Catskill Area Schools Employee Benefit Plan Indemnity

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

Coverage Period: Beginning on or after 07/01/2013

Coverage for: Single; Family | **Plan Type:** Indemnity

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 or by calling **1-800-962-6294**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	See Human Resources for **deductible** information	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** per calendar year for Home Health Care.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. **$400** per individual per calendar year.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually 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, deductibles, balanced-billed charges, and health care this plan doesn't cover.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
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 this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-962-6294**.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-866-4-USA-DOL (1-866-487-2365) to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) 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**.)

Common Medical Event	Services You May Need	Your cost if you use an In-network or 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% Coinsurance after deductible	none
	Specialist visit	20% Coinsurance after deductible	none
	Other practitioner office visit	Chiropractor: 20% Coinsurance after deductible Acupuncture Therapy: Not Covered	none
	Preventive care/screening/immunization	No Charge up to the allowed amount	Child: Covered up to age 19
If you have a test	Diagnostic test (x-ray, blood work)	No Charge up to the allowed amount	none
	Imaging (CT/PET scans, MRIs)	No Charge up to the allowed amount	none

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Common Medical Event	Services You May Need	Your cost if you use an In-network or 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.medco.com	Generic drugs	Refer to the Pharmacy Benefit Manager at www.medco.com for information regarding prescription drug coverage.	none
	Preferred brand drugs		
	Non-preferred brand drugs		
	Specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge up to the allowed amount	none
	Physician/surgeon fees	No Charge up to the allowed amount	none
If you need immediate medical attention	Emergency room services	No Charge up to the allowed amount	none
	Emergency medical transportation	No Charge up to the first $50; then 20% Coinsurance after deductible	none
	Urgent care	20% Coinsurance after deductible	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge up to the allowed amount for up to 365 days; then 20% Coinsurance after deductible	none
	Physician/surgeon fee	20% Coinsurance after deductible	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance after deductible	none
	Mental/Behavioral health inpatient services	No Charge up to the allowed amount for up to 120 days per confinement	none
	Substance use disorder outpatient services	20% Coinsurance after deductible	Limit: 60 visits per calendar year
	Substance use disorder inpatient services	No Charge up to the allowed amount	Limit: 28 days per calendar year; 42 days per lifetime

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Common Medical Event	Services You May Need	Your cost if you use an In-network or Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No Charge up to the allowed amount	none
	Delivery and all inpatient services	Delivery (Mother): No Charge up to the allowed amount Delivery (Child): No Charge up to the allowed amount	none
If you need help recovering or have other special health needs	Home health care	25% Coinsurance after separate $50 deductible	Limit: 40 visits per calendar year
	Rehabilitation services	Physical, Occupational and Speech Therapy: No Charge up to allowed amount if after related surgery or hospitalization; 20% Coinsurance after deductible otherwise Rehabilitation Facility: No Charge up to the allowed amount	Physical, Occupational and Speech Therapy limits: 20 visits each for therapy not related to surgery or hospitilization Rehabilitation Facility limit: 100 days of care
	Habilitation services	See Rehabilitation Services	See Rehabilitation Services
	Skilled nursing care	No Charge up to the allowed amount	Limit: 100 days of care
	Durable medical equipment	20% Coinsurance after deductible	none
	Hospice service	No Charge up to the allowed amount	Limit: 210 days per lifetime
If your child needs dental or eye care	Eye exam	No Charge up to the allowed amount	none
	Glasses	Not Covered	none
	Dental check-up	Dental benefits may be available from your employer.	none

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Private-duty Nursing
- Routine Foot Care
- Weight Loss Programs

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

- Chiropractic Care
- Most coverage provided outside the United States.
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan using the contact information in your Summary Plan Description or Plan Document. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 contact your plan using the contact information in your Summary Plan Description or Plan Document. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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Coverage Examples

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** $7,192
- **Patient pays** $348

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	$110
Copays	$80
Coinsurance	$158
Limits or exclusions	$0
Total	**$348**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,490
- **Patient pays** $910

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	$110
Copays	$400
Coinsurance	$400
Limits or exclusions	$0
Total	**$910**

These examples assume the plan has a $110 medical deductible and $10 generic and $15 brand name prescription drug copays.

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.
- 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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