# Westchester Community College Health Plan: Faculty

**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.MyPOMCO.com or by calling 1-800-848-0163. Includes amendments 2010-001 through -004.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | Out-of-network: **$150** per employee, **$150** spouse; **$150** child (maximum $150 for children). Does not include prescription drugs paid through Express Scripts, services paid at 100% and other services as described in your plan document. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your 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?** | No. | You do not have to meet **deductibles** for specific services, but see the chart on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Out-of-network: **$750** 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?** | Copayments, deductible, prescription drugs paid through Express Scripts, services paid at 100%, other services as described in your plan document, premiums, balance-billed charges, and health care this plan does not cover. | Even though you pay these expenses, they do not 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 in-network **providers**, see www.MyPOMCO.com or call 1-800-848-0163. | 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 does not cover are listed on page 5. See your 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 | $8 copay/visit | 20% co-insurance | ----------none---------- |
| | Specialist visit | $8 copay/visit | 20% co-insurance | ----------none---------- |
| | Other practitioner office visit | $8 copay/visit | 20% co-insurance | Acupuncture not covered. |
| | Preventive care/screening/immunization | $8 copay/visit | Varies based on type of service | See plan document for limitations. Well child: in-network: no charge; out-of-network: not covered. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $8 copay | 20% co-insurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | $8 copay | 20% co-insurance | Precertify PET scan and multiple MRI's or $200 penalty. |

| 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**<br><br>More information about **prescription drug coverage** is available at www.Express-Scripts.com. | Generic drugs | Copay/prescription Active: retail: $3; mail order: no charge. Retired: retail: $1; mail order: no charge. | The copay/ prescription (if any), in addition to amounts over Express Scripts allowance. | Limited to retail 34 day supply or mail order 180 day supply. |
| | Preferred brand drugs | Copay/prescription Active: retail: $3; mail order: no charge. Retired: retail: $4; mail order: no charge. | | |
| | Non-preferred brand drugs | See above copay limits | | Details see www.Express-Scripts.com. |
| | Specialty drugs | See above copay limits | | Details see www.Express-Scripts.com. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $8 copay/visit | 20% co-insurance | ----------none---------- |
| | Physician/surgeon fees | $8 copay/visit | 20% co-insurance | ----------none---------- |
| **If you need immediate medical attention** | Emergency room services | No charge | | ----------none---------- |
| | Emergency medical transportation | Professional or hospital owned: No charge first $50, then 20% coinsurance | | Volunteer: No charge first $50/under 50 miles or $75/over 50 miles, then 20% coinsurance. |
| | Urgent care | No charge | 20% co-insurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge for first 365 days | | Precertify or $200 penalty. 20% coinsurance beyond 365 days. |
| | Physician/surgeon fee | Surgeon: $8 copay. | 20% co-insurance | In-network physician: no charge. |

| 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 have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 100% after first $48 for visits 1-10, $40 for visits 11-30, $30 for visits 31 and over. 100% after first $60 for crisis intervention. | 20% after first $48 for visits 1-10, $40 for visits 11-30, $30 for visits 31 and over. 20% after first $60 for crisis intervention. | Benefit for number of visits for any combination of in- and out-of-network per treatment period. |
| | Mental/Behavioral health inpatient services | No charge for first 120 days/spell of illness then 20% coinsurance | | Precertify or $200 penalty. 20% coinsurance for visits beyond 120 days. Benefit days count toward the hospital 365/per spell of illness. |
| | Substance use disorder outpatient services | $8 copay/visit first 60 days/ calendar year | 20% coinsurance first 60 days/ calendar year | 20 additional visits/calendar year with 20% coinsurance; no additional benefits for alcohol abuse. |
| | Substance use disorder inpatient services | 20% co-insurance | | Precertify or $200 penalty. Limit 7 weeks/calendar year |
| **If you are pregnant** | Prenatal and postnatal care | $8 copay | 20% co-insurance | ----------none---------- |
| | Delivery and all inpatient services | No charge first 365 days | | 20% coinsurance beyond 365 days. Benefit days count toward the hospital 365 day/spell of illness. |

| 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 | No charge | | Precertify or $200 penalty. Benefit days count toward the hospital 365 day/spell of illness. |
| | Rehabilitation services | Outpatient hospital: Physical therapy $8 copay/ visit, occupational and speech therapy: no charge. | 20% coinsurance | In-network other provider: $13 copay/visit |
| | Habilitation services | | | |
| | Skilled nursing care | No charge | | Precertify or $200 penalty. Benefit days count toward the hospital 365 day/spell of illness. |
| | Durable medical equipment | No charge | 20% co-insurance | ----------none---------- |
| | Hospice service | No charge | | Precertify or $200 penalty. |
| **If your child needs dental or eye care** | Eye exam | No coverage | | ----------none---------- |
| | Glasses | No coverage | | ----------none---------- |
| | Dental check-up | No coverage | | ----------none---------- |

## 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
- Cosmetic surgery
- Dental care (adult, child)
- Long-term care
- Routine foot care
- Routine eye care (adult, child)
- 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.)**

- Bariatric surgery (morbid obesity only)
- Chiropractic Care
- Hearing Aids
- Infertility treatment
- Non-emergency care when traveling outside the U.S. unless travel is for the sole purpose of obtaining medical services
- Private-duty nursing

## 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 1-800-848-0163. 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: POMCO, 2425 James St. Syracuse, NY 13206, Tel. 1-800-848-0163. 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** $7,190/$7,200
- **Patient pays** $350/$340

**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:**

| | Active | Retired |
|---|---|---|
| Deductibles | $ 0 | $ 0 |
| Co-pays | $200 | $190 |
| Co-insurance | $ 0 | $ 0 |
| Limits or exclusions | $150 | $150 |
| **Total** | **$350** | **$340** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,000/$5,080
- **Patient pays** $400/$320

**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:**

| | Active | Retired |
|---|---|---|
| Deductibles | $ 0 | $ 0 |
| Co-pays | $320 | $240 |
| Co-insurance | $ 0 | $ 0 |
| Limits or exclusions | $ 80 | $ 80 |
| **Total** | **$400** | **$320** |

# 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.