Pension Boards-UCC

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Medical and Dental Benefits Plan: A

Coverage Period: 01/01/2020 – 12/31/2020
Coverage for: Individual or Family | **Plan Type:** PPO

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, call 1.800.642.6543, or visit www.pbucc.org. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-642-6543 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Medical: Individual/Family $300/$600 network providers, $600/$1200 out-of-network providers. Doesn't apply to preventive services or drug and physician office visit copayments. Dental: Individual/Family $100/$200.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.pbucc.org/images/pbucc/publications/Health/Non-Medicare_Highlights.pdf
Are there other deductibles for specific services?	Yes, separate $100 deductible per person for orthodontics. 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?	For network providers $2,000 individual / $4,000 family; for out-of-network providers $4,000 individual / $8,000 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?	Copayments for certain services, premiums, balance-billing charges, and health care 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. Call **1-866-763-9471** or see www.highmarkbcbs.com for a list of network providers. Call 866-851-7576 or see www.ucci.com for a list of dental network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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 provider's 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?	Except in limited instances, no physician referrals are required.	This plan will pay some or all of the costs to see a specialist for covered services but some limited instances require you have a referral before you see the specialist.

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	$25 copay/visit	40% coinsurance after deductible	Copay does not apply toward deductible or out-of-pocket limits. Plan only pays up to applicable UCR for out-of-network providers.
	Specialist visit	$25 copay/visit	40% coinsurance after deductible	In limited instances, physician referrals may be required. Copay does not apply toward deductible or out-of-pocket limits. Plan only pays up to applicable UCR for out-of-network providers.
	Preventive care/screening/ immunization	No charge	No charge	Plan only pays up to applicable UCR for out-of-network providers.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or by calling 1-800-939-3781.	Generic drugs (Tier 1)	$17 copay/retail prescription $34 copay/mail-order prescription	$17 copay/retail prescription	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription) for network provider Express Scripts pharmacy. For out-of-network provider non-Express Scripts pharmacy, must submit reimbursement claim to Express Scripts. Mail order only available in-network through Express Scripts. Retail maintenance (long-term) drug refills limited, no limit on in-network mail-order refills. If you purchase a brand-named drug when a generic substitute is available, copay plus the price difference will be required. Drug copays are not included in deductible or out-of-pocket limits.
	Preferred brand drugs (Tier 2)	$30 copay/retail prescription $75 copay/mail-order prescription	$30 copay/retail prescription	
	Non-preferred brand drugs (Tier 3)	$45 copay/retail prescription $115 copay/mail-order prescription	$45 copay/retail prescription	
	Specialty drugs (Tier 4)	**Preferred:** $30 copay/retail prescription $75 copay/mail-order prescription **Non-preferred:** $45 copay/retail	**Preferred**: $30 copay/retail prescription **Non-preferred**: $45 copay/retail prescription	

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)	
		prescription $115 copay/mail-order prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	
	Urgent care	$25 copay/visit	40% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure to precertify planned hospital admissions.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$25 copay/visit	40% coinsurance after deductible	Copay does not apply toward deductible or out-of-pocket limits. Plan only pays up to applicable UCR for out-of-network providers.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Substance use disorder outpatient services	$25 copay/visit	40% coinsurance after deductible	Copay does not apply toward deductible or out-of-pocket limits. Plan only pays up to applicable UCR for out-of-network providers.
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
If you are pregnant	Office visits	No charge after deductible	40% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Plan only pays up to applicable UCR for out-of-network providers.
	Childbirth/delivery professional services	No charge after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	No charge after deductible	40% coinsurance after deductible	

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 need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network providers.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	No charge for visual screenings at various ages and when conditions indicate	No charge for visual screenings at various ages and when conditions indicate	Optometric exams for children require separate vision plan enrollment with separate premium.
	Children's glasses	Not Covered	Not covered	Separate vision plan enrollment with separate premium required.
	Children's dental check-up	No charge	80% coinsurance after deductible	Coinsurance applies to non-preventive services and supplies. Plan only pays up to applicable UCR for out-of-network providers

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.)

- Cosmetic Surgery
- Long Term Care
- Routine eye care (Adult) (Medical plan only provides coverage for one eye exam/year, payable up to $40 after deductible. Separate vision plan enrollment with separate premium required for glasses/contacts).
- Routine Foot Care
- Weight loss programs

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

- Acupuncture (if provided by a physician or licensed acupuncturist)
- Bariatric Surgery (if medically necessary for treatment of morbid obesity)
- Dental Care (Adult)
- Hearing Aids; limit $3,000 per person/every 3 years
- Infertility treatment (covers correction of a
- Non-emergency care when traveling outside the U.S. (Most coverage provide outside the United States. Call BCBS Global Core at 1-800-810-2583 or 1-804-673-1177 collect).

• Chiropractic care	physical or medical problem related to infertility but not assisted fertilization)	• Private-duty nursing (must be required by a physician)

Your Rights to Continue Coverage: You and your dependents may be eligible for continuation coverage under the plan. If you have questions about continuation coverage, please call 1.800.642.653. 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: Highmark Blue Cross Blue Shield Customer Service Center at 1-866-763-9471 or the Pension Boards Member Services at 1-800-642-6543.

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 Minimum Value Standards? Yes.
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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-763-9471.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-763-9471.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-866-763-9471.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-763-9471.

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.

■ **The plan's overall deductible**	**$300**
■ **Specialist copayment**	**$25**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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	$300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$300**

■ **The plan's overall deductible**	**$300**
■ **Specialist copayment**	**$25**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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*	$300
Copayments	$1,200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,800**

■ **The plan's overall deductible**	**$300**
■ **Specialist copayment**	**$25**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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*	$300
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$650**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please call: **1.800.642.6543.**
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The **plan** would be responsible for the other costs of these EXAMPLE covered services.