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					
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.*	**STANDARD PPO PLAN[1]**		**PREMIER PPO PLAN[1]**		**HDHP w/ HSA[1]**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible (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
Out-of-Pocket Maximum (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
Embedded vs Non-Embedded Deductibles and Out-of-Pocket Maximums	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	20%, after deductible	40%, after deductible
Office Visits	$30 copay per visit	40%, after deductible	$20 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	20%, after deductible	40%, after deductible
Outpatient Surgery	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible	20%, after deductible	40%, after deductible
Outpatient Diagnostic (lab, x-ray, mammography)	No Charge	40%, after deductible	No Charge	40%, after deductible	20%, after deductible	40%, after deductible
Emergency Room	$150 copay per visit	$150 copay per visit	$150 copay per visit	$150 copay per visit	20%, after deductible	20%, after deductible
Urgent Care	$50 copay per visit	40%, after deductible	$50 copay per visit	$50 copay per visit	20%, after deductible	20%, after deductible
Vision Examinations (1 exam per calendar year)	$20 copayment	40%, after deductible	$20 copayment	40%, after deductible	20%, after deductible	40%, after deductible
Prescription Benefits	**STANDARD PLAN**		**PREMIER PLAN**		**HDHP PLAN[2]**	
	Pharmacy Retail	**Mail Order**	**Pharmacy Retail**	**Mail Order**	**Pharmacy Retail**	**Mail Order**
Copays: Tier 1 / Tier 2 / Tier 3	$10 / $35 / $50	$20 / $70 / $100	$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	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] 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.