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 at www.pbucc.org or by calling **1-800-642-6543**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	***Medical:*** Individual/Family **$300/$600** in-network, **$600/$1200** out-of-network. Doesn't apply to preventive care or drug and physician office visit copayments. ***Dental:*** Individual/Family **$100/$200**.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the 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 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 child (age 16 and under) 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?	Individual/Family **$2,000/$4,000** in-network, **$4,000/$8,000** out-of-network	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, copayments, balance-billed 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 medical in-network providers. Call **1-866-851-7576** or see www.ucci.com for a list of dental in-network providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some 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 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 only if you have the plan's permission before you see the specialist.

- Copayments are fixed dollar amounts (for example, $25) 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 in-network 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	$25 copay/visit	40% coinsurance after deductible	Copay does not apply toward deductible or out-of-pocket limit. Plan only pays up to applicable UCR for out-of-network.
	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 limit. Plan only pays up to applicable UCR for out-of-network.
	Other practitioner office visit	20% coinsurance after deductible for chiropractor and acupuncture	40% coinsurance after deductible for chiropractor and acupuncture	Limit: $2,000 per person/year for chiropractor and acupuncture Plan only pays up to applicable UCR for out-of-network.
	Preventive care/screening/immunization	No charge	No charge	Plan only pays up to applicable UCR for out-of-network.
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.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.

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 www.express-scripts.com or by calling 1-800-939-3781.	Generic drugs	$17 copay/retail prescription $34 copay/mail-order prescription	$17 copay /retail prescription	Covers up to a 30-day supply (retail prescription) or 31-90 day supply (mail-order prescription) for in-network Express Scripts pharmacy. For out-of-network 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 limit.
	Preferred brand drugs	$30 copay/retail prescription $75 copay/mail-order prescription	$30 copay /retail prescription	
	Non-preferred brand drugs	$45 copay/retail prescription $115 copay/mail-order prescription	$45 copay /retail prescription	
	Specialty drugs	***Preferred:*** $30 copay/retail prescription $75 copay/mail-order prescription ***Non-preferred:*** $45 copay/retail prescription $115 copay/mail-order prescription	***Preferred:*** $30 copay/retail prescription ***Non-preferred:*** $45 copay/retail 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.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	20% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
	Urgent care	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.

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 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. Plan only pays up to applicable UCR for out-of-network.
	Physician/surgeon fee	20% coinsurance after deductible	40% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	40% coinsurance after deductible	Copay does not apply toward deductible or out-of-pocket limit. Plan only pays up to applicable UCR for out-of-network.
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
	Substance use disorder outpatient services	$25 copay/visit	40% coinsurance after deductible	Copay does not apply toward deductible or out-of-pocket limit. Plan only pays up to applicable UCR for out-of-network.
	Substance use disorder inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
If you are pregnant	Prenatal and postnatal care	No charge after deductible	40% coinsurance after deductible	Copay and deductible do not apply to prenatal and postnatal office visits in-network. Plan only pays up to applicable UCR for out-of-network.
	Delivery and all inpatient services	No charge after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
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.
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
	Habilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.

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
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network.
	Hospice service	20% coinsurance after deductible	40% coinsurance after deductible	Covered only when under the supervision of a physician. Plan only pays up to applicable UCR for out-of-network.
If your child needs dental or eye care	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.
	Glasses	Not covered	Not covered	Separate vision plan enrollment with separate premium required.
	Dental check-up	No charge	No charge	Coinsurance applies to non-preventive services and supplies. Plan only pays up to applicable UCR for out-of-network.

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.)

- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if provided by a physician or licensed acupuncturist)
- Bariatric surgery (if medically necessary for treatment of morbid obesity)
- Chiropractic care
- Dental care (Adult)
- Hearing aids; limit: $3,000 per person/every 3 years
- Infertility treatment (covers correction of a physical or medical problem related to infertility but not assisted fertilization)
- Non-emergency care when traveling outside the U.S. (Most coverage provided outside the United States. Call BlueCard Worldwide at 1-800-810-2583 or 1-804-673-1177 collect.)
- 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 1.800.642.6543. 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 http://www.HealthCare.gov or call 1-800-318-2596.

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: 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.

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 page.

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 prenatal care and a hospital delivery)

- 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copays	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$300**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- 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	**$7,400**

In this example, Joe would pay:

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

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- 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 *(glucose meter)*
Rehabilitation services *(physical therapy)*

Total	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copays	$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?" on page 1.