



BENEFITS-AT-A-GLANCE

Effective: 01/01/2016 - 12/31/2016

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.

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

Pre-Determination Requirements: Genetic testing, fax clinical information to **201-460-3205**,
Attn: Pre-Determination Department

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 (OOP) Combined **	Individual: \$6,850** Family: \$13,700**	Individual: \$6,850** Family: \$13,700**
Medical Plan OOP Max**	Individual: \$4,450** Family : \$8,900**	Individual: \$4,450** Family \$8,900**
Prescription OOP Max**	Individual: \$2,400** Family : \$4,800**	Individual: \$2,400** Family: \$4,800**
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*		
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, Chemotherapy & 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.*

*** OOP maximum changes annually.*

(1) Services sent from doctor's offices to an independent lab, radiologists, or similar service providers incur an additional \$20 co-payment per service.

SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MEDICAL BENEFITS		↓All after CY deductible↓
Physician Office Visit (1)	\$20 co-pay (1)	80% of U&C charges; after \$20 co-pay (1); after CY deductible
Physician Inpatient Care, Surgery*, Anesthesia, Lab (1), X-Ray (1), Radiology (1), Infertility Care	\$20 co-pay (1)	80% of U&C charges; after \$20 co-pay (1); after CY deductible
Maternity Physician Services Hospital Services*	\$20 co-pay 100%*	80% of U&C charges after \$20 co-pay (1) & calendar year deductible 100% U &C, \$500 ded per admission*
Nursery Care (Well Baby)	100%	100% U &C, \$500 ded per admission*
Physical Therapy	100% after \$20 co-pay per schedule*	1-15 th visit: 80% of MPN rate + \$20 co-pay 16 th + visit: 50% of MPN rate + \$20 co-pay
Chiropractic Benefit	100% after \$20 co-pay*	1-15 th visit: 80% of MPN rate + \$20 co-pay 16 th + visit: 50% of MPN rate + \$20 copay
Home Infusion & IV Therapy; Speech Therapy and Durable Medical Equipment	80% after OON 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	\$20 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
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WELLNESS BENEFITS: Preventive Care to Meet ACA Requirements		
Adult Well Care Benefits: Available to ACTIVE employees (includes pre-Medicare retirees) and their dependent spouses only.		
Age 19 –65; prior to Medicare Adult Immunizations	100% One per calendar year	Covered only through In-Network Providers
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 cal year 100% - one per calendar year
Cervical Cancer Screening (Pap Smears)	100% One per calendar year	100% of U&C after \$20 co-payment; one per calendar year; includes exam, pap smear, lab & diagnostic services (1)
Routine Gynecological Examinations	100% (2 per calendar year) (1); includes HPV immunization for 11 through 26 years old	100% of U&C after \$20 co-payment (2 per calendar year) (1); includes HPV immunization for 11 through 26 years old.
Contraception Services, Implant Devices, etc.	100%	80% of U&C charges after \$20 co-pay & calendar year deductible.
Breast feeding consultation	100% One per pregnancy	100% of U&C charges after \$20 co-payment
Breast pump equipment & supplies	100% of Plan's U&C One per pregnancy and initial supplies only	100% of Plan's U&C One per pregnancy and initial supplies only
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.

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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%	\$20 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	100%;	100% of U&C
Age 2 through 5 yrs old	100%	100% of U&C
Age 6 through 18 yrs old	100%	100% of U&C
	<i>(Visitation schedule established by American Academy of Pediatrics as adopted by NYSID.)</i>	<i>(Visitation schedule established by American Academy of Pediatrics as adopted by NYSID.)</i>
Age 19 through 25	100%; one per calendar year	None (In-network only)
PRESCRIPTION DRUG BENEFITS administered by Envision Rx (1-800-361-4542)		
Mail Order administered by Costco (1-800-607-6861)		
Specialty pharmacy administered by Orchard Rx (1-877-437-9012)		
Enrollee Co-pays:		
Retail (30 day supply)	\$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 (90 day supply)	\$7.50 generic, \$30 preferred brand, \$60 non-preferred brand	Not covered
Rx Out-of-Pocket Maximum per Calendar Year		
Prescription OOP Max **	Individual: \$2,400 Family: \$4,800	Individual: \$2,400 Family: \$4,800

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