Steelworkers Health and Welfare Fund

OPEIU Local 45- Florida		September 1, 20	20 through Augu	st 31, 2021	
Option 1	Employee Only	Employee + Child	Employee + Children	Employee + Spouse	Family
Medical PPO 100/80					
Prescription Drug:					
Retail: \$10/\$40/\$70					
Mail Order: \$20/\$50/ \$100	\$554.68	¢1 21 <i>1</i> 11	¢4 740 54	¢4 244 44	¢4 740 54
Opt 1 Med and RX Plan	•	\$1,314.41	\$1,748.54	\$1,314.41	\$1,748.54
Dental (Optional)	\$27.10	\$54.18	\$75.54	\$54.18	\$75.54
Vision (Optional)	\$5.44	\$10.86	\$12.99	\$10.86	\$12.99
Med/ RX/ Den/ VIS	\$587.22	\$1,379.45	\$1,837.07	\$1,379.45	\$1,837.07
	Employee	Employee +	Employee +	Employee	
Option 2	Only	Child	Children	+ Spouse	Family
Medical PPO 90/70					
Prescription Drug:					
Retail: \$10/\$40/\$70					
Mail Order: \$30/\$100/ \$175	A457.50	\$4.004.05	\$4.407.70	* 4 *** ** **	04 407 70
Opt 2 Med and RX Plan	\$457.56	\$1,081.35 ©54.40	\$1,437.78 \$75.54	\$1,081.35	\$1,437.78 \$75.54
Dental (Optional)	\$27.10	\$54.18 \$40.96	\$75.54 \$12.00	\$54.18 \$10.86	\$75.54 \$42.00
Vision (Optional) Med/ RX/ Den/ VIS	\$5.44 \$490.10	\$10.86 \$1,146.39	\$12.99 \$1,526.31	\$10.86 \$1,146.39	\$12.99 \$1,526.31
Wed/ KA/ Dell/ VIS	7490.10	Φ1,140.39	Φ1,320.31	ў I, 140. 39	\$1,52 0. 51
Option 3 Medical PPO 80/60	Employee Only	Employee + Child	Employee + Children	Employee + Spouse	Family
Prescription Drug: Retail: \$10/\$40/ \$70					
Mail Order: \$30/\$100/ \$175 Opt 3 Med and RX Plan	\$447.04	¢4 056 00	\$1,404.11	¢4 056 00	¢1 A0A 44
Dental (Optional)	\$447.04 \$27.10	\$1,056.09 \$54.18	\$1, 404. 11 \$75.54	\$1,056.09 \$54.18	\$1,404.11 \$75.54
Vision (Optional)	\$5.44	\$10.86	\$12.99	\$10.86	\$12.99
Combined	\$479.58	\$1,121.13	\$1,492.64	\$1,121.13	\$1,492.64

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 Emergency, Urgent	Plan pays 100%	Plan Pays 90% after deductible	Plan Pays 80% after deductible	
Emergency, Orgent Care	\$150 copay ER/ \$75 copay Urgent Care	\$150 copay ER/ \$75 copay Urgent care	\$150 copay ER/ \$100 copay Urgent care	
	orgent date	Orgeni dare	Orgeni dare	
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	
	Retail copayments (Up to 30 day supply)	Retail copayments (Up to 30 day supply)	Retail copayments (Up to 31 day supply)	
	Generic \$10 Preferred brand \$40	Generic \$10 Preferred brand \$40	Generic \$10 Preferred brand \$40	
	Non-Preferred Brand \$70	Non-Preferred Brand \$70	Non-Preferred Brand \$70	
Prescription	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 Florido Moreboro		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	







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 buildin of a hos ital.

Benefit	In Network	Out of Network
	eneral Provisions	Out of Network
Effective Date	energi Fromslans	
Benefit Period	0.5.55	
Deductible (per benefit period)	Contra	act Year T
Individual	\$500	¢1 500
Family	· ·	\$1,500
	\$1,000	\$3,000
Plan Pays – payment based on the plan allowance Out-of-Pocket Limit (Includes coinsurance. Once met, plan	100%	80% after deductible
pays 100% coinsurance for the rest of the benefit period)		
Individual	None	# 5.000
Famil	None	\$5,000 \$10,000
Total Maximum Out-of-Pocket (Includes deductible,	None	Ψ10,000
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/C	llinic/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
	eventive Care (4)	
Routine Adult	l	
, Ph sical Exams	100%	80% alter deductible
Adult Immunizations	100%	80% after deductible
Routine Gynecological Exams, including a Pap Tes	100%	80% deductible does not a
Mammograms, Annual Routine	100%	80% after deductible
Mammograms, Medically Necessary	100%	80% after deductible
Diagnostic Services and Procedures	100%	80% after deductible
Routine Pediatric		
Ph sical Exams	100%	80% after deductible
Pediatric Immunizations	100%	80% (deductible does not apply)
Diagnostic Services and Procedures	100%	80% after deductible
and the first of the comment of the comment of the En	nergency Services	
Emergency Room Services	100% after \$150 cope	ay (waived if admitted)
		100% after in-network deductible for
Ambulance - Emergency and Non-Emergency	100%	emergencies; 80% after program
and the same general and the same general	100%	deductible for non-emergencies
Hospital and Medical / S	Surgical Expenses (including maternit	
Hospital Inpatient		
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services)		80% after deductible
includin hter	100%	80% after deductible
Medical Care (including inpatient visits and		
consultations)/Surgical Expenses	100%	80% after deductible
	nd Rehabilitation Services	
Physical Medicine		000/ -#
i iyələdi Medicine	100% after \$25 copay	80% after deductible /benefit period
Respiratory Therapy	100%	80% after deductible
Speech Therapy	100 % 100% alter \$25 co a	80% after deductible
1	100 /0 GROT WED 00 G	James dedications

Benefit	In Network	Out of Network
	limit: 20 visits/	
Occupational Therapy	100% after \$25 copay	80% after deductible
	limit: 20 visits/	
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 Heal	ith / Substance Abuse	
Inpatient Mental Health Services	100%	80% after deductible
Inpatient Detoxification / Rehabilitation	100%	80% after deductible
Outpatient Mental Health Services (includes virtual	1000/ 6 40-	200/ 5/ 1 1 111
behavioral health visits	100% after \$25 copay	80% after deductible
Outpatient Substance Abuse Services	100% after \$25 copay	80% after deductible
	her Services	
Allergy Extracts and Injections	100%	80% after deductible
Applied Behavior Analysis for Autism S ectrum Disorder 5	100%	80% after deductible
Assisted Fertilization Procedures	notcovered	not covered
Dental Services Related to Accidental 1n⋅u	notcovered	not covered
Diagnostic Services		
Advanced Ima_inMRI, CAT, PET scan, etc	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/ atholo , aller 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/benefitperiod	aggreg <mark>ate with visitin nurse</mark>
los ico-	100%	80% after deductible
	100%	80% after deductible
Private Duty Nursing	100%	80% after deductible
	limit: 240 hours	
Skilled Nursing Facility Care	100%limit: 100 days	80% after deductible
Fransplant Services	100%	80% after deductible
Precertification Requirements (7)	Yes	Yes
	eription Drugs	165

Prescription Drug Deductible

Individual

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.

Family

Your plan uses the Comprehensive Formulary with an Incentive Benefit Design

Specialty Drugs must be purchased at Retail or Mail Order.

none Retail Drugs (31/60/90-day Supply)

none

\$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 maternitywrelated 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 fo1Tl1ulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan fo1Tl1ularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they *cover* and in the costwsharing requirements. Your program includes coverage for both formulary and nonwformulary 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 brandwdrug 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 seK 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 p rson or by mail, fax, or email. If you need help filling 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 electronicallythrough 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

200Independence Avenue, SW

Roam 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 espaflol, Servicios de asistencia lingUistica, de forma gratuita, estiln disponib1es para usted. Uame al 1-800-876-7639.

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Se parla italiano, per lei sono dfsponibili servizi di assistenza linguistica a tito!o gratuito. Chiamare l'1-800-876-7639.

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.l-800-876-7639

Si vous parlez fran<; ais, les services d'assistance linguistique, gratuitement, sent a votre disposition. Appelez au 1-800-876-7639.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachHche Unterstutzung kostenlos zur Verfi.igung. Rufen Sie I-800-876-7639.

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Dia os6b m6wiqcych po polsku dost pna jest bezptatna pomoc j zykowa. Zadzwor'l 1-800-876-7639.

Sise KreyO! Ayisyen au pale, gen sE!vis entepret, gratis-ticheri, ki !a pou ede w. Rele nan 1-800-876-7639.

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Se a sua lingua e0 o portugues, temos atendimento gratuito para voce 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.

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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 buildin of a hos ital.

Benefit	In Network	Out of Network
	ieneral Provisions	Out of Network
Effective Date	reneral Provisions	
Benefit Period	Contro	ct Year
Deductible (per benefit period)	Contra	ct real
Individual	¢2.000	#0.000
Famil	\$3,000 \$6,000	\$6,000 \$12,000
Plan Pa s - a ment based on the lan allowance	90% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan		. c /c unter ucuacinate
pays 100% coinsurance for the rest of the benefit period)		
Individual	\$5,000	\$10,000
Famil	\$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
	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
	reventive Care (4)	
Routine Adult		
Ph sical 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 a
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 a pply)	70% after deductible
Routine Pediatric		
Ph sical Exams	100% (deductible does not apply)	70% after deductible
Pediatric Immunizations	100% (deductible does not apply)	70% deductible does not a
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
<u>E</u> r	nergency Services	
Emergency Room Services	100% after \$150 copa	w (waived if admitted)
	100 % atter \$100 cops	
Ambulance - Emergency and Non-Emergency	90% after deductible	90% after in-network deductible for
Ambulance - Emergency and Non-Emergency	90% after deductible	emergencies; 70% after program
is properties (which the state of the state	Received Warrance Small albert - 1	deductible for non-emergencies
	Surgical Expenses (including maternit	
Hospital Inpatient	90% after deductible	70% after deductible
Hospital Outpatient	90% after deductible	70% after deductible
Maternity (non-preventive facility & professional services)	90% after deductible	70% after deductible
includi hter		
Medical Care (including inpatient visits and consultations)/Surgical Expenses	90% after deductible	70% after deductible
	nd Rehabilitation Services	
Physical Medicine	100% after \$30 copay	70% after deductible
	limit: 20 visits/	
Respiratory Therapy	90% after deductible	70% after deductible
		· ·

Benefit	In Network	Out of Network
Speech Therapy	100% after \$30 copay	70% after deductible
'		s/benefit period
Occupational Therapy	100% after \$30 copay	70% after deductible
		s/benefit period
Spinal Manipulations	100% after \$30 copay	70% after deductible
' '		s/benefit period
Other Therapy Services (Cardiac Rehab, Infusion Therapy,		
Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible
Mental He	aith / 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	100% ofter \$20 consy	70% after deductible
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 S ectrum Disorder 5	90% after deductible	70% after deductible
Assisted Fertilization Procedures	not covered	notcovered
Dental Services Related to Accidental 1n·u	not covered	not covered
Diagnostic Services	1101 00 101 04	1101 00 101 00
Advanced Ima in MRI, CAT, PET scan, etc.	90% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/ atholo , aller 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 visitin nurse
Hos ice	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 hou	rs/benefit period
Skilled Nursing Facility Care	90% after deductible	70% after deductible
	limit: 100 day	/s/benefit period
Transplant Services	90% after deductible	70% after deductible
Precertification Requirements (7)	Yes	Yes
Pre	scription Drugs	
Prescription Drug Deductible		
Individual	n	ione
Family	n	ione
Prescription Drug Program (8)	Retail Drugs (31	/60/90-day Supply)
Soft Mandatory Generic		mulary generic copay
Defined by the National Pharmacy Network - Not Physician		
Network. Prescriptions filled at a non-network pharmacy are		Formulary generic copay
not covered.		ormulary brand copay
	\$70 / \$140 / \$210 Nor	n-Formulary brand copay
Your plan uses the Comprehensive Formulary with an Incentive Benefit Design		
-	Maintenance Drugs throug	gh Mail Order (90-day Supply)
		ry generic copay
Specialty Drugs must be purchased at Retail or Mail		lary generic copay
Order.		ary brand copay
	\$175 Non-Form	nulary brand copay
This is not a contract. This bonefits summary presents plan highlights		

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.
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- 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)

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- Information written in other languages

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U.S. Department of Health and Human Services

200 Independence Avenue, $\ensuremath{\mathrm{SW}}$

Room 509F, HHH Building

Washington, D.C. 20201

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

 $Complaint forms\ are\ available\ at\ http:i/www.hhs.gov/ocr/office/file/index.htrnl.$

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

Si usted habla espaflol, servidos de asistencia linguística, de forma gratuita, estitn disponib1es para usted. Uame al 1·800-876-7639.

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

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

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Se a sua lingua C o portugues, temos atendimento gratuito para voe€ no seu idioma. Ugue 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.

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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 buildin of a hos ital.

Benefit In Network	Out of Network
General Provisions	And the second s
Effective Date	
Benefit Period Contract Yea	ır
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
Famil \$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	
Ph_sical Exams100% deductible does not a pply)	60% after deductible
Adult Immunizations 100% deductible does not a pply)	60% after deductible
	% deductible does not a
Mammograms, Annual Routine 100% deductible does not apply)	60% after deductible
Mammo rams, Medical! Necessa 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
	deductible does not a
Diagnostic Services and Procedures 100% (deductible does not apply)	60% after deductible
Emergency Services	
Emergency Room Services 100% after \$150 copay (wai	
	6 after in-network deductible for
	nergencies; 60% after program
	eductible 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) includi hter 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/benefi	

Speech Therapy	tible tible tible tible tible tible tible tible tible
Occupational Therapy 100% after \$40 copay 60% after deduct limit: 20 visits/benefit period	iible iible iible iible iible iible
Spinal Manipulations Spinal Manipulation Spinal Manipulations S	iible iible iible iible iible iible
Spinal Manipulations 100% after \$40 copay	iible iible iible iible iible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) Mental Health / Substance Abuse Inpatient Mental Health Services Inpatient Detoxification / Rehabilitation Outpatient Mental Health Services (includes virtual behavioral health visits, Outpatient Substance Abuse Services Allergy Extracts and Injections Applied Behavior Analysis for Autism S ectrum Disorder 5 Dental Services Related to Accidental 1n·u Diagnostic Services Advanced Ima in MRI, CAT, PET scan, etc. Basic Diagnostic Services (standard imaging, diagnostic) Mental Health / Substance Abuse 80% after deductible 60% after deductible 80% after deductible	iible iible iible iible iible
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Basic Diagnostic Services (standard imaging, diagnostic	
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medical, lab/ atholo , aller testing) 80% after deductible 60% after deductible	ble
Durable Medical Equipment, Orthotics and Prosthetics 80% after deductible 60% after deducti	ble
Home Health Care 80% after deductible 60% after deduct	ible
limit: 90 visits/benefit ate with visitin nurse	,
Hospice 80% after deductible 60% after deducti	ble
Infertility Counseling, Testing and Treatment 6 80% after deductible 60% after deducti	ble
Private Duty Nursing 80% after deductible 60% after deducti	ble
limit: 240 hours/benefit period	
Skilled Nursing Facility Care 80% after deductible 60% after deduct	ible
limit: 100 days/benefit period	
Transplant Services 80% after deductible 60% after deduct	ible
Precertification Requirements (7) Yes Yes	
Pla Irugs	
Prescription Drug Deductible	
Individual none	
Family	
Prescription Drug Program (8) Retail Drugs (31/60/90-day Supply)	
Soft Mandatory Generic \$10 / \$30 / \$60 Formulary generic copay	
Defined by the National Pharmacy Network - Not Physician \$10 / \$30 / \$60 Non-Formulary generic copay	
Network. Prescriptions tilled at a non-network pharmacy are	
not covered. \$70 / \$140 / \$210 Non-Formulary brand copay	
Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	
	lv)
Maintenance Drugs through Mail Order (90-day Supp	ту)
Specialty Drugs must be purchased at Retail or Mail \$30 Formulary generic copay	
Order	
\$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 perfonned 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).
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U.S. Department of Health and Human Services

200 Independence Avenue, SW

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DinC k'chgo ydnihi'go, language assistance services, ci t'dli nifk'ch, bee nikli a'doowol, Cf bee m\.'ah66tT. Kqii' hodiilnih l-S00-876-7639.

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+





Female

Gene	ral 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
Scree	nings/Procedures	
Ť	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 yearsHigh-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 yearsHigh-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



Sexually Transmitted Disease (STD)
Screenings and Counseling (Chlamydia,
Gonorrhea, HIV and Syphilis)

- 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 active males and females

Immunizations

Chicken Pox (Varicella)



Diphtheria, Tetanus (Td/Tdap)



Flu (Influenza)



Haemophilus Influenzae Type B (Hib)



Hepatitis A



Hepatitis B



Human Papillomavirus (HPV)



Measles, Mumps, Rubella (MMR)



Meningitis*



Pneumonia



Shingles

Adults with no history of chicken pox: One 2-dose series

- One-time Tdap
- Td booster every 10 years

 $Every year (Must get at your PCP's office or designated pharmacy vaccination provider; \\ call Member Service to verify that your vaccination provider is in the Highmark network)$

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

At-risk or per doctor's advice: One 2-dose series

At-risk or per doctor's advice: One 3-dose series

To age 26: One 3-dose series

One or two doses

At-risk or per doctor's advice

High-risk or ages 65 and older: One or two doses, per lifetime

- Zostavax Ages 60 and older: One dose
- Shingrix Ages 50 and older: Two doses

Preventive Drug Measures That Require a Doctor's Prescription



Aspirin



Folic Acid



Raloxifene Tamoxifen

(Counseling and medication)



Tobacco Cessation



Low to Moderate Dose Select Generic Statin Drugs For Prevention of Cardiovascular Disease (CVD)

- Ages 50 to 59 to reduce the risk of stroke and heart attack
- Pregnant women at risk for preeclampsia

Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid

At-risk for breast cancer, without a cancer diagnosis, ages 35 and older

Adults who use tobacco products

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
 - Cholesterolscreening

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.

OUESTIONS?







THE 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 carerelated 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							Do	se 1			
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Do	se 4		
Flu (Influenza)**					,	Ages 6 mc	onths to 3	0 months:	1 or 2 dos	es annually	/
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Do	se 4			
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Do	se 2				Dose 3				
Measles, Mumps, Rubella (MMR)							Do	se 1			
Pneumonia			Dose 1	Dose 2	Dose 3		Do	se 4			
Polio (IPV)			Dose 1	Dose 2	Age	es 6 mont	hs to 18 m	nonths: Do	se 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. ** Highmark network.	* Must get at your PCP's office or designa	ted pharmacy vaccination provide	er. Call Member Service to verify that	your vaccination provider is in the



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			Annual	ly for fem	ales durii	ng adoles	cence an	d when ir	ndicated			
Lead Screening	When ir	When indicated (Please also refer to your state-specific recommendations)										
Cholesterol (Lipid) Screening							Once b	etween a	ges 9-11 a	ind ages	17-21	
Immunizations												
Chicken Pox		Dose 2								vaccina	reviously ited: Dose ks apart)	e 1 and 2
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5				of Tdap in d previou	f 5 doses usly	were not				1 dose every 10 yrs.
Flu (Influenza)****	Ages 3 t	o 18: 1 o	r 2 doses	annually								
Human Papillomavirus (HPV)							other c		rm protec doses who ages.			
Measles, Mumps, Rubella (MMR)			(at least from dose									
Meningitis****									Dose 1		Age 16	
Pneumonia	Per doc	tor's adv	ice									
Polio (IPV)		Dose 4										
Care for Patients With Ri	sk Facto	ors										
BRCA Mutation Screening (Requires prior authorization)					Per do	ctor's adv	ice					
Cholesterol Screening	Screeni	ng will be	e done ba	sed on th	e child's	family his	tory and	risk facto	rs			
Fluoride Varnish (Must use primary care doctor)	Ages 5 a	and your	nger									
Hepatitis B Screening									Per doc	tor's advi	ce	
Hepatitis C Screening											High-ri	sk
Latent Tuberculosis Screening												High- risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV and Syphilis)										utine che	active ind	
Tuberculin Test	Per doc	tor's adv	ice									

^{*}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

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.



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 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 (ТТҮ): 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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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

							_		IIII CELIIICEI
EMPLOYER INFORM	ATION (To Be Comp	oleted By Empl	oyer)						
Group No.	Group Namo	PEIU Local 45			Date of H	ire		Coverage / Cha	nge Effective Date
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ENROLL	CHANGE	,		Medical & RX Plan Option		Check Type of Cover	age ME	DICAL	
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□ New Hire	☐ Delete Dependent (rea	ison)		□ Option 2: 90/70		Employee Only Employee + Child		D	
☐ Reinstatement	☐ Address Change ☐ Transfer from Group	т.	Croun			Employee + Childr		D	
☐ Other				—— □ Option 3: 80/60		Employee + Spous	se	D	e vitalia di salah s
	Other					Family		D	
EMPLOYEE INFORM	ATION (To Be Com	oleted By Empl	ovee)						
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OTHER COVERAGE	If you or any famil	y members are c	overed by other	aroup health insurance, i	ncludina	Medicare, pl	lease (comolete this	section
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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 infonnation 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 fonn 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 infonnation above or any change to the infonnation I have provided in this Form. I acknowledge and agree that any personally identifiable health infonnation 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 Privacy Official.

X	I I	X	I I
Employee Signature	Date Signed Mo/Dav/Yr	Employer Signature	Date Signed Mo/Dav/Yr

USWA 007 5/18 **FUND**



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 (opti	onal)
Part 2 - BANK INFORMATION		
Name of Bank or Financial Institution		
Name as it appears on checking account		
Account from which you would like your pa	ayment to be automatically	deducted:
Please enclose a voided blank check	Account Number:	
with this authorization	Routing Number:	
Part 3- AUTHORIZATION FOR DIRECT	PAYMENT OF CONTRIB	BUTION
I hereby authorize the Steelworkers Health contribution required for my health care ber		
such withdrawals to my account. This amou	ant may be adjusted to corre	ect any overpayments or underpayments,
or to reflect any charges by the financial ins discontinue enrollment in this direct paymen		
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.