Company	FCE	USW BC/BS	USW v FCE
Plan	**2022 Plus**	**PPO Premium w/ A**	
Annual In-network deductible (Ind/Fam)	$1,200/$2,400	$300/$600	**USW $900/$1,800 less**
Out-of-pocket maximum (Ind/Fam)	$4,500/$9,000	$3,500/$7,000	**USW $1,000/$2,000 less**
Coinsurance	20% after ded	20% after ded	Even
Office visits	$30	$20	**USW $10 less**
Specialist visits	$60	$20	**USW $40 less**
Preventative services	100% no ded	100% no ded	Even
Diagnostic X-rays and lab tests	20% after ded	20% after ded	Even
Inpatient care	20% after ded	20% after ded	Even
Outpatient care	20% after ded	20% after ded	Even
Emergency room services	$200	$40 (waived if admitted)	**USW $160 less**
Urgent care	$60	$20	**USW $40 less**
Retail Prescription Drugs			
In network; 30 days - FCE/ 34 days - USW	$10	$10	Even
Generic drugs Formulary brand name	$30	$20	**USW $10 less**
Non-formulary brand name and specialty drugs	$60	$20	**USW $40 less**
Mail Order Prescription Drugs			
(up to 90 days) In network	$20	$20	Even
Generic drugs Formulary brand name	$60	$40	**USW $20 less**
Non-formulary brand name and specialty drugs	$120	$40	**USW $80 less**
Monthly Premium Rates	**0% increase**		**Premium Difference**
EE	$726.50	$774.36	-$47.86
EE + Sp	$1,758.95	$1873.94	-$114.99
EE + Ch(ren)	$1,446.75	$1726.82	-$280.07
Family	$2,383.36	$2454.72	-$71.36
PER CHECK Premium Rates			
EE	$335.31	$357.40	-$22.09
EE + Sp	$811.82	$864.90	-$53.07
EE + Ch(ren)	$667.73	$796.99	-$129.26
Family	$1100.01	$1132.95	-$32.94
Per Check Cost after H&W			
EE	**$138.29**	**$116.20**	($22.09)
EE + Sp	($338.22)	($391.30)	($53.07)
EE + Ch(ren)	($194.13)	($323.39)	($129.26)
Family	($626.41)	($659.35)	($32.94)

Figures in parenthesis are your out of paycheck cost

Summary of PPO *Benefits*

With your PPO, or Preferred Provider Organization, if you receive services from a provider who is in the PPO network, you'll receive the highest level of benefits. If you receive services from a provider who is not in the PPO network, you'll receive the lower level of benefits. In either case, you coordinate your own care. There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. Below are specific benefit levels that apply during your benefit period.

Benefit	In-Network	Out-of-Network
Benefit Period①	Calendar Year	
Deductible (per benefit period) Individual Family	 $300 $600	 $600 $1,200
Plan Payment Level – Based on the provider's reasonable charge (PRC)	80% after deductible until out-of-pocket limit is met, then 100%	60% after deductible until out-of-pocket limit is met; then 100%
Out-of-Pocket Limit (per benefit period)④ Individual Family	 $2,500 $5,000	 $5,000 $10,000
Total Maximum Out-of-Pocket⑤ (per benefit period) Individual Family	 $3,500 $7,000	 N/A N/A
Lifetime Maximum (per person)	Unlimited	Unlimited
Physician Office Visits	100% after $20 copayment	60% after deductible
Specialist Office Visits	100% after $20 copayment	60% after deductible
Urgent Care Center Visits	100% after $20 copayment	60% after deductible
Telemedicine Services⑨	100% after $0 copayment	Not Covered
Preventive Care⑦ ***Adult*** Routine Physical exams	 100% (deductible/copayment does not apply)	 Not Covered
Adult Immunizations	100% (deductible does not apply)	60% after deductible
Routine gynecological exams, including a PAP Test	100% (deductible/copayment does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Well-Women Care⑧	100% (deductible does not apply)	60% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
Pediatric Routine physical exams	 100% (deductible/copayment does not apply)	 Not Covered
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 Room Services	100% after $40 copayment (wavied if admitted)	
Spinal Manipulations	100% after $20 copayment	60% after deductible
	Limit: 20 visits/calendar year	
Physical Medicine and Speech and Occupational Therapy	100% after $20 copayment	60% after deductible
	Combined Limit: 60 visits/calendar year	
Ambulance	80% after deductible	
Applied Behavior Analysis for Autism Spectrum Disorders (ASD)⑥	80% after deductible	60% after deductible
Assisted Fertilization Procedures	Not Covered	
Dental Services Related to Accidental Injury	80% after deductible	60% after deductible
Diabetes Treatment	80% after deductible	60% after deductible
Diagnostic Services ***Advanced Imaging*** (MRI, CAT Scan, 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

Benefit	In-Network	Out-of-Network
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	
Enteral Foods	80% (deductible does not apply)	60% (deductible does not apply)
Home Infusion Therapy	80% after deductible	
Home Health Care	80% after deductible	
Hospice	80% after deductible	
Hospital Services – Inpatient	80% after deductible	60% after deductible
Hospital Services – Outpatient	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment②	80% after deductible	60% after deductible
Maternity (facility & professional services)	80% after deductible	60% after deductible
Medical/Surgical Expenses (Except Office Visits)	80% after deductible	60% after deductible
Mental Health – Inpatient	80% after deductible	60% after deductible
Mental Health – Outpatient	80% after deductible	60% after deductible
Pediatric Extended Care Services	80% after deductible	60% after deductible
	Limit: 100 days/calendar year	
Private Duty Nursing	80% after deductible	
Respiratory Therapy	80% after deductible	
Skilled Nursing Facility Care	80% after deductible	
Substance Abuse – Inpatient Detoxification	80% after deductible	60% after deductible
Substance Abuse – Inpatient Rehabilitation	80% after deductible	60% after deductible
Substance Abuse – Outpatient	80% after deductible	60% after deductible
Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
Transplant Services	80% after deductible	60% after deductible
Precertification Requirements	Performed by Member③	

For Providers in your area call 1-800-810-BLUE

① Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.

② Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy is covered.

③ Highmark Healthcare Management (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. 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.

④ Out-of-pocket limits do not include copayments, deductibles, prescription drug cost share, or amounts in excess of the Allowable Charge. Once the out-of-pocket limit is met, the plan will pay 100% for the remainder of the benefit period for benefits subject to coinsurance.

⑤ Total maximum out-of-pocket includes copayments, deductibles, prescription drug cost share and out-of-pocket limits. Once the total maximum out-of-pocket is met, the plan will pay 100% for the remainder of the benefit period. This amount is subject to change per ACA guidelines.

⑥ Coverage for eligible members to age 21. Services will be paid according to the benefit category, i.e., speech therapy. Treatment for autism spectrum disorders does not reduce visit/day limits.

⑦ Services are limited to those listed on the Highmark Preventive Schedule and the Women's Health Preventive Schedule. Gender, age and frequency limits may apply.

⑧ Benefits are provided for female members for items and services, including, but not limited to, an initial physical examination to confirm pregnancy, screening for gestational diabetes, coverage for contraceptive methods (In-Network coverage only) and counseling and breastfeeding support and counseling.

⑨ 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.

Benefit	In-Network		Out-of-Network
National Plus Prescription Drug Program (Defined by National Plus Pharmacy Network - Not Physician Network)	Retail – 34-day supply Mail Order – 90 day supply Mandatory Generic①		Not Covered
Option A	Retail ➢ $10 copayment generic ➢ $20 copayment brand	Mail-Order ➢ $20 copayment generic ➢ $40 copayment brand	
Option B	Retail ➢ $15 copayment generic ➢ $40 copayment brand	Mail Order ➢ $30 copayment generic ➢ $80 copayment brand	
Option C	Retail ➢ $20 copayment generic ➢ $50 copayment brand	Mail Order ➢ $40 copayment generic ➢ $100 copayment brand	
Option D	Retail ➢ $10 copayment generic ➢ $20 copayment brand formulary② ➢ $35 copayment non-formulary	Mail Order ➢ $20 copayment generic ➢ $40 copayment brand formulary② ➢ $70 copayment non-formulary	
Option E	Retail ➢ $15 copayment generic ➢ $30 copayment brand formulary② ➢ $45 copayment non-formulary	Mail Order ➢ $30 copayment generic ➢ $60 copayment brand formulary② ➢ $90 copayment non-formulary	
Option F	Retail ➢ $20 copayment generic ➢ $40 copayment brand formulary② ➢ $80 copayment non-formulary	Mail Order ➢ $40 copayment generic ➢ $80 copayment brand formulary② ➢ $160 copayment non-formulary	

① The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.

② The formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above.

2022 Preventive Schedule

Effective 1/1/2022

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. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

Questions?

- Call Member Service
- Ask your doctor
- Log in to your account

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening	Once a year
Illicit Drug Use Screening	Once a year
Pelvic, Breast Exam	Once a year

SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 45 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Certain Colonoscopy Preps With Prescription	• Ages 45 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk
Hepatitis C Screening	Ages 18-79
Latent Tuberculosis Screening	High-risk

* 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; age-appropriate guidance, and intimate partner violence screening and counseling for reproductive age women.

HIGHMARK

Adults: Ages 19+

SCREENINGS/PROCEDURES	
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 50 to 80 with 20-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 3D
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every 2 years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 Pap: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	• Sexually active males and females • HIV screening for adults to age 65 in the general population and those at risk, then screening over age 65 with risk factors
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap 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- or 3-dose series
Hepatitis B	At-risk or per doctor's advice: One 2- or 3-dose series
Human Papillomavirus (HPV)	• To age 26: One 3-dose series • Ages 27-45, at-risk or per doctor's advice
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	Shingrix - Ages 50 and older: Two doses
PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	• Ages 50 to 59, to reduce the risk of stroke and heart attack • Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase* inhibitor**	At risk for breast cancer, without a cancer diagnosis, ages 35 and older

* Meningococcal B vaccine per doctor's advice.
** 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.
*** Aromatase inhibitors when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
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
Select PrEP Drugs and Certain Related Services for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis

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 • Depression prevention counseling 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 • Alcohol misuse screening and counseling • Nutritional counseling for pregnant women to promote healthy weight during the pregnancy

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE		
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
Adults with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome **Adults with BMI 40 and over**	Nutritional counseling	

ADULT DIABETES PREVENTION PROGRAM (DPP)	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100–125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140–199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

2022 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.

Services include Bright Futures recommendations. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

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 Anemia 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.

** Per Bright Futures, and refer to state-specific recommendations as needed.

*** 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 12 to 18		
Illicit Drug Use Screening												●
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	
SCREENINGS												
Hematocrit or Hemoglobin Anemia 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							One dose Tdap			
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										
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												●
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check once between ages 15-18			
Tuberculin Test	Per doctor's advice											

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

Children: 6 Months to 18 Years[1]

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Oral Fluoride	For ages 6 months to 16 years whose primary water source is deficient in fluoride

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
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
Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling

ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7% to 6.4% 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 developmentally and age-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 Counseling	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
Screening for Anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent girls and adult women, including those who are pregnant or postpartum.

* 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 "grandfathered" 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 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.

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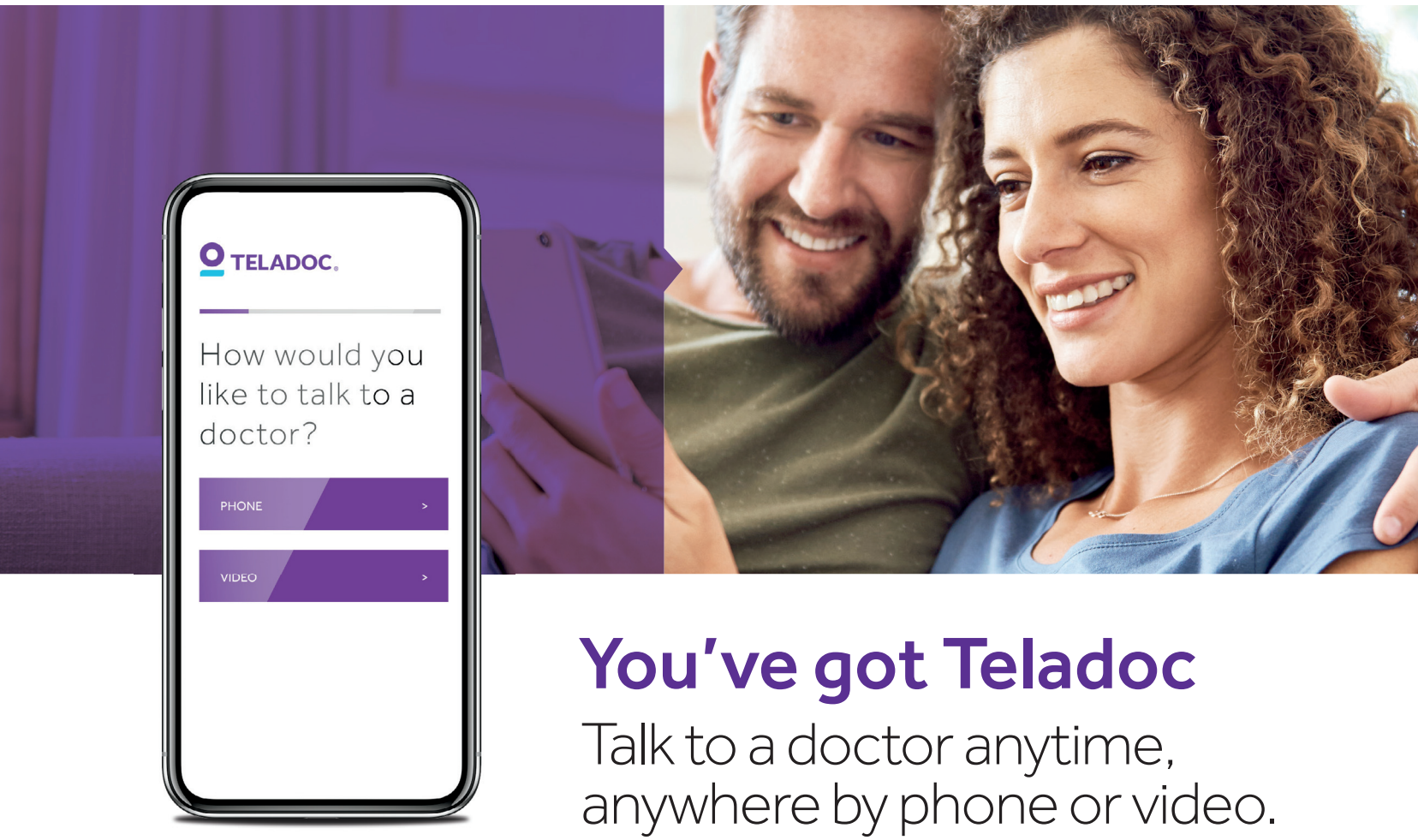

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Due to COVID-19, some employers have elected to waive member cost sharing. To obtain information about your cost sharing, please contact Highmark member service at the telephone number on the back of your ID Card. 10E-101_413370312_11062019

STEELWORKERS HEALTH & WELFARE FUND
PARTICIPATION AGREEMENT

This Participation Agreement is entered into by and between _____ ("Employer") and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union ("USW") acting on behalf of Local _____ ("Union") to implement the terms and conditions of their collective bargaining agreement dated _____, 200__ ("CBA") with respect to the provision of certain health and/or other welfare benefits to eligible employees. This Agreement also provides benefits for certain non-bargaining unit full-time employees and bargaining unit full-time employees covered under collective bargaining agreements between _____ and _____.

1. **Trust Agreement**. The Employer and the Union each agree to be legally bound by the Steelworkers Health and Welfare Fund Agreement and Declaration of Trust, as it may be amended from time to time, which is incorporated by reference into this Agreement.

2. **Benefits**. The Fund will provide eligible employees with coverage under the following benefit programs (*check all that apply and specify which program or dollar amount where applicable):*

   Medical Plan _____

   Prescription Drug _____

   Dental Plan _____

   Vision Plan _____

   Life Insurance, $_____

   Accidental Death and Dismemberment $_____

   Spouse Life Insurance, $_____

   Short Term Disability, $_____per week for _____ weeks.

   Notwithstanding any other provision of this Participation Agreement, if the Fund provides any of the benefit programs selected above through a third-party carrier, and the carrier stops offering the program, the Fund may cease to provide coverage under that program effective on the date on which the carrier stops offering the program ("program termination date") by providing notice to the Employer and the Union at least 60 days in advance of the program termination date, and the Employer will have no further obligation under Section 4 to make contributions for coverage under the program after the program termination date.

3. **Eligibility**. Unless specifically excluded in this Section 3, each common law employee who works in a job classification covered under the CBA and each eligible non-bargaining unit employee is eligible for the benefits described in Section 2 above, so long as the employee makes the applicable employee contribution, if any.

Bargaining Unit Employees – USW

(a) Effective date of coverage

(1) Coverage effective date for the employee:

First day of employment

First day of the month following ___ days of employment

Other (*describe):* _____

(2) Coverage effective date for dependents (*please refer to the Plan document for the definition of eligible dependents):*

Same date as employee

Other (*describe):* _____

(3) Employees excluded from coverage (*describe*): _____

(b) Termination of coverage

(1) Date of termination of coverage upon termination of employment:

Date of termination of employment

First day of the month following ___ days of termination of employment.

Other (*describe*): _____

(2) Date of termination of coverage upon retirement:

Date of retirement

First day of the month following ___ days of retirement

Other (*describe*): _____

(3) Date of termination of coverage upon layoff:

Date of layoff

First day of the month following __ days of layoff

Other (*describe*): _____

(4) Date of termination of coverage upon disability:

Date of disability

First day of the month following ___ days of disability

Other (*describe*): _____

(5) Date of termination of coverage upon other absence from work (describe *absence and date of termination of coverage:)*_____

Bargaining Unit Employees – Union 2

(a) Effective date of coverage

(1) Coverage effective date for the employee:

First day of employment

First day of the month following ___ days of employment

Other (*describe):* _____

(2) Coverage effective date for dependents (*please refer to the Plan document for the definition of eligible dependents):*

Same date as employee

Other (*describe):* _____

(3) Employees excluded from coverage (*describe*): _____

(b) Termination of coverage

(1) Date of termination of coverage upon termination of employment:

Date of termination of employment

First day of the month following ___ days of termination of employment.

Other (*describe*): _____

(2) Date of termination of coverage upon retirement:

Date of retirement

First day of the month following ___ days of retirement

Other (*describe*): _____

(3) Date of termination of coverage upon layoff:

Date of layoff

First day of the month following __ days of layoff

Other (*describe*): _____

(4) Date of termination of coverage upon disability:

Date of disability

First day of the month following ___ days of disability

Other (*describe*): _____

(5) Date of termination of coverage upon other absence from work (describe *absence and date of termination of coverage:)*_____

Non-Bargaining Unit Employees

(a) Effective date of coverage

(1) Coverage effective date for the employee:

First day of employment

First day of the month following ___ days of employment

Other (*describe):* _____

(2) Coverage effective date for dependents (*please refer to the Plan document for the definition of eligible dependents):*

Same date as employee

Other (*describe):* _____

(3) Employees excluded from coverage (*describe*): _____

(b) Termination of coverage

(1) Date of termination of coverage upon termination of employment:

Date of termination of employment

First day of the month following ___ days of termination of employment.

Other (*describe*): _____

(2) Date of termination of coverage upon retirement:

Date of retirement

First day of the month following ___ days of retirement

Other (*describe*): _____

(3) Date of termination of coverage upon layoff:

Date of layoff

First day of the month following __ days of layoff

Other (*describe*): _____

(4) Date of termination of coverage upon disability:

Date of disability

First day of the month following ___ days of disability

Other (*describe*): _____

(5) Date of termination of coverage upon other absence from work (describe *absence and date of termination of coverage:)*_____

4. **Contributions**.

(a) Initial Period. For the period beginning on the first day of _____, 200__, and continuing through the last day of _____, 200__, the Employer shall make payments to the Fund at the rates set forth below on behalf of each eligible employee described in Section 3 above.

	Individual	**Member + 1**	**Family**
Medical	$	$	$
Prescription Drug	$	$	$
Dental	$	$	$
Vision	$	$	$
Life/AD&D	$	$	$
Spouse Life	$	$	$
Short-term Disability	$	$	$

(b) Subsequent Periods. For any period beginning with the expiration of the rates listed in Section 4(a) above and continuing through the expiration of this Agreement, the Employer shall make payments to the Fund at the rates prescribed by the Board, or its authorized agent, on behalf of each eligible employee described in Section 3 above. Each period for which a particular rate is in effect is considered to be a "Subsequent Period." No increase in rates will take effect before the first day of the month next following the expiration of the 30-day period after notice of the increase was furnished to the Employer and the Union.

(c) Partial Coverage Months. Contributions are due for each eligible employee for each month during which the eligible employee was provided with coverage except that, for individuals who were eligible employees for only part of a month, contributions shall be paid as follows:

(1) New Coverage: Contribution is due only if employee became eligible before the 16th day of the month for which coverage is provided.

(2) Termination of Coverage: Contribution is due only if employee ceased to be an eligible employee after the 15th day of the month for which coverage is provided.

(d) Contribution Due Date. All contributions are due no later than (1) the 10th day of the month or (2) the 15th day of the month in the event that ACH Debit Authorization has been granted to the Fund, for which the benefits attributable to such contributions are provided.

5. **Adjustment of Rates.** In the event the total number of employees enrolled for any benefit described in Section 2 above during the Initial Period or any Subsequent Period increases or decreases by [five percent (5%) over 100 lives; twenty percent (20%) – under 100 lives] or more from the number of employees enrolled as of the first day of that period, the Fund

reserves the right to adjust the contribution rates charged for any benefit for the rest of that period to reflect the change in enrollment. The Fund shall notify the Employer and the Union of any such adjustment no later than 30 days before the effective date of the adjustment.

6. **Limitation on Employee and Dependent Contributions**. The monthly contribution rate, if any, charged by the Employer to an employee for any type of coverage (including coverage for dependents) may not exceed 25% of the total contribution rate for such type of coverage.

7. **Waiver of Coverage.** If the Employer requires a monthly contribution from an employee for any type of coverage (including coverage for dependents), and the employee either declines coverage as of the initial eligibility date or fails to pay the employee contribution for any subsequent month and loses coverage as a result, coverage will not be reinstated until the first day of the month following the end of an annual open enrollment period or, if there is no annual open enrollment period, the next renewal date under the contract between the Fund and the provider.

8. **Obligations With Respect to COBRA**. The Fund acknowledges that it is responsible for providing COBRA coverage to eligible covered employees and their eligible dependents under section 4980B(f) of the Internal Revenue Code. To enable the Fund to satisfy its COBRA obligations under section 4980B(f) of the Internal Revenue Code, and as required of the Employer under that section, the Employer will notify the Fund of the following qualifying events as that term is defined under that section with respect to its employees including any retirees covered by the Fund as of the date of the qualifying event, within 30 days of the qualifying event: (1) the death of the covered employee; (2) the termination (other than by reason of such employees' gross misconduct), or reduction of hours of the covered employees' employment; (3) the covered employee becoming entitled to benefits under title XVIII of the Social Security Act; or (4) a proceeding in a case under title 11, United States Code, if any retirees are covered under this Agreement. The Employer agrees to comply with any statutory changes in its notification obligations that become effective during the term of this Agreement. The Employer agrees to indemnify the Fund against all losses that the Fund incurs as a result of the Employer's failure to comply with its notification obligations set forth in this Section 7.

9. **Complete Agreement**. This Agreement is the sole and total agreement between the Employer and the Union with respect to benefits identified herein. If any other agreement between the Employer and the Union (including the CBA) contains provisions inconsistent with this Agreement, those inconsistent provisions shall have no force and effect with respect to the obligations and agreements under this Agreement.

10. **Applicable Law**. This Agreement is subject in all respects to the provisions of the Labor-Management Relations Act of 1947, as amended, and to any other applicable laws.

11. **Fund Obligations**. The Employer and the Union understand that the Fund shall not be obligated to provide benefits to any eligible employee (i) unless and until the Board's authorized agent accepts this Agreement by signing where indicated below, and (ii) with

respect to any period for which the Employer does not make the full payments to the Fund described in Section 4.

12. **Assignment**. Neither the Employer nor the Union may assign any of its rights or obligations under this Agreement to another party without the advance written consent of the Fund.

13. **Amendment**. This Agreement may be amended at any time by the written consent of the Employer, the Union and the Fund.

14. **Term.** The provisions of this Agreement shall become effective as of the first day of _____,____, and shall remain in effect until the last day of _____, ___. The termination of this Agreement shall not relieve the parties hereto of any statutory or contractual obligation to continue to provide health and/or welfare benefits to any eligible employee covered by this Agreement or to make all contributions owed to the Fund.

IN WITNESS WHEREOF, the Employer and the Union hereby execute this Agreement effective as of the date specified in Section 14 above.

UNITED STEEL, PAPER AND FORESTRY, RUBBER, MANUFACTURING, ENEGERY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION AFL-CIO-CLC on behalf of Local No. _____

_____
Employer

By: _____
Title

By: _____
International President

Attest: _____

By: _____
International Secretary/Treasurer

By: _____
International Vice President

By: _____
International Vice President

By: _____
Director

By: _____
Staff Representative

Accepted on behalf of the Steelworkers

Health and Welfare Fund on _____, _____,

By: _____
Executive Director

David McCall
Chairman

Diane Pickle
Executive Director

Frequently Asked Questions

Are benefits fully insured or self-insured?

All Fund benefits presented in this proposal are fully insured.

How many employers currently participate in the Fund?

389 employers participating as of December 31, 2020.

How many employees are currently enrolled in the Fund?

56,214 employees participating as of December 31, 2020.

How are annual Medical/Prescription Drug renewals calculated?

- Groups less than 200 covered lives: Groups with less than 200 covered lives are placed into the Fund's small group PPO pool. Each group enters that pool with their own, demographically adjusted rate. Going forward, the group will receive the overall annual pool increase.
- Groups with 200 or more covered lives: Groups with more than 200 covered lives will be experience-rated. These renewals are calculated based on a percentage of the group's own claims experience, along with a blending of trend and Highmark's overall book of business. The percentage of claims data used is based on the group's creditability at the time of the renewal.

What is the benefit period?

All benefits run on a calendar year: January 1st through December 31st.

When will rates renew?

- For PPO plans, rates will renew 12 months from the effective date of coverage.
- For Qualified High Deductible Plans, rates will renew January 1st.

All renewals will be provided to the company and USW Staff Representative no later than 90 days prior to renewal effective date.

Who is responsible for communicating enrollment, changes and terminations?

The employer is responsible for communicating all eligibility to the Fund Office. This includes initial enrollment and ongoing additions, changes, and terminations. More details of how this information may be communicated will be provided during implementation.

Who is responsible for conducting the annual Open Enrollment?

The employer is responsible for scheduling and conducting annual Open Enrollment.

Is a Participation Agreement a requirement to participate in the Fund?

Yes. Groups must enter into a Participation Agreement. The Participation Agreement will be provided and must be signed prior to the effective date of coverage. Failure to sign the Participation Agreement may result in a delay of benefits.