State-Wide Schools Cooperative Health Plan: Active Employees & Non-Medicare Retirees

Coverage Period:1/01/2015 - 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What It Costs **Coverage for:** Individual + Family | **Plan Type**:PPO/POS

This is only a summary. If you want more details about your coverage and costs, you can get the complete terms in the plan document at **www.SWSCHP.org** or by calling **1-888-P SWSCHP**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: None except non-emergency care in ER subject to Out-of-Network **deductible** Out-of-Network: **$1,000** Individual/**$3,000** Family. Doesn't apply to preventive care or inpatient hospital benefits. **Balance billing**, excluded services, copayments and coinsurance amounts do not count toward the **deductible.**	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). SWSCHP **deductibles** start 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?	Yes. In-Network Medical: **$3,000** Individual/**$6,000** Family. Prescription drugs: **$3,600** person/**$7,200** family. Non-emergency care in ER counts toward Out-of-Network **out-of-pocket limit**; Out-of-Network Medical: **$3,000 Individual/$9,000** 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?	In and Out-of-Network: premiums, **balance billing** (charges in excess of UCR), penalties for failure to obtain pre-authorization for services, health care this plan does not cover Out-of-Network also excludes copayments, **deductibles**, hospital benefits, prescription drugs.	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 in-network **providers**, see www.SWSCHP.org or call 1-888-P SWSCHP.	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**.

Questions: Call **1-888-P SWSCHP** or visit us at **www.SWSCHP.org**.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.SWSCHP.org** or call **1-888-P SWSCHP** to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $30) 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 30% would be $300. This may change if you haven't met your **deductible**. See page 4 regarding payment terms for Hospital Stays under the SWSCHP Plan.
- 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.
- These are just examples, which may not apply to SWSCHP. See the chart below for how the SWSCHP Plan pays for specific services.

Common Medical Event	Service 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	$30 copay/visit	30% coinsurance after deductible plus balance billing	Applies to family, internist, general practitioner, pediatrician and OB/GYN physicians.
	Specialist visit	$30 copay/visit	30% coinsurance after deductible plus balance billing	None
	Other practitioner office visit	$30 copay/visit	30% coinsurance after deductible plus balance billing	Pre-certification required for procedures listed on your ID card.
	Preventive care/screening/ immunization	No charge	No cost to $250; certain screenings and ob/gyn visits - 30% coinsurance after deductible plus balance billing	Subject to age and frequency limits. Out-of-Network Routine Adult Care subject to $250 maximum except for certain screenings and ob/gyn visits.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient hospital: $30 copay All other facilities: No charge	Outpatient hospital: $30 copay All other facilities: 30% coinsurance after deductible plus balance billing	None
	Imaging (CT/PET scans, MRIs)	US Imaging provider: No charge Outpatient hospital: $30 copay	30% coinsurance after deductible plus balance billing	Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.

Common Medical Event	Service 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 More information about **prescription drug coverage** is available at **www.Express-scripts.com**	Generic drugs	Retail: $7.50/script After 1 refill: $15/script Mail Order: $15/script	Retail only: $7.50/script After 1 refill: $15/script plus difference in cost	Retail - up to 30-day supply; Mail Order - up to 90-day supply. No charge for contraceptives and other Affordable Care Act (ACA) required prescriptions received from a participating pharmacy. For non-participating pharmacies, you must submit a claim and pay the difference in the cost of the drug at a participating pharmacy and the cost at a non-participating pharmacy in addition to the copay. Responsible for difference in cost between brand and generic drugs where generic equivalent is available. Some drugs may be subject to prior authorization. Step-therapy or other drug utilization management may apply.
	Brand Formulary drugs	Retail: $30/script After 1 refill: $60/script Mail Order: $60/script	Retail only: $30/script After 1 refill: $60/script plus difference in cost	
	Brand Non-formulary drugs	Retail: $50/script, $100/script after 1 refill; Mail Order: $100/script	Retail: $50/script After 1 refill: $100/script plus difference in cost	
	Specialty drugs	30-day supply: $16.67/script 60-day supply: $33/script 90-day supply: $50.00/script	Not covered	With limited exceptions, specialty drugs are only available through the Accredo Health Group and require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding facility: No charge Outpatient hospital: $30 copay/procedure	Freestanding facility: 30% coinsurance after deductible plus balance billing Outpatient hospital: $30 copay/ procedure	Precertification required except office setting.
	Physician/ surgeon fees	$30 copay/visit	30% coinsurance after deductible plus balance billing	--None--
If you need immediate medical attention	Emergency room services	Emergency room: $60 copay Per provider: $30 copay	Emergency room: $60 copay Per provider: $30 copay	Copay waived if admitted. Providers may be Out-of-Network even when ER is In-Network. Out-of-Network provider services may be subject to deductible and balance billing.
	Emergency medical transportation	$50 copay/visit	$50 copay/visit	Only includes transfers between facilities if medically necessary; separate charges for paramedic intercept not covered.
	Urgent care	$30 copay/visit	30% coinsurance after deductible plus balance billing	Includes hospital, free-standing clinics.

Common Medical Event	Service 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 a hospital stay	Facility fee (e.g., hospital room)	$100 copay/admission	$100 copay/admission	Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. Separate copay applies if admit to new facility. After 365 days, both In-network and Out-of-Network facilities subject to 30% coinsurance after deductible.
	Physician/ surgeon fee	$30 copay/visit or procedure	30% coinsurance after deductible plus balance billing	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay/visit	30% coinsurance after deductible plus balance billing	No cost sharing for testing.
	Mental/Behavioral health inpatient services	$100 copay/admission	$100 copay/admission	All care subject to penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. After 365 days, both In and Out-of-Network facilities subject to 30% coinsurance after deductible. For residential stay approval, it must meet medical criteria and facility must be accredited by The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF) or no benefits are payable. Out-of-Network facility must also be state approved.
	Substance use disorder outpatient services	$30 copay/visit	30% coinsurance after deductible plus balance billing	None.
	Substance use disorder inpatient services	$100 copay/admission	$100 copay/admission	All care subject to penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. After 365 days, both In and Out-of-Network facilities subject to 30% coinsurance after deductible. For residential stay approval, it must meet medical criteria and facility must be accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) or no benefits are payable. Out-of-Network facility must also be state approved.

Common Medical Event	Service 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 are pregnant	Prenatal and postnatal care	No charge	30% coinsurance after deductible plus balance billing	Notice should be given to Care Coordinators within 30 days of expected delivery.
	Delivery and all inpatient services	$100 copay/admission	$100 copay/admission; after 365 days, 30% coinsurance after deductible plus balance billing	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. Coverage for 365-days per spell of illness.
	Rehabilitation services	Outpatient visits: $30 copay/visit Inpatient facility: No charge	Outpatient: 30% coinsurance after deductible plus balance billing Inpatient facility: No charge	Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.
	Skilled nursing care	Inpatient facility: No charge/visit Outpatient visit - $30 copay/visit	Inpatient facility: No charge Outpatient visit: 30% coinsurance after deductible plus balance billing	Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify. Visiting nurse services may not be received at same time as home health care.
	Durable medical equipment	No charge	30% coinsurance after deductible plus balance billing	Precertification required for rentals/purchase over $500.
	Hospice service	No charge	No charge	Penalty of lesser of $250 or 50% of benefit otherwise payable for failure to pre-certify.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	You must pay 100% of these expenses, even In-Network.
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

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

- Cosmetic surgery (unless required for reconstructive surgery which is incidental to, or follows surgery or reconstructive surgery due to a congenital disease or anomaly which has resulted in a functional defect to a Dependent Child)
- Dental care (Adult and Child) (except dental or oral surgical procedures due to accidental injury or congenital disorders)
- Habilitation services
- Long-term care
- Non-emergency or non-urgent care when traveling outside the U.S.
- Routine eye care (Adult and Child)
- 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 those services.)

- Acupuncture (pre-certification required)
- Bariatric surgery (if medically necessary)
- Chiropractic care
- Hearing aids ($600 maximum once ever 48 months)
- Infertility treatment (Artificial reproduction requires pre-certification and is limited to 4 attempts per lifetime)
- Private-duty nursing (Prior authorization required. Outpatient only, maximum payment of $30/hr for participating and non-participating care.)

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 1-888 P SWSCHP (779-7247) or at www.swschp.org. You may also contact your state insurance department, 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: Member services at (888) P-SWSCHP or (888) 779-7247 or visit www.swschp.org. You may also contact the New York Department of Financial Services at http://www.dfs.ny.gov/about/contactus.htm or call 800-342-3736, 212-480-6400, or 518-474-6600. Additionally, a consumer assistance program can help you file your appeal. Contact: Community Service Society, Community Health Advocates, 105 East 22nd Street, New York, NY 10010, (888) 614-5400, http://www.communityhealthadvocates.org.

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?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1(888) 779-7247.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1(888) 779-7247.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1(888) 779-7247.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1(888) 779-7247.

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** $7,180
- **Patient pays** $360

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	$210
Coinsurance	$0
Limits or exclusions	$150
Total	**$360**

These examples are illustrative only. These examples assume that all providers are In-Network. Each provider involved may bill separately.

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

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

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	$360
Coinsurance	$0
Limits or exclusions	$40
Total	**$400**

These examples are illustrative only. These examples assume that all providers are In-Network. Copays apply per provider and per visit. Each provider involved may bill separately. Assumes that the first prescription will be filled at retail and mail order will be used thereafter and prescriptions will be filled with generic drugs.

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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