicaid or CHIP*

***Must request enrollment within 60 days of the loss of Medicaid or CHIP or the determination of eligibility for a premium assistance subsidy.**

Who Is Eligible For Benefits?

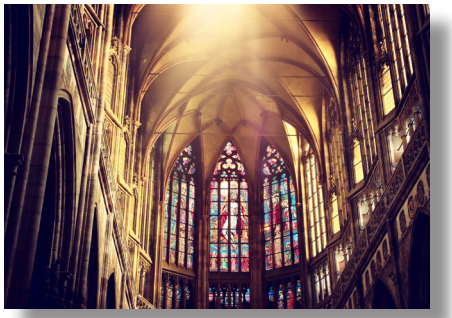
Employee Eligibility – If you are a full-time employee who works 30 hours or more per week, you are eligible to participate in the Catholic Employee Benefit Group benefit program (some exceptions may apply where noted in this guide). Benefits are effective first of the month following 60 days of employment.

Dependent Eligibility – You may also cover your eligible dependents, including: a) your spouse, b) your eligible children up to age 26. Children are defined as your natural children, stepchildren, legally adopted children, and children under your legal guardianship, c) physically or mentally disabled children of any age who are incapable of self-support.

Benefit Effective Date Determined by Employment Classification

Medical Benefits

Administered by BlueCross BlueShield of Texas



Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Catholic Employee Benefit Group.

Catholic Employee Benefit Group offers you a choice of three (3) medical plans.

With each plan, you may select where you receive your medical services. If you use in-network providers, your costs will be less.

Benefit Design	PPO Plan 1		PPO Plan 2		HDHP Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
MEDICAL						
Deductible (Individual / Family)	$1,000 / $2,000	$2,000 / $4,000	$1,500 / $3,000	$3,000 / $6,000	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Maximum (Individual / Family)	$3,000 / $6,000	$5,100 / $15,250	$4,500 / $9,000	Unlimited	$6,850 / $13,700	$13,700 / $27,400
Office Visit (Primary / Specialist)	$25 / $25 copay	40% coinsurance	$30 / $45 copay	60% coinsurance	30% coinsurance	60% coinsurance
Mental Health / Substance Abuse	20% coinsurance	40% coinsurance	30% coinsurance	60% coinsurance	30% coinsurance	60% coinsurance
Preventive Medicine	Covered 100%	40% coinsurance	Covered 100%	60% coinsurance	Covered 100%	60% coinsurance
Emergency Room	$100 copay + 20% coins, ded applies	$100 copay + 40% coins, ded applies	$300 copay + 30% coins, ded applies		30% coins, ded applies	
PRESCRIPTION DRUGS						
Retail (30 Days)						
Generic	$4 copay	40% coinsurance	$10 copay	60% coinsurance	30% coinsurance	60% coinsurance
Brand Formulary	$34 copay	40% coinsurance	$45 copay	60% coinsurance	30% coinsurance	60% coinsurance
Brand Non-Formulary	$64 copay	40% coinsurance	$85 copay	60% coinsurance	30% coinsurance	60% coinsurance
Specialty	20% coinsurance	40% coinsurance	30% coinsurance	60% coinsurance	30% coinsurance	60% coinsurance
Mail Order (90 Days)						
Mail Order	2x Retail	40% coinsurance	2.5x Retail	60% coinsurance	30% coinsurance	60% coinsurance

Health and Wellness Management

Provider Network

Where you go for care can make a difference. All medical plan options offered by the Company utilize the Blue Cross BlueShield of Texas Blue Choice PPO network. To find an in-network provider visit **bcbstx.com** or contact BCBSTX at **800.521.2227**.

Make Preventive Care a Priority

The Preventive Care benefit covers most routine outpatient physical examinations at 100% (in-network). Talk to you doctor to decide which screenings and vaccines are right for you. Below are some examples:

» Well baby care

» Routine annual physical examination (including pap smears)

» Annual hearing examinations

» Immunizations (childhood and adult)

» Routine tests for detection of colorectal cancer

» Routine lab and x-rays

» Routine mammogram

Virtual Visits

Virtual Visits, provided by Blue Cross and Blue Shield of Texas (BCBSTX) and powered by MDLIVE, are a convenient alternative for treatment of more than 80 health conditions, including

» Allergies

» Cold / Flu

» Nausea

» Sinus infections and more

Virtual Visits with licensed behavioral health therapists are available by appointment. Get virtual care for:

» Anxiety

» Depression

» Stress management and more

Activate your MDLIVE account today:

» Call MDLIVE at **888.680.8646**

» Go to **MDLIVE.com/bcbstx**

» Text BCBSTX to 635-483

» Download the MDLIVE app

BCBSTX App

Manage your benefits on the go right from your phone, with BCBSTX App.

Some of the robust features of the BCBSTX App include:

» Find an in-network doctor, hospital or urgent care facility

» Access your claims, coverage and deductible information

» View or print your member ID card

Visit the App Store or Google play to download the BCBSTX app or text BCBSTX to 33633.

Choosing Quality Care for you and your Family

Under your plan, you have access to designated specialty care facilities that have met national measures for quality and cost-efficient care. When you use a Blue Distinction® Center (BDC) doctor or hospital, you will receive the most from your benefits and know that the doctor or hospital has a record of providing proven, effective specialty care.

There are approximately 2,480 BDCs nationwide. To find a BDC near you, log in to Blue Access for Members(BAM) at **bcbstx.com/member**.

24/7 Nurseline

Nurses available anytime you need them.

Health happens – good or bad, 24 hours a day, seven days a week. Our nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. They can also answer health questions about

» Asthma

» Dizziness or severe headaches

» Back pain

» High fever

» Sore throat

» Diabetes

» A baby's nonstop crying and much more

Call the 24/7 Nurseline number on the back of your member ID card.

Retrain your Brain

More than half of people will struggle with a mental health concern at some point in their lives. Learn new skills to break old patterns that may be holding you back. Digital mental health programs from Learn to Live can help. An online assessment helps pinpoint the right programs for you.

This program is included at no added cost through your BCBSTX plan:

» Log in at **bcbstx.com**.

» Click **Behavioral Health**.

» Choose **Digital Mental Health**.

Or tap **Digital Mental Health** in the BCBSTX App.

BCBSTX members 13 to 17 years old can also use the programs. Once you've logged in to Learn to Live using the steps above, go to the **Resources** tab. Then find the **Register a Minor** link to send your teen a registration email.

Special Beginnings

The Special Beginnings maternity program supports you from early pregnancy until six weeks after delivery. An experienced Blue Cross and Blue Shield of Texas staff member will contact you and:

» Ask you questions to determine what support you will need

» Send you information about having a healthy pregnancy and baby

» Answer any questions you have and help you plan your care with your doctor

» Assist you with managing high-risk conditions such as gestational diabetes and preeclampsia

Visit the Special Beginnings website to view a video library and week-by-week pregnancy information. To access the site, log into Blue Access for Members (BAM) by visiting **bcbstx.com** and click on the "My Health" tab.

Tobacco Cessation

The Well onTarget interactive, digital tobacco cessation programs consist of methods to help members learn to quit smoking with innovative lessons developed using the most current academic and medical research.

The 6-week programs require daily interaction with members to make them most effective. It takes only about 4 minutes to check in and take advantage of the daily resources offered.

For more information call **877.806.9380** or sign up at **wellontarget.com**

Well on Target Fitness

Since you are a BCBSTX member you have access to the Well on Target Fitness Program. This program offers flexible options to get in shape and stay active. Choose from a network of gyms offering tier-pricing that fits your budget and lifestyle. This program also includes pay-as-you-go classes and is available to you and your covered dependents (16 and older).

Sign up is easy! Log into Blue Access for Members (BAM) and select "Wellness" under the "My Health" tab. Click on "Learn More" under the Fitness Program section. Follow the prompts to join the Fitness program. Or contact **888.762.2583**.

Pharmacy Plan

Things To Know About Prime Therapeutics Pharmacy

Your prescription drug benefit features a formulary drug list (a list of preferred drugs). NetResults is the pharmacy network / formulary. Your formulary can be found online at **www.primetherapeutics.com/member/documents**.

» A formulary is a list of prescription drugs, both generic and brand name, that are covered by the drug plan. Formularies are subject to change periodically. The formulary drug list is developed by Prime Therapeutics identifying drugs that offer the greatest overall value. This may result in a brand name drug being excluded when a generic equivalent is covered. Generic drugs contain the same active ingredient(s) as a brand name drug.

» Your pharmacy network is the NetResults Network. Prime Therapeutics has a national network of pharmacies for your convenience, which includes CVS, Walgreens, Walmart, as well as most other large chains and independent pharmacies.

» To access the Prime Therapeutics member center, please visit **www.primetherapeutics.com** and select "Members" at the top of the page. Scroll down to Log in to the member portal and click on "Prescription Hub" and register. You can easily find pharmacies in your area, order prescription refills, view claims, price a drug, and much more. Member services are also available at your fingertips by downloading the PrimeCentral™ Mobile App.

» If you have any questions about your prescription benefits, you can call Prime Therapeutics at **(800) 424.0472**.

Home Delivery

You could save time and money by getting maintenance medications by mail through Prime Therapeutics Pharmacy home delivery.

Enroll in Prime Therapeutics Pharmacy home delivery to get up to a 90-day supply of the medications you take regularly. Your medication will come right to your mailbox.

If you already have a 90-day prescription:

Mail your 90-day prescription and home delivery order form with payment information to Prime Therapeutics Pharmacy, P.O. Box 620968, Orlando, FL 32862, or call **800.424.8274**.

Home delivery order forms are available at **primetherapeutics.com/homedelivery**.

If you need a new prescription:

First, ask your prescriber to send your prescription to Prime Therapeutics Pharmacy. Prescribers can submit new prescriptions through one of three ways:

1. ePrescribe to Prime Therapeutics Pharmacy LLC.
2. Fax the prescription to **888.282.1349**.
3. Call the prescription in to **800.424.8274**.

Specialty Drugs

Prime Therapeutics Specialty Pharmacy is a part of your benefit program. Prime Therapeutics Specialty Pharmacy provides specialty medications and some clinical support for complex conditions, including cancer, arthritis and others. To learn more about Prime Therapeutics Specialty Pharmacy, call **866.554.2673** or visit **www.primetherapeutics.com/specialtypharmacy**.

Diabetes Medication and Supplies

Diabetic supplies that are considered durable medical equipment, such as meters, pumps, transmitters and sensors, will be covered under the medical plan according to medical plan criteria and limitations.

Health Savings Account (HSA)

The HDHP medical plan offered by CEBG meets certain IRS requirements that allow employees who enroll in it to open a Health Savings Account or HSA. An HSA allows you to contribute pre-tax payroll deductions that you can then use to pay for qualified expenses.

What is a High Deductible Health Plan (HDHP)?

A High Deductible Health Plan (HDHP) is a health plan that requires participants to pay 100% of claims cost up to the plan deductible. After meeting your deductible, you will then begin paying coinsurance, (typically the plan will pay 70% of In-Network claims while you only pay 30%). Claims for in-network wellness/preventive care are covered at 100% by the plan (at no cost to you) without having to meet your deductible.

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a pre-tax savings account designed to help you pay for current and future healthcare expenses. You and/or your employer can contribute to this account tax-free. The funds in your HSA can be used to cover qualified medical expenses for you and your eligible dependents.

If you enroll in the HSA, CEBG will make contributions to your account, and you can also contribute through payroll deductions, up to the annual limits set by the IRS. These employee contributions reduce your taxable income.

Who's eligible to enroll / contribute to an HSA?

You're eligible to enroll and/or contribute to an HSA if:

- You elect the CEBG qualified high-deductible health plan (HDHP) for 2025.
- Your only coverage is an HDHP.
- If you're covered under your spouse's plan and that plan is not a qualified HDHP, you are not eligible to contribute to an HSA.
- You are not covered by a traditional Healthcare FSA through your spouse.
- You are not covered by Medicare (part A or B), Tricare or VA Benefits*.
- You cannot be claimed as a dependent on another person's tax return (unless it's your spouse).

*Veterans with a disability rating of 10% or greater who receive hospital care or medical services from the Veterans Administration are now eligible to make contributions to an HSA.

Why would I choose to contribute to an HSA?

HSAs are funded with tax-free deductions from your paycheck. Even if you decide not to contribute, CEBG will still contribute towards your HSA. ***If you do not wish to contribute to an HSA, select $0 during enrollment.*** You can invest your balance and not pay taxes on your gains. You can use it to pay for eligible healthcare expenses now or in the future. Your spouse and dependents don't need to be covered by the HDHP in order for you to use the account funds to pay for their qualified expenses.

Can I change my HSA contribution during the year?

Yes, you can increase or decrease your HSA contribution at any point during the year as long as you do not exceed the total maximum annual contribution amount.

What can I use HSA funds for?

You can use the funds you accrue to pay for IRS-qualified expenses such as:

- Medical and prescription drug expenses
- Dental care services
- Vision care services
- Over-the-counter medications with written prescription from your doctor
- Certain medical equipment
- Long-term care and long-term care insurance premiums
- COBRA premiums
- Medicare insurance premiums and premiums under an employer-sponsored retiree medical program (once you reach age 65)

IRS Maximum Contributions for 2025 (Includes employee and employer contributions)	
Individual	$4,300
Family	$8,550
Those employees who are or will be age 55 in 2025 can contribute an additional $1,000.	

Flexible Spending Account (FSA)

Eligibility Requirements

You can use this account for eligible expenses including health, dental and vision expenses not covered by insurance that you or your dependents incur.

» You must be enrolled in one of the Medical PPO Plan options

What would I use this account for?

» Deductibles

» Copays

» Coinsurance (Medical, Dental and Vision)

» Prescription Drug expenses

» Any IRS eligible expense

How do I enroll?

Enrollment can be completed at **myenroll.com** during your annual enrollment period. You will receive a debit card in the mail once enrollment is completed. Enrollment elections cannot be changed until the next enrollment period or if you have a qualified life event. You must re-elect FSA coverage every year, enrollment does not carry forward year to year.

Card Substantiation: All Healthcare Card Purchases have to be verified within 90 days of the transaction date in accordance with IRS regulations. HSA Bank will notify you if the transaction cannot be automatically verified and provide you with instructions for how to proceed.

Contributions for 2025	
Minimum	$120
Maximum	$3,300

When are the funds available?

Your total contribution amount is front loaded into your account by your Diocese and immediately available for use. However, your contributions are deducted in equal installments from each paycheck throughout the year. The money you contribute to the account is on a pre-tax basis.

What happens if I don't use the money during the year?

The Healthcare FSA will allow you to automatically carry over up to $660 of any balance remaining at the end of 2025 to be used in 2026. No need to rush to spend the carryover dollars – there is no deadline in 2026 to spend the amount carried over.

When do I need to submit documentation?

The IRS requires HSA Bank to verify every purchase. We do that by approving your card swipes at the point of sale and paying your provider. But sometimes the provider is not registered in the merchant coding system, or we can't validate the service or item you purchased with the information given to us.

For example, if your dentist's office didn't specify what service you received, we would need documentation to make sure that it's an eligible expense. Teeth whitening is not an eligible expense, for instance. Just in case you need to submit documentation, make sure to save all your receipts for purchases and the explanations-of-benefits document that you get from the insurance company. The three different kinds of documentation you can utilize to submit are:

» An explanation-of-benefits (EOB) document that you received from your insurance company.

» A detailed receipt showing the items or services you received from the retailer or provider.

» An invoice from your provider.

Don't submit canceled checks or bank statements because they usually don't provide enough information. Also, you cannot submit your own notes as documentation.

Dental Benefits

Administered by Guardian

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Catholic Employee Benefit Group dental benefit plan. Your dental network with Guardian is the **DentalGuard Preferred Network.**

	In-Network PPO	Out-of-Network PPO
Annual Deductible	$25 per person; max of 3 per family	
Annual Benefit Maximum	$1,500	
Preventive Dental Services (cleanings, exams, x-rays)	100%	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	80%	80%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%	50%
Orthodontia Services (covered to age 19)	$1,500 Lifetime Maximum	$1,500 Lifetime Maximum

Vision Benefits

Administered by VSP

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

	In-Network (any VSP provider)	Out-of-Network (any qualified non-network provider of your choice)
Eye Exam once every 12 months	$10 copay	$45 allowance
Lenses — once every 12 months		
Single Vision Lenses	$15 copay	$30 allowance
Lined Bifocal Lenses	$15 copay	$50 allowance
Lined Trifocal Lenses	$15 copay	$60 allowance
Lenticular Lenses	$15 copay	$75 allowance
Frames once every 12 months	$130 retail allowance	$50 retail allowance
Contact Lenses once every 12 months if you elect contacts instead of lenses/frames	$130 retail allowance	$100 retail allowance

No need for an ID card. To take advantage of your VSP vision benefit, simply contact a VSP provider and let them know you have VSP coverage—they handle the paperwork for you.

Life and Accidental Death & Dismemberment Insurance

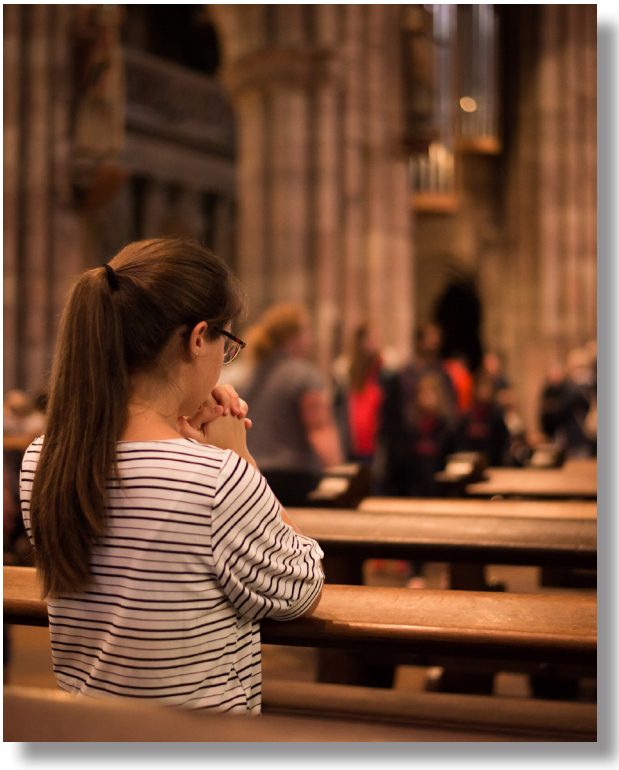
Insured by Guardian

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Catholic Employee Benefit Group. The company provides basic life insurance of $25,000 at no cost to you if you participate in the medical plans offered by Catholic Employee Benefit Group.

Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Catholic Employee Benefit Group provides AD&D coverage of $25,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above if you participate in the medical plans offered by Catholic Employee Benefit Group.



Voluntary Life and AD&D Insurance

Insured by Guardian

You may purchase life and AD&D insurance in addition to the company-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to $50,000, and up to 50% of your elected coverage for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee— Up to $250,000 in increments of $10,000

Spouse— Up to $130,000 in increments of $10,000, not to exceed 50% of employee amount

Infant (birth to 14 days)— $1,000

Children (14 days to 26)— $10,000

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local Human Resources department.

Benefit	Administrator	Phone	Website/Email
Medical	BlueCross BlueShield of Texas	800.521.2227	bcbstx.com
Pharmacy	Prime Therapeutics	800.424.0472	primetherapeutics.com
Specialty Pharmacy	Prime Therapeutics	866.554.2673	primetherapeutics.com/ specialtypharmacy
Health Savings Account (HSA)	HSA Bank	800.357.6246	hsabank.com
Flexible Savings Account (FSA)	HSA Bank	800.357.6246	hsabank.com
Dental	Guardian	800.541.7846	guardianlife.com
Vision	VSP	800.877.7195	vsp.com
Life and Accidental Death & Dismemberment	Guardian	800.525.4542	guardianlife.com
Voluntary Life and Accidental Death & Dismemberment	Guardian	800.525.4542	guardianlife.com

Legal Notices

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

» All stages of reconstruction of the breast on which the mastectomy was performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance;

» Prostheses; and

» Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact your local Diocesan Human Resources.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDS.NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ | 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Catholic Employee Benefit Group is committed to the privacy of your health information. The administrators of the Catholic Employee Benefit Group Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Jim Mitchell at **JMitchell@dioama.org**. The notice also is available online at **myenroll.com**.

HIPAA Special Enrollment Rights

Catholic Employee Benefit Group Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Catholic Employee Benefit Group Health Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Jim Mitchell at **JMitchell@dioama.org**.

Notice of Creditable Coverage

Important Notice from Catholic Employee Benefit Group About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Catholic Employee Benefit Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Catholic Employee Benefit Group has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Catholic Employee Benefit Group coverage will not be affected.

You can choose to join a Medicare drug plan and keep your current Catholic Employee Benefit Group coverage, however know that Medicare Part D will not coordinate with your current coverage.

If you do decide to join a Medicare drug plan and drop your current Catholic Employee Benefit Group coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Catholic Employee Benefit Group and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage:

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Catholic Employee Benefit Group changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

» Visit **www.medicare.gov**

» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

» Call **800.MEDICARE (800.633.4227)**. TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **800.772.1213** (TTY **800.325.0778**).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 2025
Name of Entity/Sender:	Catholic Employee Benefit Group
Contact:	Melissa Morin
Address:	555 N. Carancahua, Suite 750 Corpus Christi, TX 78401
Phone Number:	361.882.6191

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting