

**ARCHDIOCESE OF ST. LOUIS EMPLOYEE BENEFITS**  
**MAJOR PROVISIONS OF THE HEALTH INSURANCE PLAN JULY 1, 2024 – JUNE 30, 2025**

PLAN FEATURES	UNITEDHEALTHCARE MEDICAL PLAN – Group #703597					
<b>Employees may choose one of the following UnitedHealthcare Plan Options</b> <i>-The costs outlined on this chart are the costs that are paid by the member. Meeting the deductible first is only applicable where stated.</i>	STANDARD PPO PLAN <sup>1</sup>		PREMIER PPO PLAN <sup>1</sup>		HDHP w/ HSA <sup>1,2</sup> (must meet eligibility)	
	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>
<b>Calendar Year Deductible</b> (Individual / Family) Copays do not count toward deductible	\$1,000 / \$2,000	\$2,000 / \$4,000	\$750 / \$1,500	\$1,500 / \$3,000	\$2,500 / \$5,000	\$5,000 / \$10,000
<b>Out-of-Pocket Maximum</b> (Individual / Family) Out-of-Pocket maximum includes the deductible and copays	\$4,000 / \$8,000	\$8,000 / \$16,000	\$2,150 / \$4,500	\$4,500 / \$9,000	\$5,000 / \$9,000	\$10,000 / \$18,000
<b>Embedded vs Non-Embedded Deductibles and Out-of-Pocket Maximums</b>	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.	
<b>Coinsurance</b>	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
<b>Office Visits</b>	\$30 copay per visit	40%, after deductible	\$20 copay per visit	40%, after deductible	20%, after deductible	40%, after deductible
<b>Hospital Inpatient Stay</b>	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
<b>Outpatient Surgery</b>	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
<b>Outpatient Diagnostic</b> (lab, x-ray, mammography)	No Charge	40%, after deductible	No Charge	40%, after deductible	20%, after deductible	40%, after deductible
<b>Emergency Room</b>	\$150 copay per visit	\$150 copay per visit	\$150 copay per visit	\$150 copay per visit	20%, after deductible	20%, after deductible
<b>Urgent Care</b>	\$50 copay per visit	40%, after deductible	\$50 copay per visit	\$50 copay per visit	20%, after deductible	20%, after deductible
<b>Vision Examinations</b> (1 exam per calendar year)	\$20 copayment	40%, after deductible	\$20 copayment	40%, after deductible	20%, after deductible	40%, after deductible
<b>Prescription Benefits</b>	STANDARD PLAN		PREMIER PLAN		HDHP PLAN <sup>3</sup>	
	<u>Pharmacy Retail</u>	<u>Mail Order</u>	<u>Pharmacy Retail</u>	<u>Mail Order</u>	<u>Pharmacy Retail</u>	<u>Mail Order</u>
<b>Copays: Tier 1 / Tier 2 / Tier 3</b>	\$10 / \$35 / \$50	\$20 / \$70 / \$100	\$10 / \$35 / \$50	\$20 / \$70 / \$100	\$10 / \$35 / \$50 after deductible	\$20 / \$70 / \$100 after deductible
<b>Maximum Supply</b>	30 Days	90 Days	30 Days	90 Days	30 Days	90 Days

<sup>1</sup>All covered active employees in any of the UnitedHealthcare Plans automatically receive the Delta Dental and the DeltaVision plan benefits.

<sup>2</sup>HDHP w/HSA plan option includes an annual employer contribution to your HSA of either \$600 for individual or \$1,200 for family coverage.

<sup>3</sup>HDHP Plan 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		DELTA VISION PLAN (automatically enrolled if medical coverage elected)	
<i>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..</i>		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.