

**Christian Brothers Employee Benefit Trust**  
**Sample Plan #1 – Med Plan 1175 – Holy Cross Associates #86030**

	<b>PPO In-Network</b>	<b>Out-of-Network</b>
<b>CALENDAR YR. DEDUCTIBLE</b>	\$250/Individual	\$250/Individual
<b>OUT-OF-POCKET LIMIT</b>	\$1,500/Individual	\$3,000/Individual
<b>LIFETIME MAXIMUM</b>	\$2 Million	\$2 Million
<b>PHYSICIAN SERVICES</b>		
<b>Office Visits to Physician Incl. Anes., Path., and X-Ray (Primary &amp; Specialty) Incl. Preventative Care</b>	100% after \$10 Co-Pay	70% after \$20 Co-Pay
<b>Hospital Visits</b>	90% after Deductible	70% after Deductible
<b>Surgery</b>	90% after Deductible	70% after Deductible
<b>Reading of the X-Ray &amp; Lab Tests Performed at Another Location</b>	90% after Deductible (unless LabOne is used for Lab Tests then 100%)	70% after Deductible
<b>HOSPITAL SERVICES</b>	<b>Hospitalization requires Pre-Certification. Please call (800) 533-5044. Failure to call may reduce benefits.</b>	
<b>Inpatient (Semi-Private Room)</b>	90% after \$100 Co-Pay	70% after \$200 Co-Pay
<b>Outpatient Includes Preventative Care</b>	90% after Deductible	70% after Deductible
<b>Emergency Room Care</b>	90% after \$25 Co-Pay	70% after \$50 Co-Pay
<b>OTHER SERVICES</b>		
<b>Rehabilitation Services (Physical, Occupational &amp; Speech Therapy)</b>	90% after Deductible	70% after Deductible
<b>Medical Equipment, Prosthetic Appliances, Ambulance, and/or Supplies</b>	80% after Deductible	80% after Deductible
<b>MISC. LIMITED SERVICES</b>		
<b>Skilled Nursing Facility (Custodial Care Not Covered)</b>	80% after Deductible Specific limitations exist; such as, 120 day max. & 50% of semi-private room.	80% after Deductible Specific limitations exist; such as, 120 day max. & 50% of semi-private room.
<b>Home Health Care (Custodial Care Not Covered)</b>	80% after Deductible Specific limitations exist; such as, 100 visit maximum per calendar year.	80% after Deductible Specific limitations exist; such as, 100 visit maximum per calendar year.
<b>Hospice Care (Custodial Care Not Covered)</b>	80% after Deductible Specific limitations exist; such as, charges limited to \$60 per day and \$4,000 per episode maximum.	80% after Deductible Specific limitations exist; such as, charges limited to \$60 per day and \$4,000 per episode maximum.
<b>Other Practitioner Benefit (Includes Other State Licensed Practitioners; such as, Chiropractor, Optometrist, etc. Charges for acupuncture or acupressure from all eligible providers)</b>	80% after Deductible Specific limitations exist; such as, charges limited to \$50 per day and \$2,500 per year.	80% after Deductible Specific limitations exist; such as, charges limited to \$50 per day and \$2,500.

## SPECIAL LIMITED BENEFITS

<b>LIMITED TRANSPLANT BENEFIT</b>		
<b>Standard In or Out-of-Network Benefits Apply, PLUS</b>  <b>Treatment at URN Center</b>	<ul style="list-style-type: none"> <li>▪ Travel/Lodging Benefit of \$5,000 if pre-approved and Center is greater than 150 miles one-way.</li> <li>▪ Donor charges covered if charges not eligible under another plan.</li> <li>▪ PPO In Network Benefits Paid for Treatment at URN Center</li> </ul>	
	<b>Treatment at Non-URN Center</b> <ul style="list-style-type: none"> <li>▪ Individual Transplant Maximums</li> <li>▪ Lifetime Maximum Benefit of \$150,000 for all Transplants.</li> <li>▪ Charges related to Living Donor(s) are not covered.</li> </ul>	
<b>LIMITED FERTILITY BENEFIT</b>		
<b>MAXIMUM LIFETIME BENEFIT OF \$25,000</b>		
<b>Standard In or Out-of-Network Benefits Apply.</b>  <b>No Benefits Payable</b>	<p>Coverage includes treatment (including drugs) to restore fertility or promote conception, but limited to the detection and/or correction of abnormal conditions or malfunctioning reproductive organs which prevent natural conception.</p>	
	<p>Coverage does not include reversal of voluntary sterilization and any other treatment for the restoration of fertility or promotion of conception. (Procedures such as, but not limited to, in vitro fertilization, artificial insemination, surrogacy, harvesting of eggs, sperm donation, or cryopreservation are not covered.)</p>	
<b>LIMITED ORTHOTIC BENEFIT</b>		
<b>MAXIMUM LIFETIME BENEFIT OF \$500.</b>		
<b>Standard In or Out-of-Network Benefits Apply</b>	<p>Coverage includes all services, including testing and casting, related to the purchase of orthotics. This benefit will apply only when the orthotics are prescribed for specific diagnosed medical conditions, such as but not limited to: bones spurs, heel spurs or plantar fasciitis. <u>To be eligible for benefits, prior written approval from us is required.</u></p>	
<b>PSYCHIATRIC, ALCOHOL &amp; DRUG RELATED SERVICES</b>		
<b>Inpatient (All Related Charges)</b>	Hospital – 90% after \$100 Co-Pay Other – 90% after Deductible Limited to 30 days lifetime	Hospital – 70% after \$200 Co-Pay Other-70% after Deductible Limited to 30 days lifetime
<b>Partial Hospitalization/Day Treatment Program (All Related Charges)</b>	90% after Deductible Limited to 30 days per calendar year/60 days lifetime	70% after Deductible Limited to 30 days per calendar year/60 days lifetime

<b>Outpatient Services</b>	80% after Deductible Limited to 40 visits per calendar year	80% after Deductible Limited to 40 visits per calendar year
<b>PRESCRIPTION DRUG BENEFIT</b>		
<b>Retail Prescriptions for short-term medications</b>	\$10 Co-Pay Generic/\$20 Co-Pay Brand per 30 day supply at any participating pharmacy.	
<b>Mail Order Prescriptions for long-term maintenance medications</b>	\$20 Co-Pay Generics/\$40 Co-Pay Brand per 90 day supply through mail order program.	
<ul style="list-style-type: none"> <li>▪ Certain drugs are not covered by the Plan; such as, over-the-counter, contraceptives, cosmetic, steroids, appetite suppressants, those not medically necessary, experimental, etc.</li> <li>▪ Some drugs may require review of medical necessity and preauthorization before purchase is allowed.</li> <li>▪ Infertility drugs are only covered by the medical portion of the Plan and up to the specified limitations previously indicated.</li> </ul>		

**Services and Supplies are not covered by the Plan for:**

- Any sickness covered by Worker's Compensation or similar law or for any work-related injury.
- Services which are furnished by the U.S. Government.
- Experimental or investigational services.
- Educational problems, training problems or learning disorders.
- Dental services including those for Temporomandibular Joint Disorders (TMJD) or malocclusion. This does not apply to treatment of accident-related injuries during the time frame indicated in the plan.
- Treatment of painful feet, corns, or calluses, except inflammatory conditions and/or surgical procedures.
- Surgical refractive procedures (i.e. radial keratotomy), exams or the purchase of hearing aids or other corrective appliances or devices.
- Cosmetic surgery, except for certain accidental injuries during the time frame indicated in the plan.
- Sickness or injury resulting from war or any act of war.
- Custodial care, convenience services or supplies.
- Services which are not Medically Necessary or which exceed Prevailing Charges.
- Services related to restoration of fertility or promotion of conception except as described in Special Limited Benefits.
- Services related to voluntary sterilization (or it's reversal), contraception or abortion.
- Non-emergency drugs, supplements, or special diets.
- Non-emergency service performed outside the USA

This Benefit Summary provides a *brief* outline of the services covered by CBEBT. **THIS IS NOT A CONTRACT.** The complete terms of the plan are contained in Your Employee Benefits booklet issued to members. For more information regarding benefits, please call Customer Services at 1-800-807-0400.

The CBEBT is a self-funded church plan which serves employers of the Catholic Church by providing medical benefits to Plan participants for medically necessary care related to treatment of illness or injury. It is understood that the Trust works within the framework of the tenets of the Catholic Church. It is for that reason that the Trust does not provide benefits for some services which are inconsistent with the Catholic Church's position.

<b>PROCEDURES &amp; DEFINITIONS</b>	
<b>Coordination of Benefits</b>	All benefits are subject to Coordination of Benefits with other plans. The total benefits payable under this plan for a covered person when combined with other group health plan benefits will not then more than 100% of allowable expenses. (Special provisions apply to plans which indicate they are secondary only or if dependents are covered by an HMO.)
<b>Co-pay</b>	The amount which a patient is required to pay to a provider at the time of service. (Co-Pay does not apply to patient's out-of-pocket or calendar year deductible.)
<b>Deductible</b>	Amount of expense or loss to be paid by the patient before benefits are payable by the Plan.
<b>Integration with Medicare</b>	If Medicare is primary, normal plan benefits are calculated; Medicare's payment is then subtracted. You are responsible for your out-of-pocket percentage.
<b>Medical Emergency</b>	A Medical Emergency is generally defined as a sickness or injury of such a nature that failure to get immediate medical care could put a person's life in danger or cause serious harm to bodily functions.
<b>Out of Pocket Expenses (The % Patient Pays)</b>	The percent of covered charges you are financially responsible to pay. This does not include deductibles, co-pays or eligible charges already payable at 100%
<b>Out of Pocket Limit (The % Patient Pays)</b>	The total of your Out-of-Pocket Expenses plus your deductible. When this total reaches your Plan's Out-of-Pocket Limit for the calendar year, the remainder of your covered charges for the calendar year will be paid at 100%.
<b>Physician</b>	A Physician is defined as a licensed Doctor of Medicine or Osteopathy or a licensed Doctor of Podiatric Medicine.

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