

Steelworkers Health and Welfare Fund

OPEIU Local 45- Florida

July 1, 2019 through June 30, 2020

Option 1	Employee Only	Employee + Child	Employee + Children	Employee + Spouse	Employee Family
Medical PPO 100/80	\$519.22	\$1,232.32	\$1,635.09	\$1,229.32	\$1,635.09
Prescription Drug:					
Retail: \$10/\$40/ \$70					
Mail Order: \$20/\$50/ \$100					

Option 2	Employee Only	Employee + Child	Employee + Children	Employee + Spouse	Employee Family
Medical PPO 90/70	\$428.45	\$1,011.48	\$1,344.63	\$1,011.48	\$1,344.63
Prescription Drug:					
Retail: \$10/\$40/ \$70					
Mail Order: \$30/\$100/ \$175					

Option 3	Employee Only	Employee + Child	Employee + Children	Employee + Spouse	Employee Family
Medical PPO 80/60	\$418.62	\$987.87	\$1,313.16	\$987.87	\$1,313.16
Prescription Drug:					
Retail: \$10/\$40/ \$70					
Mail Order: \$30/\$100/ \$175					



OPEIU – 100/80 Incentive Formulary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date		
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$500	\$1,500
Family	\$1,000	\$3,000
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	\$5,000
Family	None	\$10,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,000	Not Applicable
Family	\$20,000	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$25 copay	80% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$25 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$25 copay	80% after deductible
Virtual Visit Originating Site Fee	100%	80% after deductible
Urgent Care Center Visits	100% after \$75 copay	80% after deductible
Telemedicine Services (3)	100%	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100%	80% after deductible
Adult Immunizations	100%	80% after deductible
Routine Gynecological Exams, including a Pap Test	100%	80% (deductible does not apply)
Mammograms, Annual Routine	100%	80% after deductible
Mammograms, Medically Necessary	100%	80% after deductible
Diagnostic Services and Procedures	100%	80% after deductible
Routine Pediatric		
Physical Exams	100%	80% after deductible
Pediatric Immunizations	100%	80% (deductible does not apply)
Diagnostic Services and Procedures	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	100%	100% after in-network deductible for emergencies; 80% after program deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$25 copay	80% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	100%	80% after deductible
Speech Therapy	100% after \$25 copay	80% after deductible

Benefit	In Network	Out of Network
	limit: 20 visits/benefit period	
Occupational Therapy	100% after \$25 copay	80% after deductible
	limit: 20 visits/benefit period	
Spinal Manipulations	100% after \$25 copay	80% after deductible
	limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100%	80% after deductible
Inpatient Detoxification / Rehabilitation	100%	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$25 copay	80% after deductible
Outpatient Substance Abuse Services	100% after \$25 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	100%	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care	100%	80% after deductible
	limit: 90 visits/benefit period aggregate with visiting nurse	
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment (6)	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
	limit: 240 hours/benefit period	
Skilled Nursing Facility Care	100%	80% after deductible
	limit: 100 days/benefit period	
Transplant Services	100%	80% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design Specialty Drugs must be purchased at Retail or Mail Order.	Retail Drugs (31/60/90-day Supply) \$10 / \$25 / \$50 Formulary generic copay \$10 / \$25 / \$50 Non-Formulary generic copay \$40 / \$80 / \$120 Formulary brand copay \$70 / \$140 / \$210 Non-Formulary brand copay Maintenance Drugs through Mail Order (90-day Supply) \$20 Formulary generic copay \$20 Non-Formulary generic copay \$50 Formulary brand copay \$100 Non-Formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.

- (6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。
请致电 1-800-876-7639。

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

Wann du Deutsch schwetzst, kannst du en Dolmetscher griegen, un iss die Hilf Koschdefrei. Kannst du 1-800-876-7639 uffruen.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-800-876-7639 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم
1-800-876-7639 .

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-800-876-7639 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-tichèr, ki la pou ede w. Rele nan 1-800-876-7639.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូន លោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-800-876-7639 ។

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyon ng tulong sa wika. Tumawag sa 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-800-876-7639 .

Diné k'ehgo yáníłt'igo, language assistance services, éí t'áá níik'eh, bee níká a'doowoł, éí bee ná'ahóót'í. Kojí' hodiłłnih 1-800-876-7639.



HDHP 90/70 Incentive Formulary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date		
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$6,600	Not Applicable
Family	\$13,200	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$30 copay	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$30 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after \$30 copay	70% after deductible
Virtual Visit Originating Site Fee	90% after deductible	70% after deductible
Urgent Care Center Visits	100% after \$75 copay	70% after deductible
Telemedicine Services (3)	100% after \$15 copay	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	70% after deductible
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	90% after deductible	90% after in-network deductible for emergencies; 70% after program deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	90% after deductible	70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$30 copay	70% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	90% after deductible	70% after deductible

Benefit	In Network	Out of Network
Speech Therapy	100% after \$30 copay limit: 20 visits/benefit period	70% after deductible
Occupational Therapy	100% after \$30 copay limit: 20 visits/benefit period	70% after deductible
Spinal Manipulations	100% after \$30 copay limit: 20 visits/benefit period	70% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	90% after deductible	70% after deductible
Inpatient Detoxification / Rehabilitation	90% after deductible	70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$30 copay	70% after deductible
Outpatient Substance Abuse Services	100% after \$30 copay	70% after deductible
Other Services		
Allergy Extracts and Injections	90% after deductible	70% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	90% after deductible	70% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible
Home Health Care	90% after deductible limit: 90 visits/benefit period aggregate with visiting nurse	70% after deductible
Hospice	90% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (6)	90% after deductible	70% after deductible
Private Duty Nursing	90% after deductible limit: 240 hours/benefit period	70% after deductible
Skilled Nursing Facility Care	90% after deductible limit: 100 days/benefit period	70% after deductible
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design Specialty Drugs must be purchased at Retail or Mail Order.	Retail Drugs (31/60/90-day Supply) \$10 / \$30 / \$60 Formulary generic copay \$10 / \$30 / \$60 Non-Formulary generic copay \$40 / \$80 / \$120 Formulary brand copay \$70 / \$140 / \$210 Non-Formulary brand copay Maintenance Drugs through Mail Order (90-day Supply) \$30 Formulary generic copay \$30 Non-Formulary generic copay \$100 Formulary brand copay \$175 Non-Formulary brand copay	

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(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy).

Treatment for autism spectrum disorders does not reduce visit/day limits.

- (6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.





OPEIU — 80/60 Incentive Formulary

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date		
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$3,000	\$5,000
Family	\$6,000	\$10,000
Plan Pays – payment based on the plan allowance	80% after deductible	60% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$7,900	Not Applicable
Family	\$15,800	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$40 copay	60% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after \$40 copay	60% after deductible
Specialist Office Visits & Virtual Visits	100% after \$40 copay	60% after deductible
Virtual Visit Originating Site Fee	80% after deductible	60% after deductible
Urgent Care Center Visits	100% after \$100 copay	60% after deductible
Telemedicine Services (3)	100% after \$20 copay	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	60% after deductible
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	60% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	60% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	60% after deductible
Pediatric Immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	60% after deductible
Emergency Services		
Emergency Room Services	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency	80% after deductible	80% after in-network deductible for emergencies; 60% after program deductible for non-emergencies
Hospital and Medical / Surgical Expenses (including maternity)		
Hospital Inpatient	80% after deductible	60% after deductible
Hospital Outpatient	80% after deductible	60% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	80% after deductible	60% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	80% after deductible	60% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$40 copay	60% after deductible
	limit: 20 visits/benefit period	
Respiratory Therapy	80% after deductible	60% after deductible

Benefit	In Network	Out of Network
Speech Therapy	100% after \$40 copay limit: 20 visits/benefit period	60% after deductible
Occupational Therapy	100% after \$40 copay limit: 20 visits/benefit period	60% after deductible
Spinal Manipulations	100% after \$40 copay limit: 20 visits/benefit period	60% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	80% after deductible	60% after deductible
Inpatient Detoxification / Rehabilitation	80% after deductible	60% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$40 copay	60% after deductible
Outpatient Substance Abuse Services	100% after \$40 copay	60% after deductible
Other Services		
Allergy Extracts and Injections	80% after deductible	60% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (5)	80% after deductible	60% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	not covered	not covered
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	60% after deductible
Home Health Care	80% after deductible limit: 90 visits/benefit period aggregate with visiting nurse	60% after deductible
Hospice	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment (6)	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible limit: 240 hours/benefit period	60% after deductible
Skilled Nursing Facility Care	80% after deductible limit: 100 days/benefit period	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements (7)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (8) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Benefit Design Specialty Drugs must be purchased at Retail or Mail Order.	Retail Drugs (31/60/90-day Supply) \$10 / \$30 / \$60 Formulary generic copay \$10 / \$30 / \$60 Non-Formulary generic copay \$40 / \$80 / \$120 Formulary brand copay \$70 / \$140 / \$210 Non-Formulary brand copay Maintenance Drugs through Mail Order (90-day Supply) \$30 Formulary generic copay \$30 Non-Formulary generic copay \$100 Formulary brand copay \$175 Non-Formulary brand copay	

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.

(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

(3) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.

(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).

(5) Coverage for eligible members to age 21. After initial analysis, services will be paid according to the benefit category (e.g. speech therapy).

Treatment for autism spectrum disorders does not reduce visit/day limits.

- (6) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (7) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (8) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

If you speak English, language assistance services, free of charge, are available to you. Call 1-800-876-7639.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-800-876-7639.

如果您说中文，可向您提供免费语言协助服务。
請致電 1-800-876-7639。

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-800-876-7639.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-800-876-7639.

Wann du Deutsch schwetzschst, kannst du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-800-876-7639 uffrufe.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다.
1-800-876-7639 로 전화.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-800-876-7639.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم
1-800-876-7639 .

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-800-876-7639.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-800-876-7639 નંબર પર ફોન કરો.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-800-876-7639.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-tichèri, ki la pou ede w. Rele nan 1-800-876-7639.

បើលោកអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូន លោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-800-876-7639 ។

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-800-876-7639.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyonang tulong sa wika. Tumawag sa 1-800-876-7639.

日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。 1-800-876-7639 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان
با تماس با شماره 1-800-876-7639 .

Diné k'chgo yáníłti'go, language assistance services, éí t'áá níí'k'ch, bee níká a'doowól, éí bee ná'ahóót'i'. Kojí' hodiłłnih 1-800-876-7639.

2019 Preventive Schedule

Effective 1/1/2019

PLAN YOUR CARE: KNOW WHAT YOU NEED AND WHEN TO GET IT

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. The preventive guidelines on this schedule depend on your age, gender, health and family history. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. Make sure you know what is covered by your health plan and any requirements before you receive any of these services.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you.

QUESTIONS?

 **Call Member Service**

 **Ask your doctor**

 **Log in to your account**

Adults: Ages 19+



Male



Female

General Health Care

 Routine Checkup* (This exam is not the work- or school-related physical)	- Ages 19 to 49: Every 1 to 2 years - Ages 50 and older: Once a year
 Pelvic, Breast Exam	Once a year

Screenings/Procedures

 Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
 Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
 Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
 Cholesterol (Lipid) Screening	- Ages 20 and older: Once every 5 years - High-risk: More often
 Colon Cancer Screening (Including Colonoscopy)	- Ages 50 and older: Every 1 to 10 years, depending on screening test - High-risk: Earlier or more frequently
 Certain Colonoscopy Preps With Prescription	- Ages 50 and older: Once every 10 years - High-risk: Earlier or more frequently
 Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
 Hepatitis B Screening	High-risk
 Hepatitis C Screening	High-risk
 Latent Tuberculosis Screening	High-risk
 Lung Cancer Screening (Requires use of authorized facility)	Ages 55 to 80 with 30-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
 Mammogram	Ages 40 and older: Once a year including 3-D
 Osteoporosis (Bone Mineral Density) Screening	Ages 60 and older: Once every 2 years

* Routine checkup could include health history; physical; height, weight and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; and age-appropriate guidance.

Adults: Ages 19+

Screenings/Procedures

 Pap Test	• Ages 21 to 65: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
  Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)	Sexually active males and females

Immunizations

  Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
  Diphtheria, Tetanus (Td/Tdap)	• One-time Tdap • Td booster every 10 years
  Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
  Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
  Hepatitis A	At-risk or per doctor's advice: One 2-dose series
  Hepatitis B	At-risk or per doctor's advice: One 3-dose series
  Human Papillomavirus (HPV)	To age 26: One 3-dose series
  Measles, Mumps, Rubella (MMR)	One or two doses
  Meningitis*	At-risk or per doctor's advice
  Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
  Shingles	• Zostavax - Ages 60 and older: One dose • Shingrix - Ages 50 and older: Two doses

Preventive Drug Measures That Require a Doctor's Prescription

  Aspirin	• Ages 50 to 59 to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
 Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
 Raloxifene Tamoxifen	At-risk for breast cancer, without a cancer diagnosis, ages 35 and older
  Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
  Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater.

* Meningococcal B vaccine per doctor's advice.

Preventive Care for Pregnant Women



Screenings and Procedures

- Gestational diabetes screening
- Hepatitis B screening and immunization, if needed
- HIV screening
- Syphilis screening
- Smoking cessation counseling
- Depression screening during pregnancy and postpartum
- Rh typing at first visit
- Rh antibody testing for Rh-negative women
- Tdap with every pregnancy
- Urine culture and sensitivity at first visit

Prevention of Obesity, Heart Disease and Diabetes



Adults With BMI 25 to 29.9 (Overweight) and 30 to 39.9 (Obese) Are Eligible For:

- Additional annual preventive office visits specifically for obesity and blood pressure measurement
- Additional nutritional counseling visits specifically for obesity
- Recommended lab tests:
 - ALT
 - AST
 - Hemoglobin A1c or fasting glucose
 - Cholesterol screening

Adult Diabetes Prevention Program (DPP)



Applies to Adults

- Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and
- Overweight or obese (determined by BMI) and
- Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.

Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.

2019 Preventive Schedule

PLAN YOUR CHILD'S CARE: KNOW WHAT YOUR CHILD NEEDS AND WHEN TO GET IT

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations depends on what the doctor thinks is right for your child.

QUESTIONS?

 Call Member Service

 Ask your doctor

 Log in to your account



Children: Birth to 30 Months¹

General Health Care	Birth	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)											
Hearing Screening											
Screenings											
Autism Screening											
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry											
Developmental Screening											
Hematocrit or Hemoglobin Screening											
Lead Screening											
Newborn Blood Screening and Bilirubin											
Immunizations											
Chicken Pox							Dose 1				
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3		Dose 4				
Flu (Influenza)**					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years. ** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.



Children: 3 Years to 18 Years¹

General Health Care	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)									Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												
Depression Screening									Once a year from ages 11 to 18			
Hearing Screening***												
Visual Screening***												
Screenings												
Hematocrit or Hemoglobin Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9-11 and ages 17-21					
Immunizations												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5				1 dose of Tdap if 5 doses were not received previously						1 dose every 10 yrs.
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9-14. 3 doses all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2 (at least 1 month apart from dose 1)										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor’s advice											
Polio (IPV)		Dose 4										
Care for Patients With Risk Factors												
BRCA Mutation Screening (Requires prior authorization)					Per doctor’s advice							
Cholesterol Screening	Screening will be done based on the child’s family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor’s advice			
Hepatitis C Screening											High-risk	
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)									• For all sexually active individuals • HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor’s advice											

*Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment. ** To confirm new diagnosis of high blood pressure before starting treatment. *** Hearing screening once between ages 11-14, 15-17 and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4 and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit. **** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network. ***** Meningococcal B vaccine per doctor's advice.

Children: 6 Months to 18 Years¹

Preventive Drug Measures That Require a Doctor's Prescription

Oral Fluoride	For preschool children older than 6 months whose primary water source is deficient in fluoride
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Prevention of Obesity and Heart Disease

Children With a BMI in the 85th to 94th Percentile (Overweight) and the 95th to 98th Percentile (Obese) Are Eligible For:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
---	--

Adult Diabetes Prevention Program (DPP) Age 18

 Applies to Adults • Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and • Overweight or obese (determined by BMI) and • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7 to 6.4 percent or Impaired Glucose Tolerance Test of 140-199mg/dl.	Enrollment in certain select CDC recognized lifestyle change DPP programs for weight loss.
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Women's Health Preventive Schedule

Services

Well-Woman Visits (Includes: preconception and first prenatal visit, urinary incontinence screening)	Up to 4 visits each year for age and developmentally appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy

Screenings/Procedures

Diabetes Screening	• High-risk: At the first prenatal visit • All women between 24 and 28 weeks pregnant • Postpartum women without Diabetes but with a history of gestational diabetes
HIV Screening and Discussion	All sexually active women: Once a year
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Discussion	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One form of contraception in each of the 18 FDA-approved methods is covered without cost sharing. If the doctor recommends a clinical service or FDA-approved item based on medical necessity, there will be no cost sharing.

Information About the Affordable Care Act (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations or your benefit coverage, please call the Member Service number on the back of your member ID card.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

¹Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grand-fathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyonang tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

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