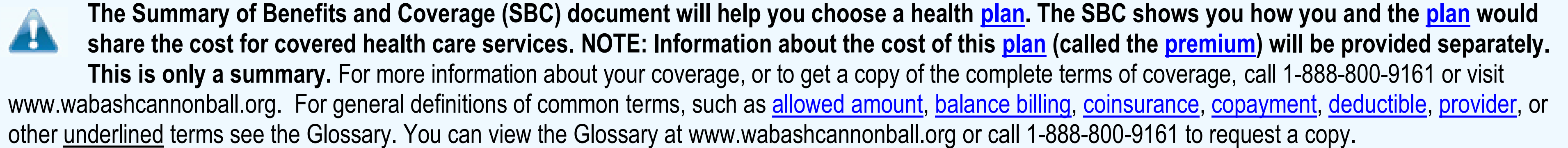
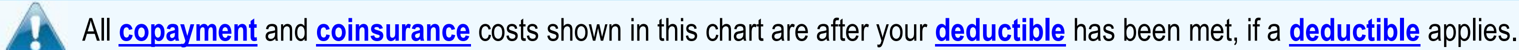


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-888-800-9161 or visit www.wabashcannonball.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.wabashcannonball.org or call 1-888-800-9161 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All services *except for:* temporomandibular joint syndrome, skilled nursing care, and weight loss programs 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?	Yes. $50 for temporomandibular joint syndrome, $100 for skilled nursing care, and $100 for weight loss programs.	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.
What is the out-of-pocket limit for this plan?	There is no out-of-pocket limit for overall medical expenses. For prescription drugs, it is $2,000.	This plan does not have an out-of-pocket limit on your overall medical expenses. The out-of-pocket limit of $2,000 is the most you could pay in a year for covered prescription drugs.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain precertification 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.bcbsil.com or call 1-800-810-2583 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
		Network Provider (You will pay the least)	Out-of-Network 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	No charge	15% coinsurance	None
	Specialist visit	No charge	15% coinsurance	None
	Preventive care/screening/ immunization	No charge	15% coinsurance	None
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% coinsurance	15% coinsurance up to $10,000, then 20% coinsurance	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.castiarx.com/formularies . Select "STANDARD FORMULARY".	Generic drugs	$9 for 30 day supply; $11 for 90 day supply	Retail cost reimbursed up to contract rate less copay	
	Brand drugs (Preferred and Non-Preferred)	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	
	Specialty drugs	Cost is based upon tier of drug (generic, preferred)	Retail cost reimbursed up to contract rate less copay	Prior authorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	15% coinsurance	
	Physician/surgeon fees	No charge	15% coinsurance	
If you need immediate medical attention	Emergency room care	No charge if deemed life threatening or emergent	No charge if deemed life threatening or emergent	20% coinsurance 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% coinsurance if deemed non-life threatening or non-emergent.
	Urgent care	No charge	15% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	15% coinsurance	Precertification is required. Maximum of 183 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge	15% coinsurance	Certain restrictions apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	15% coinsurance	Precertification is required for outpatient therapy.
	Inpatient services	No charge	15% coinsurance	Precertification is required.
If you are pregnant	Office visits	No charge	15% coinsurance	Certain restrictions apply.
	Childbirth/delivery professional services	No charge	15% coinsurance	None.
	Childbirth/delivery facility services	No charge	15% coinsurance	Precertification is required only if length of stay in connection with childbirth is greater than 48 hours following a vaginal delivery or greater than 96 hours following a delivery by cesarean section.
If you need help recovering or have other special health needs	Home health care	No charge	15% coinsurance	40 visit maximum. Precertification is required.
	Rehabilitation services Physical/Occupational/Speech Therapy Cardiac/Pulmonary Therapy	 No charge up to $3,000, then 50% coinsurance No charge	 15% coinsurance up to $3,000, then 50% coinsurance 15% coinsurance	 Precertification is required. Limited to 36 treatments for inpatient or outpatient services.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% coinsurance after $100 deductible	20% coinsurance after $100 deductible	Precertification is required. Limited to 31 days per calendar year. Must be within 14 days of inpatient hospital stay of at least 3 days.
	Durable medical equipment	No charge	15% coinsurance	Precertification is required for billed charges over $500.
	Hospice services	No charge	15% coinsurance	Precertification is required.
If your child needs dental or eye care	Children's eye exam	No charge, up to $40 max	No charge, up to $40 max	Limited to one exam per plan year.
	Children's glasses	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	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.)

- 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 and contact lenses)

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

- Bariatric surgery if determined medically necessary and meets pre-surgery requirements
- Chiropractic care (80% up to $900/year)
- Hearing aids (80% up to $300 per item once per 5 years)
- Routine eye care (adult and child) limited to one 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: For more information on your rights to continue coverage, contact the Plan at 217-429-5246. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Wabash 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 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.

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

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

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** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing] - prescriptions*** **$9/month 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	**$7,390**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$880
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$880**

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

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **20%***
- **Other *[cost sharing]*** **20%***

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$380*
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is (*if services are deemed non-life-threatening/non-emergent – note – otherwise, cost is $0)	**$380***

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