



BENEFITS-AT-A-GLANCE

Effective: July 1, 2017 – December 31, 2017

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. Empire Live Health Online (LHO): www.livehealthonline.com ; customersupport@livehealthonline.com ; (855) 603-7985
Pre-Certification	In-Patient Hospital, 2nd Surgical Opinion, Genetic Testing and Infertility
Or Notice Requirements	Treatment with pre-notice for CAT/MRI/PET/MRA imaging. Contact HealthCare Strategies (800) 764-3433 Physical Medicine (PT, OT & Chiro) Contact OptumHealth (<i>formerly MPN/ACN</i>) (888) 471-0117 Behavioral Health-Inpatient & Outpatient: Contact Quantum Health Solutions (888) 214-4001
Pre-Determination Requirements:	Questionable Services, fax Clinical Information to 201-460-3205 , Attn: Pre-Determination Department.
Plan Office:	(845) 781-4890
Exec. Director:	Mr. John Staiger (<i>Interim Plan Administrator</i>)
Claims & Eligibility:	INDECS Corporation (888) 4-INDECS (446-3327)
Plan Document (Online):	www.indecscorp.com or www.ouhealth.org 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, Medicare EOB. <i>Medicare secondary benefits are "out-of-network provider" benefits, as there is no PPO. Please be sure your provider participates with Medicare. If you are treated by a physician or provider of service who does not participate in Medicare, the charges allowed will be reduced to the Usual and Customary (U&C) amount with any costs above that being the patient's responsibility. The Plan deductible and co-insurance apply with Medicare primary benefits being "carved-out" from the Out-of-Network Plan benefits. Deductible and co-insurance apply. MEDICAL PLAN CO-PAYS DO NOT.</i>

SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Pre-Medicare Primary (PMP) Calendar Year (CY) Deductible (Ded.)	None	\$1,000 Individual/\$3,000 Family
PMP Co-Insurance	None	20% (after co-pay and CY deductible) of Usual & Customary (U&C) allowance
PMP 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)
PMP Out-of-Pocket maximum (OOP) combined **	Individual: \$7,150 ** Family: \$14,300 **	Individual: \$7,150 ** Family: \$14,300 **
PMP Medical Plan OOP Max **	Individual: \$4,650 ** Family: \$9,300 **	Individual: \$4,650 ** Family: \$9,300 **
PMP Prescription OOP Max **	Individual: \$2,500 ** Family: \$5,000 **	Individual: \$2,500 ** Family: \$5,000 **
Medicare Primary Calendar Year (CY) Deductible (Ded.)	No PPO access See Out-of-Network	\$300 Individual/\$800 Family
Medicare Primary OOP	No PPO access	\$1,000 Individual/\$1,800 Family
Lifetime medical benefit maximum	Unlimited	Unlimited
HOSPITAL BASIC BENEFITS *		
Hospital Inpatient	100% up to 365 days max, after \$100 co-pay per admission *	100% U&C, \$500 deductible for each admission; up to 365 days max*
Hospital ER	100% after \$100 co-pay	100% of U&C after \$120 co-pay
Hospital Outpatient Surgery *	100% after \$50 co-pay *	100% of U&C after \$85 co-pay
Pre-admission testing *	100%	100%
Lab/Pathology/Radiology Other (incl. PT, OT & ST *)	100% after \$50 co-pay	100% of U&C after \$85
Rehab hospital	100% up to 100 days max, after \$100 co-pay per admission *	100% up to 100 days max *
Hemodialysis, chemotherapy & radiation therapy	100% (no co-pay)	100% of U&C (no co-pay)
Home Health Care	100% up to 180 visits/days per CY*	100% U&C up to 180 visits/days per CY*
SNF	\$100 co-pay per admission 180 visits/days per CY*	100% U&C up to 180 visits/days per CY* after \$500.00 deductible for each admission.
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, per the Affordable Care Act (ACA) OOP published allowances. The 2017 Medicare primary medical out-of-pocket maximum is \$1,000 per individual and \$1,800 family.

- (1) Services sent from doctor's offices to an independent lab, radiologist, or similar service providers incur an additional \$50/\$85 (hospital) or \$25 (non-hospital) co-payment per service, except for Quest Laboratories.
- (2) Notification required.

SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MEDICAL BENEFITS		
		All after CY deductible
Physician Office Visit (1)	100% after \$25 co-pay (1)	80% of U&C charges; after \$25 co-pay (1); after CY deductible
Urgent Care Facility	100% after \$35 co-pay	80% of U&C charges; after \$45 co-pay; after CY deductible
Empire Live Health Online (Telemed 24/7 by computer, tablet or smart phone – in lieu of medical office visit, ER or Urgent Care Facility)	100% after \$10 co-pay	N/A
Laboratory other than Quest	100% after \$25 co-pay (1)	80% of U&C charges after \$25 co-pay (1); after CY deductible
Quest Laboratory	100% after \$5 co-pay	N/A
Independent radiology (not hospital), X-ray, MRI, CAT scan, PET scan	\$25 co-pay	80% of U&C charges; after \$25 co-pay (1); after CY deductible
Advanced imaging at US Imaging PPO Network (USI) requires notice to HCS (2)	100%; no co-pay	N/A
Physician Inpatient Care, Surgery, Anesthesia	100% after \$25 co-pay (1)	80% of U&C charges; after \$25 co-pay (1); after CY deductible
Maternity Physician Services Hospital Services *	\$25 co-pay 100% *	80% of U&C charges after \$25 co-pay (1) & CY deductible
Hospital Nursery Care (Well-Baby)	100%	100% U&C, \$500 deductible per admission *
Physical Therapy	OptumHealth (OH) PPO 100% after \$25 co-pay per schedule *	1-15 th visit: 80% of OH rate + \$25 co-pay 16 th + visit: 50% of OH rate + \$25 co-pay
Chiropractic Benefit	OptumHealth (OH) PPO 100% after \$25 co-pay	1-15 th visit: 80% of OH rate + \$25 co-pay 16 th + visit: 50% of OH rate + \$25 co-pay
Home Infusion, IV Therapy; Durable Med Equip (Rental up to purchase price) Wigs following chemotherapy	80% after OON Plan deductible 80% after deductible up to \$800	80% of U&C after deductible 80% after deductible up to \$800
Speech Therapy (non-hospital)	\$25 co-payment 80% after CY Plan deductible	\$25 co-payment 80% after OON Plan deductible
Mental Health Inpatient	Quantum Health PPO; 100% up to 100 days/CY * \$100 co-pay per admission;	Pre-certified – 50% U&C allowable charges, \$500 deductible, 30 day maximum *
Outpatient Calendar Year Maximum Combined Counts (Network & Out-of-Network) Lifetime Outpatient Mental Health Maximum Combined Counts (Network & Out-of-Network)	Quantum Health PPO; \$25 co-pay up to 100 visits/CY * \$100 co-pay	50% of U&C after \$25 co-pay up to 30 visits per CY, 60 visits per lifetime *
Substance Abuse Inpatient	Quantum Health PPO 100%; up to 4 weeks per confinement; 6 weeks per CY *	50% of U&C charges; after \$500 ded. per admission; up to 4 weeks per confinement; 6 weeks per CY *
Outpatient	Quantum Health PPO 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 *

SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
WELLNESS BENEFITS: Preventive Care		
MEDICAL BENEFITS		All after CY deductible
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 plus Shingles over 60	100%	Covered only through In-Network Providers
Routine Screenings and Examinations:		
Breast Cancer (Mammography) Age 35-39	100% for one baseline mammography	100% of U&C for one baseline mammography
Age 40 and older	100% for one per cal year	100% of U&C for one per cal year
High Risk – any age upon medical proof	100% for one per cal year	100% for one per cal year
Cervical Cancer Screening (Pap Smears)	100% (1) One per calendar year	100% of U&C after \$25 co- payment; one per calendar year: includes exam, Pap Smear, lab & diagnostic services (1)
Routine Gynecological Examinations	100% (2 per cal year) (1); includes HPV immunization for 11 through 26 years old	100% of U&C after \$25 co-payment (2 per cal year) (1); incl HPV immunization for 11 thru 26 yrs old
Contraception Services, Implant Devices, Inc.	100%	80% of U&C charges after \$25 co- pay and calendar year deductible
Breast feeding consultation	100% One per pregnancy	100% of U&C charges after \$25 co-payment
Breast pump equipment and 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.
Osteoporosis-Bone Mineral Density Measurement & Testing (Requirements exist for coverage-see Plan Document)	100%	\$25 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 (Colonoscopy) Age 50+; younger if due to family history (See Plan Document)	One every 60 months (1)	None
Child Well Care Benefits: Routine Physical Exam (PE) include eligible immunizations.		
Age 0 to 2 years old	100%	100% of U&C
Age 2 through 5 years old	100%	100% of U&C
Age 6 through 18 years old	100% (Visitation schedule established by American Academy of Pediatrics as adopted by NYSID.)	100% (Visitation schedule established by American Academy of Pediatrics as adopted by NYSID.)
Age 19 through 25	100%; one per calendar year	None (In-Network only)

SERVICE CATEGORY	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
PRESCRIPTION DRUG BENEFITS		
PRESCRIPTION DRUG BENEFITS administered by CVS Caremark Customer Service for pre-Medicare members, call (844-345-2792).		
MAIL-ORDER DRUGS administered by CVS Caremark, call (844-345-2792).		
SPECIALTY PHARMACY administered by CVS Caremark, call (800-237-2767)		
Medicare Primary members remain with the EnvisionRx Options (Part D plus OU supplemental coverage) until January 1, 2018. Call EnvisionRx at (844) 293-4760.		
Active members & Pre-Medicare Primary (PMP) Retirees' Co-Pays	\$5 generic, \$35 preferred brand, \$60 non-preferred brand	Mail-in claim form for reimbursement up to the amount the Plan would have paid had the Rx been from an in-network pharmacy.
Specialty Drugs	\$35 preferred brand \$60 non-preferred brand	Not covered
Retail (90 day supply) at CVS Pharmacies only.	\$10 generic, \$70 preferred brand, \$120 non-preferred brand	Not covered
Mail-Order (90 day supply)	\$10 generic, \$70 preferred brand, \$120 non-preferred brand	Not covered
Mandatory mail-order for maintenance medications (or at CVS-90 days retail stores) Note: Mandatory generics: Must fill your Rx with generics when available or your cost will be the applicable co-pay PLUS the difference in the cost of the brand minus the cost of the generic. Over-the-Counter (OTC) medication must be purchased at Members' cost when a prescription drug is available as an OTC medication.		
Rx Out-of-Pocket Maximum per Calendar Year (Actives and Pre-Medicare Prime Retirees)		
Prescription OOP Max **	Individual: \$2,500 Family: \$5,000	Individual: \$2,500 Family: \$5,000
Medicare Primary Members remain with Part D and Envision supplemental through 12/31/17. Transfer to CVS, as of 1/1/2018. Rx benefits remain the same until December 31, 2017.	<u>30 day retail co-pays:</u> \$5 generic, \$25 preferred brand, \$50 non-preferred brand <u>90 mail-order co-pays:</u> \$7.50 generic, \$37.50 preferred brand, \$75 non-preferred brand	N/A N/A N/A N/A N/A N/A

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