Coverage for: Hudson Valley Credit Union, HD5000 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?	Prescriptions other than those identified on the Preventative Generic Drug List for HVCU are subject to medical plan deductible. $5,000 / single or $10,000 / family.	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?	Yes. Drugs listed on Preventive Generic Drug List are covered before you meet your deductible.	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. More information about prescription drug coverage is available at Caremark.com and Caremark.com/90day	Generic drugs (Tier 1)	$10 Copay per prescription (retail)*; $30 Copay per prescription (mail order)*	Not Covered	*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. 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. 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. 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)*; $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 per prescription (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

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)	
	Emergency medical transportation	Not Covered	Not covered	The plan covers Prescription Drugs Only
	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 sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare 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	$5,000
Specialist *coinsurance*	20%
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$6,070**

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

The plan's overall deductible	$5,000
Specialist *coinsurance*	20%
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$600
The total Joe would pay is	**$5,600**

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

The plan's overall deductible	$5,000
Specialist *coinsurance*	20%
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	**$2,810**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,810**

*Health Reimbursement Account (HRA) will reimburse up to $1,000 of a member expense

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

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