

PBUCC Medical Plans

Administration and access	The medical plans are administered by Highmark. To find care and costs, view claims and coverage, visit http://www.highmarkbcbs.com/ or call 1-866-763-9471.
Eligibility	You may apply for coverage by filing an application within 90 days of hire. Plan coverage begins on the first day of the month following receipt of your enrollment application, or approval of your Statement of Health (if applicable.)
Overview	PBUCC has three medical plan options, Plans A, B and C as well as a Medicare Advantage Plan with Rx for Medicare-eligible participants. All three plans have the same comprehensive coverage, the same network of providers, include Prescription Drug coverage and cover preventive care at 100%. The difference in the plans are the deductibles, coinsurance, and out-of-pocket maximums.

Deductibles and Out-of-Pocket Maximums

	Highmark Plan A		Highmark Plan B		Highmark Plan C	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual deductible						
Employee only	\$300	\$600	\$500	\$1,500	\$1,000	\$3,000
All other	\$600	\$1,200	\$1,500	\$4,500	\$3,000	\$9,000
Medical out-of-pocket maximum						
Employee only	\$2,000	\$4,000	\$5,000	\$15,000	\$6,000	\$18,000
All other	\$4,000	\$8,000	\$10,000	\$45,000	\$12,000	\$54,000
Rx out-of-pocket maximum						
Employee only	\$3,000		\$3,000		\$3,000	
All other	\$6,000		\$6,000		\$6,000	

Preventive Services *(must be coded by the physician as preventive)*

	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive services can include:						
→ Routine immunizations	Covered 100% (deductible does not apply)	Covered 100% (deductible does not apply)	Covered 100% (deductible does not apply)	Covered 100% (deductible does not apply)	Covered 100% (deductible does not apply)	Covered 100% (deductible does not apply)
→ Periodic physical exams						
→ Screenings for certain types of cancers, including breast, cervical, colon, and prostate. Cardiovascular conditions, diabetes, osteoporosis and various obstetric, pediatric, vision and hearing disorders						

This document is intended as a general overview only and does not cover all aspects, restrictions, and/or limitations of this benefit. In the case of any discrepancy between this document and the Plan document, the Plan document prevails.

Healthcare Services <i>(what you pay after deductible has been met)</i>						
	Highmark Plan A		Highmark Plan B		Highmark Plan C	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Physician, Diagnostic, Imaging Services, Urgent Care						
Telehealth	0%	Not Covered	0%	Not Covered	0%	Not Covered
Primary care visit	0% after \$25 copay	40%	20%	40%	30%	50%
Specialist office visit	0% after \$25 copay	40%	20%	40%	30%	50%
Diagnostic tests & x-rays (in- or out-patient)	20%	40%	20%	40%	30%	50%
Imaging (CT/PET scans, MRIs)	20%	40%	20%	40%	30%	50%
Urgent care	0% after \$25 copay	40%	0% after \$25 copay	40%	0% after \$25 copay	50%
Emergency, Hospital Stay, Outpatient Surgery, Mental Health, Childbirth Services	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency room care	20%	20%	20%	20%	30%	30%
Emergency transportation	20%	20%	20%	20%	30%	30%
Hospital stay Facility fee (e.g., hospital room) Physician/surgeon fees	20%	40%	20%	40%	30%	50%
Outpatient surgery Facility fee (e.g., surgery center) Physician/surgeon fees	20%	40%	20%	40%	30%	50%
Mental health, behavioral health, substance abuse services - Inpatient	20%	40%	20%	40%	30%	50%
Mental health, behavioral health, substance abuse services - Outpatient	0% after \$25 copay	40%	0% after \$25 copay	40%	0% after \$25 copay	50%
Childbirth Office visits Professional services Facility services	0%	40%	0%	40%	0%	50%

This document is intended as a general overview only and does not cover all aspects, restrictions, and/or limitations of this benefit. In the case of any discrepancy between this document and the Plan document, the Plan document prevails.

Other Healthcare Services *(what you pay after deductible has been met)*

	Highmark Plan A		Highmark Plan B		Highmark Plan C	
Other Healthcare Services	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Home health care	20%	40%	20%	40%	30%	50%
Physical, occupational, speech therapy	20%	40%	20%	40%	30%	50%
Durable medical equipment	20%	40%	20%	40%	30%	50%
Skilled nursing care	20%	40%	20%	40%	30%	50%
Hospice care	20%	40%	20%	40%	30%	50%

Prescription Drugs *(available in 30-day supply or 90-day supply)*

Log in to the Express Scripts App or <http://www.express-scripts.com/> to see how your plan covers specific medications. If you have questions about your prescription drug coverage, call Express Scripts at 1-800-939-3781. Benefits vary according to whether a generic or non-generic drug is dispensed. If you choose a preferred or non-preferred brand drug when your doctor permits use of a generic equivalent, you will also pay the difference in cost.

	Highmark Plan A	Highmark Plan B	Highmark Plan C
Coverage	Pharmacy coverage is through Express Scripts. More detail is available by calling 1-800-939-3781.		
Annual deductible	Your prescription drugs do not apply to your medical deductible.		
Tier 1 Generics 30-day supply	\$17	\$17	\$17
Tier 2 Preferred brands 30-day supply	\$30	\$30	\$30
Tier 3 Non-preferred brands 30-day supply	\$45	\$45	\$45
Tier 1 Generics 90-day supply mail order	\$34	\$34	\$34
Tier 2 Preferred brands 90-day supply mail order	\$75	\$75	\$75
Tier 3 Non-preferred brands 90-day supply mail order	\$115	\$115	\$115

This document is intended as a general overview only and does not cover all aspects, restrictions, and/or limitations of this benefit. In the case of any discrepancy between this document and the Plan document, the Plan document prevails.

PBUCC Vision Plan	
Administration and access	The vision plan is administered by VSP. For coverage details, visit http://www.vsp.com/ or call 1-800-877-7195.
Eligibility	The vision plan is a stand-alone benefit with a separate application and premium.
Coverage	Covers one eye exam each calendar year. Covers <u>one</u> pair of eyeglasses or contact lenses each calendar year. Single, bi-focal and trifocal lenses only. Impact resistant lenses for dependent children.
Exam	\$10 copay
Frames	\$190 featured frame brands allowance \$170 frame allowance 20% savings on amount over allowance \$170 Walmart/Sam's Club allowance \$95 Costco frame allowance
Lens enhancements	Premium progressive lenses \$80–\$90 Custom progressive lenses \$120–\$160 Average savings of 40% on other lens enhancements
Contact lenses	\$170 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on a contact lens evaluation
Extra savings	Glasses and sunglasses – extra \$20 to spend on featured brands; 30% savings on others Routine retinal screening – no more than \$39 copay Laser vision correction – average 15% off regular price or 5% of promotional price After surgery use your frame allowance for sunglasses from any VSP doctor

This document is intended as a general overview only and does not cover all aspects, restrictions, and/or limitations of this benefit. In the case of any discrepancy between this document and the Plan document, the Plan document prevails.

PBUCC Dental Plans		
Administration and access	The dental plans are administered by United Concordia. For coverage details, visit http://www.unitedconcordia.com/ or call 1-866-851-7576.	
Eligibility	You may apply for coverage by filing an application within 90 days of hire. Plan coverage begins on the first day of the month following receipt of your enrollment application, or approval of your Statement of Health (if applicable.)	
Coverage	A PPO offers two levels of benefits. If you receive services from a dentist who is in the PPO network, you'll receive the higher level of benefits. If you receive services from a dentist who is not in the PPO network, you'll receive the lower level of benefits.	
Annual deductible Employee only All others	\$100 \$200	
Maximum benefit Covered dental services Orthodontic care	\$2,400 per person per year \$2,000 lifetime maximum	
	In-Network	Out-of-Network
Preventive services and supplies Cleaning & routine exams 2 times per year Fluoride applications to child's teeth, dental sealants, and space maintainers under age 16	100%	100%
Diagnostic and therapeutic services and supplies Fillings, extractions, root canals, etc.	80%	80%
Restorative care Inlays, onlays, crowns, bridgework, dentures, implants, etc.	50%	50%
Orthodontic care Evaluation, treatment, etc.	50% after separate deductible per person	50% after separate deductible per person

This document is intended as a general overview only and does not cover all aspects, restrictions, and/or limitations of this benefit. In the case of any discrepancy between this document and the Plan document, the Plan document prevails.