Diocese of Charlotte

Employee Benefits

Medical, Dental, Vision and Prescription Plans

July 1, 2014

Catholic Diocese of Charlotte – Employees Other Than Priests Within Network Areas

Options PPO plan gives you the freedom to see any Physician or other health care professional from the Network, including specialists, without a referral. With this plan, you will receive the highest level of benefits when you seek care from a network physician, facility or other health care professional. In addition, you do not have to worry about any claim forms or bills.

You also may choose to seek care outside the Network, without a referral. However, you should know that care received from a non-network physician, facility or other health care professional means a higher deductible and Copayment. In addition, if you choose to seek care outside the Network, your plan only pays a portion of those charges and it is your responsibility to pay the remainder. This amount you are required to pay, which could be significant, does not apply to the Out-of-Pocket Maximum. We recommend that you ask the non-network physician or health care professional about their billed charges *before you receive care*.

Some of the Important Benefits of Your Plan:

You have access to a Network of physicians, facilities and other health care professionals, including specialists, without designating a Primary Physician or obtaining a referral.

Benefits are available for office visits and hospital care, as well as inpatient and outpatient surgery.

Care Coordination℠ services are available to help identify and prevent delays in care for those who might need specialized help.

Emergencies are covered anywhere in the world.

Pap smears are covered.

Prenatal care is covered.

Routine check-ups are covered.

Childhood immunizations are covered.

Mammograms are covered.

Vision and hearing screenings are covered.

Options PPO *Benefits Summary*

Types of Coverage	Network Benefits	Non-Network Benefits
This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Summary Plan Description that you will receive upon enrolling in the Plan.** If this Benefit Summary conflicts in any way with the Summary Plan Description issued to your employer, the Summary Plan Description shall prevail. Terms that are capitalized in the Benefit Summary are defined in the Summary Plan Description. Where Benefits are subject to day, visit and/or dollar limits, such limits apply to the combined use of Benefits whether in-Network or out-of-Network, except where mandated by state law. Network Benefits are payable for Covered Health Services provided by or under the direction of your Network physician. *Prior Notification is required for certain services.	**Annual Deductible:** $550 per Covered Person per calendar year, not to exceed $1,100 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $1,200 per Covered Person per calendar year, not to exceed $2,400 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD. **Maximum Plan Benefit:** No Maximum Plan Benefit.	**Annual Deductible:** $850 per Covered Person per calendar year, not to exceed $1,700 for all Covered Persons in a family. **Out-of-Pocket Maximum:** $3,600 per Covered Person per calendar year, not to exceed $7,200 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum as specified in Section 1 of the SPD. **Maximum Plan Benefit:** No Maximum Plan Benefit.
1. Ambulance Services - Emergency only	Ground Transportation: 10 % of Eligible Expenses. Deductible does not apply. Air Transportation: 10 % of Eligible Expenses. Deductible does not apply	Same as Network Benefit
2. Dental Services - Accident only	*0% of Eligible Expenses Deductible is waived. *Prior notification is required before follow-up treatment begins.	30% Eligible Expenses after deductible *Prior notification is required before follow-up treatment begins.
3. Durable Medical Equipment A single purchase of any one type of equipment is covered. Replacement or repair is covered if medically necessary. No Annual Maximum.	*10 % of Eligible Expenses after deductible *Prior notification is required when the cost is more than $1,000.	*30 % of Eligible Expenses after deductible *Prior notification is required when the cost is more than $1,000
4. Emergency Health Services –	10 % of Eligible Expenses after deductible *Notification is required if results in an Inpatient Stay.	Same as Network Benefit *Notification is required if results in an Inpatient Stay.
5. Eye Examinations	Covered with UnitedHealthcare Vision	Covered with UnitedHealthcare Vision
6. Home Health Care Network and Non-Network Benefits are limited to 100 visits for skilled care services per calendar year.	*0 % of Eligible Expenses Deductible is waived	*30 % of Eligible Expenses after deductible
7. Hospice Care Network and Non-Network Benefits are limited to 180 days during the entire period of time a Covered Person is covered under the Plan.	*0% of Eligible Expenses Deductible is waived.	*30 % of Eligible Expenses after deductible
8. Hospital - Inpatient Stay	*10 % of Eligible Expenses after deductible Contracted Rate	*30 % of Eligible Expenses after deductible Semi-Private Rate
9. Allergy Injections Received in a Physician's Office Copay only applies if patient sees physician.	0 % of Eligible Expenses after $25 Copay	30% of Eligible Expenses after deductible
10. Maternity Services **Newborn Hospital Services**	Same as 8, 11, 12 and 13 $25 Copay on first visit. No Copayment applies to Physician office visits for prenatal care after the first visit. *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.	Same as 8, 11, 12 and 13 *Notification is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

Types of Coverage	Network Benefits	Non-Network Benefits
11. Outpatient Surgery, Diagnostic and Therapeutic Services		
Outpatient Surgery	10 % of Eligible Expenses after deductible	30 % of Eligible Expenses after deductible
Outpatient Diagnostic Services	For lab and radiology/Xray: 0% Coinsurance, Deductible waived, no copayment	30 % of Eligible Expenses after deductible
	For mammography testing: 0% Coinsurance, Deductible waived, no copayment	30 % of Eligible Expenses, deductible waived
	Pap Smear: 0% Coinsurance, Deductible waived, no copayment	30 % of Eligible Expenses after deductible
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine	10 % of Eligible Expenses after deductible	30 % of Eligible Expenses after deductible
Outpatient Therapeutic Treatments	10 % of Eligible Expenses after deductible	30 % of Eligible Expenses after deductible
12. Physician's Office Services	$25 per visit. $50 for specialist.	30 % of Eligible Expenses after deductible
13. Professional Fees for Surgical and Medical Services	10% of Eligible Expenses after deductible $25 Copayment ($50 Specialist) in Physician Office	30 % of Eligible Expenses after deductible
14. Prosthetic Devices A single purchase of any one type of appliance is covered. Replacement of device is covered only with change in patient's medical condition	10 % of Eligible Expenses after deductible Notification is required >$1,000	30 % of Eligible Expenses Notification is required > $1,000
15. Reconstructive Procedures	*Same as 8, 11, 12, 13 and 14	*Same as 8, 11, 12, 13 and 14
16. Rehabilitation Services -Outpatient Therapy Network and Non-Network Benefits are limited as follows: 40 visits of physical therapy; 40 visits of occupational therapy; 40 visits of speech therapy; 40 visits of pulmonary rehabilitation; and 40 visits of cardiac rehabilitation per calendar year.	10 % of Eligible Expenses after deductible	30 % of Eligible Expenses after deductible
17. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Network and Non-Network Benefits are limited to 100 days per calendar year.	*0 % of Eligible Expenses Deductible Waived	*30 % of Eligible Expenses after deductible
18. Transplantation Services	*0 % of Eligible Expenses via URN Facility. Travel, meal, companion and accomodation benefits apply. Non URN Network facilities also receive network benefits	*30 % of Eligible Expenses
19. Urgent Care Center Services	10 % of Eligible Expenses after deductible	30 % of Eligible Expenses after deductible

Additional Benefits

Anesthesia	10% of Eligible Expense after deductible.	Same as In Network. RAPS Program applies.
Mental Health and Substance Abuse Services – Outpatient	$25 per visit	30 % of Eligible Expenses after deductible. Applies to Out of Pocket
Mental Health and Substance Abuse Services – Inpatient and Intermediate	10% of Eligible Expense after deductible. Applies to Out of Pocket	*30 % of Eligible Expense after deductible. Applies to Out of Pocket
Spinal Treatment Benefits include diagnosis and related services and are limited to one visit and treatment per day. Network and Non-Network Benefits are limited to 20 visits per calendar year.	$50 per visit	30 % of Eligible Expenses after deductible

Exclusions

Except as may be specifically provided in Section 1 and Section 2 of the Summary Plan Description (SPD) or through a Rider to the Plan, the following are not covered:

A. Alternative Treatments

Acupressure; hypnotism; rolfing; massage therapy; aromatherapy; acupuncture; and other forms of alternative treatment.

B. Comfort or Convenience

Personal comfort or convenience items or services such as television; telephone; barber or beauty service; guest service; supplies, equipment and similar incidental services and supplies for personal comfort including air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers; devices or computers to assist in communication and speech.

C. Dental

Except as specifically described as covered in Section 1 of the SPD for services to repair a sound natural tooth that has documented accident-related damage, dental services are excluded. There is no coverage for services provided for the prevention, diagnosis, and treatment of the teeth, jawbones or gums (including extraction, restoration, and replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes). Dental implants and dental braces are excluded. Dental x-rays, supplies and appliances and all associated expenses arising out of such dental services (including hospitalizations and anesthesia) are excluded, except as might otherwise be required for transplant preparation, initiation of immunosuppressives, or the direct treatment of acute traumatic Injury, cancer, or cleft palate. Treatment for congenitally missing, malpositioned, or super numerary teeth is excluded, even if part of a Congenital Anomaly.

D. Drugs

Prescription drug products for outpatient use that are filled by a prescription order or refill. Self-injectable medications. Non-injectable medications given in a Physician's office except as required in an Emergency. Over-the-counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

F. Foot Care

Routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting, or debriding; hygienic and preventive maintenance foot care; treatment of flat feet or subluxation of the foot.

G. Medical Supplies and Appliances

Devices used specifically as safety items or to affect performance primarily in sports-related activities. Prescribed or non-prescribed medical supplies and disposable supplies including but not limited to elastic stockings, ace bandages, gauze and dressings, syringes and diabetic test strips. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces). Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 1 of the SPD.

H. Mental Health/Substance Abuse

Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health treatment of insomnia and other sleep disorders, neurological disorders, and other disorders with a known physical basis.

Treatment of conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.

Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. Residential treatment services. Services or supplies that in the reasonable judgment of the Mental Health/Substance Abuse Designee are not, for example, consistent with certain national standards or professional research further described in Section 2 of the SPD.

I. Nutrition

Megavitamin and nutrition based therapy; nutritional counseling for either individuals or groups. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

Cosmetic Procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and/or which are performed as a treatment for acne. Replacement of an existing breast implant is excluded if the earlier breast implant was a Cosmetic Procedure. (Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.)

Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation. Weight loss programs for medical and non-medical reasons. Wigs, regardless of the reason for the hair loss.

K. Providers

Services performed by a provider with your same legal residence or who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider as further described in Section 2 of the SPD (this exclusion does not apply to mammography testing).

L. Reproduction

Health services and associated expenses for infertility treatments.

Surrogate parenting.

M. Elective Abortions

N. Services Provided under Another Plan

Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements, including but not limited to coverage required by workers' compensation, no-fault automobile insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Mental Illness or Sickness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.

O. Transplants

Health services for organ or tissue transplants are excluded, except those specified as covered in Section 1 of the SPD. Any solid organ transplant that is performed as a treatment for cancer.

Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Health services for transplants involving mechanical or animal organs.

Any multiple organ transplant not listed as a Covered Health Service in Section 1 of the SPD.

P. Travel

Health services provided in a foreign country, unless required as Emergency Health Services.

Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Q. Vision and Hearing

Purchase cost of eye glasses, contact lenses, or hearing aids. Fitting charge for hearing aids, eye glasses or contact lenses. Eye exercise therapy. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

R. Other Exclusions

Health services and supplies that do not meet the definition of a Covered Health Service - see definition in Section 10 of the SPD.

Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments otherwise covered under the Plan, when such services are: (1) required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any type.

Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising prior to the date your coverage under the Plan ends.

Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.

In the event that a Non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which Copayments and/or the Annual Deductible are waived.

Charges in excess of Eligible Expenses or in excess of any specified limitation.

Surgical treatment and non-surgical treatment of obesity.

Growth hormone therapy; sex transformation operations; treatment of benign gynecomastia (abnormal breast enlargement in males); medical and surgical treatment of excessive sweating (hyperhidrosis); medical and surgical treatment for snoring, except when provided as part of treatment for documented obstructive sleep apnea. Oral appliances for snoring.

Custodial care; domiciliary care; private duty nursing; respite care; rest cures.

Psychosurgery. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke or Congenital Anomaly.

Effective July 1, 2011:

The Catholic Diocese of Charlotte believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. B eing a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources, 704-370-6299.

UnitedHealthcare Dental Options PPO/covered dental services

dental plan
Custom – P5766

	NON-ORTHODONTICS IN-NETWORK	NON-ORTHODONTICS OUT-OF-NETWORK	ORTHODONTICS IN-NETWORK	ORTHODONTICS OUT-OF-NETWORK
Individual Annual Deductible	$25	$25	$0	$0
Family Annual Deductible	$75	$75	$0	$0
Maximum *(combined for both In-Network and Out-of-Network services)*	$1000 per person per calendar year	$1000 per person per calendar year	$1000 per person per lifetime	$1000 per person per lifetime

Annual deductible applies to preventive and diagnostic services	No
Annual deductible applies to orthodontic services	No
For new enrollees, a 12-month waiting period applies to major and orthodontic services	No
Orthodontic eligibility requirement	Child Only

COVERED SERVICES	IN-NETWORK PLAN PAYS*	OUT-OF-NETWORK PLAN PAYS**	BENEFIT GUIDELINES
PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES			
Periodic Oral Examinations	100%	100%	Up to 2 per year.
Bite-Wing X-rays	100%	100%	One series of films per year.
Complete Series or Panorex X-rays	100%	100%	One time per 36 months.
Dental Prophylaxis (Cleanings)	100%	100%	Up to 2 per year.
Fluoride Treatments	100%	100%	For covered persons under the age of 16 years, up to 2 per year.
Sealants	100%	100%	For covered persons under the age of 16 years, once per first or second permanent molar every 5 years.
BASIC DENTAL SERVICES (Minor Restorative, Endodontics, Periodontics and Oral Surgery)			
Amalgam Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Composite Resin Restorations (Fillings)	80%	80%	One restoration allowed per surface every 3 years.
Space Maintainers	80%	80%	For covered persons under the age of 16 years, once per lifetime.
Root Canal Treatment	80%	80%	Once per site per lifetime.
Root Planing	80%	80%	Once every 24 months per quadrant.
Periodontal Surgery	80%	80%	Once every 36 months per site.
Simple Extraction	80%	80%	
Surgical Extraction including Impacted Wisdom Teeth	80%	80%	
General Anesthesia	80%	80%	When clinically necessary.
Palliative Treatment (Relief of Pain)	80%	80%	Covered as a separate benefit only if no other services except exam and X-rays were performed during the visit.
MAJOR DENTAL SERVICES			
Crowns	50%	50%	Once every 5 years.
Fixed Bridges	50%	50%	Once every 5 years (alternate benefits for a partial denture may be applied).
Full Dentures	50%	50%	Once every 5 years; no allowance for overdentures or customized dentures.
Inlays and Onlays	50%	50%	Once every 5 years.
Partial Dentures	50%	50%	Once every 5 years; no allowance for precision or semiprecision attachments.
Recement Bridges, Crowns, Inlays	50%	50%	Once every 6 months per restoration.
Relining Dentures	50%	50%	Once every year after the 6 month period following initial insertion.
Repairs to Full Dentures, Partial Dentures, Bridges	50%	50%	For repairs or adjustments done after 12 months following the initial insertion.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite including Phase I and Phase II	50%	50%	Preauthorization required.

*The in-network percentage of benefits is based on the discounted fee negotiated with the provider.

**The out-of-network percentage of benefits is based on the usual and customary rates prevailing in the geographic area in which the expenses are incurred.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; or United HealthCare Services, Inc.

100-3299 6/01 ©2001 United HealthGroup Incorporated

UnitedHealthcare/dental exclusions and limitations

general limitations

ORAL EXAMINATIONS Covered as a separate benefit only if no other service was done during the visit other than X-rays. Limited to 2 times per calendar year; limited to one time every 6 months.

COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to one time per 36 months.

BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.

EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.

DENTAL PROPHYLAXIS Limited to 2 times per calendar year; limited to once every 6 months.

DIAGNOSTIC CASTS Limited to one time per 24 months.

FLUORIDE TREATMENTS Limited to Covered Persons under the age of 16 years, and limited to 2 times per calendar year. Treatment should be done in conjunction with dental prophylaxis.

SEALANTS Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every 5 years.

SPACE MAINTAINERS Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustment within 6 months of installation.

AMALGAM RESTORATIONS Multiple restorations on one surface will be treated as a single filling.

PIN RETENTION Limited to 2 pins per tooth; not covered in addition to Cast Restoration.

GOLD INLAYS AND ONLAYS Limited to one time per 5 calendar years. Covered only when silver fillings cannot restore the tooth.

CROWNS Limited to one time per 5 calendar years. Covered only when a filling cannot restore the tooth.

POST AND CORES Covered only for teeth that have had root canal therapy.

SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than X-rays and exam, were done during the visit.

SCALING AND ROOT PLANING Limited to 1 time per quadrant per 24 months.

PERIODONTAL MAINTENANCE Limited to 2 times within the first 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.

FULL DENTURES No additional allowances for over-dentures or customized dentures.

PARTIAL DENTURES No additional allowances for precision or semi precision attachments.

RELINING DENTURES Limited to relining done more than 6 months after the initial insertions. Limited to 1 time per calendar year.

REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments done within 12 months after the initial insertion.

PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than exam and radiographs, were done during the visit.

OCCLUSAL GUARDS Limited to one guard every 5 years.

general exclusions

The following are not covered:

1. Dental Services that are not necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive Surgery regardless of whether or not th surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.
10. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
11. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
12. Dental Services provided in a foreign country, unless required as an Emergency.
13. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for 12 continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this 12 month period, the plan is responsible only for the procedures associated with the addition.
14. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for 12 continuous months.
15. Full mouth radiograph series in excess of once every 36 months. Panoramic radiographs in excess of once every 36 months, except when taken for diagnosis of third molars, cysts, or neoplasms.
16. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any 36 month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.
17. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every 36 months per quadrant or surgical site.
18. Root planing and scaling (ADA Code 4341) in excess of once every 24 months per quadrant.
19. Full mouth debridement (ADA Code 4355) in excess of once every 36 months.
20. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within sixty (60) months of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
21. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non- compliance, the patient is liable for the cost of replacement.
22. Denture relines for complete or partial conventional dentures for the 6 month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the first six 6 months. After the six month waiting period, relines are covered not more than once every 12 months.
23. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
24. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
25. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
26. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.
27. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.
28. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.
29. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.
30. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
31. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
32. Acupuncture; acupressure and other forms of alternative treatment.
33. General Anesthesia, except if required for patients under 6 years of age or patients with behavioral problems or physical disabilities.
34. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
35. Occlusal guards except if prescribed to control of habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.
36. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

Catholic Diocese
of Charlotte

UnitedHealthcare®

Vision Benefit Summary

Customer Service: **800-638-3120**
Provider Locator: **800-839-3242**
www.myuhcvision.com

UnitedHealthcare Vision has been trusted for more than 40 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

In-network, covered-in-full benefits (after applicable copay) include a comprehensive exam, eye glasses with standard single vision, lined bifocal, or lined trifocal lenses, standard scratch-resistant coating[1] and the frame, or contact lenses in lieu of eye glasses.

Copays for in-network services		
	Exam	$20.00
	Materials	$20.00
Benefit frequency		
	Comprehensive Exam	Once every 12 months
	Spectacle Lenses	Once every 12 months
	Frames	Once every 12 months
	Contact Lenses in Lieu of Eye Glasses	Once every 12 months
Frame benefit		
	Private Practice Provider	$130.00 retail frame allowance
	Retail Chain Provider	$130.00 retail frame allowance
Lens options		
	Standard scratch-resistant coating -- covered in full. Other optional lens upgrades may be offered at a discount. (Discount varies by provider.)	
Contact lens benefit		
	Covered-in-full elective contact lenses[4] The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full (after copay). If you choose disposable contacts, up to 6 boxes are included when obtained from a network provider. **All other elective contact lenses** A $150.00 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials copay does not apply). Toric, gas permeable and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. **Necessary contact lenses**[3] Covered in full after applicable copay.	
Out-of-network reimbursements up to (Copays do not apply)		
	Exam	$40.00
	Frames	$45.00
	Single Vision Lenses	$40.00
	Bifocal Lenses	$60.00
	Trifocal Lenses	$80.00
	Lenticular Lenses	$80.00
	Elective Contacts in Lieu of Eye Glasses[2]	$150.00
	Necessary Contacts in Lieu of Eye Glasses[3]	$210.00
Laser vision benefit		
	UnitedHealthcare Vision has partnered with the Laser Vision Network of America (LVNA) to provide our members with access to discounted laser vision correction providers. Members receive 15% off usual and customary pricing, 5% off promotional pricing at over 500 network provider locations and even greater discounts through set pricing at LasikPlus locations. For more information, call 1-888-563-4497 or visit us at www.uhclasik.com.	

[1] On all orders processed through a company owned and contracted Lab network.

[2] The out-of-network reimbursement applies to materials only. The fitting/evaluation is not included.

[3] Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following post cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses; with certain conditions of anisometropia; with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming reimbursement that UnitedHealthcare Vision will make before you purchase such contacts.

[4] Coverage for Covered Contact Lens Selection does not apply at Costco, Walmart or Sam's Club locations. The allowance for non-selection contact lenses will be applied toward the fitting/evaluation fee and purchase of all contacts.

Important to Remember:

- Benefit frequency based on last date of service.
- Your $150.00 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $120.00 toward the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store.
- You can log on to our website to print off your personalized ID card. An ID card is not required for service, but is available as a convenience to you should you wish to have an ID card to take to your appointment.
- Out-of-Network Reimbursement, when applicable: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement. Receipts must be submitted within 12 months of date of service to the following address: UnitedHealthcare Vision Attn. Claims Department P.O. Box 30978 Salt Lake City, UT 84130 FAX: 248.733.6060.
- At a participating network provider you will receive a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare Vision shall neither pay nor reimburse the provider or member for any funds owed or spent. Not all providers may offer this discount. Please contact your provider to see if they participate. Discounts on contact lenses may vary by provider. Additional materials do not have to be purchased at the time of initial material purchase. Additional materials can be purchased at a discount any time after the insured benefit has been used.

Please note: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please consult the applicable policy/certificate of coverage for a full description of benefits, including exclusions and limitations.

The following services and materials are excluded from coverage under the Policy: Post cataract lenses; Non-prescription items; Medical or surgical treatment for eye disease that requires the services of a physician; Worker's Compensation services or materials; Services or materials that the patient, without cost, obtains from any governmental organization or program; Services or materials that are not specifically covered by the Policy; Replacement or repair of lenses and/or frames that have been lost or broken; Cosmetic extras, except as stated in the Policy's Table of Benefits.

UnitedHealthcare Vision coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX and associated COC form number VCOC.INT.06.TX.

UnitedHealthcare®

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Your Personal Prescription Benefit Program

Welcome to your new prescription benefit administered by CVS Caremark. Your prescription benefit is designed to bring you quality pharmacy care that will help you save money.

The information below is a brief summary of your prescription benefits as well as some frequently asked questions about the CVS Caremark prescription benefit program. CVS Caremark and ***Diocese of Charlotte*** are confident you will find value with your new prescription benefit program.

	Retail Program	Mail Service Pharmacy
When to Use Your Benefit:	For immediate or short-term medicine needs	For maintenance or long-term medicine needs
Where:	At over 62,000 CVS Caremark participating retail pharmacies nationwide, including over 20,000 independent community pharmacies. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Local Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-800-565-7091.	Simply mail your original prescription and the mail service order form to CVS Caremark. Your medicines will be sent directly to your home, office or a location of your choice.
Your Copay*:	• **$7.50** for each generic medicine • **$25** for each brand-name medicine on the drug list • **$50** for each brand-name medicine **not** on the drug list	• **0-30 days** **$5** for each generic medicine **$17** for each brand-name medicine on the drug list **$30** for each brand-name medicine **not** on the drug list • **31-60 days** **$10** for each generic medicine **$34** for each brand-name medicine on the drug list **$60** for each brand-name medicine **not** on the drug list • **61-90 days** **$15** for each generic medicine **$50** for each brand-name medicine on the drug list **$90** for each brand-name medicine **not** on the drug list
Day Supply Limit:	**31**-day supply	**90**-day supply
Refill Limit:	One initial fill plus one refill on maintenance medicines. After two fills, retail copay will double.	None
Web Services:	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your benefit ID card ready.	
Customer Care:	Call toll-free 1-800-565-7091 or visit www.caremark.com	

(over)

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

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Frequently Asked Questions

ABOUT THE RETAIL PROGRAM

Q. Can I receive additional benefit ID cards?

A. Yes, for additional benefit ID cards, please call a Customer Care representative toll-free at 1-800-565-7091.

Q. May I fill my medicine at a non-participating pharmacy?

A. There are more than 62,000 participating pharmacies in the CVS Caremark program. When you choose to go to a non-participating pharmacy, you will pay the full prescription price. If you use a non-participating pharmacy, you should submit a paper claim form along with the original prescription receipt(s) to CVS Caremark for reimbursement of covered expenses.

Q. How do I change my prescription from a non-participating retail pharmacy to a CVS Caremark participating retail pharmacy?

A. Go to a CVS Caremark participating retail pharmacy and tell the pharmacist where your prescription is currently on file. The pharmacist will contact the pharmacy and make the transfer for you. To find a local CVS Caremark participating retail pharmacy, call a Customer Care representative toll-free at 1-800-565-7091 or click on "Find a Local Pharmacy" at Caremark.com.

Q. When should I use a retail pharmacy instead of the CVS Caremark Mail Service Pharmacy?

A. You should use the retail pharmacy for your immediate and short-term medicine needs. Use mail service for your long-term maintenance medicine needs.

ABOUT THE MAIL SERVICE PHARMACY

Q. Why should I use the CVS Caremark Mail Service Pharmacy for my prescriptions?

A. The CVS Caremark Mail Service Pharmacy is a convenient and cost-effective way for you to order up to a 90-day supply of maintenance or long-term medicine. You can have your long-term medicine delivery to your home, office or a location of your choice with free standard shipping. By using mail service you minimize trips to the pharmacy while saving money on your prescriptions.

Q. How long does it take for my prescriptions to arrive by mail?

A. You can expect to receive your prescription approximately 10 calendar days after CVS Caremark receives your order.

Q. How do I check the status of my order?

A. You can check your refill order status at www.caremark.com or by dialing the toll-free number, 1-800-565-7091.

Q. How should I ask my doctor or other prescriber to write my prescription in order to receive the maximum benefit from the CVS Caremark Mail Service Pharmacy?

A. Remind your doctor or other prescriber to write a "90-day supply plus refills", when clinically appropriate, for maintenance medicines that are purchased through the CVS Caremark Mail Service Pharmacy. CVS Caremark must fill your prescription for the exact quantity of medicine that your doctor or other prescriber prescribes, up to your plan design limit. When you need to take your maintenance medicine right away, ask your prescriber for two prescriptions:

1) The first for up to a 31-day supply and
2) The second for up to a 90-day supply, with refills when clinically appropriate.

Have the short-term supply filled immediately at a CVS Caremark participating retail pharmacy and send the 90-day supply prescription to the CVS Caremark Mail Service Pharmacy.

ABOUT THE CAREMARK DRUG LIST

Q. What is a drug list?

A. A drug list is a list of preferred prescription medicines that have been chosen because of their clinical effectiveness and safety. This list is typically updated every three months. The drug list promotes the use of preferred brand-name medicines and generic medicines whenever possible. Generic medicines are therapeutically equivalent to brand-name medicines and must be approved by the U.S. Food and Drug Administration (FDA) for safety and effectiveness. Generally, generic medicines cost less than brand-name medicines.

Q. Where can I get a drug list brochure?

A. You can get a drug list brochure by either visiting www.caremark.com or by calling a Customer Care representative toll-free at 1-800-565-7091. To save money, have your doctor or other prescriber prescribe a generic or preferred brand-name medicine from the Caremark Drug List, if appropriate. You may want to take the list with you when you visit your doctor or other prescriber for a prescription.

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