Catholic Employee Benefit Group

Coverage for: Plan Participants | **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, visit www.webtpa.com or by calling 1-800-953-2024. 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.webtpa.com or call 1-800-953-2024 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $750/Individual or $2,000/Family; For out-of-network providers $1,700/Individual or $5,000/Family	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, preventative services, physician visits, and urgent care are covered before you meet your deductible.	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?	No.	There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $5,000 family; for out-of-network providers $5,100 individual / $15,250 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, the overall family out–of–pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, deductible, copayment, Non Precertification Penalties, 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. See www.aetna.com/asa or call 1-800-953-2024 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.

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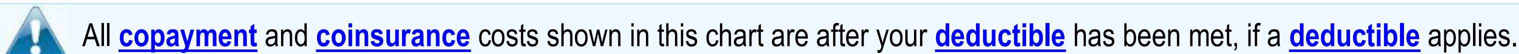
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network 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	$25 copayment	40% coinsurance	___________none____________
	Specialist visit	$25 copayment	40% coinsurance	___________none____________
	Preventive care/screening/ immunization	$25 copayment/$0 copayment for childhood immunizations through age 6.	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible applies first, then coinsurance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hchrx.com	Generic drugs (Tier 1)	$4 copayment/ retail and $8 copayment mail order	40% coinsurance	Covers up to 30-day supply (retail) 31-90 day supply (mail order).
	Preferred brand drugs (Tier 2)	$34 copayment / retail and $68 copayment mail order	40% coinsurance	Covers up to 30-day supply (retail) 31-90 day supply (mail order).
	Non-preferred brand drugs (Tier 3)	$64 copayment / retail and $128 copayment mail order	40% coinsurance	Covers up to 30-day supply (retail) 31-90 day supply (mail order).
	Specialty drugs (Tier 4)	20% coinsurance	40% coinsurance	Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification required. Failure to precert will result in non-covered charges. Refer to Summary Plan Document for services that require precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification required. Failure to precert will result in non-covered charges.
If you need immediate medical attention	Emergency room care	$100 copayment then 20% coinsurance	$100 copayment then 40% coinsurance	___________none__________
	Emergency medical transportation	20% coinsurance; deductible is waived	20% coinsurance; deductible is waived	___________none__________

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	$25 copayment then 20% coinsurance	40% coinsurance	___________none__________
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification required. Failure to precert will result in non-covered charges.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Precertification required. Failure to precert will result in non-covered charges.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	These services are not covered
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	Initial office visit $25 copayment Global fees 20% coinsurance	40% coinsurance	Routine sonograms limited to two per-pregnancy.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance up to a max allowable of $55 per day	Precertification required. Failure to precert will result in non-covered charges. Limited to 60 visits per calendar year and include therapy visits.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Occupational and Speech therapies as well as Cardiac rehabilitation are limited to 30 visits each per calendar year. Rx and treatment plan is required.
	Habilitation services	Not Covered	Not Covered	These services are not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification required. Failure to precert will result in non-covered charges. Limited to 30 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification required if over $1000.00 Failure to precert will result in non-covered charges.
	Hospice services	20% coinsurance	40% coinsurance	Precertification required. Failure to precert will result in non-covered charges. Benefit limited to 185 days/visits per lifetime
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not covered under medical plan
	Children's glasses	Not Covered	Not Covered	Not covered under medical plan
	Children's dental check-up	Not Covered	Not Covered	Not covered under medical 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.)

- Acupuncture
- Bariatric Surgery
- Birth Control Drugs, Devices or Procedures
- Care when Traveling Outside the U.S.
- Cosmetic Surgery
- Custodial Care
- Dental Care (adult)
- Dependent Child Pregnancy
- Hearing Aids
- Infertility Treatment
- Jaw Joint Disorders
- Long-term Care
- Mental Health Services
- Private-Duty Nursing
- Routine Eye Care (adult)
- Routine Foot Care
- Weight Loss Program

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care is covered under the Medical Plan-30 visits per year
- Dental/Vision covered under separate plans

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: Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: Catholic Employees Benefit Group at 888-600-7566 or WebTPA at 1-800-953-2024.

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 1-800-953-2024.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-953-2024.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-953-2024.

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** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$150
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **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	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$916
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,093**

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

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility) coinsurance** **20%**
- **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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$702
Copayments	$75
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,103**

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