



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 <u>deductible</u> ?	Medical: Individual /Family \$1,000/\$3,000 in-network , \$3,000/\$9,000 out-of-network . Doesn't apply to <u>preventive care</u> or drug and physician office visit <u>copayments</u> . Dental: Individual/Family \$100/\$200 .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	<u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.pbucc.org/images/pbucc/publications/Health/Non-Medicare_Highlights.pdf
Are there other <u>deductibles</u> for specific services?	Yes, separate \$100 deductible per child (age 16 and under) for orthodontics. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Individual/Family \$6,000/\$18,000 in-network , \$18,000/\$54,000 out-of-network	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>copayments</u> , <u>balance-billed</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Call 1-866-763-9471 or see www.highmarkbcbs.com for a list of medical <u>in-network</u> providers. Call 1-866-851-7576 or see www.ucci.com for a list of dental <u>in-network</u> providers.	If you use an <u>in-network</u> doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your <u>in-network</u> doctor or hospital may use an <u>out-of-network provider</u> for some services. Plans use the term <u>in-network</u> , <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Except in limited instances, no physician referrals are required.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .

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- **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	30% coinsurance after deductible	50% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network .
	Specialist visit	30% coinsurance after deductible	50% coinsurance after deductible	In limited instances, physician referrals may be required. Plan only pays up to applicable UCR for out-of-network .
	Other practitioner office visit	30% coinsurance after deductible for chiropractor and acupuncture	50% 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)	30% coinsurance after deductible	50% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network .
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	Plan only pays up to applicable UCR for out-of-network .

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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
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.express-scripts.com or by calling 1-800-939-3781.</p>	Generic drugs	\$17 <u>copay</u> /retail prescription \$34 <u>copay</u> /mail-order prescription	\$17 <u>copay</u> /retail prescription	<p>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, participant 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.</p> <p>If you purchase a brand-named drug when a generic substitute is available, copay plus the price difference will be required.</p> <p>Drug <u>copays</u> are not included in <u>deductible</u> or <u>out-of-pocket limit</u>.</p>
	Preferred brand drugs	\$30 <u>copay</u> /retail prescription \$75 <u>copay</u> /mail-order prescription	\$30 <u>copay</u> /retail prescription	
	Non-preferred brand drugs	\$45 <u>copay</u> /retail prescription \$115 <u>copay</u> /mail-order prescription	\$45 <u>copay</u> /retail prescription	
	<u>Specialty drugs</u>	Preferred: \$30 <u>copay</u> /retail prescription \$75 <u>copay</u> /mail-order prescription Non-preferred: \$45 <u>copay</u> /retail prescription \$115 <u>copay</u> /mail-order prescription	Preferred: \$30 <u>copay</u> /retail prescription Non-preferred: \$45 <u>copay</u> /retail prescription	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
<p>If you need immediate medical attention</p>	<u>Emergency room services</u>	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	<u>Urgent care</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .

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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 have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Penalty for failure to precertify planned hospital admissions. Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	Physician/surgeon fee	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 <u>copay</u> /visit	40% <u>coinsurance</u> after <u>deductible</u>	<u>Copay</u> does not apply toward <u>deductible</u> or <u>out-of-pocket limit</u> . Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	Mental/Behavioral health inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	Substance use disorder outpatient services	\$25 <u>copay</u> /visit	40% <u>coinsurance</u> after <u>deductible</u>	<u>Copay</u> does not apply toward <u>deductible</u> or <u>out-of-pocket limit</u> . Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	Substance use disorder inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
If you are pregnant	Prenatal and postnatal care	No charge after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<u>Copay</u> and <u>deductible</u> do not apply to prenatal and postnatal office visits <u>in-network</u> . Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	Delivery and all inpatient services	No charge after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	<u>Rehabilitation services</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	<u>Habilitation services</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	<u>Skilled nursing care</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .

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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
	<u>Hospice service</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Covered only when under the supervision of a physician. Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .
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 <u>premium</u> .
	Glasses	Not covered	Not covered	Separate vision plan enrollment with separate <u>premium</u> required.
	Dental check-up	No charge	No charge	Coinsurance applies to non-preventive services and supplies. Plan only pays up to applicable <u>UCR</u> for <u>out-of-network</u> .

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Long-term care 	<ul style="list-style-type: none"> • 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 <u>premium</u> required for glasses/contacts.) 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs

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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 medically necessary for certain conditions and 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, kwijigo holne' 1-866-763-9471.

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

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Coverage Examples

Coverage for: Individual or Family | Plan Type: PPO



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 \$1,000
Specialist copayment \$0
Hospital (facility) coinsurance 30%
Other coinsurance 30%

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)

Table with 2 columns: Total, \$12,800

In this example, Peg would pay:

Table with 2 columns: Cost Sharing (Deductibles, Copays, Coinsurance) and What isn't covered (Limits or exclusions). Total: \$1,000

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$1,000
Specialist copayment \$0
Hospital (facility) coinsurance 30%
Other coinsurance 30%

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)

Table with 2 columns: Total, \$7,400

In this example, Joe would pay:

Table with 2 columns: Cost Sharing (Deductibles*, Copays, Coinsurance) and What isn't covered (Limits or exclusions). Total: \$2,500

Mia's Simple Fracture

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

- The plan's overall deductible \$1,000
Specialist copayment \$0
Hospital (facility) coinsurance 30%
Other coinsurance 30%

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)

Table with 2 columns: Total, \$1,900

In this example, Mia would pay:

Table with 2 columns: Cost Sharing (Deductibles*, Copays, Coinsurance) and What isn't covered (Limits or exclusions). Total: \$1,300

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.

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