# Coverage for: Hudson Valley Credit Union, Premium 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 or by calling the number on the back of your pharmacy card.**

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $100 deductible per member per year for non-formulary brand drugs. $100 deductible per member per year for Generic or Formulary drugs whose Cost is equal to or greater than $1,000 retail or $3,000 mail order. $150 deductible for specialty drugs. | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible. |
| **Are there services covered before you meet your deductible?** | No. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out–of–pocket limit for this plan?** | Included with Medical | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out–of–pocket limit?** | Penalties, premiums, balance billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. You must use a network provider. For a list of preferred providers see www.express-scripts.com or call the number on your prescription card | This plan uses a provider network. You will pay less if you use a provider in the plan's network. Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | 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 provider's office or clinic** | Primary care visit to treat an injury or illness | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Specialist visit | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Preventive care/screening/ immunization | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| **If you have a test** | Diagnostic test (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) | |
| **If you need drugs to treat your illness or condition.**<br><br>More information about prescription drug coverage is available at https://www.express-scripts.com/ | Generic drugs (Tier 1) | $10 Copay per prescription (retail);<br>$30 Copay per prescription (mail order) | Not Covered | 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.<br><br>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.<br><br>Some specialty drugs qualify for copay assistance (Administered by Accredo Specialty Pharmacy). You can contact Accredo at (800) 803-2523. |
| | Preferred brand drugs (Tier 2) | $35 Copay per prescription (retail);<br>$105 Copay per prescription (mail order) | | |
| | Non-preferred brand drugs (Tier 3) | $75 Copay per prescription (retail); $225 Copay per prescription (mail order) | | |
| | Specialty drugs (Tier 4 Administered by Accredo) | 20% Coinsurance (30-day maximum supply) | | |
| **If you have outpatient surgery** | 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 |
| **If you need immediate medical attention** | Emergency room care | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Emergency medical transportation | 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) | |
| | Urgent care | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| **If you have a hospital stay** | 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 |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Inpatient services | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| **If you are pregnant** | 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) | |
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Rehabilitation services | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Habilitation services | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Skilled nursing care | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Durable medical equipment | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| | Hospice service | Not Covered | Not covered | The plan covers Prescription Drugs Only |
| **If your child needs dental or eye care** | 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.) | | |
|---|---|---|
| • Hair Growth Stimulants | • Infertility (Coverage through Carrot) | • Private-duty nursing |
| • Injectable/Implantable Medications (unless specified) | • Medical Foods – Rx and OTC (i.e. Foltx, Deplin) | • Standard Rx/OTC Equivalents |

**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. 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 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. 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 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, kwiijigo 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 s
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 plan's overall deductible | $1,000 |
| Specialist *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**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)*

| Total Example Cost | $18,000 |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $250 |
| Coinsurance | $1,250 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,500** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**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)*

| Total Example Cost | $5,600 |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $500 |
| Pharmacy | $1,000 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,500** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist *copayment* | $50 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| Total Example Cost | $2,800 |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $600 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$900** |

The plan would be responsible for the other costs of these EXAMPLE covered services.