WINhealth Platinum-SG-D: WINhealth Partners

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

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: Group Member | **Plan Type:** HMO

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 http://winhealthplans.com/media/uploads/pdfs/EOC/2015/2015 Individual EOC.pdf or by calling 1-800-868-7670.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** Individual **$1,500** Family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document 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, **out-of-network deductible** of $8,000 (individual) and $16,000 (family)	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?	**$1,500** Individual **$3,000** Family	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. **Out-of-network**: $12,000 (individual) and $24,000 (family)
What is not included in the out–of–pocket limit?	Premiums, balance-bill charges, and services this plan does not cover	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No	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 **in-network providers**, see www.winhealthplans.com or call 1-800-868-7670	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 this plan
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**.

- **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 **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	$10 Copayment/visit	50% Coinsurance	Deductible does not apply in-network
	Specialist visit	$20 Copayment/visit	50% Coinsurance	Deductible does not apply in-network
	Other practitioner office visit	$10 Copayment/visit for chiropractor	50% Coinsurance	Coverage is limited to 15 visits per plan year, spinal x-ray and manipulation only.
	Preventive care/screening/immunization	No charge	50% Coinsurance	Deductible does not apply
If you have a test	Diagnostic test (x-ray, blood work)	$10 Copayment/day	50% Coinsurance	Deductible does not apply in-network
	Imaging (CT/PET scans, MRIs)	$200 Copayment/test	50% Coinsurance	Preauthorization may be required
If you need drugs to treat your illness or condition More information about **prescription**	Generic drugs	$5 Copayment/ prescription	Not covered	Deductible does not apply
	Preferred brand drugs	$40 Copayment/ prescription	Not covered	Deductible does not apply
	Non-preferred brand drugs	$80 Copayment/ prescription	Not covered	Deductible does not apply

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
drug coverage is available at http://winhealthplans.com/media/formulary.pdf	Specialty drugs	20% Coinsurance	Not covered	Specialty drugs including injectables and biologics. Some of these drugs require preauthorization
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	Some outpatient surgeries, including podiatry, require preauthorization.
	Physician/surgeon fees	20% Coinsurance	50% Coinsurance	--None--
If you need immediate medical attention	Emergency room services	$200 Copayment/visit	$200 Copayment/visit	Deductible does not apply
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Coverage is limited to professional ambulance transport services
	Urgent care	$20 Copayment/visit	$20 Copayment/visit	Deductible does not apply
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 Copayment/day	50% Coinsurance	Requires preauthorization Maximum $1,000 copayment in-network
	Physician/surgeon fee	20% Coinsurance	50% Coinsurance	--None--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 Copayment/visit	50% Coinsurance	--None--
	Mental/Behavioral health inpatient services	$200 Copayment/day	50% Coinsurance	Requires preauthorization Maximum $1,000 copayment in-network
	Substance use disorder outpatient services	$10 Copayment/visit	50% Coinsurance	--None--
	Substance use disorder inpatient services	$200 Copayment/day	50% Coinsurance	Requires preauthorization Maximum $1,000 copayment in-network
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	50% Coinsurance	Includes vaginal delivery, caesarean section, miscarriage, complications of pregnancy and circumcision.

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
	Delivery and all inpatient services	$200 Copayment/day	50% Coinsurance	Maximum $1,000 copayment in-network
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	50% Coinsurance	Physician referral and preauthorization are required. Coverage is limited to 60 visits per incident
	Rehabilitation services	20% Coinsurance	50% Coinsurance	Coverage is limited to 40 PT and 40 OT visits per plan year. Speech therapy is limited to 20 visits per plan year. Cardiac rehab is limited to 1 course of treatment per plan year
	Habilitation services	20% Coinsurance	50% Coinsurance	Coverage is limited to 80 visits per plan year
	Skilled nursing care	20% Coinsurance	50% Coinsurance	Coverage is limited to 100-days per lifetime, preauthorization is required.
	Durable medical equipment	20% Coinsurance	50% Coinsurance	Preauthorization may be required. Please see your policy for specific exclusions
	Hospice service	20% Coinsurance	50% Coinsurance	Physician referral and preauthorization are required.
If your child needs dental or eye care	Eye exam	No charge	50% Coinsurance	Deductible does not apply Coverage is limited to one routine eye exam per plan year.
	Glasses	20% Coinsurance	50% Coinsurance	Coverage is limited to one pair of glasses or contact lenses per plan year.
	Dental check-up	No charge	50% Coinsurance	Your plan includes Pediatric Dental Coverage. Please see the Dental Plan Disclosure for a summary of your benefits.

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) • Hearing aids •	• Routine eye care (Adult) • 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.)		
• Bariatric surgery • Chiropractic care	• Infertility treatment • Long-term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing (Inpatient)

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 (800)868-7670. You may also contact your state insurance department at the Wyoming Insurance Department, (307) 773-7402, 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 Wyoming Insurance Department at: (307) 777-7402 or visit their website: http://insurance.state.wy.us/consumer.html.

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** $5,900
- **Patient pays** $1,500

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	$400
Coinsurance	$400
Limits or exclusions	$0
Total	**$1,500**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,200
- **Patient pays** $1,100

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	$300
Coinsurance	$100
Limits or exclusions	$0
Total	**$1,100**

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.