



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](http://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:
<b>What is the overall deductible?</b>	<b>\$1,000</b> Individual / <b>\$3,000</b> family Prescription drug <u>copayments</u> don't count toward the <u>deductible</u> .	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Preventive care, prescription drugs, and vision.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
<b>Are there other deductibles for specific services?</b>	Yes. Dental: <b>\$50</b> Individual / <b>\$150</b> family	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Yes. <b>10%, 15% or 20%</b> of the 1 <sup>st</sup> <b>\$15,000</b> of eligible expenses per person/or <b>\$45,000</b> 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 <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Deductibles</u> , prescription drug copays, charges for hearing aids and routine colorectal cancer screenings, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. For a list of network providers see <a href="http://www.bcbsil.com">www.bcbsil.com</a> or call 1 (800) 810-2583	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the specialist you choose without a referral.

## Catholic Diocese of Rockford: Employee 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	15% <u>coinsurance</u>	20% <u>coinsurance</u>	Chiropractor: \$1000 annual max
	<u>Specialist visit</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge for pelvic exam, pap smear, HPV test, prostate exam, PSA and mammogram.  50% coinsurance for colonoscopy and fecal occult blood test.		Covered services are limited to 1 annual gynecological exam and pap; 1 annual HPV lab; 1 annual Prostate exam and PSA; 1 mammogram ages 35-39; 1 mammogram every 2 years ages 40-49; 1 annual mammogram age 50+; 1 colonoscopy every 24 months and 1 fecal occult blood test per year. No other routine exams are covered.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <b>Cigna</b> 800-325-1404 <a href="http://www.myCigna.com">www.myCigna.com</a>	Generic drugs	\$20 copay/prescription (retail) \$20 copay/prescription (mail order)		Limits: 30-day supply (retail); 90-day supply (mail order)
	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)		Annual Flu shot: \$20 copay
	<u>Specialty drugs</u>	\$100 copay/prescription (mail order)		Limits: 30-day supply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	Physician/surgeon fees	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	<u>Urgent care</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	Physician/surgeon fees	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————

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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 need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	Inpatient services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
If you are pregnant	Office visits	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	Childbirth/delivery professional services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	Childbirth/delivery facility services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	<u>Habilitation services</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	20% <u>coinsurance</u>	————none————
	<u>Hospice services</u>	10% <u>coinsurance</u> (Inpatient) 15% <u>coinsurance</u> (outpatient)	20% <u>coinsurance</u>	————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)

## Catholic Diocese of Rockford: Employee Health Plan

**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](http://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](http://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](http://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](http://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**.

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

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## 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 <u>deductible</u>	\$1,000
■ <u>Specialist coinsurance</u>	15%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$40
<u>Coinsurance</u>	\$1,350
What isn't covered	
Limits or exclusions	\$100
<b>The total Peg would pay is</b>	<b>\$2,490</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist coinsurance</u>	15%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$1,240
<u>Coinsurance</u>	\$30
What isn't covered	
Limits or exclusions	\$150
<b>The total Joe would pay is</b>	<b>\$2,420</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,000
■ <u>Specialist coinsurance</u>	15%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$135
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,035</b>