| | Low Deductible Option | | High Deductible Option | |
|---|---|---|---|---|
| **BENEFIT** | **PPO** | **NON-PPO** | **PPO** | **NON-PPO** |
| **DEDUCTIBLE** | | | | |
| **INDIVIDUAL** | $500 | $1,000 | $2,000 | $4,000 |
| **FAMILY** | $1,500 | $3,000 | $4,000 | $8,000 |
| **COINSURANCE** | 90% | 70% | 80% | 60% |
| **OUT-OF-POCKET MAXIMUM** | | | | |
| **INDIVIDUAL** | $2,500 | $5,000 | $5,000 | $10,000 |
| **FAMILY** | $7,500 | $15,000 | $10,000 | $20,000 |
| **COPAY** | $15 | 70% after Deductible | N/A | N/A |
| **MAXIMUM LIFETIME BENEFIT** | Unlimited | | Unlimited | |
| **PHYSICIAN OFFICE VISITS** | $15 copay | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **ROUTINE/PREVENTIVE EXAMS - No cost or copay to to employee for one annual wellness visit** | **No Cost** | **No Cost** | **No Cost** | **No Cost** |
| **WELL WOMAN SERVICES - **see note above** | $15 copay | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **WELL BABY SERVICES** | | | | |
| **ROUTINE IMMUNIZATIONS** | $15 copay | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **ROUTINE CHECK UPS** | $15 copay | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **MATERNITY SERVICES (covered for dependent daughter as well)** | Copayments/Coinsurance based on setting where Covered Services are received | | | |
| **LABORATORY AND X-RAY SERVICES** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **AMBULANCE** | | | | |
| **PERCENTAGE PAYABLE** | 90% after Deductible | | 80% after Deductible | |
| **EMERGENCY ROOM SERVICES** | 90% after Deductible | 90% after Deductible | 80% after Deductible | 80% after Deductible |
| **HOSPITAL INPATIENT** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **OUTPATIENT SURGERY** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **URGENT CARE FACILITY** | $0 copay | $0 copay | 80% after Deductible | 60% after Deductible; You are responsible for any amounts charged that exceed the Maximum Allowable Amount |
| **SECOND OPINIONS** **Applies to second opinions obtained as described under Claims Procedure Precertification Surgery Procedures** | $15 copay | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **ORGAN TRANSPLANT COVERAGE** | Covered | Limited Coverage | Covered | Limited Coverage |
| **HOSPICE CARE** | No Copay or Coinsurance | | 80% after Deductible | |
| **MAXIMUM PAYABLE** | Not Specified | | Not Specified | |
| **SKILLED NURSING FACILITY** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **MAXIMUM NUMBER OF DAYS** | 90 days | | 90 days | |
| **HOME HEALTH CARE** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **MAXIMUM PAYABLE** | 90 visits per calendar year | | 90 visits per calendar year | |
| **PRIVATE DUTY NURSING** | | | | |
| **Maximum per Member per Benefit Period** | 82 visits | | 82 visits | |
| **Lifetime Maximum** | 164 visits | | 164 visits | |
| **ALCOHOL & DRUG RELATED SERVICES** | In compliance with Federal Law | | In compliance with Federal Law | |
| **INPATIENT** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **OUTPATIENT** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **BEHAVIORAL HEALTH SERVICES** | | | | |
| **INPATIENT** | 10% Coinsurance | 30% Coinsurance | 20% Coinsurance | 40% Coinsurance |
| **OUTPATIENT** | 10% Coinsurance | 30% Coinsurance | 20% Coinsurance | 40% Coinsurance |
| **Physician Home Visits & Office Services** | $15 Copayment per visit | 30% Coinsurance | 20% Coinsurance | 40% Coinsurance |

| | Low Deductible Option | | High Deductible Option | |
|---|---|---|---|---|
| **BENEFIT** | **PPO** | **NON-PPO** | **PPO** | **NON-PPO** |
| **PROSTHETICS** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **CALENDAR YEAR MAXIMUM** | Unlimited | | Unlimited | |
| **MEDICAL EQUIPMENT** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **CALENDAR YEAR MAXIMUM** | $4,000 | | $4,000 | |
| **OCCUPATIONAL, PHYSICAL & SPEECH THERAPY** | | | | |
| **CALENDAR YEAR MAXIMUM** | 20 visits per diagnosis | | 20 visits per diagnosis | |
| **PROSTATE SCREENING** | $15 copay | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **ALLERGY SHOTS** | $5 Copay | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **FERTILITY - Standard In or Out-of-Network benefits apply** | Coverage includes treatment (including drugs) to restore fertility or promote conception, but limited to the detection and/or correction of abnormal conditions or malfunctioning reproductive organs which prevent natural conception. Coverage does not include reversal of voluntary sterilization and any other treatment for the restoration of fertility or promotion of conception. (Procedures such as, but not limited to, in vitro fertilization, artificial insemination, surrogacy, harvesting eggs, sperm donation, or cryopreservation are not covered). | | Coverage includes treatment (including drugs) to restore fertility or promote conception, but limited to the detection and/or correction of abnormal conditions or malfunctioning reproductive organs which prevent natural conception. Coverage does not include reversal of voluntary sterilization and any other treatment for the restoration of fertility or promotion of conception. (Procedures such as, but not limited to, in vitro fertilization, artificial insemination, surrogacy, harvesting eggs, sperm donation, or cryopreservation are not covered). | |
| **HEARING EXAMS** | Not Covered | | Not Covered | |
| **MANIPULATION THERAPY** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **MAXIMUM VISITS** | 12 Visits | | $50 per day and $1,000 per year | |
| **BEREAVEMENT COUNSELING** | Not Covered | | Not Covered | |
| **ALL OTHER COVERED MEDICAL EXPENSES** | 90% after Deductible | 70% after Deductible | 80% after Deductible | 60% after Deductible |
| **LATE ENROLLEES** | 1 enrollment per year during the month of August | | 1 enrollment per year during the month of August | |
| **ELIGIBILITY** | **Non -Academic:** An employee of the Diocese who regularly works twenty (20) or more hours per week will be eligible to enroll for coverage under this Plan. Other employees such as temporary or seasonal will not be eligible to enroll for coverage under this Plan. **Academic & Academic Half Time Employees:** Those employees of the Diocese will be as determined by the contract with the Diocese. **Retirees:** Also eligible is a retiree of the Employer who has attained the age of sixty (60), has four (4) years and nine (9) months or more of service and have been covered under the Plan for one (1) year and is considered eligible under the Dioceses's retirement plan. | | **Non -Academic:** An employee of the Diocese who regularly works twenty (20) or more hours per week will be eligible to enroll for coverage under this Plan. Other employees such as temporary or seasonal will not be eligible to enroll for coverage under this Plan. **Academic & Academic Half Time Employees:** Those employees of the Diocese will be as determined by the contract with the Diocese. **Retirees:** Also eligible is a retiree of the Employer who has attained the age of sixty (60), has four (4) years and nine (9) months or more of service and have been covered under the Plan for one (1) year and is considered eligible under the Dioceses's retirement plan. | |
| **WAITING PERIOD** | First of the month following full-time employment | | First of the month following full-time employment | |
| **LEAVE OF ABSENCE** | No leave besides FMLA | | No leave besides FMLA | |
| **RETIREE COVERAGE** | Retirees are eligible for coverage (self-pay option) with our plan until they reach Medicare eligibility. The retiree must have attained the age of sixty (60), have four (4) years and nine (9) months or more years of service, have been covered under the insurance plan for one (1) year and be considered eligible for retirement under the Diocese's retirement plan. | | Retirees are eligible for coverage (self-pay option) with our plan until they reach Medicare eligibility. The retiree must have attained the age of sixty (60), have four (4) years and nine (9) months or more years of service, have been covered under the insurance plan for one (1) year and be considered eligible for retirement under the Diocese's retirement plan. | |
| **PRESCRIPTION DRUGS** | | | | |
| **RETAIL** | | | | |
| **GENERIC** | $10 | | $15 | |
| **FORMULARY** | $20 | | $25 | |
| **NON-FORMULARY** | $40 | | $45 | |
| **MAIL ORDER** | | | | |
| **GENERIC** | $20 | N/A | $30 | N/A |
| **FORMULARY** | $40 | N/A | $50 | N/A |
| **NON- FORMULARY** | $80 | N/A | $90 | N/A |
| **Retail Refill Limit:** | A covered person may fill an initial prescription and up to two (2) refills at the applicable retail Co-pay. For any subsequent refills, the Co-pay will be doubled. This provision will apply to medications that are taken for longer than three (3) months. | | A covered person may fill an initial prescription and up to two (2) refills at the applicable retail Co-pay. For any subsequent refills, the Co-pay will be doubled. This provision will apply to medications that are taken for longer than three (3) months. | |