Archdiocese of Lousville Benefit Summary

Benefit **period:** From 01/01/2024 through 12/31/2024 (Calendar Year).

General Cost Share & Features	In Network	Out of Network
Deductible: - Per Calendar Year - Medical only - Some services do not apply to the deductible, as indicated below.	$1,000/Individual $3,000/Family	$3,000/Individual $9,000/Family
Out-of-Pocket Maximum: - Per Calendar Year - Medical and RX combined	$6,250/Individual $12,500/Family	$18,750/Individual $37,500/Family
In Network and Out of Network Deductibles / Out-of-Pockets do not reduce each other		

Benefit	In Network	Out of Network
Physician Services		
Primary Care Physician Office Visit (includes virtual visits and spinal manipulations)	100% after $25 Co-pay	50% after Deductible
Specialist Physician Office Visit (includes virtual visits)	100% after $40 Co-pay	50% after Deductible
Behavioral Health Office Visit	100% after $40 Co-pay	50% after Deductible
Teladoc or MyCatholicDoctor Virtual visits	100%	Not Applicable
Diagnostic Testing Lab Tests/X-rays “When done in physician’s office “	Lab Tests - 100% X-rays – 100%	50% after Deductible
Preventive Care	100%	50% after Deductible
Urgent Care	100% after $40 Co-pay	50% after Deductible
Allergy Injection	100% after $0 Co-pay	50% after Deductible
Outpatient Visits or Surgery	80% after Deductible	50% after Deductible
Emergency Room Visits	80% after Deductible	50% after Deductible

Inpatient Visits or Surgery	80% after Deductible	50% after Deductible
Facility Services		
Outpatient Hospital	80% after Deductible	50% after Deductible
Emergency Room	100% after $150 Co-pay, Deductible does not apply	100% after $150 Co-pay, Deductible does not apply
Inpatient Hospital	100% after $200 Co-pay per day, limited to first 5 days of each admission	50% after Deductible
Outpatient Hospital Surgery	100% after $200 co-pay, Deductible does not apply	50% after Deductible
Limited Benefits		
Skilled Nursing Facility	80% after Deductible	50% after Deductible
	60 Day Maximum for all Skilled Nursing Facility confinements per Calendar Year	
Home Health Care	80% after Deductible	50% after Deductible
	100 Home Health Care visit maximum per Calendar Year	
Other State Licensed Practitioners Includes acupuncture, massage therapy and registered dieticians	80% after Deductible	50% after Deductible
	12 Visit Maximum per Calendar Year (All providers combined)	
Hospice Services	100% after Deductible	100% after Deductible
	180 Day Maximum per Calendar Year	
Orthotics	80% after Deductible	50% after Deductible
	$500 Maximum Lifetime Benefit for all related services	
Natural Family Planning	100%, No Deductible	100%, No Deductible
	$200 Maximum Yearly Benefit for counseling services	
Other Covered Charges		
Durable Medical Equipment	80% after Deductible	50% after Deductible
Ambulance Transportation	80% after Deductible	80% after Deductible

This document is subject to change based on the Trust Plan effective January 1 through December 31. The actual amount of benefits, if any, is subject to all plan provisions at the time of service, including eligibility, plan limitations and exclusions. For any benefits detail please refer to the SBC.

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.

Christian Brothers Employee Benefit Trust: MP 6601 - Rx 0927

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 **1-800-807-0400** 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 **1-800-807-0400** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Medical Only In-Network** $1,000 Individual / $3,000 Family **Medical Only Out-of-Network** $3,000 Individual / $9,000 Family In-Network & Out-of-Network deductibles do not 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** $6,250 Individual / $12,500 Family **Medical Only Out-of-Network** $18,750 Individual / $37,500 Family In-Network & Out-of-Network out-of-pocket limits do not 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 out-of-pocket limit	Premiums, balance-billed charges, deductible, copayment, or coinsurance amounts paid on a covered persons behalf by a foundational or manufacturer sponsored patient assistance program,	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Certain specialty pharmacy drugs are considered non-essential

Important Questions	Answers	Why This Matters:
	penalty for prescription retail refill allowances, penalty for mandatory generics, penalty for non-notification of hospital admission and other services requiring pre-certification, and health care this plan does not cover.	health benefits and fall outside the out-of-pocket limits.
Will you pay less if you use a network provider?	Yes. Your network is BlueCross BlueShield. See **myCBS.org/ppo-hcsc** or call 1-800-810-2583 for a list of 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 (You will pay the least)	Out of Network (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	$25 copayment/Visit; Deductible does not apply	50% coinsurance	Includes Virtual Care (via video or voice).
	Specialist visit	$40 copayment/Visit; Deductible does not apply	50% coinsurance	Includes Virtual Care (via video or voice). In-Network Allergy injections $5 copayment / visit; deductible does not apply.
	Preventive care/screening/immunization	No charge	50% 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.
If you have a test	Diagnostic test (x-ray, blood work)	**Lab Work** - No charge **Radiology**- No charge	50% coinsurance	Limited to services performed outside physician's office. Payment may differ based on place of

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
				service.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% 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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.myCBS.org/health** Log in and click on My Prescription Drugs or call Express Scripts at 800-718-6601. More information about the Smart 90, Generics Member Pays The Difference, Formulary , Retail Refill Allowance and SaveonSP programs is available at: **www.myCBS.org/Rx**	Generic drugs	$10 /Prescription (retail); $20 /Prescription (mail or Smart90)	Same as In-Network +20% coinsurance penalty	Deductible does not apply. Covers up to 30-day supply at retail; 90-day supply mail order or Smart90 prescription. Retail maintenance prescriptions are limited to an initial fill and two refills. If you continue to use retail, outside of the Smart 90 program, you will pay the mail order copayment for a 30-day supply. You may fill a 90-day supply at Walgreens owned retail pharmacies through the Smart90 program. If a generic equivalent is available and a brand-name medication is dispensed for any reason, you will pay the difference in cost plus the brand copayment.
	Preferred brand drugs	$35 /Prescription (retail); $70 /Prescription (mail or Smart90)	Same as In-Network +20% coinsurance penalty	
	Non-preferred brand drugs	$55 /Prescription (retail); $110 /Prescription (mail or Smart90)	Same as In-Network +20% coinsurance penalty	
	Specialty drugs	Generic 25% coinsurance / Prescription Preferred 25% coinsurance / Prescription Non-Preferred 25% coinsurance / Prescription Certain specialty pharmacy drugs are considered non-essential health benefits and copayments may be set to the maximum of above or any available manufacturer-funded copay assistance. For a complete list of non-essential specialty medications, see **mycbs.org/health/SaveonSP**		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center, hospital)	$200 copayment/Visit; Deductible does not apply	50% coinsurance	Limited to services performed outside physician's office. You may be billed amounts in excess of prevailing charges for Out-of-Network Providers. Precertification is required. A 25% penalty up to $300 may apply. Penalty does not apply to out-
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
				of-pocket limit.
If you need immediate medical attention	Emergency room care - Facility fee	$150 copayment/Admission; Deductible does not apply	$150 copayment/Admission; Deductible does not apply	Copayment is waived if admitted.
	Emergency room care - Physician/surgeon fees	No charge (Included in $150 facility copayment)	No charge (Included in $150 facility copayment)	Emergency room care may include tests and services described elsewhere in the SBC (i.e. Diagnostic tests or Imaging.) You may be billed amounts in excess of prevailing charges for Out-of-Network Providers.
	Emergency medical transportation	20% coinsurance	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	$40 copayment/Visit; Deductible does not apply	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment/Day, limited to 5 days; Deductible does not apply	50% coinsurance	Precertification is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None.
	Inpatient services	$200 copayment/Day, limited to 5 days; Deductible does not apply	50% coinsurance	Precertification is required.
If you are pregnant	Office visits	$25 copayment/Visit; Deductible does not apply	50% coinsurance	Copayment applies to initial prenatal visit only (per pregnancy). Cost sharing does not apply to preventive services.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
				care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$200 copayment/Day, limited to 5 days; Deductible does not apply	50% coinsurance	None.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits per plan year maximum.
	Rehabilitation services	20% coinsurance	50% coinsurance	None.
	Habilitation services	**Specialist**- $40 copayment/Visit; Deductible does not apply **Outpatient Facility**- 20% coinsurance	50% coinsurance	Payment may differ based on place of service. Limited to a combined 20 visits per year for all providers, including, but not limited to, physical, occupational and speech therapy. Visit limits apply to Habilitation services only.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per plan year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Check your plan document for limitations. Orthotics – Limited to $500 lifetime.
	Hospice services	0% coinsurance	0% coinsurance	Limited to 180 days per plan year maximum.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Covered up to age 5.
	Children's glasses	Not covered	Not covered	Unless covered by your vision plan.
	Children's dental check-up	Not covered	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) - Except as noted below
- Eye exam over age 5
- Hearing aids and related charges (Adult)
- 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
- Habilitation services (payable per medical necessity)
- 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
- Chiropractic care -- $25 copayment applies -- Limited to 20 visits per year
- Non-emergency care when traveling outside the U.S. (only when on assignment by ER)
- TMJ (Temporomandibular Joint Disorder) covered the same as any other illness when services rendered by a Medical Provider. Limitations apply, refer to your Plan Book for details.
- Hearing Benefit - Hearing Aids, 1 hearing aid per impaired ear every 36 months under the age of 18.
- Oral Surgical Operations. Limitations apply, refer to your Plan Book for details.

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 1-800-807-0400. 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 1-800-807-0400. A list of states with Consumer Assistance Programs is available at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-807-0400.

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

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

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-807-0400.

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	$1,000
Specialist copayment	$40
Hospital (facility) copayment	$200
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,860**

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 copayment	$40
Hospital (facility) copayment	$200
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$800
Coinsurance	$4
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,824**

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

The plan's overall deductible	$1,000
Specialist copayment	$40
Hospital (facility) copayment	$200
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$40
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$1,480**

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

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