BENEFIT	Low Deductible Option PPO	Low Deductible Option NON-PPO	High Deductible Option PPO	High Deductible Option 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	90% after Deductible	70% after Deductible	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		$10	
FORMULARY	$20		$20	
NON-FORMULARY	$40		$40	
MAIL ORDER				
GENERIC	$20	N/A	$20	N/A
FORMULARY	$40	N/A	$40	N/A
NON- FORMULARY	$80	N/A	$80	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.	