

**ARCHDIOCESE OF GALVESTON-HOUSTON
STANDARD PLAN BENEFITS AT A GLANCE
EFFECTIVE JANUARY 1, 2011**

This summary does not contain all of the provisions or limitations which apply to your Medical and Prescription Drugs coverages. For coverage details, see your benefit booklet. Upon receipt of your benefit booklet, please discard this summary, as benefits are subject to change.

The Archdiocese of Galveston-Houston 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. Being 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 to provide preventive health services without any cost sharing when provided by a PPO Provider. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on essential health 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 the Plan Administrator at:

The Archdiocese of Galveston-Houston
1700 San Jacinto
Houston, TX 77002-8291

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

STANDARD TIER		
	PPO PROVIDER	NON-PPO PROVIDER
Lifetime Maximum Payment Limit	Unlimited	
Calendar Year Deductible*		
Per Person	\$ 800	\$ 1,600
Per Family	\$ 1,600	\$ 3,200
<p>You pay one individual Deductible Amount each calendar year. For satisfaction of the family Deductible Amount, no more than one individual Deductible Amount will apply for any one person. After you satisfy the Deductible, Comprehensive Medical benefits will be payable for Covered Charges at the rate of payment shown below.</p> <p>The Copayments shown below:</p> <ul style="list-style-type: none"> • will not count toward satisfaction of the Deductible; and • will continue to apply after the Out-of-Pocket Expense limit and the Deductible are reached. 		
Out-of-Pocket Maximums*		
Per Person	\$ 3,000	\$ 6,000
Per Family	\$ 6,000	\$ 12,000
<p>If the amount you pay for Covered Charges in any one calendar year reaches the Out-of-Pocket Expense Maximum shown above, Comprehensive Medical benefits payable will be 100% of additional Covered Charges (except as described below).</p> <p>The amounts that <u>DO NOT</u> apply toward your Out-of-Pocket Expense Maximum are:</p> <ul style="list-style-type: none"> • Copayments; and • Deductibles; and • the amount you must pay because of penalty charges for failure to comply with Utilization Management Requirements as described below. 		
*PPO and Non-PPO Calendar Year Deductibles and Out-of-Pocket Maximums reduce each other.		

STANDARD TIER		
SERVICE	PPO PROVIDER	NON-PPO PROVIDER
Primary Care Physician Visit Charges	\$20 Copay per visit, then plan pays 100%	You pay Deductible, then plan pays 50%
Specialist Physician Visit Charges	\$35 Copay per visit, then plan pays 100%	You pay Deductible, then plan pays 50%
MRI, CAT, and PET Scans	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 50%
Preventive or Diagnostic Care	Plan pays 100% for the first occurrence per calendar year	You pay Deductible, then plan pays 50%
<ul style="list-style-type: none"> • Colonoscopies • Sigmoidoscopies • Mammograms • Chest x-rays 		



STANDARD TIER		
SERVICE	PPO PROVIDER	NON-PPO PROVIDER
<p>Preventive Care</p> <ul style="list-style-type: none"> • Routine Physical Exams • Routine Gynecological Exams • Immunizations • Well Child Care • Pneumococcal vaccine • Influenza vaccine • PSA (Prostate Specific Antigen) • Cholesterol screening • EKG • CBC • SMAC • CA 125 (cancer antigen) • Urinalysis • CEA (carcino embryonic antigens) • Routine lab services • Routine Colonoscopies* • Routine Sigmoidoscopies* • Routine Mammograms* • Chest x-rays* <p>*Applicable to those performed after the first occurrence per year</p>	<p><u>Primary Care Physician</u> \$20 Copay per visit, then plan pays 100%</p> <p><u>Hospital Services</u> You pay Deductible, then plan pays 80%</p>	<p>You pay Deductible, then plan pays 50%</p>
<p>Allergy Injections and Serum</p>	<p><u>Primary Care Physician</u> \$20 Copay per visit, then plan pays 100%</p> <p><u>Specialist</u> \$35 Copay per visit, then plan pays 100%</p> <p>Note: No Copay applies when a Physician's visit is not billed.</p>	<p>You pay Deductible, then plan pays 50%</p>
<p>Treatment for Diabetes Received at Diabetes Centers of America</p>	<p>\$35 Copay per visit, then plan pays 100%</p>	
<p>Inpatient Hospital Care</p> <p>Note: A newborn's Deductible will be waived provided the mother has completed the Prenatal Care Program.</p>	<p>You pay Deductible, then plan pays 80%</p>	<p>You pay Deductible, then plan pays 50%</p>
<p>Outpatient Hospital Care</p>	<p>You pay Deductible, then plan pays 80%</p>	<p>You pay Deductible, then plan pays 50%</p>



STANDARD TIER		
SERVICE	PPO PROVIDER	NON-PPO PROVIDER
X-Ray and Laboratory Services Hospital Services Primary Care Office/Clinic Services Specialist Office/Clinic Services Office/Clinic Services Billed by a Radiologist or Pathologist Quest Diagnostics Lab Card Program (outpatient lab tests only)	You pay Deductible, then plan pays 80% \$20 Copay per visit, then plan pays 100% \$35 Copay per visit, then plan pays 100% You pay Deductible, then plan pays 80% Plan pays 100%	You pay Deductible, then plan pays 50% You pay Deductible, then plan pays 50% You pay Deductible, then plan pays 50% You pay Deductible, then plan pays 50% Plan pays 100%
Emergency Room Services Medical Emergency Note: For a Medical Emergency, if the Member or covered Dependent is admitted to the Hospital, the Copay will be waived, and the Hospital Inpatient Confinement will be paid at the Inpatient Hospital Care PPO level of benefits. Non-Medical Emergency	\$150 Copay per visit, then plan pays 100% \$150 Copay per visit, then plan pays 80%	\$150 Copay per visit, then plan pays 100% \$150 Copay per visit, then you pay Deductible and the plan pays 50%
Ambulance Services Ground Ambulance Air Ambulance	\$100 Copay per occurrence, then plan pays 100% \$1,000 Copay per occurrence, then plan pays 100%	\$100 Copay per occurrence, then plan pays 100% \$1,000 Copay per occurrence, then plan pays 100%
Chiropractic Services By Any Physician Limited to a maximum benefit of \$1,500 per year	<u>Primary Care Physician</u> \$20 Copay per visit, then plan pays 100% <u>Specialist</u> \$35 Copay per visit, then plan pays 100%	You pay Deductible, then plan pays 50%
Acupuncture or Acupressure Services By Any Physician Limited to a maximum benefit of \$1,500 per year	<u>Primary Care Physician</u> \$20 Copay per visit, then plan pays 100% <u>Specialist</u> \$35 Copay per visit, then plan pays 100%	You pay Deductible, then plan pays 50%
Hearing Aids Limited to a maximum benefit of \$750 per year	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 50%



STANDARD TIER		
SERVICE	PPO PROVIDER	NON-PPO PROVIDER
Eye Exam (including refraction, whether exam is considered routine or medical) Limited to one per year	<u>Primary Care Physician</u> \$20 Copay per visit, then plan pays 100% <u>Specialist</u> \$35 Copay per visit, then plan pays 100%	You pay Deductible, then plan pays 50%
Sleep Studies/Sleep Disorders Limited to a maximum benefit of \$6,000 per lifetime	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 50%
Home Health Care Limited to 100 visits per year	You pay Deductible, then plan pays 100%	You pay Deductible, then plan pays 50%
Hospice Care Limited to a maximum of 180 days per lifetime	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 50%
Skilled Nursing Facility Care Limited to 120 days for the same or related condition	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 50%
Mental or Nervous Disorders Inpatient Services Outpatient Services <ul style="list-style-type: none"> • Office/Clinic • Outpatient Hospital 	Benefits are paid the same as any other Treatment or Service \$20 Copay per visit, then plan pays 100% Benefits are paid the same as any other Treatment or Service	Benefits are paid the same as any other Treatment or Service You pay Deductible, then plan pays 50% Benefits are paid the same as any other Treatment or Service
All Other Covered Charges	You pay Deductible, then plan pays 80%	You pay Deductible, then plan pays 50%

Uncontrollable Providers

For services provided by a Non-PPO emergency room Physician, anesthesiologist, radiologist, or pathologist, benefits will be payable at the PPO level when such services are provided at a PPO Hospital (inpatient, outpatient, and Hospital emergency room) or a licensed PPO freestanding surgical center.

Treatment or Service Not Available by a PPO Provider

If Treatment or Service for a listed Covered Charge is not available by a PPO Provider within **50 miles** of the covered person's legal residence, and you receive Treatment or Service from a Non-PPO Provider, benefits will be paid at the same level as a PPO Provider.



UTILIZATION MANAGEMENT REQUIREMENTS

A **Hospital Admission Review** must be obtained for Hospital Inpatient Confinements. You must obtain a Hospital Admission Review prior to, but no later than, the day of admission to a Hospital (for other than a Medical Emergency); and for a Medical Emergency, within two working days following a Hospital admission or as soon as reasonably possible thereafter. Failure to comply with the Hospital Admission Review requirements will result in benefits being reduced by 25% per confinement. The 25% reduction in Benefits Payable will not count toward satisfaction of the Out-of-Pocket Expense limits and will not exceed \$2,000 per individual each calendar year. Your medical ID card gives a toll-free telephone number to call for Hospital reviews.

PRESCRIPTION DRUGS – STANDARD TIER			
	RETAIL DRUGS		MAIL SERVICE DRUGS
	Member Pharmacy	Non-member Pharmacy	
Generic Drugs	\$5 Copay	50%	\$0 Copay
Preferred Brand Name Drugs	\$45 Copay	50%	\$90 Copay
Non-Preferred Brand Name Drugs	\$70 Copay	50%	\$140 Copay
Maximum Supply	30 days for each prescription		90 days for each prescription
Mandatory Mail Order: For maintenance drugs and medicines, you will be able to have original prescriptions filled by your local retail pharmacy initially for a 30-day supply, plus one refill. Then you must have your prescription for maintenance drugs and medicines filled through the mail service drug program.			

The group coverage(s) described above are self-funded by your employer with administrative services provided by the National Accounts Division of Principal Life Insurance Company. This means Principal Life does not assume any of the risk for any medical or prescription drug claims. Because this material is a summary, it does not state all coverage provisions, restrictions of coverage, benefits, conditions, limitations, or provisions required by federal law. If any provision presented here is found to be in conflict with federal law, that provision will be applied to comply with federal law. The group plan determines all rights, benefits, exclusions and limitations of the coverage described above.