

| Plan Types | FCE HSA | | | USW | USW v FCE | | |
|--|--------------------|-------------------------|------------------------|---|---------------------------|--|-------------------------------------|
| Major Medical Benefits | Current | 2022 Plan | Opt1 | QHDHP 80/60 | Current | 2022 | Opt1 |
| Annual In-network deductible (Ind/Fam) | \$2,500 / \$5,000 | \$3,000/\$6,000 | \$1,500/\$3,000 | \$2,500/\$5,000 | Even | USW \$500/\$1,000 less | FCE \$1,000/\$2,000 less |
| Out-of-pocket maximum (Ind/Fam) | \$4,250 / \$8,500 | \$5,250/\$10,500 | \$4,250/\$8,500 | \$1,750/\$3,500 (not inc. co-pay/ins or RX) \$4,250/\$8,500 Total OOPM | Even (Total OOP Max) | USW \$3,500/\$7,000 less (Total OOPM) | Even (Total OOP Max) |
| Coinsurance | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Office visits | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Specialist visits | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Preventative services | 100% no ded | 100% no ded | 100% no ded | 100% no ded | Even | Even | Even |
| Diagnostic X-rays and lab tests | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Inpatient care | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Outpatient care | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Emergency room services | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Urgent care | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Retail Prescription Drugs | | | | | | | |
| In network; 30 days - FCE/ 34 days - USW | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Generic drugs Formulary brand name | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Non-formulary brand name and specialty drugs | 20% after ded | 20% after ded | 20% after ded | 20% after ded | Even | Even | Even |
| Mail Order Prescription Drugs | | | | | | | |
| (up to 90 days) In network | 15% after ded | 15% after ded | 15% after ded | 20% after ded | FCE 5% less | FCE 5% less | FCE 5% less |
| Generic drugs Formulary brand name | 15% after ded | 15% after ded | 15% after ded | 20% after ded | FCE 5% less | FCE 5% less | FCE 5% less |
| Non-formulary brand name and specialty drugs | 15% after ded | 15% after ded | 15% after ded | 20% after ded | FCE 5% less | FCE 5% less | FCE 5% less |
| Monthly Premium Rates | 5% increase | 0% increase | 8% increase | | Premium Difference | Premium Difference | Premium Difference |
| EE | \$632.90 | \$602.74 | \$651.89 | \$586.85 | 46.05 | 15.89 | 65.04 |
| EE + Sp | \$1,521.72 | \$1,449.24 | \$1567.37 | \$1,420.18 | 101.54 | 29.06 | 147.19 |
| EE + Ch(ren) | \$1,252.94 | \$1,193.26 | \$1290.53 | \$1,308.68 | (55.74) | (115.42) | (18.15) |
| Family | \$2,059.23 | \$1,961.15 | \$2121.01 | \$1,860.32 | 198.91 | 100.83 | 260.69 |
| PER CHECK Premium Rates | | | | | | | |
| EE | \$292.11 | \$278.19 | \$300.87 | \$270.85 | 21.25 | 7.33 | 30.02 |
| EE + Sp | \$702.33 | \$668.88 | \$723.40 | \$655.47 | 46.86 | 13.41 | 67.94 |
| EE + Ch(ren) | \$578.28 | \$550.74 | \$595.63 | \$604.01 | (25.73) | (53.27) | (8.37) |
| Family | \$950.41 | \$905.15 | \$978.93 | \$858.61 | 91.80 | 46.54 | 120.32 |

Steelworkers Health and Welfare Fund Rate Proposal to

LDRM QHDHP Option

Effective Date: **March 1, 2022 through December 31, 2023**

| Plan Options | Monthly Rates | | | | | | Term (# of mos.) |
|----------------------------------|------------------------------------|--------------------|-----------------------|---------------------|------------|-----------------|---------------------|
| | Individual | Employee/ Child | Employee/ Children | Employee/ Spouse | Family | Carrier | |
| Administrative Fee | \$4.00 per member per month | | | | | Fund | 22 |
| Medical/Rx: | | | | | | Highmark | 22 |
| ➤ QHDHP 80/60 \$2,500/\$5,000 | \$586.85 | \$1,308.68 | \$1,308.68 | \$1,420.18 | \$1,860.32 | | |

* Rates for the High Deductible Health Plan (HDHP) do not include any fees associated with the administration of Health Savings Accounts. If you choose to offer the HDHP through the Fund, savings accounts can be set up through Highmark Blue Cross Blue Shield. Some additional costs may apply.

| Terms and Conditions – HDHP |
|---|
| <ul style="list-style-type: none"> ➤ Qualified High Deductible Health Plans are designed for use with a Health Savings Account. If you choose to offer the HDHP through the Fund, savings accounts can be set up through Highmark Blue Cross Blue Shield. ➤ Qualified High Deductible Health Plans must run on a calendar year. ➤ In order to implement a Qualified High Deductible Plan, we require a minimum of sixty (60) days advance written notice. ➤ All benefit programs proposed by the Fund are done so under the terms of a group contract. These benefit programs are not available on a voluntary (employee pay-all) basis. Should the bargaining parties agree to employee contributions, the Fund must be advised of this agreement prior to acceptance of the proposal. Failure to notify the Fund of employee contribution levels could cause the Fund to revoke the proposal offer. ➤ A minimum of 80% participation of all eligible employees is required for all lines of coverage elected. ➤ Company and Union must enter into a Participation Agreement. ➤ Fund Plan is full replacement for all current plans. |

| In-Network Deductible Credit - HDHP |
|--|
| <ul style="list-style-type: none"> ➤ For groups offering a qualified high deductible plan with an effective date after January 1st, the Fund may be able to offer in-network deductible credit for claims incurred during that calendar year. ➤ The current coverage must be based on a Calendar Year (January 1st through December 31st). ➤ The information for deductible credit and total maximum out-of-pocket expenses must be provided in a specific format from the group’s prior carrier and received by Highmark no later than the 24th of the effective month of Fund coverage. A listing of the required format will be provided upon request. ➤ Members will be required to pay any applicable deductible amounts until the deductible credit file is received and processed. Once the prior carrier file is loaded (this may take up to two weeks), Highmark will then need to adjust claims for members whose deductibles are now over applied due to the credit. If deductibles are over applied, this adjustment will result in additional payments that would go to the Provider. The member would then need to seek reimbursement for any overpayments directly from the Provider. ➤ Requests for in-network deductible credit must be received and reviewed by the Fund Account Executive prior to the implementation of coverage. |



Summary of Benefits

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital. **If you enroll as an individual, the deductible and out-of-pocket maximums for the "Employee Only Plan" apply. If you enroll as a family, the deductible and out-of-pocket maximums for the "Family Plan" apply and can be satisfied by one or more of your family members.**

| Benefit | Network | Out-of-Network |
|---|---|---------------------------------|
| General Provisions | | |
| Benefit Period ⁽¹⁾ | Contract Year | |
| Deductible per benefit period (Applies to Medical and Prescription Drug benefits) | | |
| Employee Only Plan | \$2,500 | \$5,000 |
| Family Plan | \$5,000 | \$10,000 |
| Plan Pays – payment based on the plan allowance | 80% after deductible | 60% after deductible |
| Out-of-Pocket Limit (Includes prescription drug cost share, coinsurance and copayments. Once met, plan pays 100% for the rest of the benefit period) | | |
| Employee Only Plan | \$1,750 | \$5,000 |
| Family Plan | \$3,500 | \$10,000 |
| Total Maximum Out-of-Pocket (Includes prescription drug cost share, deductible, coinsurance and copayments. Once met, plan pays 100% for the rest of the benefit period) | | |
| Employee Only Plan | \$4,250 | N/A |
| Family Plan | \$8,500 | N/A |
| Office/Clinic/Urgent Care Visits | | |
| Retail Clinic Visits | 80% after deductible | 60% after deductible |
| Primary Care Provider Office Visits | 80% after deductible | 60% after deductible |
| Specialist Office Visits | 80% after deductible | 60% after deductible |
| Urgent Care Center Visits | 80% after deductible | 60% after deductible |
| Telemedicine Services ⁽⁷⁾ | 100% after deductible | Not Covered |
| Preventive Care ⁽³⁾ | | |
| Routine Adult | | |
| Physical exams | 100% (deductible does not apply) | Not Covered |
| Adult immunizations | 100% (deductible does not apply) | 60% after deductible |
| Colorectal cancer screening | 100% (deductible does not apply) | 60% after deductible |
| Routine gynecological exams, including a Pap Test | 100% (deductible does not apply) | 60% (deductible does not apply) |
| Mammograms, annual routine and medically necessary | Routine: 100% (deductible does not apply) Medically Necessary: 80% after deductible | 60% after deductible |
| Diagnostic services and procedures | 100% (deductible does not apply) | 60% after deductible |
| Routine Pediatric | | |
| Physical exams | 100% (deductible 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 |
| Hospital and Medical/Surgical Expenses (including maternity) | | |
| Hospital Inpatient | | |
| Hospital Outpatient | | |
| Maternity (non-preventive facility & professional services) | 80% after deductible | 60% after deductible |
| Medical/Surgical (except office visits) | | |
| Emergency Services | | |
| Emergency Room Services | 80% after deductible | |
| Ambulance | 80% after deductible | |
| Therapy and Rehabilitation Services | | |
| Physical Medicine | 80% after deductible | 60% after deductible |
| | Limit: 20 visits/benefit period | |
| Respiratory Therapy | 80% after deductible | |
| Speech & Occupational Therapy | 80% after deductible | 60% after deductible |
| | Limit: 20 visits per therapy/benefit period | |
| Spinal Manipulations | 80% after deductible | 60% after deductible |
| | Limit: 20 visits/benefit period | |

| Benefit | Network | Out-of-Network |
|--|---|--|
| Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis) | 80% after deductible | 60% after deductible |
| Mental Health/Substance Abuse | | |
| Inpatient | 80% after deductible | 60% after deductible |
| Inpatient Detoxification/Rehabilitation | 80% after deductible | 60% after deductible |
| Outpatient | 80% after deductible | 60% after deductible |
| Other Services | | |
| Allergy Extracts and Injections | 80% after deductible | 60% after deductible |
| Applied Behavior Analysis for Autism Spectrum Disorders ⁽²⁾ | 80% after deductible | 60% after deductible |
| Assisted Fertilization Procedures | Not Covered | |
| Dental Services Related to Accidental Injury | 80% after deductible | 60% after deductible |
| Diagnostic Services | | |
| <i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.) | 80% after deductible | 60% after deductible |
| <i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing) | 80% after deductible | 60% after deductible |
| Durable Medical Equipment, Orthotics and Prosthetics | 80% after deductible | 60% after deductible |
| Home Health Care | 80% after deductible | 60% after deductible |
| Hospice | 80% after deductible | 60% after deductible |
| Infertility Counseling, Testing and Treatment ⁽⁴⁾ | 80% after deductible | |
| Private Duty Nursing | 80% after deductible | |
| Skilled Nursing Facility Care | 80% after deductible | 60% after deductible Limit: 100 days/benefit period |
| Transplant Services | 80% after deductible | 60% after deductible |
| Precertification Requirements ⁽⁵⁾ | Yes | |
| Prescription Drugs | | |
| Prescription Drug Deductible | | |
| Individual | Integrated with medical deductible | |
| Family | Integrated with medical deductible | |
| National Plus Prescription Drug Program ⁽⁶⁾ <i>Defined by the National Plus Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> | Retail Drugs (31-day Supply) Plan pays 80% after deductible | |
| <i>Your plan uses the Open Formulary.</i> | Maintenance Drugs through Mail Order (90-day Supply) Plan pays 80% after deductible | |

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

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

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

(4) 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.

(5) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If not, you are responsible for contacting MM&P. 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.

(6) At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible. If your deductible has been met, you will only pay any member responsibility based on the benefit level indicated above. You will pay this amount at the pharmacy when you have your prescription filled.

(7) 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.

This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

01/13/2022 3002BD NG W-HDHP-PPO