ORANGE - ULSTER SCHOOL DISTRICTS HEALTH PLAN

BENEFITS-AT-A-GLANCE

Plan Name:	**Orange Ulster School Districts Health Plan**
Type of Plan:	**Indemnity with PPO Benefit; No Referral Required** Basic hospital benefits; Medical services following calendar year deductible, co-insurance and co-pay for out-of-network providers; or PPO services with only a per-day/per service co-payment.
PPO Network:	**Blue Cross/Blue Shield Association's BlueCard® PPO Program** File all claims with the Blue Cross/Blue Shield Plan in the state where services are rendered. Envoy Payer ID 84105 (INDECS Corporation)
Pre-Certification Requirements:	In-Patient Hospital and 2nd Surgical Opinion: Contact **HealthCare Strategies** (800) 764-3433 Physical Medicine (PT, OT & Chiro): Contact **OptumHealth** *(formerly MPN/ACN)* **(888) 471-0117** Behavioral Health-Inpatient & Out-patient: Contact **Quantum Health Solutions (888) 214-4001**

Plan Office:	**1(845) 781-4890**
Exec. Director:	**Mr. Ike Lovelass**
Claims & Eligibility:	**INDECS Corporation** **1(888) 4-INDECS (446-3327)**
Plan Document (Online):	**www.indecscorp.com** **Click on: INDECS Connection then select either Member or Provider Login. At this point, you must have a password or register for one.**

COB:	This Plan contains a Coordination of Benefit provision which complies with the State of New York COB regulations.
Medicare Primary:	**Send Medicare primary claims to Medicare.** Send secondary claims directly to INDECS Corp., PO Box 668, Lyndhurst, NJ 07071 with Medicare provider's or member's EOB. *Medicare secondary benefits are "out-of-network provider" benefits (below) with Medicare primary benefits being "carved-out" from Plan Out-Of-Network benefits.* ***Deductible and co-insurance apply. CO-PAYS DO NOT.***

SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Annual Deductible (Ded.)	None	$300/$800 Calendar Year (CY)
Co-Insurance	None	20% (after co-pay and CY deductible) of Usual & Customary (U&C) allowance
Co-Payment (Co-pay) per day or per service	See service for amount of co-pay (1)	Applies before deductible and co-insurance-see service for amount of co-pay (1)
Out-of-pocket maximum	Not applicable	$1,000/$1,800 (co-pays do not apply to out-of-pocket maximum)
Calendar Year Medical Benefit Maximum (excludes basic hospital services)	$500,000 (combined limit for in and out-of-network. Hospital benefits do NOT accrue to calendar year max)	$500,000 (the same combined limit for In and Out-of-Network)
Lifetime medical benefit maximum	Unlimited; Except for $25,000 lifetime limit for qualified infertility procedures*	Unlimited; Except for $25,000 lifetime limit for qualified infertility procedures*
HOSPITAL BASIC BENEFITS* (Basic benefits do not accrue toward Medical CY or Lifetime Maximums.)		
Hospital Inpatient	100% up to 365 days maximum*	100% U&C,$500 ded for each pre-cert admission; up to 365 days max*
Hospital ER	100% after $50 co-pay	100% of U&C after $70 co-pay
Hospital Outpatient Surgery*	100% after $35.00 co-pay*	100% of U&C after $70.00 co-pay*
Hospital Outpatient Other (incl. Phys.Therapy*)	100% after $35.00 co-pay	100% of U&C after $70.00 co-pay
Rehab Hospital	100% up to 100 days maximum*	100% up to 100 days maximum*
Pre-admission testing*, Hemodialysis, Chemo-therapy & radiation therapy	100% (no co-pay)	100% of U&C (no co-pay)
Home Health Care & SNF	100% up to 180 visits per CY*	100% U&C up to 180 days per CY*
Hospice & Birthing Centers	100%*	100% U&C*
Hospital/Ambulance	100% limited to $50 per trip (basic benefit); balance to Medical Benefit	100% U&C limited to $50 per trip: (basic benefit) balance to Medical Benefit

**May require Pre-Certification to avoid benefit reduction. See Pre-Certification contacts listed on first page.*

(1) Services sent from doctor's offices to an independent lab, radiologists, or similar service providers incur an additional $15 co-payment per service.

SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MEDICAL BENEFITS		**↓All after CY deductible↓**
Physician Office Visit (1)	$15.00 co-pay (1)	80% of U&C charges; after $15 co-pay (1); after CY deductible
Physician Inpatient Care, Surgery*, Anesthesia, Lab (1)**, X-Ray** (1)**, Radiology** (1)**, Infertility Care**	$15.00 co-pay (1)	80% of U&C charges; after $15 co-pay (1); after CY deductible
Maternity Physician Services Hospital Services* Nursery Care (Well Baby)	 $15 co-pay 100%* 100%	80% of U&C charges after $15 co-pay (1) & calendar year deductible 100% U &C, $500 ded per admission* 100% U &C, $500 ded per admission*
Physical Therapy	100% after $15 co-pay per schedule*	1-15th visit: 80% of MPN rate + $15 co-pay 16th + visit: 50% of MPN rate + $15 co-pay
Chiropractic Benefit	100% after $15 co-pay*	1-15th visit: 80% of MPN rate + $15 co-pay 16th + visit:50% of MPN rate + %15 copay
Home Infusion & IV Therapy; Speech Therapy and Durable Medical Equipment	80% after plan deductible. Rental up to purchase price.	80% of U&C after deductible. Rental up to purchase price.
Mental Health Inpatient	100% up to 100 days/CY*	Pre-certified - 50% U&C allowable charges, $500 ded., 30 day maximum*
Oupatient	$15.00 co-pay up to 100 visits/CY*	50% of U&C plus co-pay up to 30 visits per CY, 60 visits per lifetime*
Substance Abuse Inpatient	100%; up to 4 weeks per confinement; 6 weeks per calendar year*	50% of U&C charges; after $500 deductible per admission; up to 4 weeks per confinement; 6 weeks per CY*
Outpatient	100%; up to 60 visits per CY, including 20 family visits*	50% of U&C charges; up to 60 visits per CY, including 20 family visits*

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SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
WELLNESS BENEFITS:		
Adult Well Care Benefits: **Available to ACTIVE employees (includes pre-Medicare retirees) and their dependent spouses only.**		
Age 19 –65; prior to Medicare	$15.00 co-pay/one annual visit, plus eligible immunizations (1)	Covered only through In-Network Providers
Adult Well Care Benefits: **Available to retirees and spouses with Primary (pays first) Medicare coverage.**		
Age 65+ with Medicare primary	None	80% of U&C after deductible, one annual visit, plus eligible immunizations.
Routine Screenings and Examinations:		
Breast Cancer (Mammography) Age 35-39 Age 40 and older High Risk – any age	100% for one baseline mammography 100% - one per calendar year 100% - one per calendar year	100% of U&C for one baseline mammography 100% of U&C for one per calendar year 100% - one per calendar year
Cervical Cancer (Pap Smears)	100% after $15 co-payment ; one per calendar year: includes exam, pap smear, lab & diagnostic services (1)	100% of U&C after $15 co-payment; one per calendar year: includes exam, pap smear, lab & diagnostic services (1)
Routine Gynecological Examinations	100% after $15 co-payment (2 per CY) (1); includes HPV immunization for 11 through 26 year olds	100% of U&C after $15 co-payment (2 per CY) (1); includes HPV immunization for 11 through 26 year olds
Contraception Services, Implant Devices, etc.	100% after co-payment	80% of U&C charges after $15 co-pay & calendar year deductible.

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SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
WELLNESS BENEFITS Cont'd:		
Osteoporosis-Bone Mineral Density Measurement & Testing (Requirements exist for coverage-See Plan Doc)	100% - $15 co-payment – one per CY	$15 co-payment; 80% of U&C after deductible-one per CY
Prostate Cancer (PSA Testing) Age 50+ or 40+ with family history	100% as part of Routine Physical Exam (RPE) – one per calendar year (1)	None
Colon Cancer (Colonscopy) Age 50+; younger if due to family history (See Plan Doc)	One every 60 months (1)	None
Child Well Care Benefits: Routine Physical Exams (PEs) include eligible immunizations.		
Age 0 to 2 years old Age 2 through 5 yrs old Age 6 through 18 yrs old	100%; 100% 100% *(Visitation schedule established by American Academy of Pediatrics as adopted by NYSID.)*	100% of U&C 100% of U&C 100% of U&C *(Visitation schedule established by American Academy of Pediatrics as adopted by NYSID.)*
Age 19 through 25 (only with approved student extension)	100%; after $15 co-pay; one per 2 calendar years (1)	None (In-network only)
PRESCRIPTION DRUG BENEFITS (Administered by CVS/Caremark)		
Enrollee Co-pays: Retail	$5 generic, $20 preferred brand, $40 non-preferred brand	Reimbursed to the amount the Plan would have paid had the Rx been from an in-network pharmacy
Mail-Order	$7.50 generic, $30 preferred brand, $60 non-preferred brand	Not covered

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Drugs or devices limited or excluded from coverage: drugs not requiring a written prescription (except insulin); drugs that have over-the-counter equivalents; artificial appliances, therapeutic devices, hypodermic needles and similar devices (except for insulin injection); administration of injection drugs; appetite suppressants; non-prescription vitamins or any herbal products.

Drugs for: cosmetic purposes (such as hair growth stimulants and wrinkle removers); immunization agents, biological sera, blood or blood plasma; sexual performance or stimulation improvement; patients in facilities, or limited or excluded in the Plan as listed below.

Drugs limited in coverage are: solid food products (limited to $2,500 CY); specialty Rx as administered by CVS/Caremark and medicines that require preauthorization through CVS-Caremark, such as drugs for anti-obesity, arthritis, ADD and migraine headaches.

Benefits for the following services or circumstances may be limited as detailed in the Plan Document, or excluded from coverage:

Acupuncture/Hypnosis/Biofeedback, Blood Products, Cosmetic Services, Criminal Behavior, Custodial and Maintenance Care, Dental Care, Developmental Delay, Durable Medical Equipment, Prosthetic Devices, Medical Supplies, Experimental and Investigational Treatment, Free Care, Genetic Testing, Government Programs, Late Claims Submission (15 months after service), Military Service-Connected Conditions, No-Fault Automobile Insurance, Non-Covered Services, Nutritional Therapy, Personal Comfort Services, Podiatry and Routine Foot Care, Prohibited Referral, Self-Help Diagnosis (Training & Treatment), Services starting before Coverage begins, Sexual Dysfunction, Smoking Cessation Programs, Special Charges, Social Counseling and Therapy, Timothy's Law Exclusions, Transsexual Surgery and Related Services, Unlicensed Provider, Vision and Hearing Examinations-Therapies and Supplies, War, Weight Loss Services, Workers' Compensation. All services must be Medically Necessary (as defined by the Plan, using Medicare Guidelines), ordered by a covered provider and included as Eligible and Covered under the Plan. Only Usual and Customary charges are allowed, as determined by the Plan. Refer to the Plan Document.

NOTICE: This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.