# PPSTA Benefit Trust Group Health Plan

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

**Coverage Period: 01/01/2015-12/31/2015**

**Coverage for:** Individual | **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.ppsta.MyPOMCO.com or by calling 1-866-227-9936. Includes amendments 2012-001 through -005.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0.** Please see deductibles outlined below. | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | **Outpatient services –** In-network deductible is equivalent to the Medicare deductible amount (2015 is $147). Out-of-network: $1,000 individual/$3,000 family. Does not apply to benefits paid at 100%. | 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. Medical: In-network: $1,250 individual/$2,500 family; out-of-network: $2,500 individual/$5,000 family. Prescription drugs: $1,820 individual/$3,640 family | 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?** | Precertification penalties, ancillary & extended benefits, infertility, refractive surgery, benefits paid at 100%, premiums, balance-billed charges, health care this plan doesn't cover, and other services as described in the plan document. | Even though you pay these expenses, 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 this plan use a network of providers?** | Yes. For a list of **preferred providers**, see www.ppsta.MyPOMCO.com or call 1-866-227-9936. | 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 6. See your policy or plan document for additional information about excluded services. |

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 **co-insurance** 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**, **co-payments** and **co-insurance** 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 copay/visit | 30% coinsurance | ----------none---------- |
| | Specialist visit | $25 copay/visit | 30% coinsurance | ----------none---------- |
| | Other practitioner office visit | $25 copay/visit | 30% coinsurance | Chiropractic and acupuncture limit $75/visit & combined limit of $2,500/calendar year. |
| | Preventive care/screening/immunization | No charge | 30% coinsurance | ----------none---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | X-ray: $25 copay/visit; Blood work: no charge | 30% coinsurance | In-network X-ray in excess of $2,500: $100 copay/visit |
| | Imaging (CT/PET scans, MRIs) | $100 copay/visit | 30% coinsurance | Precertify or up to $250 penalty. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.Express-Scripts.com. | Generic drugs | $10 (retail), $20 (mail order) copay/prescription | | Limited to a 31 day supply (retail) or 93 day supply (mail order). |
| | Preferred brand drugs | $35 (retail), $70 (mail order) copay/prescription | | |
| | Non-preferred brand drugs | $70 (retail), $140 (mail order) copay/prescription | | |
| | Specialty drugs | $50 (retail), $100 (mail order) copay/prescription | | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 30% coinsurance | ----------none---------- |
| | Physician/surgeon fees | Surgery under $500: no charge. | 30% coinsurance | In-network surgery over $500: $250 copay. Certain surgeries require precertification. |

| 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 immediate medical attention** | Emergency room services | $100 copay/visit | | ----------none---------- |
| | Emergency medical transportation | No charge | | $500 copay for air ambulance. See plan document for details. |
| | Urgent care | $25 copay/visit | 30% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay/visit | $500 copay then 30% coinsurance | Precertify or up to $250 reduction. |
| | Physician/surgeon fee | $25 (physician) $250 (surgeon) copay/visit | 30% coinsurance | Precertify certain surgeries. No In-network copay for surgeries under $500. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 copay/visit | 30% coinsurance | ----------none---------- |
| | Mental/Behavioral health inpatient services | $500 copay/visit | $500 copay then 30% coinsurance | Precertify or up to $250 reduction. |
| | Substance use disorder outpatient services | $25 copay/visit | 30% coinsurance | ----------none---------- |
| | Substance use disorder inpatient services | $500 copay/visit | $500 copay then 30% coinsurance | Precertify or up to $250 reduction. |
| **If you are pregnant** | Prenatal and postnatal care | $25 copay/visit | 30% coinsurance | See plan document for Healthy Beginnings program details. |
| | Delivery and all inpatient services | $500 copay (hospital) and $250 copay (delivery). | 30% coinsurance | |

| 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 | $25 copay/visit | 30% coinsurance | Precertify or up to $250 reduction. Limit 200 visits/calendar year. |
| | Rehabilitation services | $25 copay/visit | 30% coinsurance | Limit 30 visits/calendar year plus an additional 20 visits if medically necessary. |
| | Habilitation services | | | |
| | Skilled nursing care | $500 copay/visit | $500 copay then 30% coinsurance | Precertify or up to $250 reduction. Limit 100 visits/calendar year. |
| | Durable medical equipment | No charge | 30% coinsurance | Precertify equipment exceeding $500 or up to $250 reduction. |
| | Hospice service | No charge | 30% coinsurance | Precertify or up to $250 reduction. Limit 210 days/lifetime. |
| **If your child needs dental or eye care** | Eye exam | $25 copay/visit | 30% coinsurance | ----------none---------- |
| | Glasses | Not covered | | ----------none---------- |
| | Dental check-up | Not covered | | Separate plan offered |

## 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.)**

- Cosmetic surgery
- Dental care (adult & child)
- Long-term care
- Routine foot care

**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.)**

- Acupuncture
- Bariatric surgery (program enrollment required)
- Chiropractic care
- Hearing aids
- Infertility treatment (program enrollment required)
- Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services.
- Private-duty nursing
- Routine eye care
- Weight loss programs

## 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 at 1-866-227-9936. 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 x 61565 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 POMCO, 2425 James St. Syracuse, NY 13206, Tel. 1-866-227-9936. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

## Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." This health coverage does meet the minimum value standard for the benefits it provides.

*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** $5,660
- **Patient pays** $1,880

**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 | $150 |
| Co-pays | $1,580 |
| Co-insurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$1,880** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,390
- **Patient pays** $1,010

**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 | $150 |
| Co-pays | $780 |
| Co-insurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$1,010** |

# 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**, **co-payments**, and **co-insurance** 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 **co-payments**, **deductibles**, and **co-insurance**. 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.