Ivinson Memorial Hospital: Standard Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2018 – 12/31/2018

Coverage for: All | **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 tpa.uchealth.org or by calling 1- 800-207-1018.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** per person **/ $1,750** per family per calendar for In-Network and Out-of-Network providers. Does not apply to most services provided by Ivinson Memorial Hospital, preventive care received by an In-Network provider, or generic and brand name drugs purchased through the Prescription Drug Program. Prescription drug copayments do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services **after** you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Specialty drugs obtained through the Prescription Drug benefit have a separate **$250** deductible per person, per calendar year.	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. **$3,250** per person **/ $6,500** per family per calendar year for In-network and Out-of-network providers.	The **out-of-pocket limit** is the most you could pay during a policy 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?	Penalties for failure to obtain precertification for services, amounts over Usual and Customary, premiums, balance-billed charges and other health care not covered by this plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. So, a longer list of expenses means you have less coverage.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, this plan accesses 2 different networks depending on your location. For a list of **preferred providers** for First Choice of the Midwest visit www.1choicem.com or call 1-888-246-9949. For a list of **preferred providers** for PHCS-HD visit www.multiplan.com or call 1-888-342-7427.	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. Plans use the term **in-network**, **preferred**, or **participating** for providers in their network.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the "Excluded Services & Other Covered Services" section.

Questions: Call 1-800-207-1018 or visit us at tpa.uchealth.org.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf .

- **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 **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	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	10% co-insurance	In Laramie: 10% co-insurance Outside Laramie: 20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital.
	Specialist visit	10% co-insurance	In Laramie: 10% co-insurance Outside Laramie: 20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital.
If you visit a health care provider's office or clinic	Other practitioner office visit	Not Available	Chiropractor: 20% co-insurance	Chiropractor: Not Covered	Deductible applies. Chiropractic care is limited to 24 visits per calendar year and is limited to the following providers: Dr. Jeremy Jones; Dr. Mark Cupps; Dr. Darren Bressler; Dr. Terrence Dini; Dr. Jairell and the Spine & Injury Clinic.

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	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	No Charge	No Charge	50% co-insurance	Deductible does not apply to Ivinson Memorial Hospital or other In-Network providers. Covered Expenses include items and services rated A or B in the United States Preventive Services Task Force recommendations including but not limited to: office visits, well woman care, well child care, mammogram, prostate screening, routine physical examination, x-rays, laboratory blood tests, immunizations, and other preventive care services required by applicable law. Subject to age and frequency limits. Includes testing done at a sponsored health fair.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician/surgeon fees. Imaging services performed in a hospital or imaging center must be reported to the plan 48 hours in advance of the procedure or you may be assessed a penalty.
	Imaging (CT/PET scans, MRIs)	10% co-insurance	20% co-insurance	50% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	Generic drugs	Retail & Mail Order: $5 co-pay per prescription	Retail & Mail Order: $5 co-pay per prescription	Retail & Mail Order: $5 co-pay per prescription	Deductible does not apply. Covers up to a 34-day supply at a retail pharmacy and up to a 90-day supply through mail order. However, birth control will be covered for up to a 90-day supply at a retail pharmacy. Drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force are covered at 100% not subject to any copayment, coinsurance or deductible. Including certain contraceptive, certain preventive drugs and certain smoking cessation products. Prescription drugs are covered when purchased through a participating pharmacy with OptumRx. If a drug is purchased from a non-participating pharmacy or your ID card is not used, you will be responsible for the ingredient cost plus the dispensing fee in addition to the applicable co-pay amount. For more information on what is covered and not covered, contact OptumRx or see your Summary Plan Description.
	Preferred brand drugs	Retail & Mail Order: $15 co-pay per prescription plus 20% co-insurance	Retail & Mail Order: $15 co-pay per prescription plus 20% co-insurance	Retail & Mail Order: $15 co-pay per prescription plus 20% co-insurance	
	Non-preferred brand drugs	Retail & Mail Order: $25 co-pay per prescription plus 25% co-insurance	Retail & Mail Order: $25 co-pay per prescription plus 25% co-insurance	Retail & Mail Order: $25 co-pay per prescription plus 25% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	Not Available	**Briova Specialty Pharmacy** 10% co-insurance	**Briova Specialty Pharmacy** 10% co-insurance	Specialty drug deductible will apply (see page 1). All specialty pharmacy medications that are administered at home or as a scheduled visit in your Physician's office or other facility should be obtained through the Specialty Pharmacy. All specialty drugs should have prior authorization through OptumRx prior to obtaining these medications. Additional cost incurred by not using the Specialty Drug Program will be your responsibility.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician/surgeon fees. Outpatient surgical procedures performed in a hospital or surgical center must be reported to the plan 48 hours in advance of the procedure or you may be assessed a penalty.
	Physician/surgeon fees	10% co-insurance	In Laramie: 10% co-insurance Outside Laramie: 20% co-insurance	50% co-insurance	
If you need immediate medical attention	Emergency room services	**Emergencies** 10% co-insurance **Non-Emergencies** $100 co-pay per visit plus 10% co-insurance	**Emergencies** 20% co-insurance **Non-Emergencies** $100 co-pay per visit plus 20% co-insurance	**Emergencies** 20% co-insurance **Non-Emergencies** $100 co-pay per visit plus 50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician/surgeon fees. Emergency admissions must be reported within 1 business days after the admission or you may be assessed a penalty.

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Emergency medical transportation	10% co-insurance	20% co-insurance	20% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital.
	Urgent care	Not Available	20% co-insurance	50% co-insurance	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician/surgeon fees. Non-emergency hospital admissions must be reported at least 48 hours in advance of the admission or you may be assessed a penalty.
	Physician/surgeon fee	10% co-insurance	In Laramie: 10% co-insurance Outside Laramie: 20% co-insurance	50% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance	In Laramie: 10% co-insurance Outside Laramie: 20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician fees.
	Mental/Behavioral health inpatient services	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician fees. Emergency admissions must be reported within 1 business day after the admission and non-emergency hospital admissions must be reported at least 48 hours in advance of the admission or you may be assessed a penalty.
	Substance use disorder outpatient services	10% co-insurance	In Laramie: 10% co-insurance Outside Laramie: 20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician fees.
	Substance use disorder inpatient services	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician fees. Emergency admissions must be reported within 1 business day after the admission and non-emergency hospital admissions must be reported at least 48 hours in advance of the admission or you may be assessed a penalty.

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	10% co-insurance	In Laramie: 10% co-insurance Outside Laramie: 20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Deductible does apply to Physician fees. The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. The pregnancy of a dependent child is not covered.
	Delivery and all inpatient services	10% co-insurance	20% co-insurance	50% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	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	Not Available	20% co-insurance	50% co-insurance	Deductible applies. Services must be received within 14 days of discharge from a hospital or skilled nursing facility.
	Rehabilitation services	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Speech therapy, physical therapy and occupational therapy have a combined 40 visit maximum per calendar year. Rehabilitation services must be reported to the plan 48 hours in advance of the procedure or you may be assessed a penalty.
	Habilitation services	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Coverage is only provided for speech therapy when needed to correct a congenital anomaly (e.g. cleft lip or cleft palate). Benefits are combined with the calendar year maximum for rehabilitation services. Habilitation services must be reported to the plan 48 hours in advance of the procedure or you may be assessed a penalty.

Common Medical Event	Services You May Need	Your Cost If You Use Ivinson Memorial Hospital	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Skilled Nursing Facility stays must be reported to the plan at least 48 hours in advance of the stay or you may be assessed a penalty. Coverage is limited to a 30 day calendar year maximum.
	Durable medical equipment	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital.
	Hospice service	10% co-insurance	20% co-insurance	50% co-insurance	Deductible does not apply to services performed at Ivinson Memorial Hospital. Hospice care must be reported to the plan at least 48 hours in advance of services rendered or you may be assessed a penalty.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	Vision benefits are covered under a separate plan, if elected.
	Glasses	Not Covered	Not Covered	Not Covered	
	Dental check-up	Not Covered	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
- Bariatric surgery
- Cosmetic surgery, except for reconstructive surgery due to a congenital condition or reconstructive mammoplasties
- Habilitative Services, except for speech therapy
- Hearing aids
- Infertility treatment
- Long-term care
- Dental care - coverage available separately
- Non-emergency care when traveling outside the U.S.
- Routine eye care - coverage available separately
- Routine foot care
- Weight loss programs

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.)

- Chiropractic care
- Private-duty nursing, inpatient only

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon 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 [contact number]. 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: 1-800-207-1018 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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** $5,900
- **Patient pays** $1,640

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	$750
Copays	$10
Coinsurance	$880
Limits or exclusions	$0
Total	**$1,640**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,701
- **Patient pays** $1,699

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	$750
Copays	$180
Coinsurance	$769
Limits or exclusions	$0
Total	**$1,699**

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.