

# Catastrophe Major Medical Plan

## 2018 Plan Highlights

Sponsored by NYSUT Member Benefits Catastrophe Major Medical Insurance Trust  
Policy #: CMMI-003

Regardless of your age or the type of basic medical insurance you have, you and your family members could still be left with extraordinary out-of-pocket medical expenses. This is especially true if you have a serious medical issue, are confined to a nursing home/convalescent care facility for convalescent or custodial care, or need home health care.

The Catastrophe Major Medical (CMM) Plan offers supplemental coverage you and your eligible family members may need. Once the deductible is satisfied, this plan provides benefits for eligible expenses that your basic plan may not fully cover. You should review your personal coverage to determine how this plan can help serve your needs.

### Why would I need the CMM Plan?

#### ***Out-of-Pocket Medical Expenses***

The CMM Plan is designed to help with expenses not fully covered by your basic major medical, prescription drug or hospitalization insurance – including Medicare. Your basic coverage may provide adequate health insurance protection but may limit benefits. The CMM Plan was designed to help pay in excess of your basic coverage after satisfying an annual deductible. Certain benefit categories and out-of-network benefits have specific limits as described below.

Expenses must be medically necessary and for services and/or supplies ordered by a physician. Examples of eligible expenses include:

- Co-payments, co-insurance and deductibles from your basic health plan;
- Prescription drug co-pays or co-insurance costs;
- Home health care;
- Durable medical equipment;
- Private duty nursing;
- Nursing/Convalescent care; and more.

#### ***Limited Nursing/Convalescent Home Benefits***

##### **Up to \$500 Per Week – \$80,000 Lifetime Maximum Benefit**

Anyone at any age can require convalescent or custodial care in a nursing home. However, this type of benefit is not included in many health insurance plans.

Should any insured family member become confined as an inpatient in a nursing home for convalescent or custodial care due to a covered accident or illness, this plan pays room and board, general convalescent care, services, and supplies up to \$500 per week with an \$80,000 lifetime maximum benefit. Confinement must be prescribed by an attending physician and benefits will begin on the 20th day of convalescent care confinement provided by a Medicare-certified facility. Benefits will not be paid unless a Medicare-certified facility is used.

A nursing home or convalescent home means a licensed facility that has, on its premises, organized facilities to care for and treat its patients; a staff of physicians to supervise such care and treatment; and a registered nurse on duty at all times. A nursing home or convalescent home does not mean a place, or part of one, that is used mainly for the aged; treatment of substance use/abuse (alcohol/drug) disorders, or persons with mental, nervous or emotional disorders.

*NOTE: The CMM Plan is not considered to be long-term care coverage.*

***Home Health Care Benefits***

**Up to 25 Hours Per Week – 6,000 Hour Lifetime Maximum Benefit**

At some point in your life, you may require home health care. This plan provides coverage for up to 25 hours per week with a 6,000 hour lifetime maximum benefit. These visits may be for, among other things, part-time or intermittent home health care aide services, physical therapy, occupational therapy, or speech therapy. The visits must be under a program of care prescribed by the insured’s physician and provided by a home health care agency certified by a state department of health or Medicare.

(Please Note: If a home health care agency is used that is not certified by a state department of health or Medicare, you will be reimbursed for 20% of the eligible expenses (less any payment by your Basic Plan) up to the Plan’s maximum benefit.)

Home health care benefits are not dependent upon a prior nursing home or hospital stay. The home health care benefit will begin after 60 hours of paid home health care each calendar year.

**What is the deductible?**

***Annual Deductible***

The CMM Plan is designed to provide coverage for eligible medical expenses that are not covered by your Basic Plan or Medicare – after you satisfy your annual out-of-pocket deductible.

The deductible is the amount you owe each calendar year before this plan begins to pay benefits.

<b>Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>
Preventive Benefits	No deductible	No deductible
Overall Annual Out-of-Pocket Deductible	\$2,500/Individual \$5,000/Family	\$5,000/Individual
Custodial care in a Convalescent Home, Custodial Care Facility, Nursing Home, Assisted Living Facility or Skilled Nursing Facility	No deductible. Benefits start on the 20 <sup>th</sup> day of confinement. (This is not an annual requirement.)	No benefits for an Out-of-Network facility.
Home Health Care	No deductible. Benefits start after the 60 <sup>th</sup> hour of home health care has been paid.	No deductible. Benefits start after the 60th hour of home health care has been paid. The Plan then pays 20% of the eligible expenses (less any payment by your Basic Plan).

Non-eligible charges do not count toward the deductibles. Charges incurred In-Network are not counted toward the Out-of-Network deductible and charges incurred Out-of-Network are not counted toward the In-Network deductible.

## **What is the Benefit Period?**

### ***Benefit Period***

Benefit Period means the period of time during which benefits are payable. This Plan's Benefit Period is the calendar year and runs from January 1 to December 31.

## **How do In-Network and Out-of-Network benefits work?**

### ***Out-of-Network Benefits are Subject to Limits***

In general, Out-of-Network medical expenses will be limited to 70% of eligible expenses less payments made by the Basic Plan. Out-of-Network benefits include services or supplies provided by a physician, provider or facility that is not a member of your Basic Plan's Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO) or Health Maintenance Organization (HMO), and prescription drugs not listed on your Basic Plan's drug formulary list.

Out-of-Network home health care expenses will be limited to 20% of the eligible expenses (less any payment by your Basic Plan). Out-of-Network expenses for convalescent care are not covered by the CMM Plan.

## **How does the claim process work?**

### ***Submitting Claims***

The CMM claim process requires the claimant to complete a form and submit certain documentation, which may include Explanation of Benefits (EOB) statements from your basic health insurance plan(s), itemized bills from service providers and payment receipts.

## **What are the premiums?**

### ***CMM Plan Premiums***

See the rate schedule below. Premiums are based on the member's age and coverage level and will increase as the member ages. In addition, the Plan's trustees review the rates annually with the Plan's consultants to determine if rates require adjustments.

### **CMM ANNUAL PREMIUM**

Age	Member	Member + Spouse/DP	Member + Spouse/DP + Children	Member + Children
Under 40	\$ 82.90	\$165.81	\$264.55	\$181.64
40-49	\$165.75	\$331.50	\$430.24	\$264.49
50-59	\$268.42	\$536.83	\$635.57	\$367.16
60-64	\$408.56	\$817.13	\$915.87	\$507.30
65-69	\$453.93	\$907.86	\$1,007.82	\$553.89
70-74	\$501.62	\$1,003.24	\$1,108.17	\$606.55
75-79	\$565.74	\$1,131.47	\$1,240.29	\$674.55
80-84	\$634.60	\$1,269.19	\$1,386.56	\$751.97
85-89	\$641.35	\$1,282.70	\$1,401.28	\$759.93
90-94	\$648.06	\$1,296.12	\$1,415.97	\$767.91
95+	\$654.77	\$1,309.54	\$1,430.61	\$775.84

There are advantages to choosing payroll or pension deduction as your payment method.

Advantages to Payroll or Pension Deduction:

- 10% premium reduction;
- No checks to write; and
- No payment due dates to remember.

## **Who is eligible for coverage?**

### ***New Enrollments***

NYSUT members who meet the following requirements are eligible to enroll during an open enrollment period:

- 1) Currently reside in New York State;
- 2) Currently employed in a position where you are represented for purposes of collective bargaining by a NYSUT Affiliate; and
- 3) Covered by or insured under a Basic Plan (see definition below).

NYSUT members who qualify for coverage may also enroll their eligible dependents (e.g., spouse, domestic partner and children under the age of 30). Agency fee payers to NYSUT are also eligible to participate.

### ***Basic Plan Requirements***

All eligible NYSUT members and dependents must be covered by or insured under a Basic Plan. NYSUT members who were covered under the Plan on December 31, 2017 and their dependents who were covered on that date must be covered by a Basic Plan as that term was defined on December 31, 2017.

For all other participants, a Basic Plan means any and all of the following Plans in which an eligible participant is enrolled:

- New York State Health Insurance Program's Empire Plan (NYSHIP);
- New York City Health Insurance Program (NYC);
- Plan offered by Member's Employer (e.g., Article 47/Consortium plan, Article 43 plan or employer-sponsored plan) that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act;
- Other group health plan, including the group health plan of a spouse or dependent, that provides Minimum Essential Coverage and Minimum Value within the meaning of the Affordable Care Act; or
- For Medicare-eligible participants, Parts A and B or Part C (Medicare Advantage Plan).

You must have Basic prescription drug coverage in order for prescription drug benefits to be payable. If a participant is a Medicare-primary beneficiary, he or she must be enrolled in a Part D Plan or have Creditable prescription drug coverage (as defined by Medicare) through another Basic Plan. No benefits for prescription drugs will be payable under this Plan for individuals who are not enrolled in a prescription drug program.

A Basic Plan does not include an individual Plan either purchased on or off any state/federal Marketplace/Exchange.

## What else do I need to know before enrolling?

### *Important Details*

This document does not provide all details regarding the CMM Plan. To view the Plan's Summary of Benefits & Coverage (SBC), which summarizes important information about this supplemental health coverage, as well as the Plan's Notice of Privacy Practices, please visit [memberbenefits.nysut.org](http://memberbenefits.nysut.org) and click on "Insurance" and then "Catastrophe Major Medical." You may also contact Mercer Consumer, the Plan's Administrator, toll-free at **888-386-9788** to request a paper copy of both documents free of charge.

If a discrepancy arises between the Plan Highlights and the Plan Document, the Plan Document governs.

## How do I enroll?

### *How to Enroll*

The CMM Plan may offer an open enrollment period from time to time. After reviewing the details of the CMM 2018 Plan Highlights and the rate schedule, if you would like to enroll yourself and your eligible family members, complete the enrollment form and mail it with any required proof of dependent eligibility to the address below. **Please be sure to pay close attention to the open enrollment period, mailing deadline, billing information, and coverage effective date on the enrollment form.**

- 1) Complete, date and sign the enrollment form.
- 2) Make sure you list any eligible dependents you wish to insure and submit proof of eligibility.
- 3) Mail your completed enrollment form by the open enrollment period deadline to:  
NYSUT Member Benefits - CMM  
800 Troy-Schenectady Road  
Latham, NY 12110

If you are enrolled under this Plan and acquire a spouse, domestic partner or dependent child, you may request enrollment for them no later than 60 days after the marriage, birth, adoption, or placement for adoption.

**QUESTIONS...** if you have any questions, please contact Mercer Consumer toll-free at **888-386-9788**.