Central Southern Tier
Health Care Plan

-REMINDER-

Central Southern Tier Health Care Plan
Preferred Provider Organization (PPO)

As part of an ongoing process to review our Health Plan procedures, we are issuing this clarification regarding your benefits. We will be adhering to the procedures outlined in our Summary Plan Description (SPD), which are explained in further detail in this memo.

The Central Southern Tier Health Care Plan (CSTHP) utilizes a Preferred Provider Organization (PPO). A PPO is a health plan that has contracts with a group of "preferred" providers, which creates a "provider network." According to our Plan Document, our PPO Plan is designed to offer employees a higher level of benefit payment for services rendered by a medical service provider who is a member of the CSTHP Preferred Provider Organization (PPO). Our PPO Plan offers comprehensive coverage with access to participating providers across the country. Utilizing a provider within the network is the most efficient way to maximize the benefits for both the Health Care Plan and for you.

The PPO Plan also provides coverage for care rendered by providers who do not participate in either the local or national Preferred Provider Network. However, ***you may incur additional expenses*** based on the Plan's benefits for out-of-network care as well as provider balance billing, as explained below.

A copy of your Health Plan Summary is included with this reminder so that you may review your benefits.

How does the CSTHP Preferred Provider Organization work?

The CST Health Plan offers our members the freedom to choose any facility, physician or ancillary provider for your healthcare needs. However, using the services of a provider that participates in either our local or national provider network will provide you with the highest level of benefit reimbursement. You may be responsible for greater personal out of pocket expenses if you choose to use a non-participating provider and access out-of-network benefit levels.

To clarify, choosing a non-participating provider means that you are choosing to access your health care from a provider who does not participate in the CSTHP Preferred Provider Network. This means that you may incur higher out of pocket expenses than if you chose to use a participating provider.

"In-Network" Care

Medically necessary care rendered by a provider that participates with either our local or national PPO network is referred to as "in-network" care. Eligible in-network charges are either paid in full or subject to a small co-pay; refer to the Health Plan Summary for details.

To find a participating provider via the Internet, visit www.ebsrmsco.com, or you may call EBS RMSCO Customer Service at 1-877-254-3584. Network information, including telephone numbers and websites, is also available on the back of your Health Care Identification Card.

"Out-of-Network" Care

Medically necessary care rendered by a provider that does not participate with either our local or national PPO networks is referred to as "out-of-network" care. Eligible out-of-network allowable charges are subject to applicable out-of-network deductibles, co-pays and coinsurances. Refer to the Health Plan Summary for details.

After the "out-of-network" deductible has been met, the Plan will pay 80% of Usual, Customary and Reasonable (UCR) of the next $2,000 of covered expenses (other than prescription drugs) for out-of-network provider services. The member will be responsible for 20% of covered charges, to a maximum of $400 per covered person per calendar year. The member may also be responsible for any balance billing in excess of the Usual, Customary and Reasonable allowance for out-of-network services.

According to the provisions of the plan, an out-of-network allowable charge will be based on a Usual, Customary and Reasonable fee schedule. Usual, Customary and Reasonable (UCR) means the general level of charges billed by other practitioners or suppliers in the locality where the charge is incurred when providing like or comparable treatment, services or supplies.

Remember: if your out-of-network provider charges more than the Usual, Customary and Reasonable allowance, you may be balance-billed for these additional charges.

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Definitions:

In-Network Provider: A provider who agrees to participate in a group (physicians, hospitals, and ancillary providers) through which a partnership is formed with the Health Plan. This *network* of providers agrees to provide healthcare services at a negotiated price. The network for The Central Southern Tier Health Care Plan is the CSTHP Preferred Provider Organization (PPO).

In-Network Benefit: In-network benefits are paid at the higher level and are the most efficient way to maximize the benefits for both the Health Care Plan and for you, due to the negotiated contracted rates.

Out-of-Network Provider: A provider (physicians, hospitals, or ancillary provider) who does not participate in the network (in this case, the CSTHP Preferred Provider Organization (PPO)) and has not agreed to accept negotiated rates for services.

Out-of-Network Benefit: Out-of-network benefits are paid at a lower rate than in-network benefits. They are often subject to deductibles, coinsurance, and/or higher co-pays. Member may also be held liable by the provider to pay for amounts billed over the Usual, Customary and Reasonable allowance paid by the Plan.

Usual, Customary and Reasonable (UCR): aka R&C; Usual and Customary; Reasonable and Customary – refers to the "usual" fee charged by similar providers for the same services or supplies in the same geographical area (based on zip code, date of service and procedure). Plans will then pay a percentage of the UCR for out-of-network claims.

Balance Billing: The provider may bill an amount over the negotiated rate, or over the Usual, Customary and Reasonable allowance paid by the Plan. If a member utilizes care from an out-of-network provider, the provider may "balance bill" the member the difference between the original amount billed and the amount paid by the Plan. ***The member may be held responsible to directly reimburse the provider the amount billed above the Usual, Customary and Reasonable allowance, which would not have been paid by the plan.***

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Frequently Asked Questions:

Q: What provider networks are included in the CSTHP?

A: The local network is the Excellus Provider network, in partnership with two national networks – Beech Street and PHCS. In combination, these networks provide our members with access to over 500,000 participating providers across the country.

Q: How do I find out if my provider is participating in either the local or national CSTHP networks?

A: To find a participating provider via the Internet, visit www.ebsrmsco.com. Use the drop arrow at the top right hand side of the page; click and scroll down to search for a provider. Network information, including telephone numbers and websites, is also available on the back of your Health Plan Identification Card.

Q: What if my physician refers my care to an out-of-network provider or there is no physician in a particular specialty that participates with either our local or national PPO networks?

A: If there is no physician within a particular specialty in either the local or national PPO networks, or if your PPO physician refers you to an out-of-network provider, neither the out-of-network deductible or any applicable copayments will apply**. You must fill out a referral form to obtain these services at an in-network level.**

Note: if your out-of-network provider charges more than the Usual, Customary and Reasonable allowance, you may be balance-billed for these additional charges.

Q: How do I obtain a referral from my PPO provider to use the services of an out-of-network provider and have the deductible and copayments waived?

A: A referral form can be obtained from your district contact person or from your Plan Administrator. **You must submit an out-of-network referral form directly to RMSCO PRIOR TO YOUR FIRST DATE OF SERVICE.** The out-of-network deductible and copayment will be waived and benefits will be paid according to the "in-network" benefit level.

Note: if your out-of-network provider charges more than the Usual, Customary and Reasonable allowance, you may be balance-billed for these additional charges.

The referral form will remain in effect for the length of the illness if you continue to receive treatment from the same provider. ***If you intend to switch providers, or if you need to be treated for a different illness than indicated on the original referral form*, you must submit a new referral form.**

Remember – a referral form is a notification process; *it is not an approval for medical necessity*. Benefits will be paid according to the plan document.

Beginning February 1, 2013*, if you do not submit a referral form prior to your first date of service* with the out-of-network provider, all out-of-network covered charges will be subject to the out-of-network deductible and copayments. Out-of-network provider charges are subject to the Usual, Customary and Reasonable fee schedule. Note: if your out-of-network provider

charges more than the Usual, Customary and Reasonable allowance, you may be balance-billed for these additional charges. See Claims Payment examples.

Q: What if I am on vacation and need medical attention or have a dependent college student living outside the area?

A: Exceptions to the out-of-network benefit level are:

- Eligible members who receive necessary emergent medical care while vacationing outside of the network service area, or
- An enrolled covered dependent who receives necessary emergent medical care while in attendance as a full-time student at an accredited two or four year educational institution located outside of the network service area.

They will not be required to pay any out-of-network deductible or copayments, regardless of whether medical services were provided by an in-network provider or by an out-of-network provider. **Under such circumstances, the covered person should notify the Plan's Claims Administrator, RMSCO, as soon as possible prior to, or immediately following, treatment.** The Covered Person should make a reasonable effort to obtain service from an in-network provider, where available.

- A vacation is considered no more than thirty (30) days out of the area; please fill out an "On Vacation" form, which can be obtained from your district contact person.

Members can locate an in-network provider via the Internet at www.ebsrmsco.com, or by calling RMSCO at 1-877-254-3584.

Claims Inquiries
RMSCO
P.O. Box 6309
Syracuse, NY 13217
1-877-254-3584
8 am to 5 pm – Monday - Friday
www.resolutionz.com

Correspondence
RMSCO
115 Continuum Drive
Liverpool, NY 13088
1-877-254-3584
8 am to 5 pm – Monday - Friday
www.ebsrmsco.com

Note: Out-of-network provider charges will still be subject to the Usual, Customary and Reasonable fee schedule. If your out-of-network provider charges more than the Usual, Customary and Reasonable allowance, you may be balance-billed for these additional charges.

Q: How Do I Find Out What An Out-Of-Network Provider Will Charge?

A: You can ask your provider what procedure(s) and charge(s) he will be billing. You can then call RMSCO at 1-877-254-3584 to find out what their reimbursement is for the procedure(s). Remember that you may be held liable for any amounts billed above the Usual, Customary and Reasonable allowance that RMSCO will reimburse to the provider.

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Choosing a Provider:

Below are step-by-step directions for locating in-network providers and obtaining care at the highest level of benefits:

Locate an in-network provider:

www.ebsrmsco.com or 1-877-254-3584.

OR

If there is no physician within a particular specialty in either the local or national PPO networks, or if your PPO physician refers you to an out-of-network provider, you must:

a. Obtain an out-of-network referral form from your district contact or Plan Administrator.
b. Complete the form in advance of your treatment and submit it directly to RMSCO **prior to your first date of service.**
c. Upon receipt of the out-of-network referral form, RMSCO and the Plan Administrator will approve medically necessary out-of-network care.
d. If you intend to switch providers, or if you need to be treated for a different illness than indicated on the original referral form, you must submit a new referral form.
e. The out-of-network deductible and copays will be waived and eligible benefits will be paid at the in-network benefit level.

Remember that you may be held liable for any amounts billed above the Usual, Customary and Reasonable allowance that the Health Plan will reimburse to the provider.

f. To calculate your financial out-of-network responsibility in advance of your treatment, ask the provider what procedure code(s) and charge(s) he will be billing. Contact RMSCO at 1-877-254-3584 to find out what their reimbursement is for the procedure(s). Remember that you may be held liable for any amounts billed above the Usual, Customary and Reasonable allowance that the Plan will reimburse to the provider.

OR

You may have your provider file a predetermination claim with RMSCO prior to the services actually being rendered.

g. After your services are rendered, you will receive an Explanation of Benefits (EOB) from the Plan detailing how the claim was paid.
h. It is your responsibility to pay directly to the out-of-network provider any deductibles, copays, or amounts billed over Usual, Customary and Reasonable.

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Claims Payment Examples:

Mary is a member of the Central Southern Tier Health Care Plan. Below is an example of how her care would be paid in-network and out-of-network:

In-Network

Service	Charge	In-Network Negotiated Rate	Member Co-pay	Plan Payment	Member Responsibility
Office Visit	$100	$72	$10	$62	$10
In-Patient Stay	$2500	$1365	$0	$1365	$0
X-Ray - Outpatient	$250	$200	$0	$200	$0
Labwork – Outpatient	$180	$150	$0	$150	$0

Total Plan Payment: $1777

Total Member Responsibility: $10

Out-of-Network

Service	Charge	UCR	80% of UCR	Patient Deductible/ Co-pay	Plan Payment	Amount over 80% of UCR	Member Responsibility
Office Visit	$100	$85	$68	$68	$0	$17	$100
In-Patient Stay	$2500	$1880	$1440	$432	$1008	$1060	$1492
X-Ray - Outpatient	$250	$220	$176	$0	$176	$74	$74
Labwork – Outpatient	$180	$160	$128	$0	$128	$52	$52

Total Plan Payment: $1312

Total Member Responsibility: $1718

Above is an example. Member responsibility will vary depending on the type of claims submitted. Remember, your provider may obtain a plan payment predetermination from RMSCO prior to services being rendered.