LAKE COUNTY INDIANA N.E.C.A. – I.B.E.W.
HEALTH & BENEFITS PLAN

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* FAQ ABOUT ALLOWABLE AMOUNTS *

It is important to understand what allowable amounts are and how they are determined.

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1. What is an "allowable amount"?

The allowable amount is the amount of a charge by a medical provider that the Plan will consider for reimbursement. The Plan's deductible and coinsurance only apply to allowable amounts. A non-participating provider may bill you for charges in excess of the allowable amount. (Allowable amounts are also referred to as "allowable charges.")

ALLOWABLE AMOUNT FOR HOSPITALS

2. How are allowable amounts for hospital expenses determined?

The allowable amount of an inpatient or outpatient hospital bill is determined using a reference-based price. The Plan looks at what Medicare would pay and adds a percentage to that amount so that it pays more than Medicare would pay. The intent is to provide a fair and reasonable reimbursement to the facility, while at the same time protecting the plan from unreasonable and unfair overcharges.

3. What is a designated hospital?

A designated hospital is a hospital that has agreed to accept the Plan's reference-based price and not balance-bill the patient for the difference (other than the usual deductible and coinsurance).

As of December 2015, the following hospitals are designated hospitals:

Effective October 1, 2015:

Level A Designated Hospitals (Plan pays 100% with no deductible or co-pay*):

Franciscan St. Anthony Health – Crown Point, IN
Franciscan St. Anthony Health – Michigan City, IN
Franciscan St. Margaret Health – Dyer, IN
Franciscan St. Margaret Health – Hammond, IN
Franciscan Healthcare – Munster, IN

Level B Designated Hospitals (Plan pays 90% after the deductible):

Methodist Hospital – Gary, IN
Methodist Hospital – Merrillville, IN
Pinnacle Hospital – Crown Point, IN
Portage Hospital – Portage, IN
Porter Regional Hospital – Valparaiso, IN

* *100% payment applies only to the hospital's charges.*

4. Will other hospitals be added to the list of designated hospitals?

The Plan would like to add other hospitals to the list. Plan representatives will continue to negotiate with the hospitals in Northwestern Indiana that are not already participating.

5. Does this mean that non-designated hospitals aren't covered?

No. If a hospital is "non-designated," the Plan will still cover the charges (assuming they are medically necessary, incurred while the patient is eligible for benefits, etc.), but the maximum the Plan will pay is 70% of the allowable amount. And, as explained above, the allowable amount will be a percentage over and above Medicare's benefit amount. Non-designated hospitals can balance bill you for the amounts over the Plan's allowed amount.

6. What should I do in the event of an emergency?

You should not hesitate to seek treatment in an emergency. If you (or a dependent) must be admitted to a non-designated hospital, you should call Hines as soon as possible. As before, Hines will work with PNA and the Plan to determine a fair reimbursement rate for your emergency treatment.

7. What if I need to schedule inpatient medical care?

If the hospital is not a designated hospital, you should call Hines, the Plan's medical review organization, or PNA, the Plan's PPO network administrator, and ask for assistance.

PNA's telephone number is 1-888-476-2776. The number for Hines is on your I.D. card.

8. A local hospital told me I have no coverage. Is that true?

No. A non-designated hospital is like an out-of-network hospital. You have coverage, but the Plan will pay the allowable charges at the out-of-network rate. The Plan pays 70% up to 130% of the Medicare rate for out-of-network facility charges (minus your deductible if it was not previously satisfied).

ALLOWABLE AMOUNT FOR NON-HOSPITAL PROVIDERS

9. How does the Plan determine the allowable amount for outpatient facilities?

As before, the allowable amount for outpatient facility charges will be:

- The PNA negotiated amount; or
- If the facility is not in the PNA PPO network, 130% of Medicare's benefit amount. You could be balance billed for the amount in excess of the allowable charge.

The allowable amount will be paid at the 90% if the facility is in the PNA PPO network. If it is out-of-network, the Plan will pay 70% of the allowable amount.

10. How does the Plan determine the allowable amount for doctors?

As before, the allowable amount for doctors and other medical professionals will be:

- The PNA negotiated amount; or
- If the provider is not in the PNA PPO network, the reasonable and customary (R&C) amount. You could be balance billed for the amount in excess of the allowable charge.

The payment percentage will be:

- 90% of allowable charges for PPO providers;

- 90% of the allowable charges for non-PPO pathologists, anesthesiologists, radiologists and emergency room physicians if their services are provided while you are a patient at a designated hospital or being treated at a PPO doctor's office; and
- 70% of all other non-PPO provider charges.

GENERAL QUESTIONS

11. How are allowable amounts determined when Medicare pays first?

The Plan's allowable charge limits apply to retirees and their dependents who are under age 65. However, once a retiree or a retiree's dependent becomes eligible for Medicare, Medicare providers become the Plan's "preferred providers," and the Medicare-eligible participant can use any Medicare-covered hospital or doctor.

12. What if another group health plan pays first?

If a Plan participant has other group coverage that is paying primary on a claim, the participants should use the primary plan's preferred providers. Then, this Plan will calculate what it should pay as the secondary plan the same way it would had there been no other Plan. Whether the providers are designated or non-designated, or PPO or non-PPO, there will *usually* be no balance due after both plans have paid.

13. What is "balance-billing"?

Non-designated hospitals and non-PPO doctors and facilities can bill you for the balance over what the Plan determines to be the allowable amount.

If you use a non-designated hospital or a non-PPO facility or professional, the Plan will pay 70% of the allowable charge. The hospital, facility or medical professional can balance bill you for the amount over the allowable amount in addition to your 30% coinsurance and deductible.

For example:

How Balance Billing Works (Non-Designated Hospital)

Non-designated hospital's billed amount =	$15,000	300% of Medicare allowable
Medicare-allowable amount =	$5,000	
This Plan's allowable amount =	$6,500	130% of Medicare allowable
The Plan pays =	$4,550	70% of $6,500
Patient pays:		
Coinsurance (30%) =	$1,950	30% of $6,500 allowable amount
Balance bill =	+ $8,500	Amount over allowable ($15,000 - $6,500)
Total =	$10,450	

Designated hospitals and PPO providers have agreed not to balance bill you.

14. Will PNA help me after I have already incurred a substantial out-of-pocket bill?

Yes. You should call PNA at 1-888-476-2776 and ask for help. They will negotiate the charges for you, but there is no guarantee what the final charges will be. You must call PNA for assistance as soon as possible.