

# P/NW Health Benefits Consortium

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<http://www.pnwboces.org/hbc/hbc.htm>

200 BOCES Drive, Yorktown Hts. NY 10598

<http://www.aetna.com/index.htm>

Aetna customer service – 1-877-223-1685

## JOINT GOVERNANCE BOARD AUTHORIZES COVERAGE FOR ROUTINE COLONOSCOPIES

Effective January 1, 2008, the Plan will cover routine colonoscopies, subject to the following limitations:

- One routine colonoscopy every ten (10) years shall be allowed for members age fifty (50) and older;
- Non-routine colonoscopies (when medically necessary and provided for the treatment or diagnosis of an active illness or disease) will not be limited by age;
- Routine colonoscopies shall be subject to copayments and/or deductibles and coinsurance

## PROVIDERS WHO OPT OUT OF MEDICARE

Occasionally, medical providers will opt out of Medicare. This means that they will not accept Medicare's allowable fee limits and are then precluded from billing Medicare at all for at least 2-years. Physicians who opt out must clearly inform their patients. Please be aware that if you receive services from a provider who does opt out of Medicare, the health plan will pay no more for your claims than would have been paid had you visited a provider who accepts Medicare assignment.

## DEDUCTIBLES / COPAYMENTS / OUT-OF-POCKET (OOP) Effective January 1, 2008

Hospital deductible– Inpatient	\$100 per admission
Hospital deductible– Outpatient (emergency room or surgery)	\$50 per visit
Hospital deductible– Outpatient (other than emerg. rm. or surgery)	\$15 per visit
Medical deductible (out of network)– per individual	\$375* per calendar year
Medical deductible (out of network)– maximum per family	\$1,125* per calendar year
Office visit copay (in network)	\$15 per visit
Laboratory/ Radiology copay (in network)	\$10 per day
Preferred generic prescription drug copay (#see note below)	\$10 per fill
Preferred brand name prescription drug copay (#see note below)	\$20 per fill
Non-preferred prescription drug copay (#see note below)	\$30 per fill
Maximum Medical Out-Of-Pocket (in or out of network)	\$2,244* per year
Maximum Prescription Drug Out-Of-Pocket	\$1,000 per year

\*Medical services deductibles and out-of-pocket maximums are indexed each year based upon the Plan's annual cost increases. Deductibles and Out of Pocket maximums shall not be subject to limitation based upon comparison with the New York State Health Insurance Plan

# Retail pharmacy dispensing quantities generally limited to 30 days

# Mail order pharmacy dispensing quantities generally limited to 90 days

## **DEDUCTIBLES & OUT-OF-POCKET (OOP) EXPENSES**

After the deductible is met for out-of-network medical services, members are generally responsible for 20% of allowed charges. For in-network medical services, members are generally responsible for the above copayments. Once the accumulated coinsurance and copayments paid by the member, and/or member's family, reach a certain amount, the member and his family are no longer responsible for most coinsurance or copayments for the remainder of the calendar year. Effective January 1, 2008, this amount is \$2,244.

**Hospital (inpatient or outpatient) copayments, and prescription drug copayments are not considered for the above limit. There is a separate maximum OOP for prescription drug expenses: \$1,000. Charges not allowed under the plan, such as amounts that exceed reasonable and customary limits are also not considered for the above limit.** The medical out-of-pocket maximum is indexed each year based upon the Plan's annual cost increases.

## **DEPENDENT COVERAGE**

**Reminder:** It is the member's responsibility to notify his/her district benefits office when a dependent loses eligibility for coverage. This includes divorce or when a college student leaves or graduates from school. Additionally, changes that affect benefits coordination must be reported in a timely manner (generally within 60 days). These include spouses who start new jobs or enroll or lose coverage in other health insurance plans.

## **PRESCRIPTION DRUG SECONDARY CLAIMS**

When members or their dependents are covered by another prescription drug insurance plan that is primary to the Consortium's plan, they may be entitled to a supplemental benefit.

When you or your dependents purchase a drug, the Consortium requires you to pay a copayment of \$10 (GENERIC), \$20 (PREFERRED BRAND) or \$30 (NON-PREFERRED BRAND). If you paid more after your primary insurance processed the claim, then you may submit a supplemental claim to Aetna. A copy of the primary payer's explanation of benefits plus a copy of the pharmacy's receipt should be attached to a claim form and sent to the below address.

**Attn. Claims Processing  
Aetna Pharmacy Management  
PO Box 14024  
Lexington, Ky. 40512**

Claim forms may be obtained from the Consortium's web site  
(<http://www.pnwbooces.org/hbc/Forms.htm>). **Please ensure correct address is used.**

## **WOMEN'S HEALTH and CANCER RIGHTS ACT of 1998**

This notice is provided to inform members that when the health plan provides benefits for a mastectomy, the following benefits are also available to members who elect breast reconstruction surgery following the mastectomy:

- Reconstruction of the breast on which a mastectomy was performed;
- Necessary surgery and reconstruction of the other breast in order to achieve a symmetrical appearance; and
- Prostheses, special bras and coverage of complications of all stages of mastectomy including lymphedemas.

This coverage is subject to the same deductibles, coinsurance/ copayments that apply to other medical and surgical benefits covered under the plan.