Christian Brothers Employee Benefit Trust: MP 6566 - Rx 1440

Coverage for: Individual+Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 800.807.0400 or visit us at www.myCBS.org/health or email at hbscustomerservice@cbservices.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 800.807.0400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network $2,500 Individual / $5,000 Family Out-of-Network $5,000 Individual / $10,000 Family Prescription Drug $0 In-Network & Out-of-Network deductibles reduce each other.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. For Preventive care services the In-Network deductible does not apply.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Combined Medical & Prescription Drug In-Network $5,000 Individual / $10,000 Family Medical Out-of-Network $10,000 Individual / $20,000 Family In-Network & Out-of-Network out-of-pocket limits reduce each other.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, payments made by patient assistance programs, penalty for prescription retail refill allowances, penalty for non-notification of hospital admission and other services requiring pre-certification, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Your network is BlueCross BlueShield. See myCBS.org/ppo-hcsc for a list of participating medical network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copayment / visit; deductible does not apply	40% Coinsurance / visit	None.
	Specialist visit	$40 Copayment / visit; deductible does not apply	40% Coinsurance / visit	In-Network Allergy injections $5 Copayment / visit; deductible does not apply.
	Preventive care/screening/ immunization	No Charge	Primary Care - 40% Coinsurance / visit Free Standing Clinic – 40% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Out-of-Network Payment may differ based on place of service.
If you have a test	Diagnostic test (x-ray, blood work)	Lab Work – No Charge; deductible does not apply Radiology – 20% Coinsurance	40% Coinsurance	Limited to services performed outside physician's office. Payment may differ based on place of service.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Limited to services performed outside physician's office. Payment may differ based on place of service. Precertification is required. A 25% penalty up to $300 may apply. Penalty does not apply to out-of-pocket limit.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCBS.org/health and click on My Prescription Drugs or call Express Scripts at 800-718-6601.	Generic drugs	$10 / prescription (retail); $25 / prescription (mail)	Same as In-Network +20% coinsurance penalty	Covers up to 30-day supply retail prescription; 90-day supply mail order prescription. Retail purchases for maintenance prescriptions are limited to an initial fill and two subsequent refills. Members who continue to use retail will pay the mail delivery copayment, however, only up to a 30-day supply will be dispensed. See your policy or plan document for additional information.
	Preferred brand drugs	$30 / prescription (retail); $75 / prescription (mail)	Same as In-Network +20% coinsurance penalty	
	Non-preferred brand drugs	$60 / prescription (retail); $150 / prescription (mail)	Same as In-Network +20% coinsurance penalty	
	Specialty drugs	Generic 10% up to a maximum of $150 Preferred 20% up to a maximum of $150 Non-Preferred 20% up to a maximum of $250		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Limited to services performed outside physician's office. Payment may differ based on place of service. Precertification is required. A 25% penalty up to $300 may apply. Penalty does not apply to out-of-pocket limit.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care – Facility fee	20% Coinsurance after $150 Copayment; deductible does not apply		Copayment is waived if admitted.
	Emergency room care – Physician/surgeon fees	20% Coinsurance		Emergency room care may include tests and services described elsewhere in the SBC (i.e. Diagnostic tests or Imaging.)
	Emergency medical transportation	20% Coinsurance		For transportation service charges exceeding $5,000 by ground and/or air, payment will not exceed 150% of Medicare allowance for such incurred expenses. Charges include transportation and medical supplies used during transport.
	Urgent care	Primary Care – $20 Copayment; deductible does not apply Free Standing Clinic – 20% Coinsurance Emergency Room – 20% Coinsurance after $150 Copayment; deductible does not apply	Primary Care – 40% Coinsurance Free Standing Clinic – 40% Coinsurance Emergency Room – 20% Coinsurance after $150 Copayment; deductible does not apply	Payment may differ based on place of service. This applies to emergency room or urgent care services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Precertification is required. A 25% penalty up to $2,000 may apply. Penalty does not apply to out-of-pocket limit.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Specialist** – $40 Copayment / visit; deductible does not apply **Outpatient Facility** – 20% Coinsurance	**Specialist** – 40% Coinsurance / visit **Outpatient Facility** – 40% Coinsurance	Payment may differ based on place of service.
	Inpatient services	20% Coinsurance	40% Coinsurance	Precertification is required. A 25% penalty up to $2,000 may apply. Penalty does not apply to out-of-pocket limit.
If you are pregnant	Office visits	$20 Copayment / visit; deductible does not apply	40% Coinsurance	Copayment applies to initial prenatal visit only (per pregnancy). Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	None.
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Limited to 100 visits per year maximum.
	Rehabilitation services	20% Coinsurance / visit	40% Coinsurance / visit	Payment may differ based on place of service. Services for all State Licensed Practitioners, including Acupuncturist & Massage therapist visits, are limited to combined 12 visits per year.
	Habilitation services	Not covered.		Not covered.
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Limited to 120 day maximum for all confinements resulting from the same or a related illness or injury.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Check your plan document for limitations. Orthotics – Limited to $500 lifetime

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% Coinsurance	40% Coinsurance	Limited to 180 day per year maximum.
If your child needs dental or eye care	Children's eye exam	No charge.	40% Coinsurance	Covered up to age 5.
	Children's glasses	Not covered.		Unless covered by your vision plan.
	Children's dental check-up	Not covered.		Unless covered by your dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Contraceptives
- Cosmetic surgery
- Dental care (Adult)
- Eye exam over age 5
- Habilitation services
- Hearing aids and related charges
- Infertility treatment (except initial diagnosis)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Sterilization or Abortion
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (payable per medical necessity as specialist MD).
- Non-emergency care when traveling outside the U.S. (only when on assignment by ER).
- Services provided by State Licensed Practitioners within the scope of license not specifically covered under any other provisions of the medical plan, including Acupuncture, Massage Therapy, and Nutritional Counseling – Limited to 12 combined visits per year for all services.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Church plans are not covered by the Federal COBRA continuation coverage rules. For more information on your rights to continue coverage, contact the plan at 800.807.0400. You may also contact your state insurance department. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 800.807.0400. A list of states with Consumer Assistance Programs is available at cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800.807.0400.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.807.0400.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 800.807.0400.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800.807.0400.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,500
Specialist copayment	$ 40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,991

In this example, Peg would pay:

Cost Sharing	
Deductibles	$ 895
Copayments	$ 280
Coinsurance	$1,825
What isn't covered	
Limits or exclusions	$ 60
The total Peg would pay is	$3,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist copayment	$ 40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,382
Copayments	$ 940
Coinsurance	$ 346
What isn't covered	
Limits or exclusions	$ 55
The total Joe would pay is	$2,723

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist copayment	$ 40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,133
Copayments	$ 280
Coinsurance	$ 283
What isn't covered	
Limits or exclusions	$ 0
The total Mia would pay is	$1,696

The plan would be responsible for the other costs of these EXAMPLE covered services.

For more information about limitations and exceptions, see the plan or policy document at myCBS.org/health.