



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 <i>specific</i> 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, \$25) 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**.

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Orange-Ulster School Districts Health Plan

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

Coverage Period: 07/01/2016 – 12/31/2016

Coverage for: Individual/Family | Plan Type: PPO

- 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 | \$25 co-pay per visit | \$25 co-pay per visit, plus deductible and 20% co-insurance |None..... |
| | Specialist visit | \$25 co-pay per visit | \$25 co-pay per visit, plus deductible and 20% co-insurance |None..... |
| | Other practitioner office visit | \$25 co-pay per visit | \$25 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 hospital) | Co-pay \$35 per day | \$70 co-pay per day, plus deductible and 20% co-insurance |None..... |
| | Imaging (CT/PET scans, MRIs) (out-patient hospital) | 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. |

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Coverage for: Individual/Family | Plan Type: PPO

| 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 30-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 | \$25 per prescription co-pay for up to 30-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 \$37.50 per prescription for 90-day supply. |
| | Non-preferred brand drugs | \$50 per prescription co-pay for up to 30-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 \$75 per prescription for 90-day supply. |
| | Specialty drugs | \$25 or \$50 per prescription for 30-day supply | Same as in-network, but paid by plan reimbursement. | Call Envision 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 | \$25 per visit | \$25 plus deductible and 20% co-insurance. |None..... |
| If you need immediate medical attention | Emergency room services | Co-pay of \$70 per visit. | Co-pay of \$90 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 | \$25 per visit | \$25 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. |

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Orange-Ulster School Districts Health Plan

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Coverage Period: 07/01/2016 – 12/31/2016

Coverage for: Individual/Family | Plan Type: PPO

| 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 | \$25 per doctor, per visit | \$25 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 | \$25 per visit up to 100 visits per calendar year | \$25 co-pay per visit, 50% of allowable amount, after \$300 out-of-network deductible up to 30 visits per calendar year/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 allowable amount, 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 | \$25 co-pay per visit | \$25 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..... |

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Coverage for: Individual/Family | Plan Type: PPO

| 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 <u>child</u> 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.)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Eye Exams(routine; adult and child) • Hearing Aids • Weight Loss Programs | <ul style="list-style-type: none"> • Cosmetic Surgery • Glasses(adult and child) • Long-term Care | <ul style="list-style-type: none"> • Dental Care (adult and child) • Habilitation Services • Routine Foot Care • Assisted Reproductive Technology (IVF) |
|--|--|---|

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

| | | |
|---|---|--|
| <ul style="list-style-type: none"> • Bariatric Surgery – mandatory second surgical opinion required. | <ul style="list-style-type: none"> • Chiropractic care (pre-certification required) | |
| <ul style="list-style-type: none"> • Non-emergency when traveling outside the U.S. | <ul style="list-style-type: none"> • 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.

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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 \$ 7,465
- Patient pays \$ 75

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 | \$75 |
| Coinsurance | \$0 |
| Limits or exclusions | \$0 |
| Total | \$75 |

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 |

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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.

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