Catholic Diocese of Rockford: Clergy Health Plan

Coverage for: Employee & 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 1-800-435-5694 or visit us at www.pbaclaims.com. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-435-5694 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,000** Individual Prescription drug copayments don't count toward the deductible.	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. Preventive care, prescription drugs, and vision.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. Dental: **$50**/individual	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. **10%, 15% or 20%** of the 1st **$15,000** of eligible expenses per person/or **$45,000** per family. For example, if your cost equals: 10% coinsurance, the out-of-pocket limit is $1500 per person or $4,500 per family.	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Deductibles, prescription drug copays, charges for hearing aids and routine colorectal cancer screenings, premiums, balance-billing 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.
Will you pay less if you use a network provider?	Yes. For a list of network providers see www.bcbsil.com or call 1 (800) 810-2583	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.

Catholic Diocese of Rockford: Clergy Health Plan

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
		PPO Provider (You will pay the least)	Non-PPO 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	15% coinsurance	20% coinsurance	Chiropractor: $1000 annual max
	Specialist visit	15% coinsurance	20% coinsurance	
	Preventive care/screening/ immunization	No charge up to the annual max, for routine physical, related tests and immunizations; then 15% coinsurance. No charge for prostate exam and PSA. 50% coinsurance for colonoscopy and fecal occult blood test	No charge up to the annual max, for routine physical, related tests and immunizations; then 20% coinsurance. No charge for prostate exam and PSA. 50% coinsurance for colonoscopy and fecal occult blood test	There is a combine $250 annual max for a routine physical, related tests and immunizations. Prostate exam and PSA are limited to 1 annual exam (age 40+). Colonoscopy is limited to 1 every 24 months. Fecal occult blood test is limited to 1 per year.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	20% coinsurance	————none————
	Imaging (CT/PET scans, MRIs)	15% coinsurance	20% coinsurance	————none————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **Cigna** 800-325-1404 www.myCigna.com	Generic drugs	$20 copay/prescription (retail) $20 copay/prescription (mail order)		Limits: 30-day supply (retail); 90-day supply (mail order) Annual Flu shot: $20 copay
	Preferred brand drugs	$35 copay/prescription (retail) $35 copay/prescription (mail order)		
	Non-preferred brand drugs	$50 copay/prescription (retail) $50 copay/prescription (mail order)		
	Specialty drugs	$100 copay/prescription (mail order)		Limits: 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	15% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room care	15% coinsurance	20% coinsurance	————none————
	Emergency medical transportation	15% coinsurance	20% coinsurance	————none————
	Urgent care	15% coinsurance	20% coinsurance	————none————

Catholic Diocese of Rockford: Clergy Health Plan

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	15% coinsurance	20% coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	20% coinsurance	————none————
	Inpatient services	15% coinsurance	20% coinsurance	————none————
If you are pregnant	Office visits	Not Applicable	Not Applicable	————none————
	Childbirth/delivery professional services	Not Applicable	Not Applicable	————none————
	Childbirth/delivery facility services	Not Applicable	Not Applicable	————none————
If you need help recovering or have other special health needs	Home health care	15% coinsurance	20% coinsurance	————none————
	Rehabilitation services	15% coinsurance	20% coinsurance	————none————
	Habilitation services	15% coinsurance	20% coinsurance	
	Skilled nursing care	15% coinsurance	20% coinsurance	————none————
	Durable medical equipment	15% coinsurance	20% coinsurance	————none————
	Hospice services	10% coinsurance (Inpatient) 15% coinsurance (outpatient)	20% coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	No charge	No charge	1 exam per 23 month period and $40 max for exam, including refraction.
	Children's glasses	No charge	No charge	1 frame and 1 pair of lenses per 23 month period. Contact lens limit is $115 per 23 months. Single vision lens: $75 max. Frames: $80 max.
	Children's dental check-up	No charge	No charge	2 exams per calendar year

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)		
• Bariatric surgery • Cosmetic surgery	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (when performed by a physician) • Chiropractic care	• Dental care (Adult) • Hearing aids (your cost is 50% coinsurance and the max benefit is $1,000 every 5 years)	• Infertility treatment (with limits) • Private-duty nursing • Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Professional Benefit Administrators, Inc., 900 Jorie Blvd. Suite 250; Oak Brook, IL 60523-3827 or 1-800-435-5694. You may 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 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 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en español, llame al **1-800-435-5694.**

——————*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** **$1,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **15%**

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	**Not Applicable**

In this example, Peg would pay:

Cost Sharing	
Deductibles	Not Applicable
Copayments	Not Applicable
Coinsurance	Not Applicable
What isn't covered	
Limits or exclusions	Not Applicable
The total Peg would pay is	Not Applicable

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

- **The plan's overall deductible** **$1,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **15%**

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	$1,000
Copayments	$1,240
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,270**

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

- **The plan's overall deductible** **$1,000**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **15%**

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$135
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,035**

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