
The First National Guild for
Healthcare Providers of the Lower Extremity
OPEIU, GUILD 45

June 19, 2019

Local 45 of the Office and Professional Employees International Union (OPEIU), and the OPEIU announced today that all members of the OPEIU will have access to **fully insured** healthcare plans through Highmark Blue Cross Blue Shield.

Our OPEIU Local (Local 45), is offering three healthcare plan designs; the summary descriptions of those plan choices are shown below.

Each of our Local 45 states has been separately underwritten and a grid showing the state's rate for each plan and coverage is attached. Plan coverage is offered to members for single, single with child, single with multiple children, married, and family policies.

Enrollment will be through CDS Administrators, a Pittsburgh based company. CDS will also accomplish billing and continued eligibility through the term of each policy. Your eligibility is achieved and maintained through your membership in your state podiatric medical association which is a member of OPEIU Local 45.

Our OPEIU working group chose the offering Fund for a number of reasons. First, the Fund offers national coverage that allows all Local 45 states to participate. Second, the Fund offers its coverage in fully insured products offered through Highmark Blue Cross Blue Shield; and, finally, because the Fund has such a high number of participants throughout the nation.

Your OPEIU plan will be written through a "Blue Card" that is recognized by all Blue Cross Blue Shield companies in the fifty states and internationally. There are three plan designs which include pharmacy benefits. Finally, a Medicare Advantage plan is being developed now for introduction later this year.

Plans are available for review on our state association website.

Please review the available plan designs and see which fits your individual and family circumstances. Enrollment information is attached for coverage beginning in September.

John Mattiacci, DPM
President, Local 45, OPEIU

P.O. Box 299 • Camp Hill, PA 17001 • Phone: (717) 763-7665 • Fax: (717) 761-4091

# 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 | Family |
|---|---|---|---|---|---|
| Medical PPO 100/80 | $519.22 | $1,229.32 | $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 | 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 | 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 | | | | | |

**Terms and Conditions**

- All benefit programs proposed by the Fund are done so on the terms of a group contract.
- A minium of 75% participation of all eligible employees is required for all lines of coverage elected.
- OPEIU Local 45 must enter into a participation agreement
- The Fund Plan is a full replacement for all current Plans

# OPEIU Local 45

**Benefit Highlights for Comparison**
**In-Network Benefits Listed**

| | ***OPEIU Plan Option 1*** | ***OPEIU Plan Option 2*** | ***OPEIU Plan Option 3*** | ***Your Current Plan*** |
|---|---|---|---|---|
| **Deductible** | $500/$1,000 | $3,000/ $6,000 | $3,000/ $6,000 | |
| **Out-of-Pocket Limit** (includes co-insurance, once met plan pays 100% coinsurance for rest of benefit period) | none | $5000/ $10,000 | $5000/ $10,000 | |
| **Physicians visits** | $25 copay | $30 copay | $40 copay | |
| **Specialist** | $25 copay | $ 30 copay | $40 copay | |
| **Inpatient Hospital** | Plan pays 100% | Plan Pays 90% after deductible | Plan Pays 80% after deductible | |
| **Emergency, Urgent Care** | $150 copay ER/ $75 copay Urgent Care | $150 copay ER/ $75 copay Urgent care | $150 copay ER/ $100 copay Urgent care | |
| **Diagnostic Tests** | Plan pays 100% | Plan Pays 90% after deductible | Plan Pays 80% after deductible | |
| **Durable Medical Equip** | Plan pays 100% | Plan Pays 90% after deductible | Plan Pays 80% after deductible | |
| **Skilled Nursing Facility** | Plan pays 100%; Limit 100 Days per Benefit Period | Plan pays 90%; Limit 100 Days per Benefit Period | Plan pays 80%; Limit 100 Days per Benefit Period | |
| **Prescription** | ***Retail copayments (Up to 30 day supply)*** | ***Retail copayments (Up to 30 day supply)*** | **Retail copayments (Up to 31 day supply)** | |
| | Generic $10 | Generic $10 | Generic $10 | |
| | Preferred brand $40 | Preferred brand $40 | Preferred brand $40 | |
| | Non-Preferred Brand $70 | Non-Preferred Brand $70 | Non-Preferred Brand $70 | |
| | ***Mail Order copayments (Up to 90 day supply)*** | ***Mail Order copayments (Up to 90 day supply)*** | ***Mail Order copayments (Up to 90 day supply)*** | |
| | Generic $20 | Generic $30 | Generic $30 | |
| | Formulary Brand $50 | Formulary Brand $100 | Formulary Brand $100 | |
| | Non-Preferred Brand $100 | Non-Preferred Brand $175 | Non-Preferred Brand $175 | |
| **General** | **All Florida Members** | **All Florida Members** | **All Florida Members** | |
| **Member Rate** | $519.22 | $428.45 | $418.62 | |
| **Member + Child** | $1,229.32 | $1,011.48 | $987.87 | |
| **Member + Children** | $1,635.09 | $1,344.63 | $1,313.16 | |
| **Member + Spouse** | $1,229.32 | $1,011.48 | $987.87 | |
| **Family** | $1,635.09 | $1,344.63 | $1,313.16 | |

# 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)<br>Individual<br>Family | <br>$500<br>$1,000 | <br>$1,500<br>$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)<br>Individual<br>Family | <br>None<br>None | <br>$5,000<br>$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.<br>Individual<br>Family | <br>$10,000<br>$20,000 | <br>Not Applicable<br>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**<br>Physical Exams | <br>100% | <br>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**<br>Physical Exams | <br>100% | <br>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<br>limit: 20 visits/benefit period | 80% after deductible |
| 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**<br>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<br>Individual<br>Family | none<br>none | |
| Prescription Drug Program (8)<br>Soft Mandatory Generic<br>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design<br><br>**Specialty Drugs must be purchased at Retail or Mail Order.** | **Retail Drugs (31/60/90-day Supply)**<br>$10 / $25 / $50 Formulary generic copay<br>$10 / $25 / $50 Non-Formulary generic copay<br>$40 / $80 / $120 Formulary brand copay<br>$70 / $140 / $210 Non-Formulary brand copay<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$20 Formulary generic copay<br>$20 Non-Formulary generic copay<br>$50 Formulary brand copay<br>$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.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

**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 Deitsch schwetzscht, kannscht 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-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ 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 serbisyong 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 yáníłti'go, language assistance services, éí t'áá níik'eh, bee niká a'doowoł, éí bee ná'ahóót'i'. Koji' hodiilnih 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)<br>Individual<br>Family | <br>$3,000<br>$6,000 | <br>$6,000<br>$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)<br>Individual<br>Family | <br>$5,000<br>$10,000 | <br>$10,000<br>$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.<br>Individual<br>Family | <br>$6,600<br>$13,200 | <br>Not Applicable<br>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**<br>Physical Exams | <br>100% (deductible does not apply) | <br>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**<br>Physical Exams | <br>100% (deductible does not apply) | <br>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<br>limit: 20 visits/benefit period | 70% after deductible |
| Respiratory Therapy | 90% after deductible | 70% after deductible |

| Benefit | In Network | Out of Network |
|---|---|---|
| Speech Therapy | 100% after $30 copay | 70% after deductible |
| | limit: 20 visits/benefit period | |
| Occupational Therapy | 100% after $30 copay | 70% after deductible |
| | limit: 20 visits/benefit period | |
| Spinal Manipulations | 100% after $30 copay | 70% after deductible |
| | limit: 20 visits/benefit period | |
| 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**<br>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 | 70% after deductible |
| | limit: 90 visits/benefit period aggregate with visiting nurse | |
| 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 | 70% after deductible |
| | limit: 240 hours/benefit period | |
| Skilled Nursing Facility Care | 90% after deductible | 70% after deductible |
| | limit: 100 days/benefit period | |
| Transplant Services | 90% after deductible | 70% after deductible |
| Precertification Requirements (7) | Yes | Yes |
| **Prescription Drugs** | | |
| Prescription Drug Deductible<br>Individual<br>Family | none<br>none | |
| Prescription Drug Program (8)<br>Soft Mandatory Generic<br>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design<br><br>**Specialty Drugs must be purchased at Retail or Mail Order.** | **Retail Drugs (31/60/90-day Supply)**<br>$10 / $30 / $60 Formulary generic copay<br>$10 / $30 / $60 Non-Formulary generic copay<br>$40 / $80 / $120 Formulary brand copay<br>$70 / $140 / $210 Non-Formulary brand copay<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$30 Formulary generic copay<br>$30 Non-Formulary generic copay<br>$100 Formulary brand copay<br>$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.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

**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 Deitsch schwetzscht, kannscht 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-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ 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 serbisyong 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 yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Koji' hodiilnih 1-800-876-7639.

# 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)<br>Individual<br>Family | <br>$3,000<br>$6,000 | <br>$5,000<br>$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)<br>Individual<br>Family | <br>$5,000<br>$10,000 | <br>$10,000<br>$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.<br>Individual<br>Family | <br>$7,900<br>$15,800 | <br>Not Applicable<br>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**<br>Physical Exams | <br>100% (deductible does not apply) | <br>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**<br>Physical Exams | <br>100% (deductible does not apply) | <br>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<br>limit: 20 visits/benefit period | 60% after deductible |
| Respiratory Therapy | 80% after deductible | 60% after deductible |

| Benefit | In Network | Out of Network |
|---|---|---|
| Speech Therapy | 100% after $40 copay | 60% after deductible |
| | limit: 20 visits/benefit period | |
| Occupational Therapy | 100% after $40 copay | 60% after deductible |
| | limit: 20 visits/benefit period | |
| Spinal Manipulations | 100% after $40 copay | 60% after deductible |
| | limit: 20 visits/benefit period | |
| 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**<br>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 | 60% after deductible |
| | limit: 90 visits/benefit period aggregate with visiting nurse | |
| 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 | 60% after deductible |
| | limit: 240 hours/benefit period | |
| Skilled Nursing Facility Care | 80% after deductible | 60% after deductible |
| | limit: 100 days/benefit period | |
| Transplant Services | 80% after deductible | 60% after deductible |
| Precertification Requirements (7) | Yes | Yes |
| **Prescription Drugs** | | |
| Prescription Drug Deductible<br>Individual<br>Family | none<br>none | |
| Prescription Drug Program (8)<br>Soft Mandatory Generic<br>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.<br><br>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design<br><br>**Specialty Drugs must be purchased at Retail or Mail Order.** | **Retail Drugs (31/60/90-day Supply)**<br>$10 / $30 / $60 Formulary generic copay<br>$10 / $30 / $60 Non-Formulary generic copay<br>$40 / $80 / $120 Formulary brand copay<br>$70 / $140 / $210 Non-Formulary brand copay<br><br>**Maintenance Drugs through Mail Order (90-day Supply)**<br>$30 Formulary generic copay<br>$30 Non-Formulary generic copay<br>$100 Formulary brand copay<br>$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.

HIGHMARK.

An Independent Licensee of the Blue Cross and Blue Shield Association

### 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 Deitsch schwetzscht, kannscht 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-ticheri, ki la pou ede w. Rele nan 1-800-876-7639.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ 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 serbisyong 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 yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodiilnih 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<br>• 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<br>• High-risk: More often |
| **Colon Cancer Screening (Including Colonoscopy)** | • Ages 50 and older: Every 1 to 10 years, depending on screening test<br>• High-risk: Earlier or more frequently |
| **Certain Colonoscopy Preps With Prescription** | • Ages 50 and older: Once every 10 years<br>• 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.



HIGHMARK

# Adults: Ages 19+

| | |
|---|---|
| **Screenings/Procedures** | |
| **Pap Test** | • Ages 21 to 65: Every 3 years, or annually, per doctor's advice<br>• Ages 30 to 65: Every 5 years if combined Pap and HPV are negative<br>• 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<br>• 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<br>• 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<br>• 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 Months[1]

| 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 Years[1]

| 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<br>• 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 Years[1]

| 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 |

| 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<br>• Additional nutritional counseling visits specifically for obesity<br>• Recommended lab tests:<br>– Alanine aminotransferase (ALT)<br>– Aspartate aminotransferase (AST)<br>– Hemoglobin A1c or fasting glucose (FBS)<br>– Cholesterol screening |

| Adult Diabetes Prevention Program (DPP) Age 18 | |
|---|---|
| **Applies to Adults**<br>• **Without a diagnosis of Diabetes (does not include a history of Gestational Diabetes) and**<br>• **Overweight or obese (determined by BMI) and**<br>• **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. |

# 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<br>• All women between 24 and 28 weeks pregnant<br>• 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.

## [1]Information 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.

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.

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 serbisyong 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 المعاونة 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.

U65_BCBS_G_M_2Col_8pt_blk_NL

25757 10/18 CS209870

# ENROLLMENT FORM

**Steelworkers Health and Welfare Fund**
60 Boulevard of the Allies, Fifth Floor, Pittsburgh, PA 15222
Phone: 1-877-578-8710 Fax: 412-201-2250

**OPEIU Local 45 Members**

**PLEASE PRINT CLEARLY**

## EMPLOYER INFORMATION (To Be Completed By Employer)

| Group No. | Group Name | Date of Hire | Coverage / Change Effective Date |
|---|---|---|---|
| | OPEIU Local 45 | Mo/Day/Yr / / | Mo/Day/Yr / / |

**ENROLL**
- ❑ Open Enrollment
- ❑ New Hire
- ❑ Reinstatement
- ❑ Other _____

**CHANGE**
- ❑ Add Dependent (reason) _____
- ❑ Delete Dependent (reason) _____
- ❑ Address Change _____
- ❑ Transfer from Group _____ To Group _____
- ❑ Other _____

**Medical & RX Plan Option**
- ❑ Option 1: 100/80
- ❑ Option 2: 90/70
- ❑ Option 3: 80/60

**Check Type of Coverage** — **MEDICAL**

| | |
|---|---|
| Employee Only | ❑ |
| Employee + Child | ❑ |
| Employee + Children | ❑ |
| Employee + Spouse | ❑ |
| Family | ❑ |

## EMPLOYEE INFORMATION (To Be Completed By Employee)

| Social Security # | Last Name | First Name | Middle Initial | Sex M / F | Birth Date Mo / Day / Year |
|---|---|---|---|---|---|
| | | | | | / / |

**Home Address / Apt. No.** **City** **State** **Zip Code**

**Home Telephone** ( ) **Work Telephone** ( )

## COVERED FAMILY MEMBERS

| First Name | Middle Initial | Last Name (if different than the Employee) | Social Security Number | Sex M | Sex F | Birth date Mo/Day/Yr | Dependent 19 or older* FTS | Dependent 19 or older* DD |
|---|---|---|---|---|---|---|---|---|
| Spouse | | | | ❑ | ❑ | / / | | |
| Dependent | | | | ❑ | ❑ | / / | ❑ | ❑ |
| Dependent | | | | ❑ | ❑ | / / | ❑ | ❑ |
| Dependent | | | | ❑ | ❑ | / / | ❑ | ❑ |
| Dependent | | | | ❑ | ❑ | / / | ❑ | ❑ |
| Dependent | | | | ❑ | ❑ | / / | ❑ | ❑ |

* Dependent Codes: FTS - Full Time Student (FTS code to be used for retiree only plans exclusively and a Dependent Questionnaire must be completed and attached)
DD - Disabled Dependent (if dependent is over age 26 for active plans or age 19 for retiree only plans, a Disabled Dependent Certification form must be completed and attached)

## OTHER COVERAGE If you or any family members are covered by other group health insurance, including Medicare, please complete this section

| Name of Member | Name of Other Group Health Insurance (including Medicare) & Policy Number | Effective Date |
|---|---|---|
| | | / / |
| | | / / |

I certify that the information provided on this form is true to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above for benefits as described in the agreement between my employer and the Steelworkers Health and Welfare Fund ("the Fund"). I authorize any payroll deductions required for the coverage and recognize that I must enroll my dependents on this form or they will not be covered. I understand that it is my responsibility to report to my employer any change in the eligibility of the individuals listed above or any change to the information I have provided in this Form. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, the Fund may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Fund's Notice of Privacy Practices is included in the Summary Plan Description (SPD) issued by the Fund or from the Fund's Privacy Official.

| X | / / | X | / / |
|---|---|---|---|
| Employee Signature | Date Signed Mo/Day/Yr | Employer Signature | Date Signed Mo/Day/Yr |

# Authorization for Direct Payment for Steelworkers Health and Welfare Fund Contribution

**OPEIU Local 45 Members Only**

Please print in blue or black ink.

| Part 1- MEMBER INFORMATION | | | |
|---|---|---|---|
| Member Name | | | |
| Spouse (optional) | | SSN | |
| Street Address | City | State | Zip |
| Telephone Number | Email Address (optional) | | |

| Part 2 - BANK INFORMATION | |
|---|---|
| Name of Bank or Financial Institution | |
| Name as it appears on checking account | |
| Account from which you would like your payment to be automatically deducted: | |
| **Please enclose a voided blank check** | **Account Number:** _____ |
| **with this authorization** | **Routing Number:** _____ |

| Part 3- AUTHORIZATION FOR DIRECT PAYMENT OF CONTRIBUTION | |
|---|---|
| I hereby authorize the Steelworkers Health and Welfare Fund to initiate an ACH Debit to my account for the contribution required for my health care benefits and authorize the financial institution to charge such withdrawals to my account. This amount may be adjusted to correct any overpayments or underpayments, or to reflect any charges by the financial institution due to insufficient funds in my account. I may discontinue enrollment in this direct payment option at any time by notifying the Fund Office in writing. | |
| _____ | _____ |
| Signature | Date |

To begin the automatic debit payment, please forward a copy of this completed form and a voided check to:

**OPEIU Local 45**
**Steelworkers Health and Welfare Fund**
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222

Please keep a copy of this authorization for your records. If you wish to terminate this direct payment option please notify the Eligibility Administration office at the above address.