



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.optumrx.com](http://www.optumrx.com) or by calling **1-800-356-3477**.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Not applicable	This document only refers to your Rx coverage.
Are there other <u>deductibles</u> for specific services?	No, does not apply to your Rx program	You don't have to meet deductibles for specific services under the Rx program.
Is there an <u>out-of-pocket limit</u> on my expenses?	No	An out-of-pocket limit is the most you could pay during a calendar year period (January 1 <sup>st</sup> – December 31 <sup>st</sup> ) for your share of the cost of covered drugs (e.g., deductible, copay).
What is not included in the <u>out-of-pocket limit</u> ?	N/A	Not applicable to your Rx program
Is there an overall annual limit on what the plan pays?	No, does not apply to your Rx program	Not applicable to your Rx program.
Does this plan use a <u>network of providers</u> ?	Yes, please visit <a href="http://www.optumrx.com">www.optumrx.com</a> for a list of participating pharmacies	If you use a non-participating pharmacy, you will be required to pay the pharmacy the full retail cost. You can be reimbursed only what we would have paid to a participating pharmacy less your copay by filling out a drug reimbursement claim form at <a href="http://www.optumrx.com">www.optumrx.com</a> . Please note you may be reimbursed less than what you actually paid at a non-participating pharmacy.
Do I need a referral to see a specialist?	Not applicable to your Rx program	
Are there services this plan doesn't cover?	Yes	Please refer to the brochure that was enclosed with your Rx ID card which describes what drugs are covered or not covered under your program.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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- **Copayments** are fixed dollar amounts (for example, \$17) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <b>provider’s</b> office or clinic	Primary care visit to treat an injury or illness	Not applicable	Not applicable	
	Specialist visit	Not applicable	Not applicable	
	Other practitioner office visit	Not applicable	Not applicable	
	Preventive care/screening/immunization	Not applicable	Not applicable	
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	Not applicable	
	Imaging (CT/PET scans, MRIs)	Not applicable	Not applicable	
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is available at <a href="http://www.benecardpbf.com">www.benecardpbf.com</a> .	Tier 1 - Generic drugs	\$17 retail copay \$42.50 mail order copay \$42.50 Retail 90 copay	100%	30 day supply retail 90 day supply mail order Kroger Retail 90 Program
	Tier 2 - Preferred brand drugs	\$39 retail copay \$97.50 mail order copay \$97.50 Retail 90 copay	100%	30 day supply retail 90 day supply mail order Kroger Retail 90 Program
	Tier 3 - Non-preferred brand drugs	\$78 retail copay \$195 mail order copay \$195 Retail 90 copay	100%	30 day supply retail 90 day supply mail order and Kroger Retail 90 Program

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Tier 4 - Preferred Specialty (brand and generic)	\$78 retail copay \$195 mail order copay \$195 Retail 90 copay	100%	30 day supply retail 90 day supply mail order and Kroger Retail 90 Program
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not applicable	Not applicable	
	Physician/surgeon fees	Not applicable	Not applicable	
<b>If you need immediate medical attention</b>	Emergency room services	Not applicable	Not applicable	
	Emergency medical transportation	Not applicable	Not applicable	
	Urgent care	Not applicable	Not applicable	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable	Not applicable	
	Physician/surgeon fee	Not applicable	Not applicable	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Not applicable	Not applicable	
	Mental/Behavioral health inpatient services	Not applicable	Not applicable	
	Substance use disorder outpatient services	Not applicable	Not applicable	
	Substance use disorder inpatient services	Not applicable	Not applicable	
<b>If you are pregnant</b>	Prenatal and postnatal care	Not applicable	Not applicable	
	Delivery and all inpatient services	Not applicable	Not applicable	
<b>If you need help recovering or have other special health needs</b>	Home health care	Not applicable	Not applicable	
	Rehabilitation services	Not applicable	Not applicable	
	Habilitation services	Not applicable	Not applicable	
	Skilled nursing care	Not applicable	Not applicable	
	Durable medical equipment	Not applicable	Not applicable	
	Hospice service	Not applicable	Not applicable	

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# Archdiocese of Cincinnati - OptumRx

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2024 – 06/30/2025

Coverage for: Single & Family | Plan Type: Rx

If your child needs dental or eye care	Eye exam	Not applicable	Not applicable	
	Glasses	Not applicable	Not applicable	

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Dental check-up	Not applicable	Not applicable	

**Excluded Services & Other Covered Services:**

<b>Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u>.)</b>		
<ul style="list-style-type: none"> <li>• Acne Products</li> <li>• Alternative Medications</li> <li>• Anti-fungals - Topical</li> <li>• Anti-Obesity Agents</li> <li>• Bacterial Vaccines</li> <li>• Blood Pressure Devices</li> <li>• Contraceptives</li> </ul>	<ul style="list-style-type: none"> <li>• Diabetic Supplies</li> <li>• Dietary Management Products</li> <li>• Fertility Regulators</li> <li>• Hair Growth Agents</li> <li>• Impotence Agents</li> <li>• Infertility Treatments</li> <li>• Multivitamins</li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional Supplements</li> <li>• Oral Hygiene Products</li> <li>• Parenteral Therapy Supplies</li> <li>• Prenatal Vitamins</li> <li>• Smoking Deterrents</li> </ul>

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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 740-397-7422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact OptumRx at 1-800-356-3477.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **The Affordable Care Act requires most people to have health coverage that qualifies as “minimum essential coverage.” This Summary of Benefits and Coverage only applies to your prescription drug program. This prescription drug program alone, does not qualify as minimum essential coverage. However, to determine if your health coverage qualifies as minimum essential coverage, please contact the health plan at 1.800.887.6055.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This Summary of Benefits and Coverage only applies to your prescription drug program. This prescription drug program does meet the minimum value standard, please contact the health plan at 1.800.887.6055.**

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-356-3477.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$10
- Patient pays \$7,530

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$7,510
<b>Total</b>	<b>\$7,530</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,000
- Patient pays \$3,400

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$700
Coinsurance	\$0
Limits or exclusions	\$1,300
<b>Total</b>	<b>\$2,000</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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