Orange-Ulster School Districts Health Plan

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

Coverage Period: 01/01/2016 – 12/31/2016

Coverage for: Individual/Family | 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 www.indecscorp.com or by calling 1-888-446-3327.

	Answers	Why this Matters:
What is the overall deductible?	$300 Individual; $ 800 Family. Applies to **out-of-network** services only.	For out-of-network services, you must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services. The **deductible** starts over every Jan. 1. See chart on page 2 on how you pay after meeting the **deductible**.
Are there other deductibles for specific services?	No	You don't have to pay **deductibles** for specific services; however, see the chart beginning on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	$6,850 Individual; $13,700 Family.	The **out-of-pocket** limit is the most you could pay during a coverage period of one year 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?	Premiums, penalty for failure to obtain pre-certification, balance-billed charges, services the plan doesn't cover.	Even though you pay for these services, 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 the plan use a Network of providers?	Yes. For a list of in-network **providers**, see www.bcbs.com or call BC/BS 1-800-810-2583 (physician locator).	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 4. See your plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $20) 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	$20 co-pay per visit	$20 co-pay per visit, plus deductible and 20% co-insurance	……..None…….
	Specialist visit	$20 co-pay per visit	$20 co-pay per visit, plus deductible and 20% co-insurance	……..None…….
	Other practitioner office visit	$20 co-pay per visit	$20 co-pay per visit, plus deductible and 20% co-insurance	……..None…….
	Preventive care/ screening/immunizations	$ 0 co-pay per visit	Not covered.	Certain preventive services and immunizations are covered, such as mammograms and well child visits. See plan document for details on other specific benefits.
If you have a test	Diagnostic tests (e.g., x-ray, blood work) (out-patient)	Co-pay $35 per day	$70 co-pay per day, plus deductible and 20% co-insurance	……..None…….
	Imaging (CT/PET scans, MRIs) (out-patient)	Co-pay $35 per day	$70 co-pay per day, plus deductible and 20% co-insurance	Some tests require pre-certification. See plan document for details.

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.indecscorp.com	Generic drugs	$5 per prescription co-pay for up to 34-day supply	Same as in-network, but paid by plan reimbursement. Call Envision RX Option at 1-800-361-4542 for details.	Mail order is $7.50 per prescription for 90-day supply.
	Preferred brand drugs	$20 per prescription co-pay for up to 34-day supply	Same as in-network, but paid by plan reimbursement. Call Envision RX Option at 1-800-361-4542 for details.	Mail order is $30 per prescription for 90-day supply.
	Non-preferred brand drugs	$40 per prescription co-pay for up to 34-day supply	Same as in-network, but paid by plan reimbursement. Call Envision RX Option at 1-800-361-4542 for details.	Mail order is $60 per prescription for 90-day supply.
	Specialty drugs	$20 or $40 per prescription for 30-day supply	Same as in-network, but paid by plan reimbursement.	Call Orchard Specialty Pharmacy at 1-877-437-9012 for details on specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$35 per day	$70 per day, subject to copay, deductible and 20% co-insurance.	……..None……..
	Physician/surgeon fees	$20 per visit	$20 plus deductible and 20% co-insurance.	……..None……..
If you need immediate medical attention	Emergency room services	Co-pay of $50 per visit	Co-pay of $70 per visit	Co-pay may be waived if patient is admitted to hospital from ER.
	Emergency medical transportation	Subject to deductible and 20% co-insurance after Plan pays first $50 of allowed amount.		Total reimbursement for volunteer ambulance is $50 per year.
	Urgent care	$20 per visit	$20 per visit, plus deductible and 20% co-insurance.	……..None…….
If you have a hospital stay	Facility fee (e.g., hospital room)	$0	$500 per admission deductible plus any charges over allowed amount.	Pre-notification required for hospitalizations (except childbirth). Out-of-network facilities may balance bill for charges over allowed amount.

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
	Physician/surgeon fee	$20 per doctor, per visit	$20 co-pay, plus deductible and 20% co-insurance to Out-of-Network maximum.	Out-of-network providers may balance bill for charges over allowed amount
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 per visit up to 100 visits per calendar year	$20 co-pay per visit after $300 out-of-network deductible up to 30 visits per calendar year visit limit/60 visits lifetime.	Pre-notification & other limits apply to mental health and substance abuse benefits. Limits may be greater for severe, biologically based mental illness. See your plan document for details of benefits and potential penalties.
	Mental/Behavioral health inpatient services	$0 per visit up to 100 days per calendar year	50% of charges after $500 deductible, and any charges over allowed amount for up to 30 days per calendar year.	See your plan document for a complete explanation of benefits and pre-certification requirements.
	Substance abuse disorder outpatient services	$0 per visit up to 60 visits per calendar year	50% of allowable amount up to 60 visits per calendar year.	Limit includes 20 visits for family members.
	Substance abuse disorder inpatient services	$0	50 % of allowable amount after $500 deductible.	Inpatient limit is 4 weeks per confinement; 6 weeks per year.
If you are pregnant	Prenatal and postnatal care	$20 co-pay per visit	$20 per visit, plus deductible and 20% co-insurance.	……None……..
	Delivery and all inpatient services	$0	$500 per admission deductible, plus any charges over allowed amount.	……None……..

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 need help recovering or have other special health needs	Home health care	$0	All charges in excess of allowed amount.	Benefit limited to 180 days per calendar year. Pre-notification required.
	Rehabilitation services	$0 if confined to a facility	$500 deductible and all charges in excess of allowed amount.	Benefit limited to 100 days per calendar year.
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care (facility)	$0	$500 deductible and all charges in excess of allowed amount.	Benefit limit is 180 days per calendar year. Pre-notification required.
	Durable medical equipment	Deductible and 20% co-insurance	Deductible and 20% co-insurance	……..None…….
	Hospice service (out-patient care; in-patient care has different co-pays; see plan document)	$0	All charges in excess of allowed amount	Pre-notification required.
If your child needs dental or eye care	Eye exam (Routine)	Not covered.	Not covered.	Not covered.
	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 is not a complete list. Check your plan document for other excluded services.)**

- Acupuncture
- Eye Exams(routine; adult and child)
- Hearing Aids
- Weight Loss Programs
- Cosmetic Surgery
- Glasses(adult and child)
- Long-term Care
- Dental Care (adult and child)
- Habilitation Services
- Routine Foot Care

Questions: Call 1-888-446-3327 or visit us at www.indecscorp.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.indecscorp.com or call 1-888-446-3327 to request a copy.

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

• Bariatric Surgery – mandatory second surgical opinion required.	• Chiropractic care (pre-certification required)	• Infertility Treatment (Limit of $25,000 on Qualified Procedures; see Plan document for details of coverage of infertility)
• Non-emergency when traveling outside the U.S.	• Private Duty Nursing (after first 48 hours of service). No benefit when confined to a Facility.	

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium.** There are exceptions, however, such as if: 1)You commit fraud; 2) The insurer stops offering services in the State; 3) You move outside the coverage area
For more information on your rights to continue coverage, contact the insurer at 1-888-446-3327. You may also contact the New York State Department of Financial Services (insurance department) at 1-877-267-2323, ext. 61565 or www.cms.gov/ccio.

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 refer to your plan document or contact INDECS at 1-888-446-3327.

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** $ 7,480
- **Patient pays** $ 60

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	$0
Copays	$60
Coinsurance	$0
Limits or exclusions	$0
Total	**$60**

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

Amount owed to providers: $5,400
- **Plan pays** $4,440
- **Patient pays** $ 960

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	$0
Copays	$960
Coinsurance	$0
Limits or exclusions	$0
Total	**$960**

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.