Wabash Memorial Hospital Association

2016 HEALTHCARE BENEFIT SUMMARY - THE CANNONBALL PLANS

PRIMARY PLANS – ACTIVE EMPLOYEES

(EFFECTIVE FEBRUARY 20, 2015)

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	*None*	*None*
Maximum Out-of-Pocket Expense *Does not include dental, vision, or charges in excess of reasonable and customary.*	*None*	*None*
ESSENTIAL BENEFITS		
Physician Services – General *Office Visits* *Hospital Based Services* *Surgical Procedures* *Office* *Outpatient* *Inpatient*	 *100% of allowable charges* *100% of allowable charges* *100% of allowable charges* *100% of allowable charges* *100% of allowable charges*	 *85% of allowable charges* *85% of allowable charges* *85% of allowable charges* *85% of allowable charges* *85% of allowable charges*
Physician Services – Preventive *Preventive Exam* *Mammograms – 1 per calendar year* *Pap Tests / PSA* *Well-Child Care* *Immunizations* *Screenings*	 *100% of allowable charges* *100% of allowable charges* *100% of allowable charges* *100% of allowable charges* *100% of allowable charges* *100% of allowable charges*	 *85% of allowable charges* *85% of allowable charges* *85% of allowable charges* *85% of allowable charges* *85% of allowable charges* *85% of allowable charges*
Hospital Services - *Inpatient Care*	***Pre-certification required*** *100% of allowable charges – max of 183 days per calendar year*	***Pre-certification required*** *85% of allowable charges – max of 183 days per calendar year*
Hospital Services - *Outpatient Care*	*100% of allowable charges*	*85% of allowable charges*
Emergency Services *Emergency Room*	*100% if life threatening/emergent/ 80% if deemed non-life-threatening/non-emergent*	*100% if life threatening/emergent/ 80% if deemed non-life threatening/non-emergent*
Ambulance	*100% if life threatening/emergent/ 80% if deemed non-life threatening/non-emergent*	*100% if life threatening/emergent/ 80% if deemed non-life threatening/non-emergent*
Air Ambulance	*Subject to administrative approval*	*Subject to administrative approval*
Allergy Testing, Allergy Injection	*100% of allowable charges*	*85% of allowable charges*
Anesthesia	*100% of allowable charges*	*85% of allowable charges*
Cardiac or Pulmonary Therapy	*100% to 36 treatments for IP or OP*	*85% to 36 treatments for IP or OP*
Chemotherapy	***Pre-certification required*** *100% of allowable charges*	***Pre-certification required*** *85% of allowable charges*
Diagnostic Testing, Imaging and Laboratory Services	***Pre-certification of CT/MRI required*** *100% up to $10,000 then 80%*	***Pre-certification of CT/MRI required*** *85% to $10,000 then 80%*

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ESSENTIAL BENEFITS		
Dialysis	*100% to $5,000 then 80% to $10,000,50% over $10,000*	*85% to $5,000 then 80% to $10,000, 50% over $10,000*
Durable Medical Equipment *(including oxygen, orthotics/prosthetics, supplies)*	*With Administrative approval 100%* ***Over $500 precertification required*** *100% of allowable charges*	*With Administrative approval 100%* ***Over $500 precertification required*** *85% of allowable charges*
Home Health Care	***Pre-certification required*** *100% of up to 40 visits*	***Pre-certification required*** *85% to 40 visits*
Hospice	***Pre-certification required*** *100% of allowable charges*	***Pre-certification required*** *85% of allowable charges*
Mental Health and Substance Abuse *Office Visits/Outpatient Care* *Inpatient care*	***Pre-Certification Required*** *100% of allowable charges* *100% of allowable charges*	***Pre-Certification Required*** *85% of allowable charges* *85% of allowable charges*
Prescription Medicine ***FDA Approved*** - ***Generic*** - ***Brand***	*– 100% after $2,000 out-of-pocket* *$9 retail for 30 day supply* *$11 retail and mail for 90 day supply* *$20 retail for 30 day supply** *$35 retail and mail for 90 day supply** **or 20% whichever is greater*	***Does Not Apply***
Physical Therapy ***Occupational Therapy*** ***Speech Therapy***	***Pre-certification Required*** *100% up to $3,000, then 50%*	***Pre-certification Required*** *85% to $3,000, then 50%*
Skilled Nursing Care	***Pre-certification required*** *80% for 31 days per calendar year after $100 deductible* *Must be within 14 days of inpatient hospital stay of at least 3 days*	***Pre-certification required*** *80% for 31 days per calendar year after $100 deductible* *Must be within 14 days of inpatient hospital stay of at least 3 days*
Transplantation of Vital Organs	*100% of allowable charges up to $200,000 per case,25 % above $200,000*	*85% of allowable charges up to $200,000 per case 25 % above $200,000*
BENEFIT	***IN-NETWORK***	***OUT-OF-NETWORK***
NON-ESSENTIAL BENEFITS		
Chiropractic Services	*80% up to $900 per calendar year*	*80% up to $900 per calendar year*
Dental Care due to Accidental Injury	*100% up to $300 per calendar year*	*85% up to $300 per calendar year*
Dietary Consultation	*$50 once per calendar year*	*$50 once per calendar year*
Eye Exam	*$40 once per calendar year*	*$40 once per calendar year*
Hearing Aids	*80% to $300 per item, once per 5 years*	*80% to $300 per item, once per 5 years*
Hearing Test	*100% - must be physician supervised*	*85% - must be physician supervised*
Inpatient Respite Care	***Pre-certification required*** *100% up to $3,000*	***Pre-certification required*** *85% up to $3,000*
Penile Erection Devise - external	*80%*	*80%*
Penile Implant *– Dr.& hospital*	*80%*	*80%*
Sterilization *(surgical)*	100%	*85%*

BENEFIT *NON-ESSENTIAL BENEFITS*	*IN-NETWORK*	*OUT-OF-NETWORK*
Smoking Cessation	*$500 per calendar year*	*$500 per calendar year*
Temporomandibular joint Syndrome (TMJ) *Treatment –* *Surgery -*	*50% to a lifetime max of $1,250 after a $50 deductible* *100%*	*50% to a lifetime max of $1,250 after a $50 deductible* *85%*
Vision *Standard lens implanted during cataract surgery* *Corrective lens upgrade implanted during cataract surgery*	*100% per lens* *100% up to $500 per lens*	*80% per lens* *80% up to $500 per lens*
Weight Loss Program *must be medically supervised*	*80% to a lifetime max of $3,000 after a $100 deductible*	*80% to a lifetime max of $3,000 after a $100 deductible*
Weight Loss Surgery	*Subject to administrative approval*	*Subject to administrative approval*

Grandfathered Status - Wabash believes that the plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Act that apply to other plans, but must comply with certain other consumer protections in the Act. You may contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform or U.S. Department of Health and Human Services at www.healthreform.gov for protections that do not apply to the grandfathered health plans.

This is only a summary. You can obtain more detail about your coverage and costs in the plan document and Glossary of Health Insurance and Medical Terms at www.wabashcannonball.org or by calling **(888) 800-9161** .

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$ - 0 -**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**No**	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	**Yes - $2,000 for prescription drugs**	The out-of-pocket limit is the most you could pay during a coverage period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, out of network co insurance, penalties for failure to obtain precertification and health care this plan doesn't cover	Even though you pay these expenses they do not count toward the out-of- pocket limit
Is there an overall annual limit on what the plan pays?	No, there is no overall annual limit on the amount the plan pays each year	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes this plan uses Blue Cross Blue Shield network providers. If you use a non-network provider your cost may be more. For a list of network providers see www.bcbs.com or call (800) 810-2583.	If you use a network provider, the plan will pay some or all of the costs of allowable covered services. Be aware, your in-network doctor or hospital may use an out- of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	

Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Blue Cross Blue Shield in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	100% of allowable charges	85% of allowable charges	Refer to plan document for specific limitations.
	Specialist visit	100% of allowable charges	85% of allowable charges	Refer to plan document for specific limitations.
	Other practitioner office visit	100% of allowable charges	85% of allowable charges	Refer to plan document for specific limitations.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	100% of allowable charges	85% of allowable charges	Refer to plan document for specific limitations.
If you have a test	Diagnostic test (x-ray, blood work)	100% of allowable charges up to $10,000 then 80%	85% of allowable charges up to $10,000 then 80%	Refer to plan document
	Imaging (CT/PET scans, MRIs)	100% of allowable charges up to $10,000 then 80%	85% of allowable charge up to $10,000 then 80%	Precertification required. refer to plan document
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.LDIRx.com	Generic drugs	$9 for 30 day supply		
		$11 for 90 day supply		
	Preferred brand drugs	Greater of $20 or 20% for 30 day supply		
		Greater of $35 or 20% for 90 day supply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% of allowable charges	85% of allowable charges	Refer to plan document
	Physician/surgeon fees	100% of allowable charges	85% of allowable charges	Refer to plan document
If you need immediate medical attention	Emergency room services	100 % if deemed life threatening or emergent	100 % if deemed life threatening or emergent	80% if deemed non-life threatening or non-emergent
	Emergency medical transportation	100 % if deemed life threatening or emergent	100 % if deemed life threatening or emergent	80% if deemed non-life threatening or non-emergent. Air ambulance subject to admin approval
	Urgent Care facility	100% of allowable charges	85% of allowable charges	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	100% of allowable charges	85% of allowable charges	Precertification required. Maximum of 183 days per calendar year
	Physician/surgeon fee	100% of allowable charges	85% of allowable charges	Refer to plan document
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	100% of allowable charges	85% of allowable charges	Precertification required.
	Mental/Behavioral health inpatient services	100% of allowable charges	85% of allowable charges	Precertification required.
	Substance use disorder outpatient services	100% of allowable charges	85% of allowable charges	Precertification required.
	Substance use disorder inpatient services	100% of allowable charges	85% of allowable charges	Precertification required.
If you are pregnant	Prenatal and postnatal care	100% of allowable charges	85% of allowable charges	Refer to plan document
	Delivery and all inpatient services	100% of allowable charges	85% of allowable charges	Precertification required. refer to plan document

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	100% of allowable charges	85% of allowable charges	Must be precertified and limited to 40 visits – no limit if terminal
	Rehabilitation services	100% of allowable charges	85% of allowable charges	Precertification required.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	80% of allowable charges for 31 days per year after $100 deductible within 14 days of hospital stay of at least 3 days	80% of allowable charges for 31 days per year after $100 deductible within 14 days of hospital stay of at least 3 days	Precertification required.
	Durable medical equipment	100% of allowable charges	85% of allowable charges	Administrative approval required Precertification required over $500
	Hospice service	100% of allowable charges	85% of allowable charges	Precertification required.
If your child needs dental or eye care				
	Dental Care due to accident	100% up to $300		
	Eye Exam	$40 once per plan year		

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care
- Habilitation
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care

Other Covered Services (Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery if determined medically necessary and meeting pre surgery requirements
- Chiropractic Services 80% up to $900 per year
- Hearing aids 80% up to $300 per item once per 5 years
- Weight loss programs certified by physician up to 80% of $3,000 lifetime benefit

Questions: Call (888) 800-9161 or visit us at www.wabashcannonball.org .
If you are not clear about any of the terms used in this form, see the Glossary at www.wabashcannonball.org or call (888) 800-9161 to request a copy.

- Dental Due to accident up to $300

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay a premium that may be higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1 -888-800-9161. 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

Your Grievance and Appeals Rights:

If you are dissatisfied with a benefit determination of coverage under your plan, you file a written **appeal** to or file a **grievance**: Claims Manager – Wabash Memorial Hospital Association – P.O. Box 1340, Decatur, IL 62525-1340. For questions or assistance contact Customer Service at (888) 800 –9161. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www. dol.gov/ebsa/healthreform.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,540
- **Patient pays** $ 0

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$0
Total	**$0**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $4,100
- **Patient pays** $ 0

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$0
Total	**$0**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.