MEMBER BENEFITS
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Working to Benefit You

Dear Group Catastrophe Major Medical (CMM) Plan Participant:

Enclosed are your Summary of Benefits and Coverage (SBC) for your Catastrophe Major Medical (CMM) Plan sponsored by the NYSUT Member Benefits Trust and the Glossary of Health Coverage and Medical Terms. Both documents are being issued in accordance with requirements under the Patient Protection and Affordable Care Act (ACA).

The federal government developed the SBC primarily to help people who will be shopping for individual coverage in the marketplace/exchange that opened in October 2013. It was designed so that individuals can compare "apples to apples" when comparing plans; for that reason, we are not allowed to customize the SBC.

The ACA has some very strict requirements for producing the SBC, including a maximum number of pages, font size, colors, etc. In addition, included in the SBC are two examples: one for having a baby and one for managing type 2 diabetes. The benefits of your CMM Plan are intended to supplement the benefits of your basic health plan(s). Since the SBC is in the required format, it does not reflect any benefits payable by your basic plan(s) nor do the Coverage Examples reflect any portion of the costs, which may have been paid by your basic plan(s).

The Glossary of Health Coverage and Medical Terms provides definitions of common medical terms. If you have specific questions concerning your benefits under the CMM Plan, please refer to your Plan Document. To more comprehensively evaluate your insurance coverage, we recommend that you review the Summary of Benefits and Coverage for both your basic plan(s) and this plan simultaneously.

If you have any questions regarding your CMM Plan and how it supplements your basic health plan(s), please contact The Preferred Group, the plan administrator, at 800-573-7474. Thank you.

Sincerely,

NYSUT Member Benefit Trust
Plan Sponsor

(more)

Grandfathered Plan

The NYSUT Member Benefits Trust believes that the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act such as the elimination of lifetime limits on certain benefits.

Questions regarding which protections do or do NOT apply to a grandfathered health plan and what might cause a plan to change its grandfathered health plan status can be directed to the Plan Administrator at the information above. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, toll-free at 866-444-3272 or visit www.dol.gov/ebsa/healthreform. Please note that this website has a table summarizing which protections do and do NOT apply to grandfathered health plans.

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 by calling **The Preferred Group at 800-573-7474**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	If covered by a basic plan: Greater of the benefits of the Basic Plan or Covered Charges that total $25,000 incurred in a dedicated Accumulation Period. If not covered by a basic plan: Amount equal to covered charges incurred for the first 70 days of hospital confinement; the first $10,000 of radiation, chemotherapy, physical or speech therapy; the first $50,000 of services provided by all medical practitioners; and the first $2,500 of out-of-hospital Rx drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the deductible starts. 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?	No.	Not applicable because the Plan does not have an **out-of-pocket limit**.
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, such as office visits.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.
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 5. See your Plan Document for additional information about **excluded services**.

Questions: Call **The Preferred Group at 800-573-7474.**
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.dol.gov/ebsa/healthreform or call **The Preferred Group at 800-573-7474** to request a copy.

- **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 not 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	$0 after deductible plus amounts in excess of the allowance for the Covered Charge.	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is: for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Specialist visit	$0 after deductible	
	Other practitioner office visit	$0 after deductible	
	Preventive care/screening/immunization	No charge for well child visits up to age 19; all other services not covered* $0 after deductible[2]	*Age and frequency limitations apply. [2]Mammography & cytologic screening
If you have a test	Diagnostic test (x-ray, blood work)	$0 after deductible plus amounts in excess of the allowance for the Covered Charge.	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is: for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Imaging (CT/PET scans, MRIs)	$0 after deductible plus amounts in excess of the allowance for the Covered Charge.	

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need drugs to treat your illness or condition	Prescription drugs	$0 after deductible	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is: for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is: for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Physician/surgeon fees	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	
If you need immediate medical attention	Emergency room services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is: for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Emergency medical transportation	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	
	Urgent care	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is: for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Physician/surgeon fee	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is: for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Mental/Behavioral health inpatient services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	
	Substance use disorder outpatient services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	
	Substance use disorder inpatient services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	
If you are pregnant	Prenatal and postnatal care	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Delivery and all inpatient services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Limited to up to 1,200 hours/year during a benefit period (e.g., 300 visits at four (4) hours per visit). The duration and frequency may vary. Benefits payable when physician approved care is provided by a Home Health Care Agency certified by a state dept of health or as defined in Title XVIII of the Social Security Act. Physician prescribed treatment plan and daily log is required.
	Rehabilitation services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Habilitation services	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covered Charges include cumulative benefit payments and/or allowable out-of-pocket costs. The Allowance for Covered charges is for any provider who is in-network under a Basic Plan, the amount paid to the in-network provider; for all other providers, the Reasonable and Customary (R&C) amount allowed for a claim as determined by the Claim Administrator.
	Skilled nursing care	15% coinsurance after deductible plus amounts in excess of the allowance for the Covered Charge	Private Duty Nursing (up to $120 per 8 hour shift ($360/day) and maximum of $35,000 while insured.)
	Durable medical equipment	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Covers artificial limbs, crutches, wheel chairs and other medical equipment, appliances and supplies as medically necessary.

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
	Hospice service	$0 after deductible plus amounts in excess of the allowance for the Covered Charge	Limited to 210 hospice days/benefit period and 5 visits/benefit period for bereavement counseling to the family of the terminally ill person.
If your child needs dental or eye care	Eye exam	Not covered	You pay 100% of these costs. Charges for these services will be considered Covered Charges only if they result from a Non-Job Related Injury and the injury is caused by an accident which occurs while the participant is covered.
	Glasses	Not covered	You pay 100% of these costs.
	Dental check-up	Not covered	You pay 100% of these costs. Charges for these services will be considered Covered Charges only if they result from a Non-Job Related Injury to natural teeth and the injury is caused by an accident which occurs while the participant is 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.)

- Dental care, treatment or surgery (Adult) (except if they result from a non-job related injury to natural teeth; and the injury is caused by an accident which occurs while the person is covered under the Plan.)
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.)

- Acupuncture (if medically necessary and performed by a properly licensed physician)
- Bariatric Surgery (if medically necessary)
- Cosmetic surgery (only if result of non-job related injury or sickness or congenital disease or anomaly of a child resulting in functional defect.)
- Infertility treatment (for treatment of a medical condition which exhibits specific symptoms)
- Long-term care (covered charges for care in a convalescent home or custodial care facility up to $500 per week and maximum of $80,000 while insured; benefits begin on 6th day of confinement.)

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 Preferred Group, the plan administrator, at 800-573-7474. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Mercer Consumer, P.O. Box 14437, Des Moines, IA 50306-3437, Phone: 888-386-9788; or The Preferred Group, the plan administrator, at P.O. Box 15136, Albany, NY 12212, Phone: 800-573-7474.

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 not meet the minimum standard for the benefits it provides**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-348-6908.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-348-6908.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** -800-348-6908.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-348-6908.

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** $0
- **Patient pays** $7,540

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	$7,540
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$7,540**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $0
- **Patient pays** $5,400

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	$5,400
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,400**

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 Preferred Group at 800-573-7474.**
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