DIOCESE *of* LA CROSSE

HEALTH PLAN OVERVIEW - PRIESTS Group

Plan Year 2024

ST. AMBROSE
FINANCIAL SERVICES, INC.

OVERVIEW

- **Plan Year**
  - January 1 – December 31, 2024
- **Primary Medical Networks**
  - Anthem
  - www.anthem.com/contact-us/wisconsin/
  - **833.952.2061**
- **Prescription Drug / Pharmacy Benefit**
  - CVS caremark
  - www.caremark.com/
  - **800-565-7091**
- **VSP Vision Plan**
  - vsp vision care
  - Coverage included if enrolled in Health Plan
  - Can be added as a separate benefit if not enrolled in a Health Plan
  - Member Services - - **800-877-7195** or www.vsp.com
- **Delta Dental Plan**

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

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TRADITIONAL DEDUCTIBLE HEALTH PLAN

Benefit	PPO	Non-PPO
Deductible	$0.00	$0.00
Co-Insurance	90% Insurance 10% Insured to maximum out of pocket	80% Insurance 20% Insured to maximum out of pocket
Maximum Out of Pocket	$900.00	$1,300.00
Preventive / Wellness	Covered at 100% not subject to deductible	• 70% Insurance **(maximum benefit of $700)** • 30% Insured to maximum out of pocket
Prescriptions / Pharmacy Plan	Available via **CVS CAREMARK** Retail - 70% Insurance / 30% Insured to maximum out of pocket of $1,000 per individual	
Pre-Certifications	Authorization required to cover hospitalization and other certain medical procedures at least 72 hours prior for nonemergency admissions	

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Traditional Deductible Health Plan

Premiums 2024

Monthly premium effective January 1, 2024

Vision coverage included if enrolled in Health Plan

	Premium Rates Traditional Plan Deductible
Priests	$ 1,420 / month
Senior Priests - Medicare	$ 521 / month

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PRESCRIPTIONS (PHARMACY BENEFIT)

Provider – **CVS Caremark**

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

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DENTAL PLAN
PREMIUMS 2024

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

PREMIUM RATES	
Individual Only	$ 34

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VISION PLAN

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • 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. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME[†]	• $220 Featured Frame Brands allowance • $200 frame allowance • 20% savings on the amount over your allowance • $200 Walmart/Sam's Club frame allowance • $110 Costco frame allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
VSP LIGHTCARE[™†]	• $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	$25	Every 24 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on Featured Frame Brands. Go to **vsp.com/offers** for details. • 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.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		
YOUR COVERAGE GOES FURTHER IN-NETWORK			
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 **vsp.com** to find an in-network provider.			

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VISION PLAN
PREMIUMS 2024

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

NOTE:

- The Vision Insurance premium is included in the Diocese of La Crosse Priests Group Health Plan

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VOLUNTARY LIFE

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

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RESOURCES

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