ARCHDIOCESE OF WASHINGTON

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Vicar for Canonical Services
and Moderator of the Curia

February 8, 2018

Dear Brother Priests,

The Office of Human Resources has made a number of wonderful new additions to the benefits you receive. I would like to take this opportunity to highlight your benefits through the Archdiocese of Washington and those new additions. Please note that, for the avoidance of doubt, this includes both active and retired priests unless otherwise noted. Please see the attached charts for Dental, Vision and Health benefit details.

You are enrolled in the Archdiocese of Washington Health Care Plan for Priests. The health care plan is a high option PPO plan, which means that you can see a doctor of your choosing without a referral. On January 1, 2017, the health care plan changed benefit provider access from a local network (NCAS) to a nationwide network (CareFirst Administrators or CFA) which increased your access to in-network providers. Seeing an in-network provider reduces your out-of-pocket expenses.

Part of your enrollment in the health care plan includes access to our Managed Care provider, Conifer Health Solutions. Conifer works with you and your physician to develop and support a customized care treatment if you have a complex medical condition or a chronic illness. Conifer tracks health care claims and, depending on the type and volume of such claims, they may proactively reach out to you to discuss your condition and help coordinate care. However, you are also free to reach out directly to them if you have questions about the care you are receiving. Additionally, during the prior year, we improved the reimbursement rates and frequency for vision care through VSP. You can now have benefits for new lenses each year should you have a change in prescription and the plan increased the benefit for frames and contacts to $150.

One of the new additions for 2018 includes access to our TeleHealth provider as part of your enrollment in the health care plan. The provider, MDLIVE, gives you the opportunity to arrange for a consultation with a doctor for certain acute conditions such as cold and flu, headache, sore throat or allergies through telephone, website or smartphone and, where necessary, can arrange for prescriptions to treat your ailment. These remote, secure visits would limit your time away from your office and would cost significantly less than a visit to Urgent Care. To utilize this service, simply log onto www.mdlive.com/adw. Registration can be done in a matter of minutes.

Through the healthcare plan, you are also enrolled in Dental coverage. The provider access for dental is through Delta Dental. While you may see any provider of your choosing, choosing an in-network provider will reduce your out-of-pocket expenses.

As a reminder, all in-network preventive appointments are covered 100% for you. With the new year, don't forget to schedule your annual physical, dental cleaning and eye exam.

If you are incardinated in the Archdiocese of Washington, you are also eligible to participate in the Retirement Savings Plan. This plan is a 403(b) plan offered through USI Consulting Group. The first $2,000 of voluntary contributions that you make to the plan each year will be matched 100%, allowing you to more quickly meet your retirement goals.

Also new in 2018 are Flexible Spending Accounts (FSAs) FSAs allow participants to set aside pre-tax dollars to pay for out-of-pocket medical expenses such as medical, dental, vision and prescription co-pays and co-insurance. Contributing to an FSA means that you would not pay Federal and State taxes on any money you set aside. The FSA is offered through Flores and Associates and you would be eligible to next enroll during open enrollment in November of 2018 for January 1, 2019.

For priests in active service, you are enrolled in Long-Term Care (LTC) insurance through UNUM. This coverage would pay $1,500 per month for three years in a long-term care facility should you require care in a long-term care facility.

We continue to meet with our various vendors and advisors to seek new ways to both improve and ensure the cost-effectiveness of the benefits offered by the Archdiocese of Washington. Details for all of your benefits including plan documents and vendor contact information can be found in our Common Human Resources Information System (CHRIS). The bookkeeper in your location can assist with any questions you may have or you may contact the Director of HRIS and Benefits for the Archdiocese, Michele Thiec at 301 853-5306 or thiecm@adw.org.

With gratitude for your priestly ministry, I am

Sincerely in Christ,

Reverend Monsignor Charles V. Antonicelli
Vicar for Canonical Services and Moderator of the Curia

DENTAL BENEFITS

The following is a brief summary of your dental benefits. Please note that dental benefits are bundled with the Medical Plan. The administrator of the Archdiocese of Washington's Dental Plan is Delta Dental. This is a dental PPO Plan with a Point of Service feature. If you have any questions regarding your benefits or the status of a claim, please call Delta Dental at 1 (800) 932-0783. For a list of participating dentists, check their website at www.midatlanticdeltadental.com under "Dentist Directory".

DELTA DENTAL BENEFITS PRIEST OPTION PLAN	
Calendar Year Deductible	$50
Calendar Year Maximum Per Individual	$1,500
Diagnostic & Preventive	100%
Basic Restorative, Oral Surgery, Endodontics, Periodontics	100% After deductible
Major Restorative, Prosthodontics	90% After deductible

VISION BENEFITS

The following is a brief summary of your vision benefits. Please note that vision benefits are bundled with the Medical Plan. The administrator of your vision benefits is VSP. If you have any questions regarding your VSP benefits, please call VSP at 1 (800) 877-7195 or visit their website at: www.vsp.com.

Vision Benefits	VSP Network Doctor	Non-VSP Doctor
Eye Exam	Covered in full	$15 copay, covered up to $52
Lenses including: - Single Vision - Lined bi-focal - Lined tri-focal	$25 copay applies to lenses and a frame, then lenses are covered in full and the frame of your choice is covered up to $150. Plus up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings.	$25 copay applies to lenses and a frame: Covered up to $55 Covered up to $75 Covered up to $95
Frames	$25 copay applies to a frame if lenses are not purchased, then the frame of your choice is covered up to $150. Plus 20% off any out-of-pocket costs. In addition, you'll also receive 20% off on additional prescription glasses and sunglasses.*	Covered up to $45
Contact Lenses - When you choose contacts instead of glasses, your allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your eye exam to ensure proper fit of contacts.	No copay, covered up to $150 Plus 15% off the cost of your contact lens exam (fitting and evaluation).*	No copay, covered up to $105
Benefits are limited to one exam and one pair of lenses or contacts every 12 months and one frame every 24 months. *Available from the same VSP doctor who provided your eye exam within the last 12 months.		

Archdiocese of Washington: High Option Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual, Family | **Plan Type:** PPO

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.cfablue.com or by calling 877-889-2478.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual / **$500** family for in-network providers; **$500** individual / **$1,000** family for out-of-network providers. Does not apply to emergency room, hospice care and prescription drugs. In-network, does not apply to office visits, preventive care, acupuncture, urgent care centers and delivery. Pre-certification penalties, copayments and balance-billed charges don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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?	Yes. **$2,000** individual / **$4,000** family for in-network providers; **$4,000** individual / **$8,000** family for out-of-network providers.	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?	Prescription drugs, pre-certification penalties, 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**.
Does this plan use a network of providers?	Yes. See **www.cfablue.com** or call **877-889-2478** for a list of in-network providers.	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?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
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**.

Questions: Call 877-889-2478 or visit us at **www.cfablue.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call 877-889-2478 to request a copy.

- **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 in-network **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	$20/visit	40% coinsurance	——————none——————
	Specialist visit	$20/visit	40% coinsurance	——————none——————
	Other practitioner office visit	50% coinsurance for chiropractor and $20/visit for acupuncture	Not covered	Maximum $1,500/year for chiropractor and 20 visits/year for acupuncture.
	Preventive care / screening / immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Applies when test is billed separately from office visit.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	

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.express-scripts.com or call 1-866-265-9458.	Generic drugs	$15/prescription (retail) $30/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	Covers up to a 34-day supply (retail) or 90-day supply (mail order). If you purchase a brand name drug in lieu of a generic drug, your copayments may be higher, as described in the plan document. When received at an in-network pharmacy, no charge for over-the-counter drugs related to preventive care (prescription required). Rx Out-of-Pocket Maximum: **$4,600** individual / **$9,200** family.
	Preferred brand name drugs	$30/prescription (retail) $60/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Non-preferred brand name drugs	$45/prescription (retail) $90/prescription (mail order)	Applicable copayment, plus charges in excess of the allowed amount	
	Specialty drugs	Applicable copayment	Applicable copayment, plus charges in excess of the allowed amount	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$100/visit then 10% coinsurance	$100/visit then 10% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	——————none——————
	Urgent care	$20/visit	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Pre-certification required. Failure to pre-certify will reduce covered charges by $250 Failure to request extension of original certification will result in denial of benefits for the remainder of the hospital stay.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	——————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	$20/visit	40% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance	Pre-certification required (penalty applies).
	Substance use disorder outpatient services	$20/visit	40% coinsurance	——————none——————
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance	Pre-certification required (penalty applies).
If you are pregnant	Prenatal and postnatal care	$20/visit up to $200/pregnancy then No charge	40% coinsurance	——————none——————
	Delivery and all inpatient services	$20/visit up to $200/pregnancy for delivery 10% coinsurance for inpatient	40% coinsurance	Pre-certification required for inpatient (penalty applies).
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Maximum 100 visits/treatment plan Pre-certification required
	Rehabilitation services	10% coinsurance	40% coinsurance	Maximum 30 visits/year for physical therapy. Pre-certification required for physical and occupational therapy
	Habilitation services	Not covered	Not covered	Not covered under this medical plan.
	Skilled nursing care facility	20% coinsurance	40% coinsurance	Maximum 30 days/year. Pre-certification required (penalty applies).
	Durable medical equipment	10% coinsurance	40% coinsurance	Pre-certification required in excess of $1,500
	Hospice service	No charge	No charge	Maximum 6 months/lifetime.

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 your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered under this medical plan.
	Glasses	Not covered	Not covered	Not covered under this medical plan.
	Dental check-up	Not covered	Not covered	Not covered under this medical plan.

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.)

- Bariatric surgery
- Cosmetic surgery, unless restoring bodily function or correcting deformity resulting from non-cosmetic surgery, accidental injury, or congenital defect
- Dental care (adult & child), unless due to accidental injury
- Glasses (adult & child), unless due to accidental injury or intraocular surgery
- Habilitation services
- Hearing aids, unless due to accidental injury
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S., if purpose of travel is to receive care
- Routine eye care (adult & child)
- Routine foot 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 (maximum 20 visits/year)
- Chiropractic care (maximum $1,500/year)
- Private-duty nursing

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 CFA at 866-945-9852. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 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 the plan at 877-889-2478. You can also contact the Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the DC Office of the Health Care Ombudsman and Bill of Rights, 899 North Capitol Street, NE, 6th Floor, Room 6037, Washington, DC 20002, 1-877-685-6391, healthcareombudsman@dc.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 provides 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 meets the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 877-889-2478.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-889-2478.
CHINESE (中文): **如果需要中文的帮助**, 请拨打这个号码 877-889-2478.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-889-2478.

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

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:** $6,740
- **Patient pays:** $800

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	$100
Copayments	$40
Coinsurance	$510
Limits or exclusions	$150
Total	**$800**

Managing Type 2 Diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,960
- **Patient pays:** $1,440

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	$90
Copayments	$1,110
Coinsurance	$0
Limits or exclusions	$240
Total	**$1,440**

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.