Wabash Memorial Hospital Association: Cannonball Plan

Coverage Period: 01/01/17-12/31/17

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wabashcannonball.org or by calling 1-8888-800-9161.

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?	Yes $50 for Temporomandibular Joint Syndrome $100 for Skilled Nursing Care $100 for Weight Loss Programs There are no other specific deductibles	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
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 (usually one year) 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, for a list of **preferred providers** see www.bcbs.com or call (800) 810-2583.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of 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	You can see the **specialist** you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 4. See your Member Handbook for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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**, **copayments** and **coinsurance** 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	No charge.	15% co-insurance	
	Specialist visit	No charge.	15% co-insurance	
	Other practitioner office visit	No charge.	15% co-insurance	
	Preventive care/screening/immunization	No charge.	15% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work) and Imaging (CT/PET scans, MRIs)	No charge up to $10,000 then 20%	15% up to $10,000 then 20%	Precertification is required for all imaging
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	Retail cost reimbursed up to contract rate less copay	
	Preferred brand drugs	Greater of $20 or 20% for 30 day supply; Greater of $35 or 20% for 90 day supply	Retail cost reimbursed up to contract rate less copay	
	Non-preferred brand drugs	Greater of $20 or 20% for 30 day	Retail cost reimbursed up to contract rate less copay	

		supply; Greater of $35 or 20% for 90 day supply		
	Specialty drugs	Cost is based upon tier of drug (generic, preferred brand drug, non-preferred brand drug), as listed above.	Retail cost reimbursed up to contract rate less copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	15% co-insurance	
	Physician/surgeon fees	No charge.	15% co-insurance	
If you need immediate medical attention	Emergency room services	No charge if deemed life threatening or emergent	No charge if deemed life threatening or emergent	20% if deemed non-life threatening or non-emergent
	Emergency medical transportation	No charge if deemed life threatening or emergent	No charge if deemed life threatening or emergent	20% if deemed non-life threatening or non-emergent
	Urgent care	No charge.	15% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	15% co-insurance	Precertification required. Maximum of 183 days per calendar year
	Physician/surgeon fee	No charge.	15% co-insurance	Certain restrictions apply
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge.	15% co-insurance	Precertification required for outpatient therapy
	Mental/Behavioral health inpatient services	No charge.	15% co-insurance	Precertification required
	Substance use disorder outpatient services	No charge.	15% co-insurance	Precertification required for outpatient therapy
	Substance use disorder inpatient services	No charge.	15% co-insurance	Precertification required
If you are pregnant	Prenatal and postnatal care	No charge.	15% co-insurance	Certain restrictions apply
	Delivery and all inpatient services	No charge.	15% co-insurance	Prenotification required

If you need help recovering or have other special health needs	Home health care	No charge up to 40 visits.	15% co-insurance up to 40 visits	Precertification is required
	Rehabilitation services Physical Therapy/Occupational Therapy/Speech Therapy Cardiac Therapy / Pulmonary Therapy	 No charge up to $3,000, then 50% No charge	 15% co-insurance up to $3,000, then 50% 15% co-insurance	 Precertification is required Limited to 36 treatments for inpatient or outpatient
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% of allowable charges for 31 days per year after $100 deductible within 14 days of hospital stay of at least 3 days	20% 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	No charge with administrative approval	15% co-insurance with administrative approval	Precertification required for amounts over $500
	Hospice service	No charge.	15% co-insurance	Precertification required
If your child needs dental or eye care	Eye exam	$40 once per plan year	$40 once per plan year	Limited to one exam per plan year
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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 (Adult)
- Infertility Treatment
- Long Term Care
- Non-Emergency Care when traveling outside the U.S.
- Private-duty Nursing
- Routine Foot Care
- Vision care (glasses & contact lenses)

Other Covered Services (This isn't a complete list. 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)
- Hearing aids (80% up to $300 per item once per 5 years)
- Routine Eye Care (Adult & Child) limited to 1 eye exam per year up to $40 (subject to coordination with a primary vision plan)
- Weight Loss Programs certified by physician 80% up to $3,000 lifetime benefit (after $100 deductible)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly 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 217-429-5246. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Claims Department at 217-429-5246. Or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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** $7,500
- **Patient pays** $ 40

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
Copays	$40
Coinsurance	$0
Limits or exclusions	$0
Total	**$40**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,820
- **Patient pays** $ 580

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$580
Coinsurance	$0
Limits or exclusions	$0
Total	**$580**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

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