ARCHDIOCESE OF ST. LOUIS EMPLOYEE BENEFITS
MAJOR PROVISIONS OF THE HEALTH INSURANCE PLAN JULY 1, 2025 – JUNE 30, 2026

PLAN FEATURES	UNITEDHEALTHCARE MEDICAL PLAN – Group #703597			
Employees may choose one of the following UnitedHealthcare Plan Options *-The costs outlined on this chart are the costs that are paid by the member. Meeting the deductible first is only applicable where stated.*	**COMPREHENSIVE (PPO) PLAN[1]**		**BASE (HDHP w/ HSA) PLAN[1,2,3]** (must meet eligibility)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible (Individual / Family) Copays do not count toward deductible	$1,250 / $2,500	$2,500 / $5,000	$2,500 / $5,000	$5,000 / $10,000
Out-of-Pocket Maximum (Individual / Family) Out-of-Pocket maximum includes the deductible and copays	$5,000 / $10,000	$10,000 / $20,000	$5,000 / $9,000	$10,000 / $18,000
Embedded vs Non-Embedded Deductibles and Out-of-Pocket Maximums **Deductibles and Out-of-Pocket Maximums follow a calendar year of January 1st- December 31st.*	Embedded, meaning; If more than one person in the family is covered, each person must meet the individual deductible amount stated above until the total amount of deductible expenses paid by all family members meets the overall family deductible. The embedded out-of-pocket maximum amounts will work the same way.		Non-Embedded, meaning: If more than one person in the family is covered, no one in the family is eligible for benefits until the family deductible is satisfied, and the family coverage Out-of-Pocket Maximum stated above applies.	
Coinsurance	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
Office Visits	$30 copay per visit	40%, after deductible	20%, after deductible	40%, after deductible
Hospital Inpatient Stay	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
Outpatient Surgery	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
Outpatient Diagnostic (lab, x-ray, mammography)	No Charge	40%, after deductible	20%, after deductible	40%, after deductible
Emergency Room	$150 copay per visit	$150 copay per visit	20%, after deductible	20%, after deductible
Urgent Care	$50 copay per visit	40%, after deductible	20%, after deductible	20%, after deductible
Vision Examinations (1 exam per calendar year)	$20 copayment	40%, after deductible	20%, after deductible	40%, after deductible
Prescription Benefits	**COMPREHENSIVE (PPO) PLAN**		**BASE (HDHP W/HSA) PLAN[4]**	
	Pharmacy Retail	**Mail Order**	**Pharmacy Retail**	**Mail Order**
Copays: Tier 1 / Tier 2 / Tier 3	$10 / $35 / $50	$20 / $70 / $100	$10 / $35 / $50 after deductible	$20 / $70 / $100 after deductible
Maximum Supply	30 Days	90 Days	30 Days	90 Days

[1]All covered active employees in any of the UnitedHealthcare Plans automatically receive the *Delta Dental* and the *DeltaVision* plan benefits.
[2]Base Plan (HDHP w/HSA) option includes an annual employer contribution to your HSA of either $600 for individual or $1,200 for family coverage (prorated for mid-year enrollments).
[3]Participants are expected to follow all Catholic directives when using HSA funds for qualified expenses.
[4]Base Plan (HDHP w/HSA) includes an Expanded Preventive Drug List, whereby medications on the list may be covered at the applicable copay only, no deductible applies. Please be sure to call UHC at the number on your ID Card to inquire about your prescription drug costs before filling a prescription.

PLAN FEATURES – Group #1873-1000	**DELTA DENTAL PLAN** (automatically enrolled if medical coverage elected)	
Annual Deductible (Individual / Family)- *Paid by member*	**$50 / $100**	
	PPO Network	**Premier and Non-Network**
Preventative Care - (Covered in Full by Delta – Deductible Waived)	**100%**	**100%**
Basic Care *–Paid by Delta*	**90%**	**80%**
Major Care *–Paid by Delta*	**60%**	**50%**
Orthodontia (Children to Age 19 - $2,000 Lifetime Maximum) *–Paid by Delta*	**50%**	**50%**
Calendar Year Maximum (Individual / Family) - *Paid by Member*	**$2,000 per individual**	
PLAN FEATURES – Group #20070020	**DELTAVISION PLAN** (automatically enrolled if medical coverage elected)	
Copays are paid by members. Allowances are amounts that Delta pays towards the cost of materials and anything over that allowance is the member's responsibility (except where stated). For Out-of-Network, reimbursements are amounts that Delta will pay back to members when a member submits a claim..	**IN-NETWORK**	**OUT-OF-NETWORK**
Eye Exam (every 12 months)	**$10 copay**	**Reimbursed up to $40**
Eyeglass Lenses (every 12 months): Single/Bifocal/Trifocal	**$25 copay**	**Reimbursed up to $20/$40/$60**
Eyeglass Frames (every 24 months)	**$150 retail allowance + 20% of costs in excess of allowance**	**Reimbursed up to $60**
Contact Lenses in lieu of eyeglass lenses and frames (every 12 months)	**$150 retail allowance after $25 copay**	**Reimbursed up to $90**

The above exhibit attempts to highlight the major provisions of the Employee Benefit Plans. Additional benefits will be found in the respective plan brochures. In all cases, the Plan Document or Policy will serve as the legal basis for the terms and provisions of coverage. This document is for illustration purposes only.