PSSU LOCAL UNIT HEALTH AND WELFARE FUND – Bucks County

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

Coverage Period: 05/01/2018 – 4/30/2019
Coverage for: Family
Plan Type: Prescription/Dental/Vision

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.pssuhwfund.org or call the Fund office at (717)526-4856 or (888)243-1524. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.pssuhwfund.org/SBCUniformGlossary.pdf or call 1-888-243-1524 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs & services this **plan** covers.
Are there services covered before you meet your deductible?	No	You will have to meet the **deductible** before the **plan** pays for any services.
Are there other deductibles for specific services?	Yes, $25/individual or $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 the out-of-pocket limit for this plan? (Prescription Only)	$6,350/individual or $12,700/family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing, charges and healthcare this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.pssuhwfund.org or call (888)243-1524	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plans network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **providers** charge and what your **plan** pays **(balance billing).** Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a referral.

NOTE: THIS SUMMARY ONLY COVERS YOUR PRESCRIPTION, DENTAL AND VISION BENEFITS. YOU MIGHT RECEIVE A SEPARATE SUMMARY FROM YOUR EMPLOYER DESCRIBING YOUR MEDICAL BENEFITS.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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 ---
	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 More information about prescription drug coverage is available at www.Express-Scripts.com	Generic drugs	$10 copay/prescription for retail; $10 copay/prescription for mail order	Full price of prescription with reimbursement of network pharmacy cost less applicable copay.	Retail copay covers up to 30-day supply and mail order copay covers 31-90 day supply. 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	$20 copay/prescription for retail; $30 copay/prescription for mail order	Full price of prescription with reimbursement of network pharmacy cost less applicable copay.	
	Non-preferred brand drugs	$40 copay/prescription for retail; $60 copay/prescription for mail order	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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 care	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 fees	Not Covered	Not Covered	--- none ---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	--- none ---
	Inpatient services	Not Covered	Not Covered	--- none ---
If you are pregnant	Office visits	Not Covered	Not Covered	--- none ---
	Childbirth/delivery professional services	Not Covered	Not Covered	--- none ---
	Childbirth/delivery facility services	Not Covered	Not Covered	--- none ---
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 services	Not Covered	Not Covered	--- none ---

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Covered in full	Reimbursement based on non-participating provider schedule	Once every 12 months
	Children's glasses	Covered in full within plan limitations	Reimbursement based on non-participating provider schedule	Frames: once every 12 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.
	Children's dental check-up	$25 deductible/person $75 deductible/family (not applicable to diagnostic, preventive or orthodontic care)	Reimbursement is made to enrollee based on non-participating provider schedule. Provider may balance bill.	Annual maximum: $2,500 per individual. Orthodontia: $3,000 lifetime maximum; 20% coinsurance.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Dental care (adult)
- Routine eye care (adult)
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 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.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **No**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,800
The total Peg would pay is	**$12,800**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,400
The total Joe would pay is	**$7,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,900
The total Mia would pay is	**$1,900**

Note: These conditions are not covered, so patient pays 100 percent.