If you were hospitalized today, how much do you think your out-of-pocket expenses would be?

Your total expense, including deductible & coinsurance, could be as high as $6,000 or more!

Benefit Connection is a low-cost program designed to help you pay for covered out-of-pocket expenses you may incur while you are either confined in a hospital or being treated as an out-patient for an injury or an illness.

Catholic Diocese of Brownsville has chosen a plan design that offers you an optimal offset of expenses due to high deductibles and high out-of-pocket maximums.

**Basic Plan Benefits offered to employees of Catholic Diocese of Brownsville**

- **Hospital Confinement Benefit** - This benefit is designed to offset the cost you incur as an in-patient in the hospital when your primary comprehensive major medical policy applies such expenses to your deductible or coinsurance maximum, up to the $1,000 calendar year maximum per insured person.

- **Out-Patient Benefit** - This benefit offsets the cost you incur for out-patient treatment when your primary major medical policy applies such expenses to your deductible or coinsurance maximum, up to the $1,000 benefit limit, and up to a maximum of three out-patient occurrences per family per calendar year. An "occurrence" is the treatment, or the series of treatments, for a specific injury or illness within a calendar year. Expenses related to physician office visits are not included in this benefit. Covered expenses include:
  - Surgery in an Out-Patient Facility or a Physician's Office
  - Emergency Room visits
  - Diagnostic testing, Lab & X-ray at a diagnostic or hospital out-patient facility or at a Physician's office if the cost is not included in the global office visit fee and is not part of wellness/preventive care

*For expenses to be eligible under this plan they must be medically necessary for the treatment of an injury or illness. Expenses not covered by your group major medical plan are not covered.*

**How to File a Claim**

When you enroll in the Benefit Connection plan, you will receive an ID card, along with specific instructions on how to file a claim. This form outlines the procedures you should follow to obtain a claim form, what you need to file a claim, and where you should send your claim. Simply stated, you will need to submit a completed claim form, itemized bills (NOT balance due statements), and EOB's that correspond to the itemized bills.

Claims may be filed at any time, but must be filed no longer than 12 months from the date of service in order to be eligible for coverage.

This information sheet highlights the important features of the product. The policy has limitations and exclusions. The exact provisions governing the insurance are contained in the master policy issued to each group on form number GAPP-4200, policy series G4200. Your carrier representative can supply you with costs and complete details of coverage.

**Arranged/Administered By:**
Special Insurance Services, Inc.
2740 Dallas Parkway, Suite 100
Plano, Texas 75093
(972) 788-0699 ☑️ (800) 767-6811
Fax: (972) 960-0377

**Offered to Employees of:**
Catholic Diocese of Brownsville

**Offered By:**
Daniel Sanchez
Insurance Solutions
3200 N. 23rd
McAllen TX 78501
956-687-1717
Fax 956-687-1716
Catholic Diocese of Brownsville

Assumed Effective Date: January 01, 2017
State of Domicile: TX (requires state specific enrollment materials)

AVAILABLE ONLY TO GROUPS WITH 2 OR MORE ENROLLED LIVES

### Employer Contributions
- **Employer Contributes to Employee Only Cost:** 0 %
- **Employer Contributes to Dependent Cost:** 0 %

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,000 Hospital Confinement Benefit</td>
<td></td>
</tr>
<tr>
<td>$1,000 Outpatient Benefit</td>
<td></td>
</tr>
</tbody>
</table>

### Payroll Deduction Factors
- Payroll Period: Bi-Weekly
- Pay Periods: 26

### Monthly Cost Table

#### Under Age 40:
- **Insured Only:**
  - Rate: $20.88
  - HIP Fee: $0.74
  - Monthly Cost: $21.62
- **Insured & Spouse:**
  - Rate: $38.38
  - HIP Fee: $1.35
  - Monthly Cost: $39.73
- **Insured & Child(ren):**
  - Rate: $51.51
  - HIP Fee: $1.81
  - Monthly Cost: $53.32
- **Insured & Family:**
  - Rate: $68.53
  - HIP Fee: $2.40
  - Monthly Cost: $70.93

#### Ages 40-49:
- **Insured Only:**
  - Rate: $27.01
  - HIP Fee: $0.95
  - Monthly Cost: $27.96
- **Insured & Spouse:**
  - Rate: $49.55
  - HIP Fee: $1.74
  - Monthly Cost: $51.30
- **Insured & Child(ren):**
  - Rate: $54.72
  - HIP Fee: $1.92
  - Monthly Cost: $56.64
- **Insured & Family:**
  - Rate: $78.76
  - HIP Fee: $2.69
  - Monthly Cost: $81.45

#### Ages 50 & Above:
- **Insured Only:**
  - Rate: $58.58
  - HIP Fee: $2.06
  - Monthly Cost: $60.64
- **Insured & Spouse:**
  - Rate: $107.63
  - HIP Fee: $3.77
  - Monthly Cost: $111.40
- **Insured & Child(ren):**
  - Rate: $102.21
  - HIP Fee: $3.58
  - Monthly Cost: $105.79
- **Insured & Family:**
  - Rate: $148.89
  - HIP Fee: $6.25
  - Monthly Cost: $155.24

### Total Lives & Est. Monthly Cost:
- Total Lives: 0
- Est. Monthly Cost: $0.00

### Composite Rating

**Composite Rating NOT AVAILABLE DUE TO SIZE, EMPLOYER CONTRIBUTION LEVEL OR DUAL PLANS**

### Composite Plan Rates

<table>
<thead>
<tr>
<th>Composite Info</th>
<th>Total Lives</th>
<th>Composite Plan Rate</th>
<th>HIP Fee</th>
<th>Composite Cost</th>
<th>Est. Monthly Cost</th>
<th>Payroll Period</th>
<th>Bi-Weekly Pay Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured Only</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Insured &amp; Spouse</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Insured &amp; Child(ren)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Insured &amp; Family</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</tr>
</tbody>
</table>

*Composite Plan Rates are indications only and are subject to change under the following conditions:*
1. At the time of initial enrollment when final group make-up and plan selections are determined; 2) the increase or decrease in the number of Insureds covered under the contract exceeds 25% from inception to the annual anniversary date; or 3) the employer adds or deletes subsidiaries or affiliated companies or divisions.

### Composite Plan Rates

1. The Composite Plan Rates may be changed on the next following Premium Due Date after either 2 or 3 shown above have occurred given at least 31 days advance written notice.

### Full Monthly Rate

2. The full monthly rate is payable regardless of the payroll deduction method used by the employer. Premiums are NOT pro-rated for partial periods of coverage.

### Health Insurance Providers Fee

3. The exact provisions governing the insurance are contained in the master policy issued to each group on form number GAPP-4200. This product is not available in all states.

### Underwritten by Companion Life Insurance Company, Columbia, South Carolina.

### NOT FOR USE WITH CONSUMER SALES

These rates are for a one-person family rate. If used with an employer, present with an approved marketing brochure that describes the benefits, exclusions, and limitations of the policy.

We wish to bind coverage effective: using (circle one) AGE-BANDED RATES COMPOSITE RATES IF AVAILABLE

Signature of Employer's Authorized Representative: