

Diocese of La Crosse: Employee PPO Plan



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, <https://eoc.anthem.com/eocdps/aso>. 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 (833) 952-2061 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|--|
| What is the overall <u>deductible</u>? | \$1,250/person or \$2,500/family for <u>In-Network Providers</u> . \$2,500/person or \$5,000/family for <u>Out-of-Network Providers</u> . | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan , 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. <u>Preventive Care</u> . For more information see below. | This plan 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. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this plan? | \$2,500/person or \$5,000/family for <u>In-Network Providers</u> . \$5,000/person or \$10,000/family for <u>Out-of-Network Providers</u> . | 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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premiums</u> , <u>balance-billing</u> charges, health care this plan doesn't cover, and <u>Out-of-Network Transplants</u> . | 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. See www.anthem.com/find-care/?alphaprefix=AMF or call (833) 952-2061 for a list of <u>network providers</u> . Costs may vary by site of service and how the <u>provider</u> bills. | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network . 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 <u>provider's</u> charge and what your plan 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 referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |
|--|-----|--|

 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 Provider (You will pay the least) | Non-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 | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Virtual visits (Telehealth) benefits available. |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | Virtual visits (Telehealth) benefits available. |
| | <u>Preventive care/screening/immunization</u> | No charge | 30% <u>coinsurance</u> | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | -----none----- |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at Caremark.com or call 1 800 565 7091. | Tier 1 - Typically Generic | Retail: 30% <u>coinsurance</u> (\$10 minimum) Mail-Order: \$25 <u>copay</u> <u>deductible</u> does not apply. | 30% <u>coinsurance</u> <u>deductible</u> does not apply. | Provider means pharmacy for purposes of this section. Prescription Out-of-Pocket Maximum - \$1,000 individual/\$3,000 family |
| | Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs | Retail: 30% <u>coinsurance</u> (\$10 minimum) Mail-Order: \$75 <u>copay</u> <u>deductible</u> does not apply. | 30% <u>coinsurance</u> <u>deductible</u> does not apply. | Retail: Up to a 30 day supply. Mail-Order: Up to a 90 day supply. |
| | Tier 3 - Typically Non-Preferred Brand and Generic drugs | Retail: 30% <u>coinsurance</u> (\$10 minimum) Mail-Order: \$75 <u>copay</u> <u>deductible</u> does not apply. | 30% <u>coinsurance</u> <u>deductible</u> does not apply. | You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by Caremark called CVS Specialty Pharmacy. Certain drugs may have a preauthorization requirement or may result in a higher cost. |
| | Tier 4 - Typically Preferred Specialty (brand and generic) | CVS Specialty Pharmacy \$0 or 30% <u>coinsurance</u> | Not covered (retail and home delivery) | |

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---------------------------------------|--|---|---|--|
| | | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| | | <u>deductible</u> does not apply. | | <p>If you use a non-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.</p> <p>Certain preventive medications are covered at No Charge.</p> <p>See the website listed for information on drugs covered by your plan. Not all drugs are covered.</p> <p>Contraceptives are NOT a covered benefit.</p> <p>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.</p> <p>Tier 4 Specialty Drugs as approved by CVS Prudent Rx program will be covered at \$0 copay if the member is enrolled in the Prudent Rx program. If the member is not enrolled in the Prudent Rx program, the member will be subject to 30% coinsurance of the cost of the drug.</p> |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 30% <u>coinsurance</u> | \$250/visit, <u>deductible</u> does not apply for Ambulatory Surgical Center for In- <u>Network Providers</u> . |

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | In-Network Provider (You will pay the least) | Non-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | -----none----- |
| If you need immediate medical attention | Emergency room care | \$200/visit then 20% coinsurance | Covered as In- Network | Copayment waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | Covered as In- Network | Ambulance Services are limited to \$50,000/benefit period. |
| | Urgent care | 20% coinsurance | 30% coinsurance | -----none----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 30% coinsurance | -----none----- |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit 20% coinsurance Other Outpatient 20% coinsurance | Office Visit 30% coinsurance Other Outpatient 30% coinsurance | Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none----- |
| | Inpatient services | 20% coinsurance | 30% coinsurance | -----none----- |
| If you are pregnant | Office visits | 20% coinsurance | 30% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 30% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 30% coinsurance | 40 visits/benefit period. |
| | Rehabilitation services | 20% coinsurance | 30% coinsurance | *See Therapy Services section. |
| | Habilitation services | 20% coinsurance | 30% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 30% coinsurance | 30 days/admission for skilled nursing services. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | *See Durable Medical Equipment Section |
| | Hospice services | 20% coinsurance | 30% coinsurance | -----none----- |
| If your child needs dental or eye care | Children's eye exam | 20% coinsurance | 30% coinsurance | *See Vision Services section |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | -----none----- |

Excluded Services & Other Covered Services:

| | | |
|--|------------------------------|--------------------|
| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.) | | |
| • Bariatric surgery | • Children's dental check-up | • Cosmetic surgery |

* For more information about limitations and exceptions, see the plan or policy document at <https://eoc.anthem.com/eocdps/aso>.

- Dental care (Adult)
- Long-term care
- Weight loss programs
- Glasses for a child
- Private-duty nursing
- Infertility treatment
- Routine foot care

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

- Acupuncture
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Chiropractic care 2,000 maximum/benefit period
- Routine eye care (Adult)
- Hearing aids 1 item(s)/ear every 3 years for children 18 years of age or under.

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: Office of the Commissioner of Insurance, 125 South Webster Street, Madison, Wisconsin 53703-3474, (608) 266-3585, (800) 236-8517, (608) 266-3586, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov, or contact Anthem at the number on the back of your ID card. 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 on how 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov

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.

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 <u>plan's</u> overall <u>deductible</u> | \$1,250 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,250 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$2,570 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,250 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$4,300 |
| The total Joe would pay is | \$5,400 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$1,250 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ <u>Hospital (facility) coinsurance</u> | 20% |
| ■ <u>Other coinsurance</u> | 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:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,250 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$1,660 |

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

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 952-2061

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት ሙብት አለዎት። አስተርጓሚ ለማናገር (833) 952-2061 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 952-2061.

Armenian (հայերեն): Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 952-2061:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ b̄ídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̀á (833) 952-2061.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 952-2061 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (833) 952-2061 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(833) 952-2061。

Dinka (Dinka): Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tāäuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (833) 952-2061.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 952-2061.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 952-2061 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 952-2061.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 952-2061.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 952-2061.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 952-2061.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 952-2061.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 952-2061 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 952-2061.

Igbo (Igbo): O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (833) 952-2061.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 952-2061.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 952-2061.

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Language Access Services:

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