Administered by: KAISER PERMANENTE® Kaiser Permanente Insurance Company

Archdiocese of Los Angeles

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

Coverage Period: 07/01/2016-06/30/2017

Coverage for: Individual & Family **Plan Type: EPO**

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 www.KP.org or by calling 1-866-213-3062.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**$1,500** Individual/ **$3,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Some copayments, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.kp.org or call 1-866-213-3062.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example, $15) 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 plan **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 provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment	Not Covered	$12 copayment for Group Visits
	Specialist visit	$25 copayment	Not Covered	$12 copayment for Group Visits
	Other practitioner office visit	$25 copayment for Acupuncture Services; $15 copayment for Chiropractic Care	Not Covered	20 visits per calendar year for Chiropractic care
	Preventive care/screening/immunization	No Charge	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	---none---
	Imaging (CT/PET scans, MRIs)	No Charge	Not Covered	---none---

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	Retail: $10 Mail: $20	Not Covered	Retail copayment is up to 30-day supply. Mail Order copayment is up to a 100-day supply. Emergency Contraception Drugs and Contraceptive Devices are not covered.
	Preferred brand drugs	Retail: $20 Mail: $40	Not Covered	Retail copayment is up to 30-day supply. Mail Order copayment is up to a 100-day supply. Emergency Contraception Drugs and Contraceptive Devices are not covered.
	Non-preferred brand drugs	Follows the Generic/Brand cost share	Not Covered	Non-preferred brand drugs through formulary exception
	Specialty drugs	Follows the Generic/Brand cost share	Not Covered	---none---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	$25 copayment	Not Covered	---none---
If you need immediate medical attention	Emergency room services	$100 copayment		---none---
	Emergency medical transportation	$50 copayment		---none---
	Urgent care	$25 copayment		---none---
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	$250 copayment	Not Covered	---none---

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copayment	Not Covered	---none---
	Mental/Behavioral health inpatient services	$250 copayment	Not Covered	---none---
	Substance use disorder outpatient services	$25 copayment	Not Covered	---none---
	Substance use disorder inpatient services	$100 copayment	Not Covered	---none---
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	---none---
	Delivery and all inpatient services	$250 copayment	Not Covered	---none---
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	3 visits per day 100 visits per calendar year
	Rehabilitation services	$25 copayment	Not Covered	---none---
	Habilitation services	$25 copayment	Not Covered	---none---
	Skilled nursing care	No Charge	Not Covered	100 days per benefit period
	Durable medical equipment	20% coinsurance	Not Covered	---none---
	Hospice service	No Charge	Not Covered	Services are for Life Expectancy of 12 months or less
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	---none---
	Glasses	No Charge	Not Covered	$175 Allowance every 24 months
	Dental check-up	Not covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Hearing Aids • Non-emergency care when traveling outside the U.S.	• Cosmetic Surgery • Infertility Treatment • Private Duty Nursing	• Dental Care • Long Term Care • Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture • Routine Eye Care (Adult)	• Bariatric Surgery • Routine Foot Care	• Chiropractic Care

The Archdiocese of Los Angeles offers standardized health care plans for employees and religious members of the Archdiocese and their eligible family members. The Archdiocese of Los Angeles health plans are bound by the Ethical and Religious Directives for Catholic Health Care Services published by the National Conference of Catholic Bishops. The plans intend to provide benefits that are in compliance with these Directives. The Directives can be reviewed http://www.usccb.org/about/doctrine/ethical-and-religiousdirectives. If you are an Archdiocese health plan participant, even if you are not Catholic or even if you possess personal beliefs in contravention of these Directives, we will still intend to only provide benefits that are in compliance with these Directives. _The Archdiocese of Los Angeles summary plan descriptions may contain language which may be argued to be inconsistent with the Directives; however, services which are contrary to the Ethical and Religious Directives for Catholic Health Care Services are meant to be specifically excluded by the Archdiocese health plans.

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 1-877-303-7382. 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**, or the U.S. Department of Health and Human Services at **1-877-267-2323** x61565 or **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: Administrative Committee, c/o Kaiser Foundation Health Plan, Inc., 20th Floor, Ordway Building, 1 Kaiser Plaza, Oakland, CA 94612. 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**, or the U.S. Department of Health and Human Services at **1-877-267-2323** x61565 or **www.cciio.cms.gov**. Additionally, a consumer assistance program can help you file your appeal. Contact

California Department of Managed Health Care Help Center

980 9th Street, Suite 500

Sacramento, CA 95814

888-466-2219

http://www.healthhelp.ca.gov
helpline@dmhc.ca.gov

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." **This plan or policy does provide minimum essential coverage.**

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 health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-213-3062.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-213-3062.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-213-3062.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-213-3062.

Your health benefits will be **self-insured** by your employer, union, or Plan sponsor. Kaiser Permanente Insurance Company will provide certain administrative services for the Plan **and** will not be an insurer **of the Plan** or financially liable for health care benefits under the Plan.

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

Archdiocese of Los Angeles

Coverage Examples

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** $7,120
- **Patient pays** $ 420

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$270
Co-insurance	$0
Limits or exclusions	$150
Total	**$420**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,420
- **Patient pays** $ 980

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$650
Co-insurance	$250
Limits or exclusions	$80
Total	**$980**

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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.