

**ARCHDIOCESE OF ST. LOUIS EMPLOYEE BENEFITS
MAJOR PROVISIONS OF THE HEALTH INSURANCE PLAN JULY 1, 2017 – JUNE 30, 2018**

PLAN FEATURES	UNITEDHEALTHCARE MEDICAL PLAN – Group #703597			
Employees must choose one of the following two medical plans: United Healthcare Standard Plan or United Healthcare Premier Plan	STANDARD PLAN		PREMIER PLAN	
	<u>In-Network</u>	<u>Out-of-Network</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Calendar Year Deductible (Individual / Family)	\$1,000 / \$2,000	\$2,000 / \$4,000	\$400 / \$800	\$600 / \$1,200
Out-of-Pocket Maximum (Individual / Family) Out-of-Pocket maximum includes the deductible and copayment.	\$4,000 / \$8,000	\$8,000 / \$16,000	\$1,650 / \$3,300	\$2,100 / \$4,200
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Coinsurance paid by member	20%	40%	20%	40%
Office Visits	\$30 copay	40%	\$20 copay	40%
Hospital Inpatient Stay	20%	40%	20%	40%
Outpatient Surgery	20%	40%	20%	40%
Outpatient Diagnostic (lab, x-ray, mammography)	\$0 copay	40%	\$0 copay	40%
Emergency Room	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Urgent Care	\$50 copay	40%	\$50 copay	\$50 copay
Mental Health and Substance Abuse - Inpatient	20%	40%	20%	40%
Mental Health and Substance Abuse - Outpatient	\$30 copay	40%	\$20 copay	40%
Home Health Care (limit to 100 visits/ calendar year)	20%	40%	20%	40%
Vision Examinations (1 exam per calendar year)	100% after \$20 copayment	60% after deductible	100% after \$20 copayment	60% after deductible
Prescription Benefits	STANDARD PLAN		PREMIER PLAN	
	<u>Pharmacy Retail</u>	<u>Mail Order</u>	<u>Pharmacy Retail</u>	<u>Mail Order</u>
Copays: Tier 1 / Tier 2 / Tier 3	\$10 / \$35 / \$50	\$20 / \$70 / \$100	\$10 / \$35 / \$50	\$20 / \$70 / \$100
Maximum Supply	30 Days	90 Days	30 Days	90 Days

All covered active employees in either the United Healthcare Standard or Premier Plan automatically receive the Delta Dental Plan.

PLAN FEATURES – Group #1873-1000	DELTA DENTAL PLAN	
Annual Deductible - (Individual / Family)	\$50 / \$100	
	PPO Network	Premier and Non-Network
Preventative Care - (Covered in Full – Deductible Waived)	100%	100%
Basic Care	90%	80%
Major Care	60%	50%
Orthodontia - (Children to Age 19 - \$1,500 Lifetime Maximum)	50%	50%
Calendar Year Maximum - (Individual / Family)	\$1,500 / \$3,000	

The above exhibit attempts to highlight the major provisions of the Employee Benefit Plans. Additional benefits will be found in the prospective plan brochure. 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.