

Christian Brothers Employee Benefit Trust Plan Option: MP 5308 – RX 1405

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

Coverage Period: 7/1/13-6/30/14

Coverage for: Individual+Family| Plan Type: HPPO



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.myCBS.org/health or by calling 1-800-807-0400.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-Network \$500 Individual / \$500 Family Out-of-Network \$500 Individual / \$500 Family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. If a <u>copayment</u> is indicated the <u>deductible</u> does not apply, however, your <u>copayments</u> will reduce your <u>deductible</u> . Your <u>deductible</u> starts over each July 1. See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . In-Network & Out-of-Network <u>deductibles</u> reduce each other. For preventive services the In-Network <u>deductible</u> does not apply.
Are there other <u>deductibles</u> for specific services?	Yes. \$500 Individual drugs. Applies to Retail & Mail.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services. There are no other <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	In-Network Yes. \$500 Individual / \$500 Family Out-of-Network Yes. \$500 Individual / \$500 Family	The <u>out-of-pocket limit</u> 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. Your medical <u>deductible</u> , <u>copayments</u> , and <u>coinsurance</u> apply toward the <u>out-of-pocket limit</u> . In-Network & Out-of-Network <u>out-of-pocket limits</u> reduce each other.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, your costs for prescription drugs, 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 <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes limits on specific covered services.
Does this plan use a <u>network of providers</u> ?	Yes. Your network is Cigna. See www.myCBS.org/ppc-cigna for a list of medical participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Please note, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .

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Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> 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 <u>excluded services</u> .



- 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		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>Copayment</u> / visit	20% <u>Coinsurance</u> / visit	None.
	Specialist visit	\$25 <u>Copayment</u> / visit	20% <u>Coinsurance</u> / visit	In-Network Allergy injections \$5 <u>Copayment</u> / visit.
	Other practitioner office visit	No Charge	20% <u>Coinsurance</u> / visit	Limited to 12 visits per year, combined for all providers including, but not limited to acupuncturists & massage therapists.
	Preventive care / screening / immunization	No charge	Primary Care - 20% <u>Coinsurance</u> Free Standing Clinic – 20% <u>Coinsurance</u>	Health Care Reform guidelines apply. Out-of-Network Payment may differ based on place of service.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% <u>Coinsurance</u>	Limited to services performed outside physician's office. Payment may differ based on place of service.

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>Coinsurance</u>	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.
If you need drugs to treat your illness or condition To find more information about <u>prescription drug coverage</u> or to locate a network pharmacy log into www.myCBS.org/health and click on My Prescription Drugs or call Express Scripts at 800-718-6601.	Generic drugs	\$10 / prescription (retail); \$20 / prescription (mail order)	Same as In-Network +20% coinsurance penalty	Covers up to 30-day supply retail prescription; 90-day supply mail order prescription.
	Preferred drugs	\$25 / prescription (retail); \$60 / prescription (mail order)	Same as In-Network +20% coinsurance penalty	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.
	Non-Preferred drugs	\$50 / prescription (retail); \$125 / prescription (mail order)	Same as In-Network +20% coinsurance penalty	See your policy or plan document for additional information.
	Specialty drugs	As categorized above		Prescriptions are limited to a separate \$6,350 Individual / \$12,700 Family <u>out-of-pocket limit</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>Coinsurance</u>	None.
	Physician/surgeon fees	No Charge	20% <u>Coinsurance</u>	None.
If you need immediate medical attention	Emergency room services	No Charge		None.
	Emergency medical transportation	No Charge		None.

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		In-Network Provider	Out-of-Network Provider	
	Urgent care	Primary Care - \$25 <u>Copayment</u> Free Standing Clinic – No Charge Emergency Room - No Charge	Primary Care / Free Standing Clinic - 20% <u>Coinsurance</u> Emergency Room – No Charge	Payment may differ based on place of service. This applies to emergency room or urgent care services.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>Coinsurance</u>	Precertification is required. A 25% penalty up to \$2,000 may apply.
	Physician/surgeon fee	No Charge	20% <u>Coinsurance</u>	None.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Specialist – \$25 <u>Copayment</u> / visit Outpatient Facility – No Charge	Specialist – 20% <u>Coinsurance</u> / visit Outpatient Facility – 20% <u>Coinsurance</u>	Payment may differ based on place of service.
	Mental/Behavioral health inpatient services	No Charge	20% <u>Coinsurance</u>	Precertification is required. A 25% penalty up to \$2,000 may apply.
	Substance use disorder outpatient services	Specialist – \$25 <u>Copayment</u> / visit Outpatient Facility – No Charge	Specialist – 20% <u>Coinsurance</u> / visit Outpatient Facility – 20% <u>Coinsurance</u>	Payment may differ based on place of service.
	Substance use disorder inpatient services	No Charge	20% <u>Coinsurance</u>	Precertification is required. A 25% penalty up to \$2,000 may apply.
If you are pregnant	Routine prenatal and postnatal care	\$25 <u>Copayment</u> / visit	20% <u>Coinsurance</u> / visit	<u>Copayment</u> applies to initial prenatal visit only (per pregnancy).
	Delivery and all inpatient services	No Charge	20% <u>Coinsurance</u>	None.

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		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	No Charge	20% <u>Coinsurance</u>	Limited to 100 visits per year maximum.
	Rehabilitation services	No Charge	20% <u>Coinsurance</u>	Payment may differ based on place of service.
	Habilitation services	Not covered		Not covered.
	Skilled nursing care	No Charge	20% <u>Coinsurance</u>	Limited to 120 day maximum for all confinements resulting from the same or a related illness or injury.
	Durable medical equipment	No Charge	20% <u>Coinsurance</u>	Check your plan document for limitations.
	Hospice service	No Charge	20% <u>Coinsurance</u>	Limited to 180 day per year maximum.
If your child needs dental or eye care	Eye exam	Not covered		Unless covered by your vision plan.
	Glasses	Not covered		Unless covered by your vision plan.
	Dental check-up	Not covered		Unless covered by your dental 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery Dental care (Adult) Dental check-up (Child) Eye exam / Glasses (Child) 	<ul style="list-style-type: none"> Habilitation services Hearing aids Infertility treatment (except initial diagnosis) Long-term care Private-duty nursing 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care Weight loss programs Contraceptives Sterilization or Abortion
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.)		
<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. (only when on assignment by ER) TMJ (Temporomandibular Joint Disorder) limited to \$2,500 maximum benefit per lifetime. 		

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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 1-800-807-0400. 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: the Plan at 1-800-807-0400. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:

Para obtener asistencia en Español, llame al 1-800-807-0400.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-807-0400.

(中文): 如果需要中文的帮助, 请拨打这个号码 1-800-807-0400.

Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-807-0400.

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

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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 \$6,890
- Patient pays \$650

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby) charges considered under dependent coverage	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$ 500
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$ 150
Total	\$ 650

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

- Amount owed to providers: \$5,400
- Plan pays \$4,820
- Patient pays \$ 580

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	\$ 500
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$ 80
Total	\$ 580

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.
- 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 expense.