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.
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 pharmacy, 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 PRESCRIPTION, DENTAL AND VISION 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 ---

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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 need drugs to treat your illness or condition **More information about prescription drug coverage is available at http://pssuhwfund.org or call (717)526-4856 or (888)243-1524**	Generic drugs	$3 copay/prescription for 30-day retail supply; $3 copay/prescription for 90-day mail order supply	Full price of prescription with reimbursement of network pharmacy cost less applicable copay.	Some drugs may require prior authorization. If the necessary prior authorization is not obtained, the drug may not be covered. Plan allows for two retail fills of a maintenance medication, then must use mail-order. For brand drugs, if a generic is available, you will pay the cost difference between the brand and generic plus applicable copay.
	Preferred brand drugs	$5 copay/prescription for 30-day retail supply; $10 copay/prescription for 90-day mail order supply	Full price of prescription with reimbursement of network pharmacy cost less applicable copay.	
	Non-preferred brand drugs	$15 copay/prescription for 30-day retail supply; $30 copay/prescription for 90-day mail order supply)	Full price of prescription with reimbursement of network pharmacy cost less applicable copay.	
	Specialty drugs	Same as retail copays	Not Covered	Must be filled by Accredo, which is Express Scripts's specialty pharmacy.
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 ---

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 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	No charge	Reimbursement based on non-participating provider schedule	Once every 12 months
	Glasses	No charge	Reimbursement based on non-participating provider schedule	Frames: once every 24 months Lenses: once every 12 months Additional cost for extra materials (e.g., UV coating) and for frames in excess of allowance. Contact lenses (cosmetic): $150 allowance.
	Dental check-up	$25 deductible/person $75 deductible/family (not applicable to diagnostic, preventative or orthodontic care)	Reimbursement based on non-participating provider schedule	Orthodontia: $3,000 lifetime maximum benefit; 20% coinsurance.

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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	• Infertility treatment	• Private-duty nursing
• Bariatric Surgery	• Long-term care	• Routine foot care
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Cosmetic surgery		

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)	• Hearing aids	• Routine eye 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 grievances and appeals regarding your drug coverage, call the number on the back of your prescription benefit card or visit www.express-scripts.com. 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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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does not meet the minimum value standard for the benefits it provides. Although the coverage under the PSSU Local Unit Health and Welfare Fund does not satisfy the minimum value standard, your employer-provided major medical coverage and the prescription coverage under this Fund, taken together, might meet the minimum value standard.

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** $90
- **Patient pays** $7,450

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	$10
Coinsurance	$0
Limits or exclusions	$7,440
Total	**$7,450**

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

Amount owed to providers: $5,400
- **Plan pays** $2,640
- **Patient pays** $2,760

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	$120
Coinsurance	$0
Limits or exclusions	$2,640
Total	**$2,760**

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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