# PSSU LOCAL UNIT HEALTH AND WELFARE FUND – Huntingdon Area School District

**Coverage Period: 05/01/2015 – 4/30/2016**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Family | Plan Type: Dental

**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 document by visiting http://pssuhwfund.org or calling the Fund office at (717)526-4856 or (888)243-1524.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $0 | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | Yes, $25/individual and $75/family for certain dental care. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| **Is there an out–of–pocket limit on my expenses?** | No | There's no limit on how much you could pay during a coverage period for your share of the cost of covered services. |
| **What is not included in the out–of–pocket limit?** | This plan has no **out-of-pocket limit**. | Not applicable because there's no **out-of-pocket limit** on your expense. |
| **Is there an overall annual limit on what the plan pays?** | No | The chart starting on page 2 describes any limits on what the plan will pay for specific covered services. |
| **Does this plan use a network of providers?** | Yes. For a list of participating providers, see http://pssuhwfund.org or call (888)243-1524 | If you use an in-network provider, this plan will pay some or all the costs of covered services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**NOTE: THIS SUMMARY ONLY COVERS YOUR DENTAL BENEFITS. YOU MIGHT RECEIVE A SEPARATE SUMMARY FROM YOUR EMPLOYER DESCRIBING YOUR MEDICAL BENEFITS.**

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not Covered | Not Covered | --- none --- |
| | Specialist visit | Not Covered | Not Covered | --- none --- |
| | Other practitioner office visit | Not Covered | Not Covered | --- none --- |
| | Preventive care/screening/immunization | Not Covered | Not Covered | --- none --- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not Covered | Not Covered | --- none --- |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Not Covered | --- none --- |
| **If you need drugs to treat your illness or condition** | Generic drugs | Not Covered | Not Covered | --- none --- |
| | Preferred brand drugs | Not Covered | Not Covered | --- none --- |
| | Non-preferred brand drugs | Not Covered | Not Covered | --- none --- |
| | Specialty drugs | Not Covered | Not Covered | --- none --- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | --- none --- |
| | Physician/surgeon fees | Not Covered | Not Covered | --- none --- |
| **If you need immediate medical attention** | Emergency room services | Not Covered | Not Covered | --- none --- |
| | Emergency medical transportation | Not Covered | Not Covered | --- none ---- |
| | Urgent care | Not Covered | Not Covered | --- none --- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Covered | Not Covered | --- none --- |
| | Physician/surgeon fee | Not Covered | Not Covered | --- none --- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Not Covered | Not Covered | --- none --- |
| | Mental/Behavioral health inpatient services | Not Covered | Not Covered | --- none --- |
| | Substance use disorder outpatient services | Not Covered | Not Covered | --- none ---- |
| | Substance use disorder inpatient services | Not Covered | Not Covered | --- none --- |
| **If you are pregnant** | Prenatal and postnatal care | Not Covered | Not Covered | --- none --- |
| | Delivery and all inpatient services | Not Covered | Not Covered | --- none --- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not Covered | --- none --- |
| | Rehabilitation services | Not Covered | Not Covered | --- none --- |
| | Habilitation services | Not Covered | Not Covered | --- none --- |
| | Skilled nursing care | Not Covered | Not Covered | --- none --- |
| | Durable medical equipment | Not Covered | Not Covered | --- none --- |
| | Hospice service | Not Covered | Not Covered | --- none --- |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | --- none --- |
| | Glasses | Not Covered | Not Covered | --- none --- |
| | Dental check-up | $25 deductible/person<br>$75 deductible/family<br>(not applicable to diagnostic or preventive care).<br>20% coinsurance for major restorative services. | Reimbursement based on non-participating provider schedule.<br>20% coinsurance for major restorative services. | Annual maximum: $1,000 per individual.<br>Orthodontia: not covered. |

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## Excluded Services & Other Covered Services:

| **Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.) | | |
|---|---|---|
| • Acupuncture | • Hearing aids | • Private-duty nursing |
| • Bariatric Surgery | • Infertility treatment | • Routine eye care (adult) |
| • Chiropractic care | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

| **Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) |
|---|
| • Dental care (adult) |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Fund office at (717)526-4856 or (888)243-1524. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Humman Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice or assistance, you can contact the Fund office at (717)526-4856 or (888)243-1524. Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Consumer Assistance Program of the Pennsylvania Insurance Department at (877)881-6388.

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

**Amount owed to providers:** $ 7,540
- **Plan pays** $0
- **Patient pays** $7,540

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $7,540 |
| **Total** | **$7,540** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

**Amount owed to providers:** $5,400
- **Plan pays** $0
- **Patient pays** $5,400

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $0 |
| Coinsurance | $0 |
| Limits or exclusions | $5,400 |
| **Total** | **$5,400** |

Note: These numbers assume the patient does not have medical insurance. If the patient has medical insurance, his costs may be lower. For more information please call (717)526-4856 or (888)243-1524.

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# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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