ARCHDIOCESE OF ST. LOUIS EMPLOYEE BENEFITS
MAJOR PROVISIONS OF THE HEALTH INSURANCE PLAN JULY 1, 2023 – JUNE 30, 2024

PLAN FEATURES	UNITEDHEALTHCARE MEDICAL PLAN – Group #703597			
Employees may choose one of the following two medical plans: United Healthcare Standard Plan or United Healthcare Premier Plan *-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 PLAN**		**PREMIER PLAN**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible (Individual / Family)	**$1,000 / $2,000**	**$2,000 / $4,000**	**$750 / $1,500**	**$1,500 / $3,000**
Out-of-Pocket Maximum (Individual / Family) **Out-of-Pocket maximum includes the deductible and copay.**	**$4,000 / $8,000**	**$8,000 / $16,000**	**$2,150 / $4,500**	**$4,500 / $9,000**
Coinsurance	**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**
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**	**No Charge**	**40%, after deductible**
Emergency Room	**$150 copay per visit**	**$150 copay per visit**	**$150 copay per visit**	**$150 copay per visit**
Urgent Care	**$50 copay per visit**	**40%, after deductible**	**$50 copay per visit**	**$50 copay per visit**
Vision Examinations (1 exam per calendar year)	**$20 copayment**	**40%, after deductible**	**$20 copayment**	**40%, after deductible**
Prescription Benefits	**STANDARD PLAN**		**PREMIER PLAN**	
	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**
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* and the *DeltaVision* Plan.

PLAN FEATURES – Group #1873-1000	DELTA DENTAL PLAN	
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**	
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 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.