Diocese *of* La Crosse

& Its Affiliates

Employee Medical Benefit Plan

Priests Group

Plan Year January 1 - December 31, 2021

St. Ambrose
Financial Services, Inc.

OVERVIEW

- **Plan Year**
  - January 1, 2021 through December 31, 2021
- **Premiums**
  - The premiums for 2021 Plan Year are provided after each benefit and a summary page at the end
- **SERVE YOU RX - PRESCRIPTION DRUG / PHARMACY BENEFIT –** www.serve-you-rx.com
  - Phone – Member Services 800-759-3203
  - Email – www.serve-you-rx.com/contact/

- **VSP Vision Plan** – VSP.com
  - Included with the Health Plan or can be added as a separate benefit if not enrolled in the Health Plan
  - Receive access to care from great eye doctors, quality eyewear at low out-of-pocket costs
  - No Vision Plan card is required, simply inform your provider that you have VSP Vision Plan
  - Member Services - - **800-877-7195** or **www.vsp.com**
- **Delta Dental Plan** – https://www.deltadentalwi.com/DDWI/s/
  - Dental insurance can play a key role in your overall health.

TRADITIONAL DEDUCTIBLE HEALTH PLAN

Benefit	PPO	Non PPO
Deductible	**$0.00**	**$0.00**
Co-Insurance	90% Insurance 10% Insured to maximum out of pocket	80% Insurance 20% Insured to maximum out of pocket
Maximum Out of Pocket	$900.00	$1,300.00
Preventive / Wellness	Covered at 100% not subject to deductible	• 70% Insurance **(maximum benefit of $700)** • 30% Insured to maximum out of pocket
Prescriptions / Pharmacy Plan	Available via **SERVE YOU RX** Retail - 70% Insurance / 30% Insured to maximum out of pocket of $1,000 per individual	
Pre-Certifications	Authorization required to cover hospitalization and other certain medical procedures at least 72 hours prior for nonemergency admissions	

The above information is an outline of some of the benefits and is not intended to be all inclusive. Additional information can be found in the **Diocese of La Crosse Priests Group Medical Benefit Plan** located at http://stambrosefinancial.com.

TRADITIONAL DEDUCTIBLE HEALTH PLAN

PREMIUMS 2021

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2021

VISION COVERAGE INCLUDED IF ENROLLED IN HEALTH PLAN

PREMIUM RATES

TRADITIONAL PLAN DEDUCTIBLE

Priests	$ 1,325 / month
Senior Priests – Medicare	$ 496 / month

The above information is an outline of some of the charges and is not intended to be all inclusive. Additional information can be found in the **Diocese of La Crosse Priests Group Medical Benefit Plan** located at http://stambrosefinancial.com **- Priests Group Employee Medical Benefit Plan**.

PRESCRIPTIONS (PHARMACY BENEFIT)

- Provider – **SERVE YOU RX**
  - Check with provider to see if a generic equivalent is available for brand name/non-generic drugs.
  - Part of the Medical ID card which is presented when purchasing prescription drugs at participating pharmacies in your area. The Pharmacy Benefit is as follows:
    - Retail purchases at a pharmacy for generic prescriptions - 30% copayment of the total drug cost, with a minimum payment of $10 per prescription, or actual total cost if less than $10.
    - Brand name prescriptions - 30% copayment of the total drug cost.
  - **Mail Order option**
    - Approximately 80% of the prescription drugs currently used are maintenance drugs and typically can be purchased via the mail order option - saves time and money.

The above information is an outline of some of the benefits and is not intended to be all inclusive. Additional information can be found in the **Diocese of La Crosse Priests Group Medical Benefit Plan** located at http://stambrosefinancial.com - **Priests Group Employee Medical Benefit Plan**.

DENTAL PLAN

COVERAGE SUMMARY – Delta Dental

Deductible	$0.00	$1,500 - Maximum Benefit per participant per plan year	
	Family - Deductible = $0	$ 3,000 - Maximum Benefit per plan year	
Diagnostic & Preventative	Examinations, Bitewing X-rays, Teeth Cleaning **2 times per benefit year**		100%
Preventive Charges			100%
Basic Dental	• Extractions & other oral surgery, • Restorations - amalgam, composite (front teeth), stainless steel prefabricated crowns (1 per tooth in a 3-year period • Endodontics (root canal treatment & therapy) • Periodontics (treatment of gum • Repairs/adjustments to prosthetic appliances & Dentures • Anesthesia and Injections • Emergency Palliative Treatment		80%
Major Dental	• Crowns, inlays or onlays • Prosthetics - fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth • Porcelain veneers on crowns on the six front teeth, bicuspids and upper first molars.		50%

The above information is an outline of some of the charges covered and is not intended to be all inclusive. Additional information can be found in the **Diocese of La Crosse Priests Group Dental Benefit Plan** located at http://stambrosefinancial.com - **Priests Group Dental Benefit Plan.**

DENTAL PLAN
PREMIUMS 2021

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2021

	PREMIUM RATES
Individual Only	$ 32

The above information is an outline of some of the charges and is not intended to be all inclusive. Additional information can be found in the **Diocese of La Crosse Priests Group Dental Benefit Plan** located at http://stambrosefinancial.com - **Priests Group Dental Benefit Plan.**

VISION PLAN

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
WellVision Exam	Focuses on your eyes and overall wellness	$ 10	Every 12 months
Prescription Glasses		$ 25	See frame/lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® or Walmart frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children		Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$ 0 $ 95 - $ 105 $ 150 - $ 175	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)		Every 12 months
Primary EyeCare	• Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Visit your VSP doctor for medical and urgent eyecare.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

The above information is an outline of some of the benefits and is not intended to be all inclusive. Additional information can be found in the **Diocese of La Crosse Priests Group Medical Benefit Plan** located at http://stambrosefinancial.com - **Priests Group Medical Benefit Plan**.

VISION PLAN
PREMIUMS 2021

MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2021

NOTE:

- The Vision Insurance premium is included in the Diocese of La Crosse Priests Group Health Plan

VOLUNTARY LIFE

Eligibility	Active Status
Benefits	Life insurance in $10,000 increments up to $500,000 (not to exceed 5 times annual income). Non-medical maximum of $150,000
Costs	Monthly premium charges depend on age and benefit amount elected. Premiums are paid by the employee.
Can I be turned down?	If enrolled when first eligible, employee and dependents can be covered for up to the non-medical (guarantee issue) maximum listed without medical questions, provided the eligibility requirements listed above are met.
When Can I Enroll?	Enrollment must take place within 31 days following the first day of work in a position which meets the eligibility requirements. This includes a change in scheduled hours to a position that would meet eligibility requirements. Late enrollees will be required to wait until the next annual enrollment to apply and will be subject to medical review and could be turned down by the insurance company.
Coverage Effective Date	Coverage will be effective the first of the month following the first day of work. Late enrollees will be effective on the first of the month following approval by the carrier's underwriting department
Links	Additional information can be found at http://stambrosefinancial.com or select one of the following links: • Voluntary Life Summary of Benefits • Voluntary Life Enrollment Form

The above information is an outline of information for this specific insurance and is not intended to be all inclusive. Additional information can be found in the **Diocese of La Crosse Priests Group Medical Benefit Plan** located at http://stambrosefinancial.com - **Priests Group Employee Medical Benefit Plan**.

RESOURCES

ST. AMBROSE
FINANCIAL SERVICES, INC.

Website: **http://stambrosefinancial.com**

Email: **SAFS@stambrosefinancial.com**

Phone #: **608.791.2669**

- **Dennis Herricks,** Executive Director
  608-519-9893 / dherricks@stambrosefinancial.com
- **Rachel Melde**, Benefits Coordinator
  608-519-9895 / rmelde@stambrosefinancial.com
- **Cheryl Cummings** – Accounting Manager
  608-519-9894 / ccummings@stambrosefinancial.com
- **Lori Dickman**, Accounting Clerk
  608-519-9896 / ldickman@stambrosefinancial.com

SERVE YOU Rx
Welcome
How to Make the Most
of Your Pharmacy Benefit
Learn more
on next page

We are here to serve you.

Serve You Rx has been selected to provide the pharmacy benefit for you and your covered family members. We are here to serve you by helping you maximize your pharmacy benefit and better manage your prescription drug costs through informed decision making.

Questions?

Serve You Rx customer service representatives are available 364 days per year to provide assistance. Simply call us or go online:

800-759-3203

serve-you-rx.com

Your pharmacy benefit services

Serve You Rx connects you with the tools and resources you need to make informed decisions about your pharmacy benefit and medications.

Following are a few steps you can take to make the most of your pharmacy benefit:

1 Sign up for the Serve You Rx Member Portal

The Serve You Rx website, serve-you-rx.com, has a password-protected member section where you can research drugs, compare prescription costs, find participating network pharmacies, track medication history, and more.

HOW CAN YOU SAVE MONEY ON PRESCRIPTIONS?

- **Switch to a lower cost medication.** Ask your prescriber if your treatment has a generic alternative.
- **Use mail service.** For medications you take regularly, mail service offers a 90-day supply often for less than what you would pay at a retail pharmacy.
- **Use our online tools** to compare pharmacy prices and research lower cost medication alternatives.

2 Find an In-Network Pharmacy

The Serve You Rx nationwide pharmacy network has thousands of pharmacies, including all chain pharmacies, independent community pharmacies, and mail service pharmacies operated by Serve You Rx. To find a participating pharmacy or to check if your current pharmacy is in our network, log in to the Member Portal at serve-you-rx.com and use the pharmacy search feature or call us at 800-759-3203.

3 Maximize Savings with Mail Service

Mail service can save you time and money by delivering medications right to your door that you take regularly for chronic conditions, such as high blood pressure, high cholesterol, and diabetes.

Our mail order pharmacies provide:

- Free standard home delivery
- A three-month supply of prescriptions that likely cost less than you would pay at a retail pharmacy
- Pharmacists who are available 24/7 to answer questions about your mail prescriptions
- Convenient refill options online, by phone, and by mail
- Secure and confidential packaging that protects against weather and tampering

4 Refer to the Serve You Rx Preferred Drug List

A Preferred Drug List (PDL) is a list of prescription medications covered by your prescription drug plan. Its purpose is to help you and your prescriber choose safe, effective, and cost-efficient drug treatments.

Using drugs on the PDL often results in lower out-of-pocket costs. You can learn what drugs are listed on the PDL by visiting serve-you-rx.com or by calling Serve You Rx customer service at 800-759-3203.

5 Explore Lower-Cost Options

Generic drugs contain the same active ingredients as their brand-name counterparts and can be considerably less expensive. Therefore, an FDA-approved generic equivalent will be dispensed whenever possible based on availability and your prescriber's approval.

If you choose to have your prescription filled with a brand-name drug when a generic is available, you may be required to pay the cost difference in addition to your copay. We recommend that you ask your prescriber or pharmacist if a generic is available for your medications, as this may provide considerable cost savings for you.

Serve You Rx customer service representatives are available 364 days per year to provide assistance. Simply call us or go online.

800-759-3203

serve-you-rx.com

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DENTAL BENEFITS

Prepared for the *Diocese of La Crosse & Its Affiliates*

Effective January 1,2021

The summary below does not cover all plan details. Further information can be found in the summary plan description or dental benefit handbook. That document provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply. If there are any discrepancies between information found here and the group contract, the group contract shall govern.

Benefit Plan Design		**Delta Dental PPO** When you see a Delta Dental PPO dentist	**Delta Dental Premier** When you see a Delta Dental Premier or any other dentist
Individual Annual Maximum		$1,500	$1,500
Family Annual Maximum		$3,000	$3,000
Deductible	**Individual**	$0	$0
	Family	$0	$0
Dependent Eligibility Dependents are eligible through the end of the month in which they attain age 26			
Diagnostic & Preventive Services			
Exams		100%	100%
Fluoride treatments		100%	100%
Cleanings		100%	100%
Fluoride treatments		100%	100%
X-rays		100%	100%
Space maintainers		100%	100%
Sealants		100%	100%
Emergency treatment to relieve pain		100%	100%
Deductible applies		No	No
Basic & Major Services			
Fillings		80%	80%
Endodontics – nonsurgical		80%	80%
Endodontics – surgical		80%	80%
Periodontics – nonsurgical		80%	80%
Periodontics – surgical		80%	80%
Extractions - nonsurgical		80%	80%
Extractions - surgical and other oral surgery		80%	80%
Crowns, inlays, onlays		50%	50%
Bridges and dentures		50%	50%
Repairs and adjustments to bridges and dentures		80%	80%
Implants		50%	50%
Deductible applies		No	No
Orthodontic Services			
Coverage		N/A	N/A

Prepared for the Diocese of La Crosse & Its Affiliates

A Better PPO from Delta Dental

Delta Dental is the nation's largest and oldest dental-benefits specialist built on the guiding principle that dental benefits should be simple and hassle-free. Delta Dental of Wisconsin was founded in 1962 with the same goal. Combined, member companies of the Delta Dental Plans Association serve more than 59 million people in nearly 97,000 groups nationwide.

With some PPO plans, you don't get much choice of providers. And if you go out of network, your provider may balance-bill you. But your Delta Dental PPO plan is different. The Delta Dental PPO network, with more than 165,000 dentist locations nationwide, is backed by the Delta Dental Premier network, with more than 247,000 dentist locations nationwide – almost 80% of the nation's dentists. Your lowest out-of-pocket costs come from seeing a Delta Dental PPO dentist, but you'll also enjoy cost advantages if you see a Delta Dental Premier dentist. That means savings on out-of-pocket costs **and** better choice. Here's an example:

PPO Savings, With A "Safety Net"	Delta Dental PPO Dentist	Delta Dental Premier Dentist	Out-of-Network Dentist
Dentist's Normal Fee	**$720**	**$720**	**$720**
Allowed Amount	**$590**	**$680**	**$680**
Dentist Fee Adjustment Due to Delta Dental Agreement	**$130**	**$40**	**None**
50% Benefit Paid by Plan	**$295**	**$340**	**$340**
Patient Responsibility	**$295**	**$340**	**$380**

Advantages of Delta Dental Network Dentists	Delta Dental PPO Network Dentists	Delta Dental Premier Network Dentists	Noncontracted Dentists
Agreed-to fee ceilings (no balance-billing): *Dentist agrees to fee ceilings. If his/her normal charge is higher than the fee ceiling, he/she can't pass the balance on to you.*	✓	✓	
Additional fee schedule savings: *Dentist agrees to a reduced fee schedule. Saves out-of-pocket expenses for you.*	✓		
Convenient claims processing: *Dentist is required to file claims on your behalf, saving you the hassle of doing so yourself. Claims payments go directly to the dentist.*	✓	✓	
Treatment guarantees: *Examples -- Repair or replace dental restorations should they fail within 24 months.*	✓	✓	

Confirming Your Coverage

If you are not sure of the effective date of your coverage, please call Delta Dental at 800-236-3712 before you have any dental work done.

Also, before scheduling appointments for extensive dental care, you may ask your dentist to send the treatment plan to Delta Dental. The plan will be reviewed by Delta Dental and you and your dentist will receive a **Predetermination of Benefits** form. You and your dentist may then discuss the treatment and your out-of-pocket costs. Delta Dental encourages you to be informed about your dental care.

Delta Dental's Website

www.deltadentalwi.com has a lot to offer. You can use it to obtain coverage information under your plan, check the status of a claim, find a network dentist, evaluate your oral health and learn ways to improve and protect it.

Visit **www.deltadentalwi.com** for eligibility, claims or dentist information.

Also, our Benefit Advisors are available every weekday from 7:30 a.m. to 5 p.m. (Central Time) to answer your questions. Call us at 800-236-3712. We look forward to talking with you!

Welcome to VSP®!

Life is better in focus,™ and we make your overall eye health and wellness our top priorities. As a VSP member, you have access to the best care and cutting-edge technologies at the lowest out-of-pocket costs.

Get started at vsp.com:

Check your VSP vision coverage and find a VSP network doctor to get the most out of your vision benefit.

Take advantage of Exclusive Member Extras, like an extra $20 to spend on featured frame brands and savings of up to 40% on lens enhancements, to save even more on your eyewear.[1] Visit a doctor who participates in the Premier Program for additional bonus offers.

Print a Member Vision Card—if you'd like one. There's no ID card necessary—just tell your provider you have VSP.

You deserve access to personalized and affordable vision care. That's why we're committed to ensuring that you experience a lifetime of good vision.

YOUR VISION & HEALTH COME FIRST WITH VSP

Create an account, find a VSP network doctor, and see your benefit at **vsp.com** today!

DID YOU KNOW?

* You have access to more than 30,000 network doctors.
* 9 out of 10 members reported satisfaction over the past 5 years
* As a member you'll get Exclusive Member Extras that you won't find anywhere else

Visit vsp.com/memberjourney to check out a fun, interactive version of your VSP journey.

Questions? **vsp.com | 800.877.7195**

1. Check your frame coverage to see if this offer applies. Brands and promotions are subject to change.

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Your VSP Vision Benefits Summary

DIOCESE OF LA CROSSE AND ITS AFFILIATES and VSP provide you with an affordable eyecare plan.

VSP Coverage Effective Date: 07/01/2019

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses		$25	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® or Walmart frame allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$0 $95 - $105 $150 - $175	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Primary EyeCare	• As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
Your Monthly Contribution	$4.95 Member only $11.82 Member + family		
	Your Coverage with Out-of-Network Providers		
	Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Contact us. **800.877.7195 | vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

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VSP, VSP Vision care for life, eyeconic.com, and WellVision Exam are registered trademarks, and "Life is better in focus." is a trademark of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other company names and brands are trademarks or registered trademarks of their respective owners.

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.bpaco.com or call 1-800-236-7789. 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 call1-800-236-7789 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** for Preferred Providers and **$500** for Non-Preferred providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Pre-admission testing, E-visits, and prescription drugs; and Preferred Provider physician/office visits, preventive care up to $700, and mental/behavioral health and substance abuse outpatient treatment 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.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	**$900** for Preferred providers and **$1,300** for Non-Preferred providers	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, charges over the maximum allowable charges, ineligible charges, charges in excess of the plan maximums/limitations, pre-certification penalties, copays, prescription ancillary charges, manufacturer copay assistance coinsurance charges that exceed the plan specialty drug copay, 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.the-alliance.org** or call **1-800-223-4139** or **www.preferredone.com** or call **1-800-451-9597** or **www.phcs.com** or call **1-800-922-4362** or **www.multiplan.com** or call **1-800-546-3887** 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
		Preferred Provider (You will pay the least)	Non-Preferred 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/visit; Deductible does not apply	20% coinsurance	Office visit charge only.
	Specialist visit	$25/visit; Deductible does not apply	20% coinsurance	Office visit charge only.
	Preventive care/screening/ immunization	No charge; Deductible does not apply, up to $700 maximum per calendar year benefit, then 10% coinsurance	20% coinsurance, up to $700 per calendar year maximum benefit	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)	10% coinsurance	20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at www.bpaco.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.serve-you-rx.com**	Generic drugs	$10/prescription (retail) $20/prescription (mail order) Deductible does not apply	$10/prescription (retail) Deductible does not apply	One copay per 34-day supply, maximum 90-day supply (retail prescription); one copay per 90-day supply (mail order prescription). Immunizations are covered $0/immunization (retail); Deductible does not apply.
	Preferred brand drugs	$25/prescription (retail) $50/prescription (mail order) Deductible does not apply	$25/prescription (retail) Deductible does not apply	
	Non-preferred brand drugs	$25/prescription (retail) $50/prescription (mail order) Deductible does not apply	$25/prescription (retail) Deductible does not apply	
	Specialty drugs	Per applicable Copay 30% copay -IPC Copay Assistance Program		Covers up to a maximum 34-day supply. IPC Copay covers up to a maximum 30-day supply. Please see Prescription Drug Benefit section within your Plan Document for details. IPC Copay Assistance Program-the program will cover most if not all of the copay amount. Any actual out of pocket costs at point of sale will apply to the maximum out of pocket as applicable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	————none————
	Physician/surgeon fees	10% coinsurance	20% coinsurance	————none————
If you need immediate medical attention	Emergency room care	$200/visit, then 10% coinsurance after PPO deductible		Copay waived if admitted on inpatient basis within 24 hours for the same condition.
	Emergency medical transportation	10% coinsurance	20% coinsurance	————none————
	Urgent care	10% coinsurance	20% coinsurance	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Services must be pre-certified in order to avoid a $100 penalty per occurrence.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	————————none————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit; Deductible does not apply 10% coinsurance- intensive outpatient/partial hospitalization	20% coinsurance	————————none————————
	Inpatient services	10% coinsurance	20% coinsurance	Services must be pre-certified in order to avoid a $100 penalty per occurrence.
If you are pregnant	Office visits	Not applicable	Not applicable	Not applicable
	Childbirth/delivery professional services	Not applicable	Not applicable	Not applicable
	Childbirth/delivery facility services	Not applicable	Not applicable	Not applicable
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Maximum of 4 hours/visit in any 24 hour period and limited to a maximum of 40 visits per calendar year.
	Rehabilitation services	10% coinsurance	20% coinsurance	————————none————————
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	10% coinsurance	20% coinsurance	Limited to 30 days per confinement. Services should begin within 14 days after discharge from an inpatient confinement of at least 3 consecutive days. Services must be pre-certified in order to avoid a $100 penalty per occurrence.
	Durable medical equipment	10% coinsurance	20% coinsurance	Rental cannot exceed the purchase price.
	Hospice services	10% coinsurance	20% coinsurance	Patient's life expectancy must be 6 months or less.

If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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.)

- Bariatric surgery
- Cosmetic surgery (except due to a covered surgical procedure, accident or birth defect)
- Dental care (Adult) (except for limited oral surgery. See dental plan document section for benefits.)
- Dental check-up (Child)
- Glasses (Child)
- Habilitation services
- Hearing aids (except if needed as a result of a covered injury)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Child)
- Routine foot care (unless medically necessary)
- Weight loss programs (unless for morbid obesity)

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

- Acupuncture
- Chiropractic care (except routine and maintenance)
- Coverage provided outside the United States. See www.bpaco.com.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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: visit www.bpaco.com or call 1-800-236-7789. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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.

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 plan's overall deductible** **$500**
- ***Specialist copayment*** **$25**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	n/a
Copayments	n/a
Coinsurance	n/a
What isn't covered	
Limits or exclusions	n/a
The total Peg would pay is	**n/a**

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

- **The plan's overall deductible** **$500**
- ***Specialist copayment*** **$25**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	$100
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$900**

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

- **The plan's overall deductible** **$500**
- ***Specialist copayment*** **$25**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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, Mike would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mike would pay is	**$900**

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

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

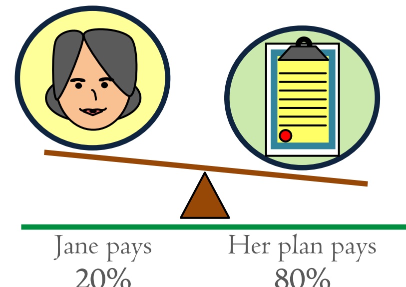
Allowed Amount
This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

Appeal
A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim
A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

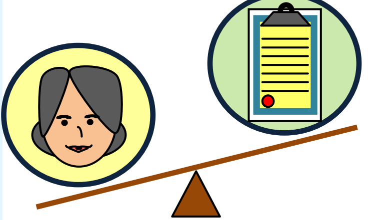
Complications of Pregnancy
Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost Sharing
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions
Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible



(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

Individual Responsibility Requirement

Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Health coverage that will meet the individual responsibility requirement. 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.

Minimum Value Standard

A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment

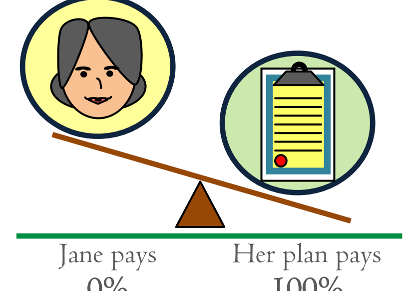
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-particiapting" instead of "out-of-network provider".

Out-of-pocket Limit

The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

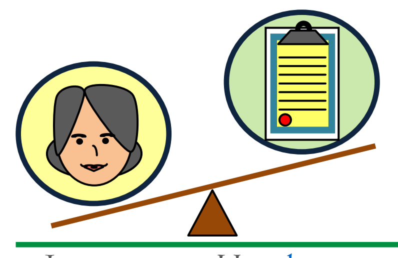
Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

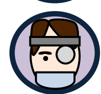


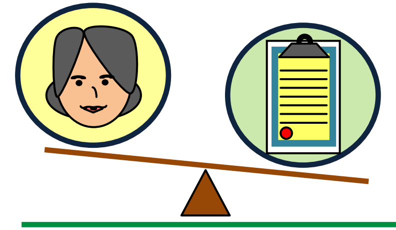
Jane pays 100% | Her plan pays 0%

Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0



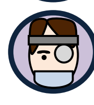


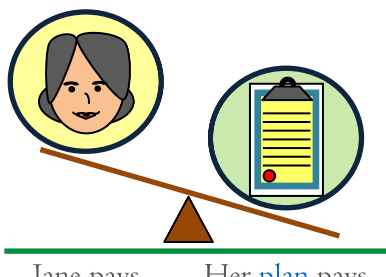
Jane pays 20% | Her plan pays 80%

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100





Jane pays 0% | Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125