

M&G Jesuit Volunteer Corp. - Volunteers

August 1, 2020 Employee Cost Sheet

Carrier	Christian Brothers Services
Plan	\$175 / 20%
Network	Aetna Signature Administrators
Deductible (Ind/Fam)	\$175 / \$350
Out-of-Pocket Max (Ind/Fam)	\$2,750 / \$5,500**
<u>Physician / Office Services</u>	
Primary / Specialist	20% after Ded.
Telemedicine / Virtual Visits	20% after Ded.
Urgent Care	20% after Ded.
<u>Hospital Services</u>	
Inpatient / Outpatient	20% after Ded.
Emergency Room	20% after Ded.
<u>Additional Services</u>	
Basic Lab & X-Ray	Lab: Covered in full after Ded. X-Ray: 20\$ after Ded.
Advanced Imaging	20% after Ded.
Alternative Care	Acupuncture: 20% after Ded., 12 visit max.
Adult Vision	Not Included
Prescription	All Tiers: 20% after Ded.
Prescription HRA	Contraceptive Prescriptions Only: Employee pays the first \$15 generic / \$30 brand name, HRA reimburses the remaining balance

* Deductible Waived

** All services incl. in Out of Pocket Max.

In and out of network deductibles and out of pockets no longer cross-accumulate

To enroll in the Prescription HRA please contact Tracy Clark
 email: tracyc@mymgteam.com
 phone: 971-236-9068



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1.800.852.4877 or visit us at www.myCBS.org/health or email at hbscustomerservice@cbservices.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1.800.852.4877 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>Combined Medical & Prescription Drug In-Network \$175 Individual / \$350 Family Medical Out-of-Network \$175 Individual / \$350 Family In-Network & Out-of-Network <u>deductibles</u> do not reduce each other.</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, 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>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. For <u>Preventive care</u> services, the In-Network <u>deductible</u> does not apply.</p>	<p>This <u>plan</u> 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 <u>plan</u> 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/</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>Combined Medical & Prescription Drug In-Network \$2,750 Individual / \$5,500 Family Medical Out-of-Network \$2,750 Individual / \$5,500 Family In-Network & Out-of-Network <u>out-of-pocket limits</u> do not reduce each other.</p>	<p>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 <u>plan</u>, 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.</p>

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<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, <u>balance-billed</u> charges, <u>deductible</u>, <u>copayment</u>, or <u>coinsurance</u> amounts paid on a covered persons behalf by a foundational or manufacturer sponsored patient assistance program, penalty for prescription retail refill allowances, penalty for mandatory generics, penalty for non-notification of hospital admission and other services requiring pre-certification, and health care this plan does not cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p> <p>Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the <u>out-of-pocket limits</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. Your network is Aetna Signature Administrators. See myCBS.org/ppo-aetna or call 1.800.852.4877 for a list of participating medical <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. 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 <u>plan</u> 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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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)	Out-of-Network Provider (You will pay the most)	
<p>If you visit a health care <u>provider's</u> office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>20% <u>Coinsurance</u> / visit</p>	<p>40% <u>Coinsurance</u> / visit</p>	<p>Virtual Care (via video or voice) <u>In-Network</u> only.</p>
	<p><u>Specialist</u> visit</p>	<p>20% <u>Coinsurance</u> / visit</p>	<p>40% <u>Coinsurance</u> / visit</p>	<p>Virtual Care (via video or voice) <u>In-Network</u> only.</p>
	<p><u>Preventive care/screening/immunization</u></p>	<p>No Charge</p>	<p>40% <u>Coinsurance</u> / visit</p>	<p>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.</p>

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Lab Work – No Charge; <u>deductible</u> does not apply Radiology – 20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to services performed outside physician’s office. Payment may differ based on place of service.
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to services performed outside physician’s office. Payment may differ based on place of service. Precertification is required. A 25% penalty up to \$300 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myCBS.org/health Log in and click on My Prescription Drugs or call Express Scripts at 800-718-6601. More information about the Smart 90, Generics Member Pays The Difference, <u>Formulary</u> , Retail Refill Allowance and SaveonSP programs is available at: www.myCBS.org/Rx	Generic drugs	20% / prescription (retail & mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	Covers up to 30-day supply at retail; 90-day supply mail order or Smart90 prescription. Retail maintenance prescriptions are limited to an initial fill and two refills. If you continue to use retail, outside of the Smart 90 program, you will pay the mail order <u>copayment</u> for a 30-day supply. You may fill a 90-day supply at Walgreens owned retail pharmacies through the Smart90 program. If a generic equivalent is available and a brand-name medication is dispensed for any reason, you will pay the difference in cost plus the brand <u>copayment</u> .
	Preferred brand drugs	20% / prescription (retail & mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	
	Non-preferred brand drugs	20% / prescription (retail & mail or Smart90)	Same as In-Network +20% <u>coinsurance</u> penalty	
	<u>Specialty drugs</u>	Generic 10% up to a maximum of \$150 Preferred 20% up to a maximum of \$150 Non-Preferred 20% up to a maximum of \$250 Certain specialty pharmacy drugs are considered non-essential health benefits and <u>copayments</u> may be set to the maximum of above or any available manufacturer-funded copay assistance. For a complete list of non-essential specialty medications, see mycbs.org/health/SaveonSP		

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center, hospital)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to services performed outside physician's office. You may be billed amounts in excess of prevailing charges for <u>Out-of-Network Providers</u> . Precertification is required. A 25% penalty up to \$300 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u> – Facility fee	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	None.
	<u>Emergency room care</u> – Physician/surgeon fees	20% <u>Coinsurance</u>	20% <u>Coinsurance</u>	<u>Emergency room care</u> may include tests and services described elsewhere in the SBC (i.e. <u>Diagnostic tests</u> or <u>Imaging</u> .) You may be billed amounts in excess of prevailing charges for <u>Out-of-Network Providers</u> .
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>		For transportation service charges exceeding \$5,000 by ground and/or air, payment will not exceed 150% of Medicare allowance for such incurred expenses. Charges include transportation and medical supplies used during transport.
	<u>Urgent care</u>	Primary Care – 20% <u>Coinsurance</u> Free Standing Clinic – 20% <u>Coinsurance</u> Emergency Room – 20% <u>Coinsurance</u>	Primary Care – 40% <u>Coinsurance</u> Free Standing Clinic – 40% <u>Coinsurance</u> Emergency Room – 20% <u>Coinsurance</u>	Payment may differ based on place of service. <u>Deductible</u> and <u>coinsurance</u> applies to <u>urgent care</u> services billed via the emergency room or outpatient clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Precertification is required. A 25% penalty up to \$2,000 may apply. Penalty does not apply to <u>out-of-pocket limit</u> .
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None.
	Inpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Precertification is required. A 25% penalty up to \$2,000 may apply. Penalty does not apply to out-of-pocket limit.
If you are pregnant	Office visits	20% <u>Coinsurance</u> / visit	40% <u>Coinsurance</u>	<u>Coinsurance</u> applies to initial prenatal visit only (per pregnancy). <u>Cost sharing</u> does not apply to preventive services.
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	None.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 100 visits per year maximum.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u> / visit	40% <u>Coinsurance</u> / visit	Services for all State Licensed Practitioners, including Acupuncturist & Massage therapist visits, are limited to combined 12 Visits per Year.
	<u>Habilitation services</u>	Specialist – 20% <u>Coinsurance</u> / visit Outpatient Facility – 20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Payment may differ based on place of service. Limited to a combined 20 visits per year for all <u>providers</u> , including, but not limited to, physical, occupational and speech therapy. Visit limits apply to <u>Habilitation services</u> only.
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 120 day maximum for all confinements resulting from the same or a related illness or injury.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Check your <u>plan</u> document for limitations. <u>Orthotics</u> – Limited to \$500 lifetime
	<u>Hospice services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 180 day per year maximum.
	If your child needs dental or eye care	Children’s eye exam	No charge.	40% <u>Coinsurance</u>
Children’s glasses		Not covered.		Unless covered by your vision <u>plan</u> .

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered.		Unless covered by your dental <u>plan</u> .

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.)		
<ul style="list-style-type: none"> • Contraceptives • Cosmetic surgery • Dental care (Adult) • Eye exam over age 5 	<ul style="list-style-type: none"> • Hearing aids and related charges • Infertility treatment (except initial diagnosis) • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Sterilization or Abortion • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care (payable per medical necessity as <u>specialist</u> MD). • <u>Habilitation services</u> (payable per medical necessity). • Non-emergency care when traveling outside the U.S. (only when on assignment by ER). • Services provided by State Licensed Practitioners within the scope of license not specifically covered under any other provisions of the medical <u>plan</u>, including Acupuncture, Massage Therapy, and Nutritional Counseling – Limited to 12 combined visits per year for all services. 		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. Church plans are not covered by the Federal COBRA continuation coverage rules. For more information on your rights to continue coverage, contact the plan at 1.800.852.4877. You may also contact your state insurance department. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1.800.852.4877. A list of states with Consumer Assistance Programs is available at cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 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.

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1.800.852.4877.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1.800.852.4877.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1.800.852.4877.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1.800.852.4877.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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 \$175
- Specialist coinsurance 20%
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 175
Copayments	\$ 0
Coinsurance	\$2,350
<i>What isn't covered</i>	
Limits or exclusions	\$ 60
The total Peg would pay is	\$2,585

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

- The plan's overall deductible \$175
- Specialist coinsurance 20%
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 175
Copayments	\$ 0
Coinsurance	\$1,410
<i>What isn't covered</i>	
Limits or exclusions	\$ 55
The total Joe would pay is	\$1,640

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

- The plan's overall deductible \$175
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic tests (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 175
Copayments	\$ 0
Coinsurance	\$ 385
<i>What isn't covered</i>	
Limits or exclusions	\$ 0
The total Mia would pay is	\$ 560

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

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CHRISTIAN
BROTHERS
SERVICES

Employee Benefit Trust
1205 Windham Parkway
Romeoville, IL 60446
800.807.9460 / 630.378.3005 fax

Request for Group Coverage/Enrollment Form

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain provisions contained within this plan may or may not apply while you are covered. PLEASE READ THE FOLLOWING CAREFULLY.

SPECIAL ENROLLMENT RIGHTS

If you waive (or decline) enrollment for yourself or your dependents because of other health coverage, you may later enroll within 31 days of a loss of other health coverage. Loss of health coverage includes separation, divorce, death, termination of employment, reduction in work hours, exhaustion of COBRA continuation or state continuation, or if employer contributions toward your coverage have terminated.

In addition, any change in your family status may allow you to enroll within 31 days of the event. It includes marriage, birth, adoption, or placement for adoption of a child. (See Special Enrollment Form)

With the Onset of the **Children's Health Insurance Program Reauthorization Act of 2009** two additional enrollment opportunities apply for CBEBT Trust members and their enrolled dependents if either of the following occurs:

- Termination of Medicaid or Children's Health Insurance Program (**CHIP**) due to loss of eligibility; or
- Become eligible for state premium assistance under Medicaid or **CHIP**.

Trust members and their dependents who are eligible but not enrolled for coverage under the Christian Brothers Employee Benefit Trust are allowed up to **60 days** to request coverage under the group health plan.

Please contact your employer for any clarification regarding your enrollment in the CBEBT.

Please read and fill out ALL applicable sections carefully. Form must be completed entirely or can result in a delay. Please print or type. If you are Waiving medical coverage, ALL applicable* fields in Section 1 Must Be Completed.

1. Employee Information

*Location Name:	Jesuit Volunteer Corp NW	*Location #:	14058
*First Active Day of Work:		Enrollment Use Only: Effective Date of Coverage:	
Annual Salary:		Occupation:	
*Last Name:		*First Name:	
*Home Address:			
*City:		*State:	
		*Zip Code:	
*Social Security #:		*Date of Birth:	
* Email Address:		* Home/Cell Phone:	
* <input type="checkbox"/> Male <input type="checkbox"/> Female * <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Religious			

2. Benefit Election(s) or Waiver of Medical Coverage

I request to enroll myself and any applicable dependents below to the benefits my employer offers and following the group's "tiered" structure with the type of coverage as chosen here:

<u>Who is to be Covered</u>	<u>Type of Coverage</u>
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Medical
<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Medical
<input type="checkbox"/> Employee + Child (ren)	<input type="checkbox"/> Medical
<input type="checkbox"/> Family	<input type="checkbox"/> Medical

** Spouse and Child(ren) cannot be enrolled in coverage(s) not selected by the employee, and Dependent coverage(s) must match **

Dependent Information

List the name of each dependent and answer each question for each dependent	Social Security Number	Birthdate MM/DD/YY	Sex M/F	Are you Legal Guardian	Step-Child	Disabled Dependent
Spouse:				N/A	N/A	N/A
List Children Below						

Waiver of Medical Coverage (Complete only if waiving coverage)

I hereby certify that I have been given an opportunity to apply for medical coverage. I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualifying event/special enrollment opportunity or during the next open enrollment period. **I decline coverage for:**

Myself Spouse Dependent Child(ren) Myself and all Dependents

because:

Spouse's Plan Individual Policy Medicare Medicaid Another employer plan Other _____

Signature of Employee:	Date:
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3. Other Coverage/ Authorization To Release Information

As a new participant of the Christian Brothers Employee Benefit Trust, it is necessary for you to complete the information requested below. Failure to do so will result in a delay in processing your initial request for benefits.

Employee Name:	
Social Security Number:	
Address:	

Other Coverage Information

Please **X** one of the following categories and provide the requested information if it applies.

Single
 Married
 Divorced
 Widowed
 Religious

Spouse's Name:			
Spouse's Date of Birth:		Spouse's Social Security #:	
Do you have any additional Employers?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide employer name, address and telephone number. _____ _____ _____	
Do you have any other coverages (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide carrier name, address and telephone number. _____ _____ _____	
Do your dependent children (if any) have any other coverages (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide carrier name, address and telephone number. (Please attach additional information if other coverage is not applicable for all dependent children) _____ _____ _____	
Is your spouse employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide employer name, address and telephone number. _____ _____ _____	
Spouse's other coverage (including AARP)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide carrier name, address and telephone number. _____ _____ _____	

ANY CHANGE IN OTHER COVERAGE INFORMATION MUST BE REPORTED TO OUR OFFICE.

<p>I HEREBY CERTIFY THAT ALL INFORMATION, STATEMENTS AND ANSWERS MADE ON THIS FORM ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.</p>	Signature (Employee): Date:
<p>AUTHORIZATION TO RELEASE INFORMATION: I authorize any physician, hospital, or other health care provider to release to Christian Brothers Employee Benefit Trust, or its representative, any information regarding my medical history, symptoms, treatment, examination results, or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for one year from the date signed. I understand I have a right to receive a copy of this authorization.</p>	Signature (Employee): Date:

Christian Brothers Employee Benefit Trust History

The ***Christian Brothers Employee Benefit Trust (CBEBT)*** was established on January 1, 1977, by the Christian Brothers. It began in 1966 as a collective effort to provide a comprehensive package of Employee Benefits to the employees of the Christian Brothers schools. As the news spread of the benefits and savings received by participating in a large group, it was opened in 1977 to any Catholic institution registered in the Kenedy Catholic Directory nationwide.

The **CBEBT** has evolved into a cooperative effort of Catholic organizations continuously working together to provide a package of benefits for their employees in a cost-effective manner.

The **CBEBT** is governed by a board of Trustees who have been elected by the members of the Trust. The Trustees have contracted with ***Christian Brothers Services*** to act as the Plan Administrator for the Trust. ***Health Benefit Services*** is the division of ***Christian Brothers Services*** that administers all the benefits plans funded by the Trust.

Christian Brothers Services Mission Statement

The Mission of ***Christian Brothers Services*** is to serve the Catholic Community by helping to fulfill organizational and managerial needs through the development of quality, cost-effective, innovative programs and administrative services.

We accomplish this mission in collaboration with other Catholic organizations by combining leadership and insight with the practice of good business principles and belief in the tenets of the Catholic Church.

Important Phone Numbers

Customer Service/Benefit Information : 800.807.0400

Christian Brothers Health Benefit Services
1205 Windham Parkway, Romeoville, IL 60446-1679