Group Catastrophe Major Medical Plan

Plan Highlights – Policy #: CMMI-004

Effective January 1, 2023

Sponsored by NYSUT Member Benefits Catastrophe Major Medical Insurance Trust

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. While your basic coverage may provide adequate insurance protection, some benefits may be limited. 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 that you and your eligible family members may need. Once the deductible has been satisfied, this plan provides benefits for eligible expenses that your basic plan does 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?

The CMM Plan is designed to reimburse you for out-of-pocket expenses not fully covered by your basic major medical, prescription drug or hospitalization insurance – including Medicare - after you satisfy the annual deductible. As described below, certain benefit categories and out-of-network benefits have specific limits, and certain benefits categories are not subject to the annual deductible.

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.

$2,500 Critical Illness Benefit

If you are diagnosed with a critical illness on or after your coverage effective date, you will be paid a one-time lump sum of $2,500 to help cover the additional costs of increased medical care. The money can go toward visiting family members' airfare costs, an upgraded hospital room, bills that would go unpaid due to loss of income… whatever you may need. Critical illnesses are defined in the Plan Document and include a heart attack, stroke, terminal illness, cancer, quadriplegia, major organ transplant, or coronary bypass surgery. No Deductible applies to this benefit, and it is payable one time per covered individual while eligible for benefits under the Plan.

Nursing/Convalescent Home Benefits

Up to $72 per Day – $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 reimburses room and board, general convalescent care, services, and supplies (less any payment by your Basic Plan) up to $72 per day 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 or, in the case of an Assisted Living Facility, a facility licensed to operate under the laws of the state in which it is located.

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; people with substance use/abuse (alcohol/drug) disorders; or people 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 calendar 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 that is Medicare-certified or licensed or certified by a state department of health or other regulatory authority responsible for licensing or certifying home health care agencies.

Please Note: If a home health care agency is used that is not Medicare-certified or licensed or certified by a state's regulatory authority, you will be reimbursed for 30% 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 Plan's 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 reimburse you for your eligible expenses.

Description	In-Network	Out-of-Network
Preventive Benefits	No deductible	No deductible
Overall Annual Out-of-Pocket Deductible	$2,000/Individual $4,000/Family	$5,000/Individual
Critical Illness Benefit	No deductible	No deductible
Custodial care in a Convalescent Home, Custodial Care Facility, Nursing Home, Assisted Living Facility or Skilled Nursing Facility	No deductible. Benefits start on the 20th day of confinement. (This is not an annual requirement.)	No benefits for an Out-of-Network facility.

Description	In-Network	Out-of-Network
Home Health Care	No deductible. Benefits start after the 60th hour of home health care has been paid each calendar year.	No deductible. Benefits start after the 60th hour of home health care has been paid each calendar year. The Plan then pays 30% 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 Plan's Benefit Period?

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

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

In general, In-Network medical expenses are reimbursed at 100% of eligible expenses less payments made by the Basic Plan, and Out-of-Network medical expenses are reimbursed at 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).

Reimbursement for Out-of-Network home health care expenses (i.e., if you use a home health care agency that is not Medicare-certified or licensed or certified by a state's regulatory authority) will be limited to 30% of the eligible expenses (less any payment by your Basic Plan), up to the maximum benefit. Out-of-Network expenses for convalescent care are not covered by the CMM Plan.

How does the claim process work?

The CMM claim process requires the claimant to complete a claim form and submit certain documentation to **HealthSmart Benefit Solutions, Inc**. - the Administrator responsible for **claims processing and coordination of appeals** for benefit period effective dates of January 1, 2018 and beyond. Documentation may include Explanation of Benefits (EOB) statements from your basic health insurance plan(s), itemized bills from service providers and payment receipts. Visit the HealthSmart website at ***healthsmart.com/nysut*** or contact them toll-free at **844-552-7805.**

Who is eligible to enroll in the Group CMM Plan?

Each Group Purchaser decides who is eligible for coverage. For example, a Group Purchaser may choose to cover only Group Members; another Group Purchaser may allow Group Members' dependents, such as a spouse, domestic partner and/or children, to enroll.

If your Group Purchaser has elected to make coverage available to your dependents, and if you (the Group Member) acquire a new dependent through a "life event" such as marriage, birth, adoption, or placement for adoption, enrollment must be requested within 60 days after the event. Notify your Group Purchaser of the request and provide proof of dependent status (as applicable).

As of January 1, 2019, retired individuals are not eligible to be enrolled by Group Purchasers as new Group Members, and Group Members who retire on or after that date will no longer be eligible to participate.

What is the CMM Plan's Basic Plan requirement?

All eligible participants and dependents must be covered by or insured under a basic health plan (Basic Plan). Group 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, the participant 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;
- Medicaid;
- A State Children's Health Insurance Plan (CHIP); or
- TRICARE.

What else do I need to know?

This document does not provide all details regarding the CMM Plan. The following documents are available free of charge at ***memberbenefits.nysut.org*** and clicking on "Groups/Locals/Funds," then "Programs for Groups" and then "Group Catastrophe Major Medical Plan" or by contacting NYSUT Member Benefits at **800-626-8101**.

- Summary of Benefits & Coverage (SBC), which summarizes important information about this supplemental health coverage; and
- The Plan's Notice of Privacy Practices

If a discrepancy arises between this document and the Group CMM Plan Document, the Group CMM Plan Document governs.

If you have any questions or would like to request another copy of the Group CMM Plan Document (Policy #CMMI-004), please contact NYSUT Member Benefits CMM Insurance Trust at **800-626-8101**.