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 healthcare 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, visit www.pensions.org or call Member Services at 1-800-773-7752. 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.pensions.org or call 1-800-773-7752 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For member/family each: Network: 1.5% of participation basis[1]; Out of Network: 2.5% of participation basis; capped at 2.5% combined. Does not apply to preventive care, office visits, or prescription drugs. Copayments and coinsurance amounts don't count toward the **network deductible.**	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 3 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes.	Preventive services, prescription and office visit copays
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	**5%** of participation basis for all network medical, behavioral health, and prescription drug costs (capped at **$7,900** for individual and **$15,800** for family combined), **15%** out of network, for family combined. Prescription drug costs, other than non-preferred brand drugs, are capped at a family coinsurance maximum of **$3,000**.	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 healthcare expenses.

[1] Participation basis generally means the greater of your effective salary or $44,000 (minimum dues basis). Effective salary generally means your base salary plus any other compensation received during a plan year from your employing organization, including any sums paid as housing (including utilities and furnishings); its meaning may depend on the type of coverage you have. Contact the Board of Pensions for more information.

Important Questions	Answers	Why This Matters
What is not included in the out-of-pocket limit?	Premium (dues), balance-billed charges, and healthcare expenses this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.highmarkbcbs.com or call **1-888-835-2959**.	If you use an in-network doctor or other healthcare **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 chart starting on page 3 for how this plan pays different kinds of **providers**.
Will you pay less if you use a network provider?	Yes.	For all services except for emergency services, it is less costly to use network providers.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	50% coinsurance	Does not count toward deductible or out-of-pocket limit
	Specialist visit	$45 copay/visit	50% coinsurance	Does not count toward deductible or out-of-pocket limit
	Preventive care/screening/ immunization	No charge	50% coinsurance for office visit; no charge for screenings and immunizations	For visit with primary care physician, pediatrician, or gynecologist
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Pre-certification required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com.	Preventive generic drugs	$5 copay/prescription (retail, 30-day fill); $15 copay/prescription (retail, 90-day fill); $12.50 copay/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preventive preferred brand drugs	$20 copay/prescription (retail, 30-day fill); $60 copay/prescription (retail, 90-day fill); $50 copay/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preventive non-preferred brand drugs	Does not apply		
	Generic drugs	$10 copay/prescription (retail, 30-day fill); $30 copay/prescription (retail, 90-day fill); $25 copay/prescription (mail, 90-day fill)	Specified copay/prescription (retail, 30- or 90-day fill)	Prior authorization or step therapy program may apply.

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**.	Preferred brand drugs	30% coinsurance, min $20 to max $100 (retail, 30-day fill); 30% coinsurance, min $60 to max $300 (retail, 90-day fill); 30% coinsurance, min $50 to max $250 (mail, 90-day fill)	30% of contracted rate	Prior authorization or step therapy program may apply.
	Non-preferred brand drugs	50% coinsurance, min $50 to max $150 (retail, 30-day fill); 50% coinsurance, min $150 to max $450 (retail, 90-day fill); 50% coinsurance, min $125 to max $375 (mail, 90-day fill)	50% of contracted rate	Prior authorization or step therapy program may apply.
	Specialty drugs	Same percentages and minimums and maximums as above for preferred and non-preferred brands	Same percentages of contracted rate as above for preferred and non-preferred brands	Prior authorization or step therapy program may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Pre-certification required within 48 hours if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	To nearest appropriate facility
	Urgent care	$45 copay/visit	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Pre-certification required
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
	Outpatient services	20% coinsurance	40% coinsurance	Pre-certification required

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 mental health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	Pre-certification required (within 48 hours of admission for mental health and substance abuse inpatient services).
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Pre-certification required within the first three months of pregnancy
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following caesarean section
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following caesarean section
If you need help recovering or have other special health needs	Home healthcare	20% coinsurance	40% coinsurance	100 visits annually of up to 8 hours each
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	See Guide to Your Healthcare Benefits.
	Skilled nursing care	20% coinsurance	40% coinsurance	180 days maximum annual limit for extended care facilities
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice services	20% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	$25 copay/visit (with VSP provider)	Reimbursed up to $45 after $25 copay	Limited to one exam per year
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

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
- Dental care
- Experimental or investigational medical treatment
- Long-term care
- Private-duty nursing
- 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 a state-licensed acupuncturist
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Hearing aids (and fittings)
- Most coverage provided outside the United States
- Routine eye exam through VSP

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending on the circumstances, you may be eligible to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium (dues)**, which may be significantly higher than the premium (dues) you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact Member Services at 1-800-773-7752. You may also contact the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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**. The plan documents and administrative rules will provide complete information on how to appeal a denial of coverage and/or file a grievance. For questions about your rights, this notice, or assistance, or to request copies of plan documents, you can contact Member Services at 1-800-773-7752.

Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have healthcare coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-773-7752.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-773-7752.

Korean (한국어): 한국어로 도움이 필요하시면, 1-800-773-7752 로 전화하십시오.

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

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

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 prenatal care and a hospital delivery)

The plan's overall deductible	$805
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$805
Copayments	$0
Coinsurance	$2,399
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,204**

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

The plan's overall deductible	$805
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$805
Copayments	$405
Coinsurance	$1,319
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,529**

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

The plan's overall deductible	$805
Specialist *[cost sharing]*	$45
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$805
Copayments	$0
Coinsurance	$219
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,024**

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

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Important Questions	Answers	Why This Matters
What is the overall deductible?	**$2,000** individual/**$4,000** family **Network deductible** does not apply to office visits, preventive care services, diagnostic tests, imaging tests, urgent care, and prescription drug expenses. Copayments and coinsurance amounts don't count toward the **network deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for some 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 3 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes.	Preventive services, prescription and office visit copays, as well as copays for certain services, i.e., therapy.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Total maximum out of pocket of **$7,900** individual/**$15,800** family.	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 healthcare expenses.

Important Questions	Answers	Why This Matters
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare expenses this plan doesn't cover do not apply to your total maximum out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Does this plan use a network of providers?	Yes. For a list of network providers, see www.highmarkbcbs.com or call **1-888-835-2959**.	If you use an in-network doctor or other healthcare **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 chart starting on page 3 for how this plan pays different kinds of **providers**.
Will you pay less if you use a network provider?	Yes.	As the plan does not pay for out-of-network services, it is less costly to use **network providers**.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	Not covered	——————none——————
	Specialist visit	$60 copay/visit	Not covered	——————none——————
	Preventive care/screening/ immunization	No charge	Not covered	For visit with primary care physician, pediatrician, or gynecologist
If you have a test	Diagnostic test (X-ray, blood work)	$65 copay/visit	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$200 copay/visit	Not covered	Pre-certification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**.	Preventive generic drugs	$6 copay/prescription (retail, 30-day fill); $18 copay/prescription (retail, 90-day fill); $15 copay/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preventive preferred brand drugs	$30 copay/prescription (retail, 30-day fill); $90 copay/prescription (retail, 90-day fill); $75 copay/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preventive non-preferred brand drugs	Does not apply		
	Generic drugs	$12 copay/prescription (retail, 30-day fill); $36 copay/prescription (retail, 90-day fill); $30 copay/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	Preferred brand drugs	35% coinsurance, min $35 to max $150 (retail, 30-day fill); 35% coinsurance, min $105 to max $450 (retail, 90-day fill); 35% coinsurance, min $85 to max $375 (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Same percentages and minimums and maximums as above for preferred and non-preferred brand drugs	Not covered	Prior authorization or step therapy program may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Pre-certification required within 48 hours if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	To the nearest appropriate facility
	Urgent care	$60 copay/visit	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification required
	Physician/surgeon fees	20% coinsurance	Not covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Pre-certification required
	Inpatient services	20% coinsurance	Not covered	Pre-certification required (within 48 hours of admission for mental health and substance abuse inpatient services).
If you are pregnant	Office visits	20% coinsurance	Not covered	Pre-certification required within the first three months of pregnancy and when admitted to deliver
	Childbirth/delivery professional services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following caesarean section

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)	
	Childbirth/delivery facility services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following caesarean section
If you need help recovering or have other special health needs	Home healthcare	20% coinsurance	Not covered	100 visits annually of up to 8 hours each
	Rehabilitation services	$40 copay/visit	Not covered	
	Habilitation services	20% coinsurance	Not covered	See Guide to Your Healthcare Benefits.
	Skilled nursing care	20% coinsurance	Not covered	180 days maximum annual limit for extended care facilities
	Durable medical equipment	20% coinsurance	Not covered	——————none——————
	Hospice services	20% coinsurance	Not covered	——————none——————
If your child needs dental or eye care	Children's eye exam	$25 copay (at VSP provider)	Not covered	Limited to one exam per year
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	——————none——————

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.)

- Infertility treatment
- Experimental or investigational medical treatment
- Cosmetic surgery
- Dental care (Adult)
- Private-duty nursing
- Long-term care
- 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.)

- Chiropractic Care
- Emergency coverage provided outside the United States. See www.bcbsa.com.
- Bariatric surgery
- Acupuncture if provided by a physician or a state-licensed acupuncturist
- Routine eye exam through VSP
- Hearing aids (and fittings)

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending on the circumstances, you may be eligible to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium (dues)**, which may be significantly higher than the premium (dues) you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact Member Services at 1-800-773-7752. You may also contact the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Does This Coverage Provide Minimum Essential Coverage?

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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Korean (한국어): 한국어로 도움이 필요하시면, 1-800-773-7752 로 전화하십시오.

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 prenatal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$2,000
Copayments	$0
Coinsurance	$2,160
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$4,160**

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

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$2,000
Copayments	$420
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,500**

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

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$1,200
Copayments	$320
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,520**

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

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 healthcare 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, visit www.pensions.org or call Member Services at 1-800-773-7752. 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.pensions.org or call 1-800-773-7752 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	**$3,000** individual **$6,000** family Copayments and coinsurance amounts don't count toward the **network deductible.**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for most 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 3 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes.	Preventive services
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific preventive services, but see the chart starting on page 3 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Total maximum out of pocket of **$6,750** individual **$13,500** family.	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 healthcare expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and healthcare expenses this plan doesn't cover do not apply to your total maximum out-of-pocket limit.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Does this plan use a network of providers?	Yes. For a list of network providers, see **www.highmarkbcbs.com** or call **1-888-835-2959**.	If you use an in-network doctor or other healthcare **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 chart starting on page 3 for how this plan pays different kinds of **providers**.
Will you pay less if you use a network provider?	Yes.	As the plan does not pay for out-of-network services, it is less costly to use **network providers**.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.

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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	——————none——————
	Specialist visit	20% coinsurance	Not covered	——————none——————
	Preventive care/screening/ immunization	No charge	Not covered	For visit with primary care physician, pediatrician, or gynecologist
If you have a test	Diagnostic test (X-ray, blood work)	20% coinsurance	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Pre-certification required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**.	Preventive generic drugs	$6 copay/prescription (retail, 30-day fill); $18 copay/prescription (retail, 90-day fill); $15 copay/prescription (mail, 90-day fill) Not subject to deductible	Not covered	Prior authorization or step therapy program may apply.
	Preventive preferred brand drugs	$30 copay/prescription (retail, 30-day fill); $90 copay/prescription (retail, 90-day fill); $75 copay/prescription (mail, 90-day fill) Not subject to deductible	Not covered	
	Preventive non-preferred brand drugs	Does not apply		

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.optumrx.com**.	Generic drugs	30% coinsurance to $150 max copay/prescription (retail, 30-day fill); $450 max copay/prescription (retail, 90-day fill); $375 max copay/prescription (mail, 90-day fill)	Not covered	Prior authorization or step therapy program may apply.
	Preferred brand drugs	30% coinsurance to $150 max copay/prescription (retail, 30-day fill); $450 max copay/prescription (retail, 90-day fill); $375 max copay/prescription (mail, 90-day fill)	Not covered	
	Non-preferred brand drugs	Not covered	Not covered	
	Specialty drugs	Same percentages and minimums and maximums as above for preferred and non-preferred drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	
	Physician/surgeon fees	20% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Pre-certification required within 48 hours if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	To the nearest appropriate facility
	Urgent care	20% coinsurance	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Pre-certification required
	Physician/surgeon fees	20% coinsurance	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 you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Pre-certification required
	Inpatient services	20% coinsurance	Not covered	Pre-certification required (within 48 hours of admission for mental health and substance abuse inpatient services).
If you are pregnant	Office visits	20% coinsurance	Not covered	Pre-certification required within the first three months of pregnancy and when admitted to deliver
	Childbirth/delivery professional services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following caesarean section
	Childbirth/delivery facility services	20% coinsurance	Not covered	Includes hospital stay of at least 48 hours following vaginal delivery; 96 hours following caesarean section
If you need help recovering or have other special health needs	Home healthcare	20% coinsurance	Not covered	100 visits annually of up to 8 hours each
	Rehabilitation services	20% coinsurance	Not covered	
	Habilitation services	20% coinsurance	Not covered	See Guide to Your Healthcare Benefits.
	Skilled nursing care	20% coinsurance	Not covered	180 days maximum annual limit for extended care facilities
	Durable medical equipment	20% coinsurance	Not covered	——————none——————
	Hospice services	20% coinsurance	Not covered	——————none——————
If your child needs dental or eye care	Children's eye exam	$25 copay (at VSP provider)	Not covered	Limited to one exam per year. Individuals enrolled in the HDHP will be automatically enrolled in the VSP vision exam benefit. The vision exam benefit is not considered part of the HDHP.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

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.)

- Experimental or investigational medical treatment
- Cosmetic surgery
- Dental care (Adult)
- Private-duty nursing
- Hearing aids (and fittings)
- Long-term care
- 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.)

- Chiropractic Care
- Emergency coverage provided outside the United States. See www.bcbsa.com.
- Bariatric surgery
- Acupuncture if provided by a physician or a state-licensed acupuncturist
- Routine eye exam through VSP
- Infertility treatment
- Hearing aids (and fittings)

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending on the circumstances, you may be eligible to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium (dues)**, which may be significantly higher than the premium (dues) you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact Member Services at 1-800-773-7752. You may also contact the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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**. The plan documents and administrative rules will provide complete information on how to appeal a denial of coverage and/or file a grievance. For questions about your rights, this notice, or assistance, or to request copies of plan documents, you can contact Member Services at 1-800-773-7752.

Does This Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have healthcare coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does This Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-773-7752.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-773-7752.

Korean (한국어): 한국어로 도움이 필요하시면, 1-800-773-7752 로 전화하십시오.

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

* For more information about limitations and exceptions, see the plan or policy document at www.pensions.org.

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 prenatal care and a hospital delivery) Has family coverage

- **The plan's overall deductible** **$6,000**
- **Specialist *[cost sharing]***
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **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	$6,000
Copayments	$0
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**7,360**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition) Has member only coverage

- **The plan's overall deductible** $3,000
- **Specialist *[cost sharing]***
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **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	$3,000
Copayments	$0
Coinsurance	$880
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$3,880**

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

- **The plan's overall deductible** $6,000
- **Specialist *[cost sharing]***
- **Hospital (facility) *[cost sharing]*** **20%**
- **Other *[cost sharing]*** **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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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