



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 <u>deductible</u>?	The calendar year <u>deductible</u> is \$1,000 . 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes, the following services are covered before you meet your deductible: preventive care, diabetic supplies purchased from Direct Healthcare, prescription drugs, hearing aids, 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.
Are there other <u>deductibles</u> for specific services?	Yes, there is a separate \$50 calendar year deductible for dental care.	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.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	The calendar year <u>out-of-pocket limit</u> is met after your <u>coinsurance</u> is applied to \$15,000 of eligible expenses.	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.
What is not included in the <u>out-of-pocket limit</u>?	The <u>out-of-pocket limit</u> does not include <u>deductibles</u> , copays, <u>coinsurance</u> for hearing aids, routine colorectal cancer screenings and benefits payable at 50% when a person refuses to participate in the case management program, <u>premiums</u> , <u>balance-billing</u> charges, 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> .
Will you pay less if you use a <u>network provider</u>?	Yes. For a list of network providers visit www.bcbsil.com or call (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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	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% <u>coinsurance</u>	20% <u>coinsurance</u>	Chiropractor: \$1000 annual max
	Specialist visit	15% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge, no <u>deductible</u> up to \$250 first dollar annual max, for routine physical, related tests and immunizations; then <u>deductible</u> and 15% coinsurance. No charge, no <u>deductible</u> , for prostate exam and PSA. 50% <u>coinsurance</u> (no <u>deductible</u>) for colonoscopy and fecal occult blood test	No charge, no <u>deductible</u> up to \$250 first dollar annual max, for routine physical, related tests and immunizations; then <u>deductible</u> and 20% coinsurance. No charge, no <u>deductible</u> , for prostate exam and PSA. 50% <u>coinsurance</u> (no <u>deductible</u>) for colonoscopy and fecal occult blood test	The \$250 first dollar annual max is combined for PPO and Non-PPO Providers. 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% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at (800) 325-1404 www.myCigna.com	Generic drugs	\$20 copay/prescription (retail) \$20 copay/prescription (mail order)		<u>Deductible</u> does not apply.
	Preferred brand drugs	\$35 copay/prescription (retail) \$35 copay/prescription (mail order)		Limits: 30-day supply (retail); 90-day supply (mail order)
	Non-preferred brand drugs	\$50 copay/prescription (retail) \$50 copay/prescription (mail order)		Annual Flu shot: \$20 copay
	Specialty drugs	\$100 copay/prescription (mail order)		Limit: 30-day supply
If you have outpatient surgery	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—————
If you need immediate medical attention	Emergency room care	15% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	Emergency medical transportation	15% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	Urgent care	15% <u>coinsurance</u>	20% <u>coinsurance</u>	—————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% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	Physician/surgeon fees	15% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u>	20% <u>coinsurance</u>	—————none—————
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	—————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	<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>	Your cost share for diabetic supplies purchased from Direct Healthcare: \$20 copay, no <u>deductible</u> , for test strips; 20% <u>coinsurance</u> , no <u>deductible</u> , for insulin pump and supplies; 20% <u>coinsurance</u> for other contracted supplies.
	<u>Hospice services</u>	10% <u>coinsurance</u> (inpatient) 15% <u>coinsurance</u> (outpatient) 15% <u>coinsurance</u> (bereavement counseling)	20% <u>coinsurance</u>	Bereavement counseling: \$500 maximum.
If your child needs dental or eye care	Children's eye exam	Not Applicable	Not Applicable	Not Applicable
	Children's glasses	Not Applicable	Not Applicable	Not Applicable
	Children's dental check-up	Not Applicable	Not Applicable	Not Applicable

Catholic Diocese of Rockford: Clergy Health Plan

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
- Long-term care
- Routine foot care
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- 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)
- Dental care
- Infertility treatment (with limits)
- Chiropractic care
- Hearing aids (your cost is 50% coinsurance and the max benefit is \$1,000 every 5 years)
- Private-duty nursing
- Routine eye care

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)

■ <u>The plan's overall 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*)

Total Example Cost	Not Applicable
---------------------------	-----------------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	Not Applicable
<u>Copayments</u>	Not Applicable
<u>Coinsurance</u>	Not Applicable
<i>What isn't covered</i>	
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)

■ <u>The plan's overall 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*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$1,240
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
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)

■ <u>The plan's overall 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*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

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