Catholic Employee Benefit Group Diocese of Corpus Christi Benefits Plans Effective July 1, 2021

Service	CEBG Grandfathered Plan 2020-2021 (Only eligible for Employees on Plan as of June	CEBG Basic Plus PPO Plan	CEBG High Deductible Health Plan (HSA Eligible)
Annual Deductible--Medical	In-Network $750 Individual/$2000 Family; Non-Network $1,700/$5,000	In-Network $1,250 Individual/$2,500 Family; Non-Network $5,000/$10,000	In-Network $1,750 Individual/$3,500 Family; Non-Network $3,000/$6,000
Office Visit Co-pay	$25 each visit in-network; 40% Non-Network	$30 each visit PCP/$45 Specialist in-network; 40% coinsurance non-network	20% after deductible; 40% Non-Network
Out-of-Pocket Maximum--Medical; Includes Coinsurance, Copays, and	$3,000 Individual/$5,000 Family; Non-Network $5,100/$15,250	In-Network $4,500/$9,000; Non-Network Unlimited Unless Unavailable	In-Network $4,500/$9,000; Non-network $9,000/$12,000
ER Co-pay	$100 after deductible plus coinsurance	$300 after deductible plus coinsurance	20% after deductible
Urgent Care Co-pay	$25, then 20% coinsurance, 40% Non-Network	$75	20% after deductible; 40% Non-Network, after deductible
Inpatient Co-pay Per Admit	None	$250 copay	None
Inpatient Services	20% In-Network/40% Non-Network	30% Network/60% Non-Network	20% after deductible; 40% Non-Network
Outpatient Services	20% In-Network/40% Non-Network	30% Network/60% Non-Network	20% after deductible; 40% Non-Network
Radiology Imaging	20% In-Network/40% Non-Network	30% Network/60% Non-Network	20% after deductible; 40% Non-Network
Laboratory	20% In-Network/40% Non-Network	30% Network/60% Non-Network	No charge independent free standing lab/20% all other; 40% Non-Network
Mental Health/Substance Abuse	Not Covered	30% Covered/60% Non-Network	20% after deductible/ 40% Non-Network
Preventive Medicine	Office Visit Co-Pay; then 100%	100% Covered with no maximum/ 60% Non-Network	100% Covered with no maximum/ 40% Non-Network
Annual Deductible--Prescription Drugs	None	None	With Medical
Out-of-Pocket Maximum--Prescription Drugs	None	$2,500 individual/$5,000 family	With Medical
Prescription Drugs	$4 Generic/$34 Brand Formulary/ $64 Brand Non-Formulary. Mail Order/90 days 2 x; Non-Network 40%. Contraceptives Not Covered.	$5 Generic/$45 Brand Formulary/ $85 Brand Non-Formulary-Mail Order/90 days 2x. Non-Network 60%. Preventive medications and smoking deterrents 100% covered not subject to cost share. Contraceptives not covered.	20% after deductible; 50% Non-Network; Contraceptives not covered.
Employee Portion of Monthly Benefits Premiums (Includes Medical, Prescription Drug, Dental, Vision, Life Insurance, AD&D, and EAP)			
Employee Only Premium Monthly	$108.00	$75.00	$50.00
Employee + Spouse	$630.00	$975.00	$633.00
Employee + Child/ren	$734.00	$525.00	$233.00
Employee + Family Premium Monthly	$734.00	$1,275.00	$733.00