Wabash Memorial Hospital Association

2021 BENEFIT SUMMARY
SECONDARY PLANS 2, 6, 12, 13, 14 & 23 – EFFECTIVE JANUARY 1, 2021
PIGGY-BACK PLANS

As secondary payor, Wabash will pay, subject to all Plan provisions, the balance of remaining eligible expenses unpaid by the primary insurer, not to exceed the Plan's normal plan liability and the applicable annual Plan maximums. It is the responsibility of the member to provide Wabash with the explanation of benefits (EOB) received from the primary insurer. If Wabash does not receive such (EOB), the claim cannot be paid. Member is responsible for the services not covered by the primary insurer and/or this secondary plan. No pharmacy benefits are provided on secondary plans.

BENEFIT	*ELIGIBLE AFTER PRIMARY INSURANCE PAYMENT*	*NOT ELIGIBLE*
Air Ambulance	*No Benefit*	*This Plan does not provide coverage for air ambulance*
Allergy Testing, Allergy Injections	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Anesthesia	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Cardiac or Pulmonary Therapy *Inpatient or Outpatient*	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan* *Limit of 36 treatments per calendar year*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*

BENEFIT	ELIGIBLE AFTER PRIMARY INSURANCE PAYMENT	NOT ELIGIBLE
Chemotherapy	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Chiropractic Services *Note – If primary insurance denies the service, the Plan pays 80%, up to $500 per calendar year*	*If covered by primary insurance, the patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Dental Care due to Accidental Injury	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan, up to $300 per calendar year*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Diagnostic Testing, Imaging and Laboratory Services	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Dialysis	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Dietary Consultation *Note – if primary insurance denies the service, the Plan pays up to $50 once per calendar year*	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*

BENEFIT	ELIGIBLE AFTER PRIMARY INSURANCE PAYMENT	NOT ELIGIBLE
Durable Medical Equipment *(including but not limited to oxygen, orthotics/prosthetics and related supplies)*	*No Benefit*	*This Plan does not provide coverage for durable medical equipment*
Emergency Services *Emergency Room/Ambulance*	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Eye Exam *Note – if primary insurance denies the service, the Plan pays up to $40 once per calendar year*	*If covered by primary insurance, the patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Hearing Aids *Note – if primary insurance denies the service, the Plan pays 80%, up to $300 per item, once every 5 years*	*If covered by primary insurance, the patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Hearing Test	*If covered by primary insurance, the patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Home Health Care	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan* *Maximum of 40 visits per calendar year*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*

BENEFIT	ELIGIBLE AFTER PRIMARY INSURANCE PAYMENT	NOT ELIGIBLE
Hospice	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Hospital Services - Inpatient Care	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan* *Maximum of 183 days per calendar year*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Hospital Services - Outpatient Care	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Inpatient Respite Care	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan, up to $3,000 per calendar year*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Mental Health and Substance Abuse	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*

BENEFIT	ELIGIBLE AFTER PRIMARY INSURANCE PAYMENT	NOT ELIGIBLE
Physical Therapy ***Occupational Therapy*** ***Speech Therapy***	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Physician Services – General *Office Visits* *Hospital Based Services* *Surgical Procedures* *Office* *Outpatient and Inpatient*	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Skilled Nursing Care	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan, up to 31 days per calendar year, after $100 deductible*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Temporomandibular Joint Syndrome (TMJ) - Treatment	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan, up to $1,250 lifetime maximum, after $50 deductible*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Temporomandibular Joint Syndrome (TMJ) - Surgery	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Transplant Services	*No Benefit*	*This Plan does not provide coverage for transplantation of vital organs*

BENEFIT	*ELIGIBLE AFTER PRIMARY INSURANCE PAYMENT*	*NOT ELIGIBLE*
Vision *Standard lens implanted during cataract surgery* *Corrective lens upgrade implanted during cataract surgery*	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan* *No Benefit*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network*
Weight Loss Program *Must be medically supervised*	*The patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan, up to $3,000 lifetime maximum, after $100 deductible*	*Services not covered by primary insurance* *Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*
Wellness Benefit *Note – if primary insurance denies the service as preventive/routine care, the Plan pays 80%, up to $500 per calendar year*	*If covered by primary insurance, the patient deductible and/or coinsurance/copayment after primary insurance payment, not excluded by the Plan*	*Charges in excess of the primary carrier's allowable charges for claims from providers not participating in the primary network* *Charges in excess of Plan benefit*

ANNUAL MAXIMUM BENEFIT BY PLAN	
Plan 2 - Non-Contract Employee	***$5,000***
Plan 6 - Retiree Non-Contract	***$5,000***
Plan 12 - One Dependent	***$5,000***
Plan 13 - Two Dependents	***$7,000***
Plan 14 - Three Dependents	***$9,000***
Plan 23 - Four or More Dependents	***$11,000***