



Coverage for: Hudson Valley Credit Union, HD2800 Plan

 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 documents at [www.express-scripts.com](http://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 <a href="#">deductible</a> ?	Prescriptions other than those identified on the Preventative Generic Drug List for HVCU are subject to medical plan deductible. \$2,800 / single or \$5,600 / family.	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Drugs listed on Preventive Generic Drug List</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Included with Medical	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. You must use a network provider. For a list of preferred providers see <a href="http://www.express-scripts.com">www.express-scripts.com</a> or call the number on your prescription card	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	Not Applicable.

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO network (You will pay the least)	Non EPO network (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Specialist</a> visit	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Preventive care/screening/immunization</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not Covered	Not covered	The plan covers Prescription Drugs Only
	Imaging (CT/PET scans, MRIs)	Not Covered	Not covered	The plan covers Prescription Drugs Only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO network (You will pay the least)	Non EPO network (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition.</b></p> <p>More information about <a href="https://www.express-scripts.com/">prescription drug coverage</a> is available at <a href="https://www.express-scripts.com/">https://www.express-scripts.com/</a></p>	Generic drugs (Tier 1)	\$10 Copay per prescription (retail)*; \$30 Copay per prescription (mail order)*	Not Covered	<p>*Subject to the medical plan calendar year deductible with the exception of the Preventive Generic Drug List that will be immediately be subject to copays.</p> <p>The plan covers up to a 30 days' supply (retail prescription); 90 days' supply (mail order prescription). Mail order co-pays are 3 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.</p> <p>Coverage of certain infertility expenses will be covered through Carrot (up to \$45,000 lifetime combined medical/Rx maximum); for more information please refer to the Carrot Infertility HRA Plan Document.</p> <p>Some specialty drugs qualify for copay assistance (Administered by Accredo Specialty Pharmacy). You can contact Accredo at (800) 803-2523.</p>
	Preferred brand drugs (Tier 2)	\$35 Copay per prescription (retail)*; \$105 Copay per prescription (mail order)*		
	Non-preferred brand drugs (Tier 3)	\$75 Copay per prescription (retail)*; \$225 Copay per prescription (mail order)*		
	<a href="#">Specialty drugs</a> (Tier 4 Administered by Accredo)	20% Coinsurance per prescription (30-day maximum supply)		
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not covered	The plan covers Prescription Drugs Only
	Physician/surgeon fees	Not Covered	Not covered	The plan covers Prescription Drugs Only
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO network (You will pay the least)	Non EPO network (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Urgent care</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not Covered	Not covered	The plan covers Prescription Drugs Only
	Physician/surgeon fee	Not Covered	Not covered	The plan covers Prescription Drugs Only
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	Not Covered	Not covered	The plan covers Prescription Drugs Only
	Inpatient services	Not Covered	Not covered	The plan covers Prescription Drugs Only
<b>If you are pregnant</b>	Office visits	Not Covered	Not covered	The plan covers Prescription Drugs Only
	Childbirth/delivery professional services	Not Covered	Not covered	
	Childbirth/delivery facility services	Not Covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		EPO network (You will pay the least)	Non EPO network (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Rehabilitation services</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Habilitation services</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Skilled nursing care</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Durable medical equipment</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
	<a href="#">Hospice service</a>	Not Covered	Not covered	The plan covers Prescription Drugs Only
<b>If your child needs dental or eye care</b>	Children's eye exam	Not Covered	Not covered	The plan covers Prescription Drugs Only
	Children's glasses	Not Covered	Not covered	The plan covers Prescription Drugs Only
	Children's dental check-up	Not Covered	Not covered	The plan covers Prescription Drugs Only

## Excluded Services & Other Covered Services:

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

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"><li>• Hair Growth Stimulants</li><li>• Injectable/Implantable Medications (unless specified)</li></ul> | <ul style="list-style-type: none"><li>• Infertility (Coverage through Carrot)</li><li>• Medical Foods – Rx and OTC (i.e. Foltx, Deplin)</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Standard Rx/OTC Equivalents</li></ul> |
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**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#) or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program may help you file your [appeal](#). A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

### Does this [plan](#) Provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this [plan](#) Meet the Minimum Value Standard? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-826-9781.

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

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost](#) the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby (9 months of in network pre natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,800
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$5,070</b>

### Managing Joe's Type 2 Diabetes (a year of routine in network care of a well controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,800
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1,100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$5,400</b>

### Mia's Simple Fracture (in network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,800
■ <a href="#">Specialist coinsurance</a>	30%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,810</b>

\*Health Reimbursement Account (HRA) will reimburse up to \$750 of a member expense

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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