

Ulster County
Summary of Benefits and Coverage
and
Required Federal Notices
Plan Year 2013

County of Ulster: POS

Coverage Period: 1/1/2013-12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual and Family Plan Type: POS



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.empireblue.com or by calling 1-800-342-9816.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: \$0 Out-of-network: \$2,000/individual; \$5,000/family Deductible does not apply to out-of-network home health services.	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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In-network: No. Out-of-network: Yes, \$8,000/individual; \$20,000/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 ?	Your out-of-network deductible does not count towards your out-of-network out of pocket limit.	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 participating medical providers, see www.empireblue.com or call 1-800-342-9816.	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 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 1-800-342-9816 or visit us at www.empireblue.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.empireblue.com or call 1-800-342-9816 to request a copy.

October 2012



- **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**.)
- 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	\$20 Copay /visit	40% Coinsurance	None
	Specialist visit	\$20 Copay /visit	40% Coinsurance	None
	Other practitioner office visit	\$20 Copay /visit	40% Coinsurance	None
If you have a test	Preventive care/screening/immunization	No Charge	40% Coinsurance	None
	Diagnostic test (x-ray, blood work)	No Charge	40% Coinsurance	None
	Imaging (CT/PET scans, MRI's)	No Charge	40% Coinsurance	Preauthorization Required
If you need drugs to treat your illness or condition	Generic	Not Covered	Not Covered	
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	None
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g, ambulatory surgery center)	No Charge	40% Coinsurance	Preauthorization Required
	Physician/surgeon fees	No Charge	40% Coinsurance	Preauthorization Required

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	\$100 Copay	Copay waived if admitted
	Emergency medical transportation	No Charge	Not Covered	None
	Urgent care	\$20 Copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	40% Coinsurance	Preauthorization required.
	Physician/surgeon fee	No Charge	40% Coinsurance	Preauthorization required.
	Mental/Behavioral health outpatient services	\$20 Copay/visit	40% Coinsurance	Preauthorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	No Charge	40% Coinsurance	Preauthorization required.
	Substance use disorder outpatient services	\$20 Copay/visit	40% Coinsurance	Preauthorization required.
	Substance use disorder inpatient services	No Charge	40% Coinsurance	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	No Charge	40% Coinsurance	None
	Delivery and all inpatient services	No Charge	40% Coinsurance	None

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	40% Coinsurance	Limited to 200 visits per calendar year
	Rehabilitation services	\$20 Copay/visit	40% Coinsurance	Preauthorization required.
	Habilitation services	\$20 Copay/visit	40% Coinsurance	Preauthorization required.
	Skilled nursing care	No Charge	40% Coinsurance	Preauthorization required. Limited to 60 days per calendar year
	Durable medical equipment	No Charge	40% Coinsurance	Preauthorization required.
If your child needs dental or eye care	Hospice service	No Charge	40% Coinsurance	Limited to 210 days per lifetime
	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	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
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the US
- Private duty Nursing
- Routine eye care
- 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
- Infertility treatment

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 your plan administrator. 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.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

Empire Blue Cross Blue Shield: P.O. Box 1407, Church Street Station, New York, NY 10008.

You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-EBSA (3272) or www.dol/ebsa/healthreform.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le ayudamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已投保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-entrol ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bec a tah ni'ingoo ei doocia'i, shikaa adocohwoi' inizanigo t'aa' dine k'ejigo, t'aa' shoodi ha ma'almhi ya sidahi' bich'i' naabidhi'kiid. Ei doo hiiha daago ni batija'go ho'abalagi' bich'i' hodlihi. Hai'tha' iin'raago e'ya, t'aa' shoodi' dine ya ataha' halne'igi' ni beesh, bec hanc'i' wo'lar' bi'ki' si'miligi' b'k'chigo bich'i' hodlihi.

—————*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 \$7,370
- Patient pays \$ 170

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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
Total	\$170

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$ 2,470
- Patient pays \$ 1,280

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	\$0
Coinsurance	\$0
Limits or exclusions	\$2,930
Total	\$2,930

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.

Questions: Call 1-855-333-5735 or visit us at www.anthem.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com or call 1-855-333-5735 to request a copy.

Ulster County POS Prescription Drug Plan:

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family | Plan Type: PDP



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.express-scripts.com or by calling the number on the back of your pharmacy card.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$ 00.00	You must pay all 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 1 st). See the chart 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 don't 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?	No	There's no limit on how much you could pay during a coverage period for your share of covered services
What is not included in the out-of-pocket limit ?	This plan has no out of pocket limit	Not applicable because there's no out of pocket limit on your expenses.
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
Does this plan use a network of providers ?	Yes. For a list of preferred providers see www.express-scripts.com or call the number on your prescription card	If you use an in-network pharmacy or other health care provider, this plan will pay some or all of the costs of covered services. 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	See your policy or plan document for information about excluded services

Questions: Call the number on the back of your pharmacy card or visit us at www.express-scripts.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the end of this document or call 1-845-340-3545 request a copy.

OMB Control Numbers 1545-2229,
1210-0147, and 0938-1146

Corrected on May 11, 2012

Ulster County POS Prescription Drug Plan: Coverage Period: 01/01/2013 – 12/31/2013
Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family | Plan Type: PDP

- **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**.)
- Your cost sharing does depend on whether a provider is in a network

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	The plan does cover Prescription Drugs only
	Specialist visit	Not covered	
	Other practitioner office visit	Not covered	
	Preventive care/screening/immunization	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	The plan does cover Prescription Drugs only
	Imaging (CT/PET scans, MRIs)	Not covered	
If you need drugs to treat your illness or condition	Generic drugs	\$5.00	The plan covers up to a 30 days' supply (retail prescription); 90 days' supply (mail order prescription). Mail order co-pays are 2.0 times the retail co-pays. Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require pre-authorization. If the necessary pre-authorization is not obtained, the drug may not be covered.
	Preferred brand drugs	\$20.00	
	Non-preferred brand drugs	\$40.00	
	Specialty drugs	Co-pays are the same as retail	
More information about prescription drug coverage is available at www.express-scripts.com	Generics	\$ 5.00	
	Preferred brand	\$20.00	
	Non-preferred brand	\$40.00	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	The plan does cover Prescription Drugs only
	Physician/surgeon fees	Not covered	

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Ulster County POS Prescription Drug Plan: Coverage Period: 01/01/2013 – 12/31/2013
Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family | Plan Type: PDP

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Not covered	The plan does cover Prescription Drugs only
	Emergency medical transportation	Not covered	
	Urgent care	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	The plan does cover Prescription Drugs only
	Physician/surgeon fee	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	The plan does cover Prescription Drugs only
	Mental/Behavioral health inpatient services	Not covered	
	Substance use disorder outpatient services	Not covered	
	Substance use disorder inpatient services	Not covered	
If you are pregnant	Prenatal and postnatal care	Not covered	The plan does cover Prescription Drugs only
	Delivery and all inpatient services	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	The plan does cover Prescription Drugs only
	Rehabilitation services	Not covered	
	Habilitation services	Not covered	
	Skilled nursing care	Not covered	
	Durable medical equipment	Not covered	
	Hospice service	Not covered	
If your child needs dental or eye care	Eye exam	Not covered	The plan does cover Prescription Drugs only
	Glasses	Not covered	
	Dental check-up	Not covered	

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Ulster County POS Prescription Drug Plan:

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family| Plan Type: PDP

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.)

- | | |
|--|---|
| <ul style="list-style-type: none">• Acupuncture• Bariatric Surgery• Chiropractic Care• Cosmetic Surgery• Routine Eye Care (Adults) | <ul style="list-style-type: none">• Dental Care• Hearing Aids• Infertility Treatment• Long Term Care• Non-emergency care when traveling outside the U.S.• Routine Eye Care• Routine Foot Care• Private Duty nursing• 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.)

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 (contact number). 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.cchto.com.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 call the number on the back of your pharmacy card or visit www.express-scripts.com.

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Ulster County POS Prescription Drug Plan: Coverage Examples

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Single, 2 Person, Family | Plan Type: PDP

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 \$200 (minus copays)
- Patient pays \$ 7350

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	\$
Copays	\$
Coinsurance	\$
Limits or exclusions	\$
Total	\$7350

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

- Amount owed to providers: \$5,400
- Plan pays \$2,900 (minus copays)
- Patient pays \$

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	\$
Copays	\$
Coinsurance	\$
Limits or exclusions	\$
Total	\$2500

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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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County of Ulster: PPO

Coverage Period: 1/1/2013-12/31/2013

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual and Family 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.empireblue.com or by calling 1-800-342-9816.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: \$0 Out-of-network: \$500/individual; \$1,250/family Deductible does not apply to out-of-network home health services.	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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In-network: No. Out-of-network: Yes. \$1,000/individual; \$2,500/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 ?	Your out-of-network deductible does not count towards your out-of-network out of pocket limit.	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 participating medical providers, see www.empireblue.com or call 1-800-342-9816.	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 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 1-800-342-9816 or visit us at www.empireblue.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.empireblue.com or call 1-800-342-9816 to request a copy.

October 2012



- **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**.)
- 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	\$20 Copay /visit	20% Coinsurance	None
	Specialist visit	\$20 Copay /visit	20% Coinsurance	None
	Other practitioner office visit	\$20 Copay /visit	Not Covered	None
If you have a test	Preventive care/ screening/immunization	No Charge	No Charge	None
	Diagnostic test (x-ray, blood work)	No Charge	20% Coinsurance	None
If you need drugs to treat your illness or condition	Imaging (CT/PET scans, MRI's)	No Charge	20% Coinsurance	Preauthorization Required
	Generic	Not Covered	Not Covered	
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	None
If you have outpatient surgery	Specialty drugs	Not Covered	Not Covered	
	Facility fee (e.g., ambulatory surgery center)	No Charge	20% Coinsurance	Preauthorization Required
	Physician/surgeon fees	No Charge	20% Coinsurance	Preauthorization Required

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	\$100 Copay	Copay waived if admitted
	Emergency medical transportation	No Charge	Not Covered	None
	Urgent care	\$20 Copay/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% Coinsurance	Preauthorization required.
	Physician/surgeon fee	No Charge	20% Coinsurance	Preauthorization required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 Copay/visit	20% Coinsurance	Preauthorization required.
	Mental/Behavioral health inpatient services	No Charge	20% Coinsurance	Preauthorization required.
	Substance use disorder outpatient services	\$20 Copay/visit	20% Coinsurance	Preauthorization required.
	Substance use disorder inpatient services	No Charge	20% Coinsurance	Preauthorization required.
If you are pregnant	Prenatal and postnatal care	No Charge	20% Coinsurance	None
	Delivery and all inpatient services	No Charge	20% Coinsurance	None

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	20% Coinsurance	Limited to 200 visits per calendar year
	Rehabilitation services	\$20 Copay/visit	Not Covered	Preauthorization required.
	Habilitation services	\$20 Copay/visit	Not Covered	Preauthorization required.
	Skilled nursing care	No Charge	Not Covered	Preauthorization required. Limited to 60 days per calendar year
	Durable medical equipment	No Charge	Not Covered	Preauthorization required.
If your child needs dental or eye care	Hospice service	No Charge	Not Covered	Limited to 120 days per lifetime
	Eye exam	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	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
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the US
- Private duty Nursing
- Routine eye care
- 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
- Infertility services

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 your plan administrator. 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.ccoio.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

Empire Blue Cross Blue Shield: P.O. Box 1407, Church Street Station, New York, NY 10008.

You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-EBSA (3272) or www.dol/ebsa/healthreform.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le solicitamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng rulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'uh ni'ligoo ei doocla'i, shikaa adoolwo'of i'fizi'ngoo t'aa' diné k'ejigro, t'aa' shoodi ba na'ámbi' ya sidáhi bich'i' naabúdi'itkiid. Eí doo bi'gha da'ngo ni ba'ni'ngoo ho'a'atagú bich'i' hodúini. Hai'da'q iia'ra'ngoo e'ya, t'aa' shoodi' d'ine' ya atáha halne'igat ni' béesh bee hane'y' wo'la' b'í'la' s'i' miligá' b'í'ke'ngo b'ach'i' hodúini.

—————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 \$7,370
- Patient pays \$ 170

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	\$0
Coinsurance	\$0
Limits or exclusions	\$170
Total	\$170

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

- Amount owed to providers: \$5,400
- Plan pays \$ 2,470
- Patient pays \$ 1,280

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	\$0
Coinsurance	\$0
Limits or exclusions	\$2,930
Total	\$2,930

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.

Questions: Call 1-855-333-5735 or visit us at www.anthem.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com or call 1-855-333-5735 to request a copy.

Ulster County PPO Prescription Drug Plan:

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family | Plan Type: PDP



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.express-scripts.com or by calling the number on the back of your pharmacy card.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$ 00.00	You must pay all 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 1 st). See the chart 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 don't 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?	No	There's no limit on how much you could pay during a coverage period for your share of covered services
What is not included in the out-of-pocket limit?	This plan has no out of pocket limit	Not applicable because there's no out of pocket limit on your expenses.
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
Does this plan use a network of providers ?	Yes. For a list of preferred providers see www.express-scripts.com or call the number on your prescription card	If you use an in-network pharmacy or other health care provider, this plan will pay some or all of the costs of covered services. 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	See your policy or plan document for information about excluded services

Questions: Call the number on the back of your pharmacy card or visit us at www.express-scripts.com.

Corrected on May 11, 2012

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the end of this document or call 1-845-340-3545 request a copy.

OMB Control Numbers 1545-2229,
1210-0147, and 0938-1146

Ulster County PPO Prescription Drug Plan: Coverage Period: 01/01/2013 – 12/31/2013
Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family| Plan Type: PDP

- **Co-payments** 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**.)
- Your cost sharing does depend on whether a provider is in a network

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	The plan does cover Prescription Drugs only
	Specialist visit	Not covered	
	Other practitioner office visit	Not covered	
	Preventive care/screening/immunization	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	The plan covers up to a 30 days' supply (retail prescription); 90 days' supply (mail order prescription). Mail order co-pays are 2.0 times the retail co-pays. Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require pre-authorization. If the necessary pre-authorization is not obtained, the drug may not be covered.
	Imaging (CT/PET scans, MRIs)	Not covered	
If you need drugs to treat your illness or condition	Generic drugs	\$10.00	The plan does cover Prescription Drugs only
	Preferred brand drugs	\$25.00	
	Non-preferred brand drugs	\$40.00	
	Specialty drugs	Co-pays are the same as retail	
More information about prescription drug coverage is available at www.express-scripts.com	Generics	\$10.00	The plan does cover Prescription Drugs only
	Preferred brand	\$25.00	
	Non-preferred brand	\$40.00	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	The plan does cover Prescription Drugs only
	Physician/surgeon fees	Not covered	

Questions: Call the number on the back of your pharmacy card or visit us at www.express-scripts.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the end of this document or call 1-845-340-3545 request a copy.

Ulster County PPO Prescription Drug Plan: Coverage Period: 01/01/2013 – 12/31/2013
Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family| Plan Type: PDP

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	Not covered	The plan does cover Prescription Drugs only
	Emergency medical transportation	Not covered	
	Urgent care	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	The plan does cover Prescription Drugs only
	Physician/surgeon fee	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	The plan does cover Prescription Drugs only
	Mental/Behavioral health inpatient services	Not covered	
	Substance use disorder outpatient services	Not covered	
	Substance use disorder inpatient services	Not covered	
If you are pregnant	Prenatal and postnatal care	Not covered	The plan does cover Prescription Drugs only
	Delivery and all inpatient services	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	The plan does cover Prescription Drugs only
	Rehabilitation services	Not covered	
	Habilitation services	Not covered	
	Skilled nursing care	Not covered	
	Durable medical equipment	Not covered	
	Hospice service	Not covered	
If your child needs dental or eye care	Eye exam	Not covered	The plan does cover Prescription Drugs only
	Glasses	Not covered	
	Dental check-up	Not covered	

Questions: Call the number on the back of your pharmacy card or visit us at www.express-scripts.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the end of this document or call 1-845-340-3545 request a copy. **3 of 6**

Ulster County PPO Prescription Drug Plan:

Coverage Period: 01/01/2013 – 12/31/2013

Summary of Benefits & Coverage: What the Plan Covers & What it Costs/Coverage for: Single, 2 Person, Family | Plan Type: PDP

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
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Routine Eye Care (Adults)
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care
- Routine Foot Care
- Private Duty nursing
- 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.)

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 (contact number). 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.ccoio.com.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 call the number on the back of your pharmacy card or visit www.express-scripts.com

Questions: Call the number on the back of your pharmacy card or visit us at www.express-scripts.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **the end of this document** or call 1-845-340-3545 request a copy.

Ulster County PPO Prescription Drug Plan: Coverage Examples

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Single, 2 Person, Family | Plan Type: PDP

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 (in normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$200 (minus copays)
- Patient pays \$ 7350

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	\$
Copays	\$
Coinsurance	\$
Limits or exclusions	\$
Total	\$7350

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

- Amount owed to providers: \$5,400
- Plan pays \$2,900 (minus copays)
- Patient pays \$

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	\$
Copays	\$
Coinsurance	\$
Limits or exclusions	\$
Total	\$2500

Questions: Call the number on the back of your pharmacy card or visit us at www.express-scripts.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the end of this document or call 1-845-340-3545 request a copy.

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.

Questions: Call the number on the back of your pharmacy card or visit us at www.express-scripts.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the end of this document or call 1-845-340-3545 request a copy.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See [Balance Billing](#).)

Appeal

A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A preferred provider may *not* balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.

You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy

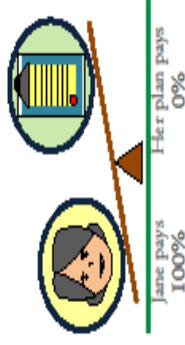
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your health insurance or plan doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care

Health care services a person receives at home.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance

The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance

The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do *not* contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do *not* contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care you pay for out-of-network. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.



Jane pays

0%

Her plan pays

100%

Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or pre-certification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage

Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500 Co-insurance: 20% Out-of-Pocket Limit: \$5,000



Required Federal Notices

Special Enrollment Rights

If you are declining enrollment for yourself, your spouse or your dependents in the medical, dental and vision plans because of other medical coverage, you may be able to enroll yourself and your family in this plan provided that you request enrollment within 30 days after your previous coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

Creditable Coverage

You should be provided with a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA, when COBRA coverage ceases, if you request it before you lose coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage from the plan, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in other coverage.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMO's to provide certain benefits for mastectomy patients who elect breast reconstruction.

In the case of a plan participant who is receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan.

Required Federal Notices

Notice of Special Open Enrollment for Dependent Children Under The Age of 26

The recently passed health reform bill ,the Patient Protection and Affordable Care Act, has extended the coverage of dependent children to their 26th birthday. This applies regardless of whether they are married or financially dependent on the parent.

You will need to complete the Rose & Kiernan enrollment form if your child is not currently enrolled on our plan. The child will remain on your plan until the end of the month in which they turn 26.

Children's Health Insurance Program Reauthorization Act of 2009

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (the "Act"). The state children's health insurance program ("CHIP") provides health insurance for children whose families cannot afford private healthcare but do not qualify for federal Medicaid. The Act expands CHIP by providing additional special enrollment rights related to group health plan coverage. The new law also permits state subsidies of employer provided group health premiums for eligible children and families and imposes new notice and disclosure obligations for employers that maintain group health plans.

Important Notice from Ulster County About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Ulster County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Ulster County has determined that the prescription drug coverage offered by the Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Express Scripts coverage through Ulster County may be affected. If you enroll in a Medicare prescription drug plan you and your eligible dependents may not be eligible to receive all of your current prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current Express Scripts coverage through Ulster County, be aware that you and your dependents may not be able to get this coverage back.

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Ulster County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Ulster County changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 15, 2012
 Name of Entity/Sender: Brenda Bartholomew
 Contact--Position/Office: Personnel Officer
 Address: 244 Fair Street, Kingston, NY 12402
 Phone Number: 845-340-3545

CMS Form 10182-CC

Updated April 1, 2011

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