

BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA

Fund Office: BeneSys Inc. P.O. Box 160 Troy MI 48099-0160 /Phone: (412) 317-6538 / (877) 270-1199 / Fax: (412) 307-3691

November 5, 2025

2026 OPEN ENROLLMENT

Open Enrollment Period is December 8, 2025 – December 31, 2025

PLEASE NOTE:

**IF YOU DO NOT WISH TO MAKE ANY CHANGES, YOU DO NOT NEED TO TAKE ANY ACTION
HOWEVER**

MRA ONLY MUST RECERTIFY SEE WAIVER OF MEDICAL PLAN PARTICIPATION FORM

Dear Retiree:

Enclosed is your enrollment packet for benefits effective January 1, 2026. The Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania (Plan) will offer the same six benefit options through Highmark Blue Cross Blue Shield as in 2025. There are four options with the Performance Blue network and two options with the PPO Blue network. The PPO Blue plans utilize an expanded network, which includes the majority of UPMC facilities and doctors. You can choose which benefit option best meets your needs. The medical plans (except for Plan F – High Deductible \$9,200 Plan) offer a chance to earn new credits under the Medical Reimbursement Account (MRA), but only if you continue to work and be credited with new work hours.

If you continue to work but do not want to elect health care coverage through the Plan, you may also choose to “opt out” of medical and prescription drug benefits and enroll in the Medical Reimbursement Account (MRA) only option. This option is only available to participants who have access to group health plan coverage (as described in the MRA Opt-Out Waiver Certification form) through their spouse and continue to work and be credited with new work hours. **If you are retired and not accruing any new work hours, this “opt out” option does NOT apply to you.**

Details regarding the benefit options are detailed below.

Medical & Prescription Benefit Plan Options

You can select between six (6) different medical and prescription benefit plans. Summaries of Benefits for each of the Medical and Prescription Plans are included in this mailing. These plans are as follows:

1. **Plan A – Base Plan**
2. **Plan B – Buy-Up Plan** – Plan B and Plan E are the only plans that include dental and vision benefits. This plan also has lower deductibles, copayments, and out-of-pocket maximums, but a higher monthly cost.
3. **Plan C – Buy-Down Plan** – This plan has increased deductibles, copayments, coinsurance and out-of-pocket maximums; however, the cost for this plan is lower.

4. **Plan D – Base Plan (Expanded Network)** – This plan is comparable to plan A in terms of eligibility and monthly cost, however, the expanded PPO Blue network includes a majority of UPMC facilities and providers as in-network providers. In order to offset the cost of the broader network, the plan deductibles and out-of-pocket maximum are higher (see *Summary of Benefits*).
5. **Plan E – Buy Up Plan (Expanded Network)** – This plan is comparable to plan B in terms of monthly cost, however, the expanded PPO Blue network includes a majority of UPMC facilities and providers as in-network providers. In order to offset the cost of the broader network, the plan deductibles and out-of-pocket maximums are higher (see *Summary of Benefits*). This plan includes dental and vision benefits.
6. **Plan F – High Deductible \$9,450 Plan** – This is the newer plan option. It has a catastrophic level deductible and higher copayments, but a lower cost than the other plans.

Monthly Premium

The monthly Retiree rates effective January 1, 2026, are detailed below.

Rate Tier	Base Plan Plan A	Buy-Up Plan Plan B <i>(includes dental and vision)</i>	Buy-Down Plan Plan C	Base Plan Plan D	Buy-Up Plan Plan E <i>(includes dental and vision)</i>	High Deductible Plan F
Single	\$713.07	\$781.68	\$590.11	\$713.07	\$781.68	\$526.06
Participant/Child(ren)	\$1,283.53	\$1,407.03	\$1,062.21	\$1,283.53	\$1,407.03	\$946.90
Participant & Spouse	\$1,426.14	\$1,563.36	\$1,180.23	\$1,426.14	\$1,563.36	\$1,052.11
Family	\$2,709.67	\$2,970.39	\$2,242.43	\$2,709.67	\$2,970.39	\$1,999.02

Note: If you had a balance in your Medical Reimbursement Account (MRA) after you retired from active employment, and you remain a member in good standing, you may use it for eligible health care expenses (see IRS Publication 502), including your retiree health care premiums. MRA credits will no longer be forfeited if not used within 12 months.

Other Information

Open Enrollment:

The Open Enrollment Period is December 8, 2025, through December 31, 2025.

Please complete the enclosed enrollment form and return to the Fund Office.

Completed forms must be received in the Fund Office no later than December 31, 2025.

If you do NOT want to change benefit plans, you are NOT required to complete an enrollment form. Retirees who are currently enrolled in a benefit plan who want to remain in the same plan do NOT need to submit a completed enrollment form. Only those who wish to change benefit plans are required to submit an enrollment form electing the new benefit plan.

IMPORTANT: Once you enroll in a Plan, you CANNOT change plans until the next Open Enrollment period unless you have a qualifying life event in accordance with IRS provisions.

Your legal marital status changes:

- Marriage
- Divorce, legal separation, or annulment
- Death of your spouse

The number of your eligible children changes:

- Birth or adoption of a child
- Child gains or loses eligibility for coverage under the plan
- Death of a child

Your family member's benefits eligibility changes because of a change in his or her eligibility or coverage under another employer's plan:

- A change in work schedule or status that causes him or her to gain or lose eligibility
- He or she gains a benefit option or loses coverage
- He or she makes new coverage choices during his or her employer's annual enrollment
- Your or your family member's COBRA coverage from another employer expires
- You or your family member becomes eligible for or loses Medicare or Medicaid
- You or your family member loses coverage under a government's or educational institution's plan

Medical & Prescription ID Cards:

For 2026, you will receive a new ID cards.

Sincerely,

The Board of Trustees

Consent Form For Bricklayers Benefit Funds
***Consent for Receiving Benefit Plan Disclosures and Information Electronically
Through the Bricklayer Member Portal and Through Email Alerts***

Individuals covered by any of the following three funds (“Funds”) are entitled to receive certain plan documents, disclosures and other information required by ERISA (Employee Retirement Income Security Act of 1974) and other pertinent laws:

1. Bricklayers Pension Fund of Western Pennsylvania
2. Three Rivers Annuity Fund
3. Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania

The Trustees of the Funds understand that many individuals prefer to receive required materials electronically rather than in paper form. They wish to offer you the ability to access at your convenience required Fund materials and disclosures when you logon to the member portal that is available to all Fund participants.

If you so consent to receive the documents and notices described below (called “Documents”) via our member portal website, you also are consenting to receive at your email address alerts from the Trustees about any new Documents posted on the portal.

- Summary Plan Descriptions (SPDs) for all three Funds plus summaries of any modifications to the SPDs.
- Annual notice that explains how you are invested by default under the Annuity Fund if you fail to make your own investment decision
- HIPAA Notice of Privacy Practices describing the circumstances under which your health information may be used or disclosed by the Welfare Fund.
- HIPAA Special Enrollment Rights Notice advising you of your rights to enroll in the Welfare Fund outside of open enrollment due to a life event, such as a loss of other coverage or the addition of a dependent
- CHIP Notice of Availability of Premium Assistance advising of the potential availability of premium assistance from appropriate state agencies if you or your dependent is eligible for Medicaid or CHIP.
- Women’s Health and Cancer Rights Act Notice advising of the required benefits for mastectomy-related reconstructive surgery, prostheses, and treatment of physical complications of mastectomy.
- Summaries of Benefits and Coverage (SBCs) for the Welfare Fund. The SBC provides in a comparative format the different health plan options available to you along with any modifications to the SBCs.
- Notice of Creditable Coverage to help you decide whether to elect Medicare Part D prescription drug benefits
- Summary Annual Reports for the Welfare and Annuity Funds plus Annual Funding Notices for the Pension Fund, which summarize important financial information about the Funds.
- Annual Notice of Funding Status for the Pension Fund
- Other required Notices and Disclosures.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the Notice of Creditable Coverage contained on the member portal for more details. You are responsible for providing a copy to your Medicare-eligible dependents covered under the group health plan.

If you are newly eligible for participation or newly enrolled in any plan, it is strongly recommended that you review these notices to better understand your rights under the plan and the options available to you before making any decisions about your elections.

Important: Receipt of this form does not necessarily mean you are eligible for one or more of the Funds referenced above. Refer to the Documents or to BeneSys, the Third Party Administrator, to determine your eligibility for any of the Funds.

Accessing the Member Portal/Website: You can access the member portal at www.baclocal9benefits.org. You will need to use your user name and password to access the Documents. New employees should receive their user name and password when first eligible. If you need to register for the portal or you need a new user name and password, please feel free to contact BeneSys:

- by phone at (877) 270-1199,
- by email to baclocal9contact@benesys.com
- by fax at (412) 307-3691 or
- by mail at BeneSys, Inc. 100 Kingston Drive, Pittsburgh, PA 15235.

To access the portal, there are no special software or hardware requirements. ***You should register for portal access in order to be able to access current information about your benefits even if you do not wish to opt-out of receiving paper notices.***

What You Must Do: If you're interested in receiving these Documents through the portal in lieu of receiving paper copies, you need only complete two tasks:

1. Complete and return to BeneSys this Written Consent Form using the above email address. Although we prefer that you email this Consent Form, you may also fax or mail it using the above fax or mailing address. ***You must include your email address legibly in the space provided below for BeneSys to contact you electronically.***
2. BeneSys will email to you a test email using the email address that you provide. Open the test email when you receive it and click on the link it provides to the member portal/website. This will serve to confirm your ability to receive email messages and to access the member portal.

Your Right to a Paper Copy: You will always have a right to change your decision or to request a paper version of any of the Documents at no charge. Feel free to contact BeneSys through one of the methods described above to request a paper copy if you wish. You must send BeneSys a written notice if you wish to withdraw your consent and start receiving paper copies of these Documents in the future.

Consent to Receive Fund Materials and Disclosures Through The Bricklayers Member Portal and Through Email Alerts

I have read this entire Written Consent Form and hereby consent to receiving through the Bricklayers Member Portal the Documents described above. I also consent to being notified about any materials newly-posted on the member portal through email alerts sent to my email address. I understand that neither my receipt nor signature of this Written Consent Form is meant to imply or guarantee eligibility for any of the Bricklayer Funds described above.

I understand that I will receive copies and updates of the documents *only* through the member portal unless I affirmatively exercise my right to request paper copies.

I understand that I must provide an email address below which the Fund Trustees will use to send email alerts to me about updated Documents that become available on the member portal. If I change my email address, I understand I should notify BeneSys by emailing BeneSys at baclocal9contact@benesys.com using my email address disclosed below with the subject line, "New Email Address." I will include in the email message my full name, address, and phone number.

I understand that I may withdraw this Consent at any time without charge by emailing to BeneSys a message that indicates in the subject line "Consent Withdrawn for Electronic Disclosures" and that includes in the body my full name, address and phone number. Alternatively, I may withdraw this Consent by faxing or mailing to BeneSys at the address noted above a written letter that states that I wish to withdraw this Consent and that includes my full name, address and phone number.

I understand that it is my responsibility to withdraw this Consent if I wish and that this Consent will remain in effect until I withdraw it.

(Your Name) - Print

(Your Signature)

(Date)

E-Mail Address (***Please print legibly***)

BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA

Fund Office: BeneSys Inc P.O. Box 160 Troy MI 48099 /Phone: (412) 317-6538 / (877) 270-1199 /Fax: (412) 307-3691

Plan Enrollment Form

Participant Name: _____

Participant SSN#: _____ Participant Date of Birth: _____

Participant Mailing Address: _____

Participant Telephone #: _____ Email Address _____

Health Plan Option Selected (check one):

- Base Plan (Plan A)** – Performance Blue Flex PPO \$500/\$1000
- Buy-Up Plan (Plan B)** - Performance Blue Flex PPO \$250/\$500 deductible¹
- Buy-Down Plan (Plan C)** - Performance Blue Flex PPO \$4000/\$8000 deductible¹
- Base Plan Expanded Network (Plan D)** – PPO Blue Plan \$2000/\$4000 deductible
- Buy-Up Plan Expanded Network (Plan E)** – PPO Blue Plan \$1500/\$3000 deductible
- High Deductible \$9,450 (Plan F)** – Performance Blue \$9,450/\$18,400 deductible

¹Performance Blue deductibles are based on the in-network Enhanced Value benefit.

Participant Signature: _____ Date: _____



Bricklayers & Allied Craftworkers Local 9 Welfare Fund of Western PA
 PO Box 160
 Troy, MI 40899-0160
 Phone: (412) 317-6538 or Toll Free: (877) 270-1199
 www.BACLocal9Benefits.org

VITAL INFORMATION FORM

Email Completed Documentation: enrollmentdocs@benesys.com

New Hire Enrollment Adding Dependent(s) Demographic Change(s)

MEMBER Information: (Please Print)

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: _____ - _____ - _____ Phone Number: (____) _____ Cell/Home _____

Date of Birth: ____/____/____ Gender: (circle one) Male Female

Marital Status: (circle one) Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: (circle one) Active Retired Disabled COBRA

Email Address: _____ Alternate Phone Number: _____

Medicare Claim Number: (This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ Spouse # _____ **Dependent # & Name** _____

DEPENDENTS: - Include Spouse (If additional space is needed, please use 2nd sheet, be sure to include marriage certificate and birth certificates, please see dependent coverage letter)

FULL NAME	RELATION	BIRTH-DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

***Dependent children will remain eligible until the age of 26.*

BENEFICIARY(ies): (Death Benefits-Medical)

If a minor is named as beneficiary, insurance proceeds can only be paid to a legally appointed/qualified guardian.

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
_____	_____	____/____/____	____-____-____	_____	_____
(Primary)					
_____	_____	____/____/____	____-____-____	_____	_____
(Secondary)					
_____	_____	____/____/____	____-____-____	_____	_____

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits, including retroactively cancelling my coverage.

MEMBER SIGNATURE _____

Date _____

(OVER)

OTHER INSURANCE INQUIRY

Signature Required Below

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____) _____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

Coverage provides minimum value under the PPACA: (*circle one*) Yes No

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

I understand that if I make a false statement or materially misrepresent the information on this form, my coverage may be retroactively cancelled. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of any acts of fraud or material misrepresentation.

I Have No Other Insurance (Initial): _____

Member Signature: _____

Date: _____

BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA

Fund Office: Benesys Inc., P.O. Box 160 Troy, MI / Phone: (412) 317-6538 / (877) 270-1199 / Fax: (412) 307-3691

WAIVER OF MEDICAL PLAN PARTICIPATION AND PROOF OF OTHER COVERAGE FOR PLAN YEAR 2026

OPT-OUT/MEDICAL REIMBURSEMENT ACCOUNT (MRA) ONLY OPTION

ONLY those participants who have coverage through a GROUP health plan through either their spouse or parent are eligible to enroll in the MRA only benefit. Participants (or dependents) who purchase individual medical coverage (such as through the Insurance Exchange, Individual Marketplace or Medicare) CANNOT enroll in the MRA only option.

*(This form **plus the medical ID card or cards** for you and your dependents are required if you elect to Opt-Out of the medical and prescription benefit coverage offered by the Plan and to enroll in the MRA Only option for 2026.)*

PARTICIPANT'S NAME: _____ SOCIAL SECURITY #: _____

I. WAIVER OF PARTICIPATION

Under the terms of Bricklayers & Allied Craft Workers Welfare Fund of Western Pennsylvania (the "Plan"), I, and my eligible dependents, if any, are eligible to participate in the Medical and Prescription Drug benefits under the Plan. The terms, conditions and costs involved, if any, to enroll in those benefits have been fully explained to me. However, I hereby waive enrollment in the Medical and Prescription Drug benefits under the Plan, for myself (and any spouse and eligible dependents) because I am / we are covered by the group health plan listed in section II below. I understand that I will be eligible for contributions to a Medical Reimbursement Account for the Plan Year under the terms of the Plan only if I provide the information below and certify that I (plus any spouse and dependents) have coverage under another health plan that is a group health plan that provides minimum coverage (and not any individual coverage). I may permanently opt out and waive future reimbursements from the MRA annually during open enrollment and as of when I cease to work additional hours.

II. PROOF OF OTHER COVERAGE

I certify that I, and my spouse and eligible dependents, if any, are enrolled in the following group health plan that provides minimum value. I will contact the Fund Office described above if I (or my spouse or any eligible dependent) ceases to be enrolled in the following group health plan:

Name of Group Health Plan: _____

Policyholder Name & Effective Date: _____

Employer/Plan Sponsor: _____

Address of Employer/Plan Sponsor: _____

III. CERTIFICATION

I certify that to the best of my knowledge the plan described above is a group health plan that provides minimum value coverage which means that it covers at least 60% of the total allowed cost of benefits provided under the plan and that it provides substantial coverage for patient care and physician services. I also certify that the above information is true and correct as of the date indicated below.

Signature

Date

BRICKLAYERS OF WESTERN PA COMBINED FUNDS, INC.
IMPORTANT INFORMATION ABOUT BENEFICIARY
DESIGNATIONS

The ***Beneficiary Designation Form*** allows you to designate one or more beneficiaries to receive applicable benefits in the event of your death. If we do not have a designated beneficiary on file in the Fund Office, or if you do not name a beneficiary, payment may not be made to the person(s) you intend to receive the benefit. For further information regarding payment of death benefits, please refer to your Summary Plan Description. **No change in beneficiary designation shall be effective or binding on the Fund or the Trustees unless it is received by the Fund Office prior to the time any payments are made to the beneficiary(ies) whose designation is on file.**

It is also important that you keep the Fund informed of your current address. Address changes must be submitted in writing to the Fund Office.

DEFINITIONS

You may find the following definitions helpful in completing this form:

Primary Beneficiary(ies)- the person(s) or entity you designate as the first in line to receive your benefit. You may name more than one Primary Beneficiary. Payment will be made in equal shares unless otherwise specified. The percentages you list for all beneficiaries should total 100%. In the event that a designated primary beneficiary predeceases you, the benefit will be paid to the remaining primary beneficiaries pro rated in proportion to their designated percentages or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies)- the person(s) or entity you designate to receive your benefit in the event your primary beneficiary predeceases you. You may name more than one Contingent Beneficiary. Payment will be made in equal shares unless otherwise specified. The percentages you list for all beneficiaries should total 100%. In the event that a designated contingent beneficiary predeceases you, the benefit will be paid to the remaining contingent beneficiaries pro rated in proportion to their designated percentages or all to the sole remaining contingent beneficiary.

Health/Welfare - a multiemployer health and welfare fund that provides medical, prescription, dental, vision, death and other benefits.

Pension - a multiemployer defined benefit pension fund. The Pension Plan provides several kinds of pension benefits with varying eligibility requirements and benefit amounts. Please refer to your most current annual statement or contact the Fund office for a summary of your hours.

Annuity - a multiemployer retirement plan that provides you with an individual account that can be invested through the recordkeeper, John Hancock. At retirement you can select the distribution options or keep the account invested.

INSTRUCTIONS

- Complete this form to designate one or more beneficiaries to receive applicable benefits in the event of your death for **EACH** Fund indicated.
- If you need additional space, please attach a separate sheet of paper.
- The Participant must read, sign and date the authorization.
- Spousal signatures must be notarized.
- Submit the completed form to the Fund office, c/o Benesys, 3660 Stutz Drive, Suite 101, Canfield OH 44406 and keep a copy for your records.

BENEFICIARY DESIGNATION FORM

BRICKLAYERS OF WESTERN PA COMBINED FUNDS, INC.

Participant's Name		Social Security Number	
Telephone Number	Birth Date (MM/DD/YYYY)	Home Local	
Address	City	State	Zip Code
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Divorced (Provide Copy of divorce decree(s)) <input type="checkbox"/> Single <input type="checkbox"/> Widowed (Provide Copy of death certificate.) <input type="checkbox"/> Separated		

BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA

Primary Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %
(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

Contingent Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %
(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

THREE RIVERS ANNUITY FUND

Primary Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

If you are married and have named someone other than your Spouse to receive some or all of your Annuity Fund benefit as a primary beneficiary, such a designation will only be valid if you obtain your spouse's consent as evidenced by his or her signature below, which must be acknowledged by a Notary Public.

(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

Contingent Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

If you are not married on the date you sign this Beneficiary Designation Form, but subsequently become married prior to benefit commencement, you understand that this designation of beneficiary shall cease to be effective upon your marriage and you should consider filing a new Beneficiary Card. You hereby agree to notify BeneSys in writing in the event of marital status changes.

<p><u>PARTICIPANT SIGNATURE:</u> I certify that all information furnished in this form is true to the best of my knowledge. I understand and agree that any misrepresentation by me may constitute grounds for denial of benefits to me or my behalf or for the cancellation or recovery of benefit payments made in reliance thereon.</p>	<p><u>SPOUSAL CONSENT:</u> I swear that I am the legal spouse of the Participant named above. I understand that the Annuity Fund is obligated to pay Annuity benefits to me as sole primary beneficiary in the event of my spouse's death, unless I consent to the designation of some other individual as indicated below. I have reviewed this entire form and consent to the designation of: _____ as the primary beneficiary (ies) for Annuity benefits. Such designation may not be changed or revoked without my consent.</p>
<p><u>SIGNED:</u></p>	<p><u>SIGNED:</u></p>
<p><u>DATED:</u></p>	<p><u>DATED:</u></p>
<p><u>NOTARY PUBLIC:</u> State of _____ County of _____</p> <p>On this, the _____ day of _____, 20____, before me personally appeared _____, the above designated Spouse, who executed the foregoing Spousal Consent and acknowledged that he or she executed the same as his or her free act or deed. In witness whereof, I hereto set my hand and seal</p> <p style="text-align: center;">Notary Public: _____ My Commission Expires: _____</p>	

BRICKLAYERS PENSION FUND OF WESTERN PENNSYLVANIA

Primary Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

If you are married and have named someone other than your Spouse to receive some or all of your Pension Fund benefit as a primary beneficiary, such a designation will only be valid if you obtain your spouse's consent as evidenced by his or her signature below, which must be acknowledged by a Notary Public.

(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

Contingent Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

If you are not married on the date you sign this Beneficiary Designation Form, but subsequently become married prior to benefit commencement, you understand that this designation of beneficiary shall cease to be effective upon your marriage and you should consider filing a new Beneficiary Card. You hereby agree to notify BeneSys in writing in the event of marital status changes.

<p><u>PARTICIPANT SIGNATURE:</u> I certify that all information furnished in this form is true to the best of my knowledge. I understand and agree that any misrepresentation by me may constitute grounds for denial of benefits to me or my behalf or for the cancellation or recovery of benefit payments made in reliance thereon.</p>	<p><u>SPOUSAL CONSENT:</u> I swear that I am the legal spouse of the Participant named above. I understand that the Pension Fund is obligated to pay Pension benefits to me as sole primary beneficiary in the event of my spouse's death, unless I consent to the designation of some other individual as indicated below. I have reviewed this entire form and consent to the designation of: _____ as the primary beneficiary (ies) for Pension benefits. Such designation may not be changed or revoked without my consent.</p>
<u>SIGNED:</u>	<u>SIGNED:</u>
<u>DATED:</u>	<u>DATED:</u>
<p><u>NOTARY PUBLIC:</u> State of _____ County of _____</p> <p>On this, the _____ day of _____, 20____, before me personally appeared _____, the above designated Spouse, who executed the foregoing Spousal Consent and acknowledged that he or she executed the same as his or her free act or deed. In witness whereof, I hereto set my hand and seal</p> <p style="text-align: center;">Notary Public: _____</p> <p style="text-align: center;">My Commission Expires: _____</p>	

BUILDING TRADES PENSION FUND OF WESTERN PENNSYLVANIA

Primary Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

If you are married and have named someone other than your Spouse to receive some or all of your Pension Fund benefit as a primary beneficiary, such a designation will only be valid if you obtain your spouse's consent as evidenced by his or her signature below, which must be acknowledged by a Notary Public.

(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

Contingent Beneficiaries: If you need more than two Contingent Beneficiaries, please attach a separate sheet.

(1) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

(2) Name		Social Security Number	
Address			
City		State	Zip Code
Telephone Number	Relationship	Birth Date (MM/DD/YYYY)	Beneficiary %

If you are not married on the date you sign this Beneficiary Designation Form, but subsequently become married prior to benefit commencement, you understand that this designation of beneficiary shall cease to be effective upon your marriage and you should consider filing a new Beneficiary Card. You hereby agree to notify Benesys in writing in the event of marital status changes.

<p><u>PARTICIPANT SIGNATURE:</u> I certify that all information furnished in this form is true to the best of my knowledge. I understand and agree that any misrepresentation by me may constitute grounds for denial of benefits to me or my behalf or for the cancellation or recovery of benefit payments made in reliance thereon.</p>	<p><u>SPOUSAL CONSENT:</u> I swear that I am the legal spouse of the Participant named above. I understand that the Pension Fund is obligated to pay Pension benefits to me as sole primary beneficiary in the event of my spouse's death, unless I consent to the designation of some other individual as indicated below. I have reviewed this entire form and consent to the designation of: _____ as the primary beneficiary (ies) for Pension benefits. Such designation may not be changed or revoked without my consent.</p>
<p><u>SIGNED:</u></p>	<p><u>SIGNED:</u></p>
<p><u>DATED:</u></p>	<p><u>DATED:</u></p>
<p><u>NOTARY PUBLIC:</u> State of _____ County of _____</p> <p>On this, the _____ day of _____, 20____, before me personally appeared _____, the above designated Spouse, who executed the foregoing Spousal Consent and acknowledged that he or she executed the same as his or her free act or deed. In witness whereof, I hereto set my hand and seal</p> <p style="text-align: center;">Notary Public: _____</p> <p style="text-align: center;">My Commission Expires: _____</p>	

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Performance Flex Blue PPO – Base Plan A – Group numbers 107141-00,01,70

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period(1)	Calendar year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.)			
Individual	\$500	\$1,500	\$6,750
Family	\$1,000	\$3,000	\$11,250
Plan Pays – payment based on the plan allowance	90% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)			
Individual	\$1,250	\$3,750	\$10,000
Family	\$2,250	\$6,750	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	\$10,150		Not applicable
Family	\$20,300		Not applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after \$20 copayment	100% after \$40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$20 copayment	100% after \$40 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after \$40 copayment	100% after \$80 copayment	50% after deductible
Urgent Care Center Visits	100% after \$40 copayment	100% after \$80 copayment	50% after deductible
Telemedicine (5)	100% after \$15 copayment		Not covered
Preventive Care(2)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	90% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	90% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	90% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	90% after deductible	70% after deductible	50% after deductible


Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Emergency Services			
Emergency Room Services	100% after \$125 copayment (waived if admitted)		
Ambulance (7)	90% after enhanced deductible		
Ambulance – Non-Emergency	90% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Respiratory Therapy	90% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Spinal Manipulations	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	90% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	90% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	90% after enhanced deductible		50% after deductible
Outpatient	100% after \$15 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	90% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	90% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	90% after deductible	70% after deductible	50% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	90% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	90% after deductible	70% after deductible	50% after deductible
Home Health Care	90% after deductible	70% after deductible	50% after deductible
Hospice	90% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(3)	90% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	90% after deductible	70% after deductible	50% after deductible
	Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	90% after deductible	70% after deductible	50% after deductible
	Limit: 100 days per benefit period		
Transplant Services	90% after deductible	70% after deductible	50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program(6) <i>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.</i>	Retail Drugs 31-day Supply (Mandatory Generic) \$10 generic copayment \$55 brand copayment - formulary \$80 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
	Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic) \$20 generic copayment \$110 brand copayment - formulary \$160 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
Incentive Choice Home Program	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled through the home delivery.		

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year is from January 1-December 31.
- (2) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (3) 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.
- (4) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (5) 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/Substance abuse benefit
- (6) The formulary is an extensive list of Food and 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

*The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

- (7) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-800-241-5704. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>\$500 individual/\$1,000 family enhanced value <u>network</u>. \$1,500 individual/\$3,000 family standard value <u>network</u>. \$6,750 individual/\$11,250 family out-of-<u>network</u>. All in-<u>network</u> services are credited to both the enhanced and standard value <u>deductibles</u></p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. Office visits, <u>preventive care services</u>, <u>emergency room care</u>, <u>urgent care</u>, <u>outpatient mental health</u>, <u>outpatient substance abuse</u>, <u>rehabilitation services</u>, and <u>prescription drug benefits</u> are covered before you meet your <u>network deductible</u>. <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>\$1,250 individual/\$2,250 family enhanced value <u>network</u>. \$3,750 individual/\$6,750 family standard value <u>network</u>. All in-<u>network</u> services are credited to both the enhanced and standard value <u>out-of-pocket limits</u>. Up to a \$10,150 individual/\$20,300 family, combined enhanced and standard value total maximum <u>out-of-pocket</u>. \$10,000 individual/\$20,000 family <u>out-of-network</u>.</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Network</u>: <u>Premiums</u>, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.</p> <p><u>Out-of-network</u>: <u>Copayments</u>, <u>premiums</u>, balance-billed charges, <u>prescription drug expenses</u>, and health care this plan doesn't cover.</p> <p>Yes. See www.myhighmark.com or call 1-800-241-5704 for a list of <u>network providers</u>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p> <p>You pay the least if you use a <u>provider</u> in <u>Enhanced Network</u>. You pay more if you use a <u>provider</u> in <u>Standard Network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan pays</u> (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p> <p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>No.</p>	
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$40 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Please refer to your <u>preventive</u> schedule for additional information.
	<u>Specialist visit</u>	\$40 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$80 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a test If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myhighmark.com	<u>Diagnostic test</u> (x-ray, blood work) <u>Imaging</u> (CT/PET scans, MRIs)	10% <u>coinsurance</u> 10% <u>coinsurance</u>	30% <u>coinsurance</u> 30% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	<u>Copayments</u> , if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse. <u>Precertification</u> may be required.
	Generic drugs	\$10 <u>copay/</u> prescription (retail) \$20 <u>copay/</u> prescription (mail order) <u>Deductible does not apply.</u>	\$10 <u>copay/</u> prescription (retail) \$20 <u>copay/</u> prescription (mail order) <u>Deductible does not apply.</u>	Not covered	Not covered
	<u>Formulary Brand drugs</u>	\$55 <u>copay/</u> prescription (retail) \$110 <u>copay/</u> prescription (mail order) <u>Deductible does not apply.</u>	\$55 <u>copay/</u> prescription (retail) \$110 <u>copay/</u> prescription (mail order) <u>Deductible does not apply.</u>	Not covered	
	<u>Non-Formulary Brand drugs</u>	\$80 <u>copay/</u> prescription (retail) \$160 <u>copay/</u> prescription (mail order) <u>Deductible does not apply.</u>	\$80 <u>copay/</u> prescription (retail) \$160 <u>copay/</u> prescription (mail order) <u>Deductible does not apply.</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	All tiers: Subject to enhanced value <u>network deductible</u>
	<u>Urgent care</u>	\$40 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$80 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	The <u>copayment</u> , if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse
If you have a hospital stay	Facility fees (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Pre-certification may be required.
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Standard value <u>network</u> : Subject to enhanced value <u>network deductible</u> Pre-certification may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	50% coinsurance	<p>Cost sharing does not apply for <u>preventive services</u>.</p> <p>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p><u>Network</u>: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information.</p> <p>Precertification may be required.</p>
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	50% coinsurance	<p>Pre-certification may be required.</p> <p>Combined <u>network</u> and out-of-<u>network</u>: 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per benefit period.</p> <p>Combined <u>network</u> and out-of-<u>network</u>: <u>habilitation and rehabilitation services</u>.</p> <p>Limit does not apply to therapy services prescribed for the treatment of mental health or substance abuse</p> <p>Pre-certification may be required.</p>
	<u>Rehabilitation services</u>	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% coinsurance	
	<u>Habilitation services</u>	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% coinsurance	
	<u>Skilled nursing care</u>	10% coinsurance	30% coinsurance	50% coinsurance	<p>Combined <u>network</u> and out-of-<u>network</u>: 100 days per benefit period.</p> <p>Pre-certification may be required.</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	10% coinsurance	30% coinsurance	50% coinsurance	Precertification may be required.
	Hospice services	10% coinsurance	30% coinsurance	50% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Hearing aids
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcare.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim appeal](#) or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-241-5704.
- The Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

[Does this plan provide Minimum Essential Coverage? Yes](#)

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

[Does this plan meet the Minimum Value Standards? Yes](#)

If your [plan](#) doesn’t meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

_____ To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$500
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,770

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$500
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,660

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$500
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$80
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$880

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-241-5704.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1 -855-873-4106.

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 lib्रेng 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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (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.

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Performance Flex Blue PPO – Buy Up Plan B – Group numbers 107141-10,11,80

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period(1)	Calendar year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.)			
Individual	\$250	\$1,500	\$6,750
Family	\$500	\$3,000	\$11,250
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)			
Individual	N/A	\$3,750	\$10,000
Family		\$6,750	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	\$10,150		Not applicable
Family	\$20,300		Not applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after \$10 copayment	100% after \$40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$10 copayment	100% after \$40 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after \$20 copayment	100% after \$80 copayment	50% after deductible
Urgent Care Center Visits	100% after \$20 copayment	100% after \$80 copayment	50% after deductible
Telemedicine (5)	100% after \$5 copayment		Not covered
Preventive Care(2)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	100% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	100% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	100% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	100% after deductible	70% after deductible	50% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Emergency Services			
Emergency Room Services	100% after \$125 copayment (waived if admitted)		
Ambulance (7)	100% after enhanced deductible		
Ambulance – Non-Emergency	100% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Respiratory Therapy	100% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Spinal Manipulations	100% after \$10 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	100% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	100% after enhanced deductible		50% after deductible
Outpatient	100% after \$10 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	100% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	100% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible	50% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible	50% after deductible
Home Health Care	100% after deductible	70% after deductible	50% after deductible
Hospice	100% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(3)	100% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	100% after deductible	70% after deductible	50% after deductible
	Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	100% after deductible	70% after deductible	50% after deductible
	Limit: 100 days per benefit period		
Transplant Services	100% after deductible	70% after deductible	50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program(6) <i>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.</i>	Retail Drugs 31 day Supply (Mandatory Generic) \$10 generic copayment \$55 brand copayment - formulary \$80 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
	Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic) \$20 generic copayment \$110 brand copayment - formulary \$160 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
Incentive Choice Home Program	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled through the home delivery.		

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year is from January 1-December 31.
- (2) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (3) 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.
- (4) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (5) 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/Substance abuse benefit
- (6) The formulary is an extensive list of Food and 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

*The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

(7) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

! The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-800-241-5704. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 individual/\$500 family enhanced value <u>network</u> . \$1,500 individual/\$3,000 family standard value <u>network</u> . \$6,750 individual/\$11,250 family out-of- <u>network</u> . All in- <u>network</u> services are credited to both the enhanced and standard value <u>deductibles</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of deductible expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Office visits, <u>preventive care services</u> , <u>emergency room care</u> , <u>urgent care</u> , <u>outpatient mental health</u> , <u>outpatient substance abuse</u> , <u>rehabilitation services</u> , and <u>prescription drug benefits</u> are covered before you meet your <u>network deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the deductible amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$0 individual/\$0 family enhanced value <u>network</u> . \$3,750 individual/\$6,750 family standard value <u>network</u> . All in- <u>network</u> services are credited to both the enhanced and standard value <u>out-of-pocket limits</u> . Up to a \$10,150 individual/\$20,300 family, combined enhanced and standard value total maximum out-of-pocket. \$10,000 individual/\$20,000 family out-of- <u>network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Network</u>: <u>Premiums</u>, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.</p> <p><u>Out-of-network</u>: <u>Copayments</u>, <u>premiums</u>, balance-billed charges, <u>prescription drug expenses</u>, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.myhighmark.com or call 1-800-241-5704 for a list of <u>network providers</u>.</p>	<p>You pay the least if you use a <u>provider</u> in <u>Enhanced Network</u>. You pay more if you use a <u>provider</u> in <u>Standard Network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan pays</u> (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$40 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Please refer to your <u>preventive</u> schedule for additional information.
	<u>Specialist</u> visit	\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$80 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	No charge <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myhighmark.com	Generic drugs	\$10 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	\$10 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order. <u>Specialty drugs</u> limited to 30-day supply.
	<u>Formulary</u> Brand drugs	\$55 <u>copay</u> /prescription (retail) \$110 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	\$55 <u>copay</u> /prescription (retail) \$110 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Non-Formulary</u> Brand drugs	\$80 <u>copay</u> /prescription (retail) \$160 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	\$80 <u>copay</u> /prescription (retail) \$160 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	No charge	No charge	No charge	All tiers: Subject to enhanced value <u>network deductible</u>
	<u>Urgent care</u>	\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$80 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse
If you have a hospital stay	Facility fees (e.g., hospital room)	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$10 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	No charge	No charge	50% <u>coinsurance</u>	Standard value <u>network</u> : Subject to enhanced value <u>network deductible</u> Precertification may be required.
If you are pregnant	Office visits	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for preventive services.
	Childbirth/delivery professional services	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information	
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)		
If you need help recovering or have other special health needs	Childbirth/delivery facility services	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.	
		No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>		
		\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>		
	Home health care <u>Rehabilitation services</u>	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Combined network and out-of-network: 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per benefit period. Combined network and out-of-network: <u>habilitation and rehabilitation services</u> . Limit does not apply to therapy services prescribed for the treatment of mental health or substance abuse Precertification may be required.	
		No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>		
		No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>		
	If your child needs dental or eye care	<u>Skilled nursing care</u>	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Combined network and out-of-network: 100 days per benefit period. Precertification may be required.
		<u>Durable medical equipment</u>	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
		<u>Hospice services</u>	No charge	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
		Children's eye exam	Not covered	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	-----none-----	
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Hearing aids
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcare.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-241-5704.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$320

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,270

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$550

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-241-5704.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1 -855-873-4106.

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 lib्रेng 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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (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.

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Performance Flex Blue PPO – Buy Down Plan C – Group numbers 107141-20,21,90

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out-of-pocket. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
General Provisions			
Benefit Period (1)	Calendar year		
Deductible (per benefit period) (All in-network services are credited to both the standard and the enhanced deductibles.)			
Individual	\$4,000	\$6,000	\$6,750
Family	\$8,000	\$12,000	\$11,250
Plan Pays – payment based on the plan allowance	80% after deductible	70% after deductible	50% after deductible
Out-of-Pocket Limit (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)			
Individual	\$6,650	\$6,880	\$10,000
Family	\$13,300	\$13,760	\$20,000
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug and other qualified medical expenses, Network only) Once met, the plan pays 100% of covered services for the rest of the benefit period.			
Individual	\$10,150		Not applicable
Family	\$20,300		Not applicable
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after \$30 copayment	100% after \$40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$30 copayment	100% after \$40 copayment	50% after deductible
Specialist Office & Virtual Visits	100% after \$60 copayment	100% after \$80 copayment	50% after deductible
Urgent Care Center Visits	100% after \$60 copayment	100% after \$80 copayment	50% after deductible
Telemedicine (5)	100% after a \$25 copayment		Not covered
Preventive Care (2)			
Routine Adult			
Adult immunizations	100% (deductible does not apply)		50% after deductible
Colorectal cancer screening	100% (deductible does not apply)		50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)		50% after deductible
Physical exams	100% (deductible does not apply)		50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)		50% (deductible does not apply)
Routine Pediatric			
Diagnostic services and procedures	100% (deductible does not apply)		50% after deductible
Pediatric immunizations	100% (deductible does not apply)		50% (deductible does not apply)
Physical exams	100% (deductible does not apply)		50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	80% after deductible	70% after deductible	50% after deductible
Hospital Outpatient	80% after deductible	70% after deductible	50% after deductible
Maternity (non-preventive facility & professional services. Includes dependent daughter.)	80% after deductible	70% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/ Surgical Expenses	80% after deductible	70% after deductible	50% after deductible

Benefit	Network		Out-of-Network
	Enhanced Value	Standard Value	
Emergency Services			
Emergency Room Services	100% after \$125 copayment (waived if admitted)		
Ambulance (7)	80% after enhanced deductible		
Ambulance – Non-Emergency	80% after enhanced deductible		
Therapy, Rehabilitative and Habilitative Services			
Physical Medicine (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Respiratory Therapy	80% after deductible	70% after deductible	50% after deductible
Speech & Occupational Therapy (Rehabilitative and Habilitative)	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Spinal Manipulations	100% after \$15 copayment	100% after \$30 copayment	50% after deductible
	Limit: 30 visits per benefit period		
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	70% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	80% after enhanced deductible		50% after deductible
Inpatient Detoxification/Rehabilitation	80% after enhanced deductible		50% after deductible
Outpatient	100% after \$15 copayment		50% after deductible
Other Services			
Allergy Extracts and Injections	80% after deductible	70% after deductible	50% after deductible
Assisted Fertilization Procedures	Not Covered		
Dental Services Related to Accidental Injury	80% after deductible	70% after deductible	50% after deductible
Diagnostic Services			
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	80% after deductible	70% after deductible	50% after deductible
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	70% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	80% after deductible	70% after deductible	50% after deductible
Home Health Care	80% after deductible	70% after deductible	50% after deductible
Hospice	80% after deductible	70% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(3)	80% after deductible	70% after deductible	50% after deductible
Private Duty Nursing	80% after deductible	70% after deductible	50% after deductible
	Limit: 240 hours/benefit period		
Skilled Nursing Facility Care	80% after deductible	70% after deductible	50% after deductible
	Limit: 100 days per benefit period		
Transplant Services	80% after deductible	70% after deductible	50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program(6) <i>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.</i>	Retail Drugs 31-day Supply (Mandatory Generic) \$15 generic copayment \$60 brand copayment - formulary \$80 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
	Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic) \$30 generic copayment \$120 brand copayment - formulary \$160 brand copayment – non-formulary Specialty Drugs – Limited to a 30 day supply		
Incentive Choice Home Program	After the 2 nd fill of a maintenance medication at a retail pharmacy, a \$5 penalty applies if not filled through the home delivery.		

- (1) Your group's benefit period is based on a Calendar Year. The Calendar Year is from January 1-December 31.
- (2) Services are limited to those listed on the Preventive Schedule (Women's Health Preventive Schedule may apply). Gender, age and frequency limits may apply.
- (3) 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.
- (4) Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (5) 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/Substance abuse benefit
- (6) The formulary is an extensive list of Food and 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

*The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.

clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

(7) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

! The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-800-241-5704. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$4,000 individual/\$8,000 family enhanced value network. \$6,000 individual/\$12,000 family standard value network. \$6,750 individual/\$11,250 family out-of-network. All in-network services are credited to both the enhanced and standard value deductibles.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, <u>preventive care services</u> , <u>emergency room care</u> , <u>urgent care</u> , <u>outpatient mental health</u> , <u>outpatient substance abuse</u> , <u>rehabilitation services</u> , <u>habilitation services</u> , and <u>prescription drug benefits</u> are covered before you meet your network deductible. <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$6,650 individual/\$13,300 family enhanced value network. \$6,880 individual/\$13,760 family standard value network. All in-network services are credited to both the enhanced and standard value out-of-pocket limits. Up to a \$10,150 individual/\$20,300 family, combined enhanced and standard value total maximum out-of-pocket. \$10,000 individual/\$20,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Network</u>: <u>Premiums</u>, <u>balance-billed charges</u>, and <u>health care this plan doesn't cover</u> do not apply to your total maximum <u>out-of-pocket</u>.</p> <p><u>Out-of-network</u>: <u>Copayments</u>, <u>premiums</u>, <u>balance-billed charges</u>, <u>prescription drug expenses</u>, and <u>health care this plan doesn't cover</u>.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.myhighmark.com or call 1-800-241-5704 for a list of <u>network providers</u>.</p>	<p>You pay the least if you use a <u>provider</u> in <u>Enhanced Network</u>. You pay more if you use a <u>provider</u> in <u>Standard Network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).</p> <p>Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
<p>If you visit a <u>health care provider's office</u> or <u>clinic</u></p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$30 <u>copay</u>/visit <u>Deductible</u> does not apply.</p>	<p>\$40 <u>copay</u>/visit <u>Deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u></p>	<p>You may have to pay for services that aren't <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p> <p>Please refer to your <u>preventive schedule</u> for additional information.</p>
	<p><u>Specialist</u> visit</p>	<p>\$60 <u>copay</u>/visit <u>Deductible</u> does not apply.</p>	<p>\$80 <u>copay</u>/visit <u>Deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u></p>	
	<p><u>Preventive care/screening/immunization</u></p>	<p>No charge <u>Deductible</u> does not apply.</p>	<p>No charge <u>Deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u></p>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myhighmark.com	Generic drugs	\$15 <u>copay</u> /prescription (retail) \$30 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	\$15 <u>copay</u> /prescription (retail) \$30 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order. <u>Specialty drugs</u> are limited to a 30-day supply.
	<u>Formulary</u> Brand drugs	\$60 <u>copay</u> /prescription (retail) \$120 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	\$60 <u>copay</u> /prescription (retail) \$120 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
If you have outpatient surgery	<u>Non-Formulary</u> Brand drugs	\$80 <u>copay</u> /prescription (retail) \$160 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	\$80 <u>copay</u> /prescription (retail) \$160 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Precertification may be required.
	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	20% <u>coinsurance</u> 20% <u>coinsurance</u>	30% <u>coinsurance</u> 30% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay/visit Deductible</u> does not apply.	\$125 <u>copay/visit Deductible</u> does not apply.	\$125 <u>copay/visit Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	All tiers: Subject to enhanced value <u>network deductible</u> .
	<u>Urgent care</u>	\$60 <u>copay/visit Deductible</u> does not apply.	\$80 <u>copay/visit Deductible</u> does not apply.	50% <u>coinsurance</u>	The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse
If you have a hospital stay	Facility fees (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay/visit Deductible</u> does not apply.	\$15 <u>copay/visit Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Standard value <u>network</u> : Subject to enhanced value <u>network deductible</u> Pre-certification may be required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Cost sharing</u> does not apply for <u>preventive services</u>.</p> <p>Depending on the type of services, a <u>copayment</u>, <u>coinsurance</u>, or <u>deductible</u> may apply.</p> <p><u>Maternity care</u> may include tests and services described elsewhere in the SBC (i.e. ultrasound.)</p> <p><u>Network</u>: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information.</p> <p><u>Prerecertification</u> may be required.</p>
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<p>Combined <u>network</u> and out-of-<u>network</u>: 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per benefit period.</p> <p>Combined <u>network</u> and out-of-<u>network</u>: <u>habilitation</u> and <u>rehabilitation services</u>. Limit does not apply to therapy services prescribed for the treatment of mental health or substance abuse</p> <p><u>Prerecertification</u> may be required.</p>
	<u>Rehabilitation services</u>	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
	<u>Habilitation services</u>	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enhanced Network Provider (You will pay the least)	Standard Network Provider	Out-of-Network Provider (You will pay the most)	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 100 days per benefit period. Precertification may be required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Hearing aids
- Routine foot care
- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (Adult)
- Routine eye care (Adult)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Chiropractic care
- Non-emergency care when traveling outside the U.S. See www.bcbglobalcare.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-241-5704.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$4,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$4,000
Copayments	\$10
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,770

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$4,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
Deductibles	\$900
Copayments	\$1,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$4,000
- Specialist copayment \$60
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
Deductibles	\$1,300
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-241-5704.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1 -855-873-4106.

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 lib्रेng 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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (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.

Summary of PPO Blue Benefits

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.

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Base Plan D

Group numbers 104916-00,01,70

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period ⁽¹⁾	Calendar Year	
Deductible (per benefit period)		
Individual	\$2,000	\$6,750
Family	\$4,000	\$11,250
Plan Pays – payment based on the plan allowance	90% after deductible	50% after deductible
Out-of-Pocket Maximums (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)		
Individual	\$2,250	\$10,000
Family	\$4,500	\$20,000
Total Maximum Out of Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) ⁽⁸⁾ Once met, plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,150	Not applicable
Family	\$20,300	
Autism Spectrum Disorders (ASD) Maximum (per person) ⁽²⁾	90% after deductible	50% after deductible
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after \$20 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$20 copayment	50% after deductible
Specialist Office Visits	100% after \$40 copayment	50% after deductible
Urgent Care Center Visits	100% after \$40 copayment	50% after deductible
Telemedicine ⁽⁷⁾	100% after \$15 copayment	Not covered
Preventive Care ⁽³⁾		
Routine Adult		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient		
Hospital Outpatient		
Maternity (non-preventive facility & professional services)	90% after deductible	50% after deductible
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	100% after \$125 copayment (waived if admitted)	
Ambulance ⁽⁹⁾	90% after deductible	
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	
Respiratory Therapy	90% after deductible	50% after deductible
Speech & Occupational Therapy	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	

drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

- (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 Outpatient Mental Health benefit.
- (8) Effective with plan years beginning on or after January 1, 2014, the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expenses.
- (9) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

! The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-800-241-5704. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000 individual/\$4,000 family <u>network</u> . \$6,750 individual/\$11,250 family out-of- <u>network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Office visits, <u>preventive care services</u> , <u>emergency room care</u> , <u>urgent care</u> , outpatient mental health, outpatient substance abuse, <u>rehabilitation services</u> , and <u>prescription drug benefits</u> are covered before you meet your <u>network deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$2,250 individual/\$4,500 family <u>network out-of-pocket limit</u> , up to a total maximum out-of-pocket of \$10,150 individual/\$20,300 family. \$10,000 individual/\$20,000 family out-of- <u>network</u> .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Network</u> : <u>Premiums</u> , <u>balance-billed charges</u> , and <u>health care</u> this <u>plan</u> doesn't cover do not apply to your total maximum out-of-pocket. <u>Out-of-network</u> : <u>Copayments</u> , <u>premiums</u> , <u>balance-billed charges</u> , <u>prescription drug expenses</u> , and <u>health care</u> this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

An example of a benefit book can be found at <https://shop.highmark.com/sales#!/sbc-agreements>.

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.myhighmark.com or call 1-800-241-5704 for a list of network providers.</p>	<p>This plan uses a <u>provider network</u>. You will pay less if you use a provider in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Please refer to your <u>preventive schedule</u> for additional information.
	<u>Specialist</u> visit	\$40 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) <u>Imaging</u> (CT/PET scans, MRIs)	10% <u>coinsurance</u> 10% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse. Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.myhighmark.com.</p>	Generic drugs	\$10 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order. <u>Specialty drugs</u> limited to a 30-day supply.
	<u>Formulary</u> Brand drugs	\$55 <u>copay</u> /prescription (retail) \$110 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Non-Formulary</u> Brand drugs	\$80 <u>copay</u> /prescription (retail) \$160 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Pre-certification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$125 <u>copay/visit</u> <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Out-of-network: Subject to <u>network deductible</u> .
	<u>Urgent care</u>	\$40 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse
If you have a hospital stay	Facility fees (e.g., hospital room)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Prerecertification may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Prerecertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Prerecertification may be required.
	Inpatient services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Prerecertification may be required.
If you are pregnant	Office visits	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
				<u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information. Prerecertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Recertification may be required.
	<u>Rehabilitation services</u>	\$15 <u>copay/visit</u> <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Combined <u>network</u> and <u>out-of-network</u> : 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per benefit period. Limit does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Recertification may be required.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Combined <u>network</u> and <u>out-of-network</u> : 100 days per benefit period. Recertification may be required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Recertification may be required.
	<u>Hospice services</u>	10% <u>coinsurance</u>	50% <u>coinsurance</u>	Recertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See [http:// www.bcbsglobalcare.com](http://www.bcbsglobalcare.com)
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-241-5704.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$2,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,170

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$2,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$20
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$2,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,300
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-241-5704.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-855-873-4106.

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 lib्रेng 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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (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.

Summary of PPO Blue Benefits

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.

Bricklayers and Allied Craft Workers Welfare Fund of Western PA

Buy Up Plan E

Group numbers 104916-10,11,80

Benefit	Network	Out-of-Network
General Provisions		
Benefit Period ⁽¹⁾	Calendar Year	
Deductible (per benefit period)		
Individual	\$1,500	\$6,750
Family	\$3,000	\$11,250
Plan Pays – payment based on the plan allowance	100% after deductible	50% after deductible
Out-of-Pocket Maximums (Includes deductible and coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period.)		
Individual	N/A	\$10,000
Family		\$20,000
Total Maximum Out of Pocket (Includes deductible, coinsurance, copays and other qualified medical expenses, Network only) ⁽⁸⁾ Once met, plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,150	Not applicable
Family	\$20,300	
Autism Spectrum Disorders (ASD) Maximum (per person) ⁽²⁾	100% after deductible	50% after deductible
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after \$10 copayment	50% after deductible
Primary Care Provider Office Visits	100% after \$10 copayment	50% after deductible
Specialist Office Visits	100% after \$20 copayment	50% after deductible
Urgent Care Center Visits	100% after \$20 copayment	50% after deductible
Telemedicine ⁽⁷⁾	100% after \$5 copayment	Not covered
Preventive Care ⁽³⁾		
Routine Adult		
Physical exams	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% after deductible	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Routine Pediatric		
Physical exams	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient		
Hospital Outpatient		
Maternity (non-preventive facility & professional services)	100% after deductible	50% after deductible
Medical/Surgical (except office visits)		
Emergency Services		
Emergency Room Services	100% after \$125 copayment (waived if admitted)	
Ambulance ⁽⁹⁾	100% after deductible	
Therapy and Rehabilitation Services		
Physical Medicine	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	
Respiratory Therapy	100% after deductible	
Speech & Occupational Therapy	100% after \$15 copayment	50% after deductible
	Limit: 30 visits per calendar year	

drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.

- (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 Outpatient Mental Health benefit.
- (8) Effective with plan years beginning on or after January 1, 2014, the Network Total Maximum Out-of-Pocket as mandated by the federal government must include deductible, coinsurance, copays, and any qualified medical expenses.
- (9) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits

! The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-800-241-5704. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 individual/\$3,000 family <u>network</u> . \$6,750 individual/\$11,250 family out-of- <u>network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, <u>preventive care services</u> , <u>emergency room care</u> , <u>urgent care</u> , outpatient mental health, outpatient substance abuse, <u>rehabilitation services</u> , and <u>prescription drug benefits</u> are covered before you meet your <u>network deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$0 individual/\$0 family <u>network out-of-pocket limit</u> , up to a total maximum out-of-pocket of \$10,150 individual/\$20,300 family. \$10,000 individual/\$20,000 family out-of- <u>network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Network</u> : <u>Premiums</u> , <u>balance-billed charges</u> , and <u>health care</u> this <u>plan</u> doesn't cover do not apply to your total maximum out-of-pocket. <u>Out-of-network</u> : <u>Copayments</u> , <u>premiums</u> , <u>balance-billed charges</u> , <u>prescription drug expenses</u> , and <u>health care</u> this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

An example of a benefit book can be found at <https://shop.highmark.com/sales#!/sbc-agreements>.

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.myhighmark.com or call 1-800-241-5704 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you visit a health care provider's office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$10 <u>copay/visit</u> <u>Deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u></p>	<p>You may have to pay for services that aren't <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p> <p>Please refer to your <u>preventive</u> schedule for additional information.</p>
	<p><u>Specialist</u> visit</p>	<p>\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u></p>	
	<p><u>Preventive care/screening/immunization</u></p>	<p>No charge <u>Deductible</u> does not apply.</p>	<p>50% <u>coinsurance</u></p>	
<p>If you have a test</p>	<p><u>Diagnostic test</u> (x-ray, blood work) Imaging (CT/PET scans, MRIs)</p>	<p>No charge</p>	<p>50% <u>coinsurance</u></p>	<p>Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse. Precertification may be required.</p>
		<p>No charge</p>	<p>50% <u>coinsurance</u></p>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.myhighmark.com</p>	Generic drugs	\$10 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.
	<u>Formulary</u> Brand drugs	\$55 <u>copay</u> /prescription (retail) \$110 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	<u>Specialty drugs</u> are limited to a 30-day supply.
	<u>Non-Formulary</u> Brand drugs	\$80 <u>copay</u> /prescription (retail) \$160 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	50% <u>coinsurance</u>	Prerecertification may be required.
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	Prerecertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$125 <u>copay</u> /visit <u>Deductible</u> does not apply.	\$125 <u>copay</u> /visit <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	No charge	No charge	<u>Out-of-network</u> : Subject to <u>network deductible</u> .
	<u>Urgent care</u>	\$20 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	The copayment, if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse
If you have a hospital stay	Facility fees (e.g., hospital room)	No charge	50% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <u>copay</u> /visit <u>Deductible</u> does not apply.	50% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	No charge	50% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No charge	50% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	No charge	50% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
				<u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information. Pre-certification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	50% coinsurance	Recertification may be required.
	<u>Rehabilitation services</u>	\$15 copay/visit <u>Deductible</u> does not apply.	50% coinsurance	Combined <u>network</u> and out-of- <u>network</u> : 30 physical medicine visits, 30 speech therapy visits, and 30 occupational therapy visits per benefit period. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Recertification may be required.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	No charge	50% coinsurance	Combined <u>network</u> and out-of- <u>network</u> : 100 days per benefit period. Recertification may be required.
	<u>Durable medical equipment</u>	No charge	50% coinsurance	Recertification may be required.
	<u>Hospice services</u>	No charge	50% coinsurance	Recertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----none-----

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See <http://www.bcbsglobalcare.com>
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-241-5704.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,500
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,570

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- Specialist copayment \$20
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,300
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-241-5704.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-855-873-4106.

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 libheng 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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (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.

Bricklayers Performance Blue \$9450 Plan

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.

Group#s 107141-30,31,32

Benefit	In Network	Out of Network
General Provisions		
Benefit Period (1)	Calendar Year	
Deductible (per benefit period)		
Individual	\$9,450	\$18,900
Family	\$18,900	\$37,800
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period)		
Individual	None	None
Family	None	None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,150	Not Applicable
Family	\$20,300	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after deductible	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after deductible	80% after deductible
Specialist Office Visits & Virtual Visits	100% after deductible	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after deductible	80% after deductible
Telemedicine Services (3)	100% after deductible	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	80% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after deductible	
Ambulance - Emergency (6)	100% after deductible	100% after in-network deductible
Ambulance - Non-Emergency (6)	100% after deductible	80% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	80% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Respiratory Therapy	100% after deductible	100% after in-network deductible
Speech Therapy	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	

Benefit	In Network	Out of Network
Occupational Therapy	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Spinal Manipulations	100% after deductible	80% after deductible
	Limit: 20 visits/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	80% after deductible
Outpatient Substance Abuse Services	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
	limit: 90 visits/benefit period	
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	80% after deductible
Private Duty Nursing	100% after deductible	80% after deductible
	240 hours per benefit period	
Skilled Nursing Facility Care	100% after deductible	80% after deductible
	100 days per benefit period	
Transplant Services	100% after deductible	80% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	none none	
Prescription Drug Program (10) Hard Mandatory Generic <i>National Plus</i> <i>Prescriptions filled at a non-network pharmacy are not covered.</i> <i>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design</i>	Retail Drugs 31/60/90-day Supply Tier One: 100% after deductible Tier Two: 100% after deductible Tier Three: 100% after deductible Specialty Drugs (31 day supply only) 100% after deductible Maintenance Drugs through Mail Order (90-day Supply) 100% after deductible	

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 Calendar Year which runs from January 1 to December 31.

(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) Telemedicine Services (acute care for minor illnesses available on-demand 24/7), must be performed by a Highmark Designated Telemedicine Provider. Additional services provided by a Designated Telemedicine Provider are paid according to the benefit category that they fall under (e.g. Behavioral Health is eligible under the Outpatient Mental Health Services benefit).

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

(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.

(6) Air Ambulance services rendered by out-of-network providers will be covered at the highest network level of benefits.

(7) Services for the treatment of Autism Spectrum Disorders are covered for eligible members to age 21. After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will

be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits. If ASD benefit period dollar maximum applies, only non-essential health benefits will accumulate.

(8) 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.

(9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.

(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the hard mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand drug copayment plus the difference in cost between the brand and generic drugs. With the Smart90 CVS Network, after two fills at a retail pharmacy that is not CVS you must choose between a 90-day supply through CVS retail pharmacy stores or through Express Scripts Mail Order Pharmacy. Your plan requires that you use Accredo specialty pharmacy for select specialty medications. The Copay Armor program helps members to afford high cost medications (mostly specialty) by leveraging manufacturer coupon dollars. Members will not need to change where prescriptions are filled and will be contacted by Pillar Rx for cost savings enrollment.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield or Highmark Choice Company, which are independent licensees 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>.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

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，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 المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

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

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

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

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

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

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

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

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

! The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myhighmark.com or call 1-800-241-5704. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1-800-241-5704 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$9,450 individual/\$18,900 family <u>network</u> . \$18,900 individual/\$37,800 family out-of- <u>network</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the deductible amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Office visits, <u>preventive care services</u> , <u>emergency room care</u> , <u>urgent care</u> , outpatient mental health, outpatient substance abuse, <u>rehabilitation services</u> , and <u>prescription drug benefits</u> are covered before you meet your <u>network deductible</u> . <u>Copayments</u> and <u>coinsurance</u> amounts don't count toward the <u>network deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$0 individual/\$0 family <u>network out-of-pocket limit</u> , up to a total maximum out-of-pocket of \$10,150 individual/\$20,300 family. \$0 individual/\$0 family out-of- <u>network</u> .	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Network</u> : <u>Premiums</u> , <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover do not apply to your total maximum out-of-pocket. Out-of- <u>network</u> : <u>Copayments</u> , <u>premiums</u> , <u>balance-billed charges</u> , <u>prescription drug expenses</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

An example of a benefit book can be found at <https://shop.highmark.com/sales#!/sbc-agreements>.

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.myhighmark.com or call 1-800-241-5704 for a list of network providers.</p>	<p>This plan uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Please refer to your <u>preventive</u> schedule for additional information.
	<u>Specialist</u> visit	\$60 <u>copay/visit</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) Imaging (CT/PET scans, MRIs)	No charge No charge	20% <u>coinsurance</u> 20% <u>coinsurance</u>	Copayments, if any, do not apply to diagnostic services prescribed for the treatment of mental health or substance abuse. Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.myhighmark.com</p>	Generic drugs	\$15 <u>copay</u> /prescription (retail) \$30 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Up to 31-day supply retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order. <u>Specialty drugs</u> are limited to a 30-day supply.
	<u>Formulary</u> Brand drugs	\$75 <u>copay</u> /prescription (retail) \$150 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Non-Formulary</u> Brand drugs	\$100 <u>copay</u> /prescription (retail) \$200 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% <u>coinsurance</u>	Prerecertification may be required.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Prerecertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$175 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$175 <u>copay/visit</u> <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of-network: Subject to <u>network deductible</u> .
	<u>Urgent care</u>	\$60 <u>copay/visit</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	The <u>copayment</u> , if any, does not apply to urgent care services prescribed for the treatment of mental health or substance abuse
If you have a hospital stay	Facility fees (e.g., hospital room)	No charge	20% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	No charge	20% <u>coinsurance</u>	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay/visit</u> <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	No charge	20% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	No charge	20% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No charge	20% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	No charge	20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
				<u>Network</u> : The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health <u>Preventive Schedule</u> for additional information. Pre-certification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	20% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 90 visits per benefit period, combined with visiting nurse. Precertification may be required.
	<u>Rehabilitation services</u>	\$60 <u>copay</u> /visit <u>Deductible</u> does not apply.	20% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 20 physical medicine visits, 20 speech therapy visits, and 20 occupational therapy visits per benefit period. The limit, if any, does not apply to therapy services prescribed for the treatment of mental health or substance abuse. Precertification may be required.
	<u>Habilitation services</u>	Not covered	Not covered	-----none-----
	<u>Skilled nursing care</u>	No charge	20% <u>coinsurance</u>	Combined <u>network</u> and out-of- <u>network</u> : 100 days per benefit period. Precertification may be required.
	<u>Durable medical equipment</u>	No charge	20% <u>coinsurance</u>	Precertification may be required.
	<u>Hospice services</u>	No charge	20% <u>coinsurance</u>	Precertification may be required.
	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----none-----
	If your child needs dental or eye care			

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcare.com
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. The Pennsylvania Department of Consumer Services at 1-877-881-6388. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Highmark, Inc. at 1-800-241-5704.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$9,200
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$9,200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$9,260

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$9,200
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,420

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$9,200
- Specialist copayment \$30
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-241-5704.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield and Highmark Choice Company which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com; or for a paper copy, call 1-855-873-4106.

Discrimination is Against the Law

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 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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U.S. Department of Health and Human Services

200 Independence Avenue, SW

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Washington, D.C. 20201

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ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

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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.

Summary of Benefits: Blue Edge Dental Flex

Blue Edge Dental Flex plan options provide you maximum flexibility. Benefits are paid at the same level for care received from any provider. The listed percentages represent the portion of the maximum allowable charge (MAC) for which the plan is responsible. Network providers agree to accept the MAC as payment in full and agree to file your claims. **If you receive covered services from an out-of-network provider, the plan will apply the percentages shown to the MAC for covered services and you will be responsible for the difference, up to the provider's charge.** Standard deductibles, exclusions and limitations apply. Network dentists may elect to discount non-covered services and services above the annual maximum. Discounts vary by service and region and when agreed to by the provider; not permitted in all jurisdictions.

Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania Blue Edge Dental Flex Value 4 - NS

Network	Advantage	
Deductible – Individual/Family (waived for In and Out-of-network Class I services)	\$0	
Benefit Period Maximum per member	\$1,000	
Class I Services		
Exams	100%	
X-rays	100%	
Cleanings	100%	
Fluoride Treatment	100%	
Sealants	100%	
Space Maintainers	100%	
Palliative Treatment (Emergency)	100%	
Class II Services		
Simple Extractions	50%	
Basic Restorative (Fillings), Posterior Resins	50%	
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures	50%	
General Anesthesia	50%	
Class III Services		
Oral Surgery (including Surgical Extractions)	20%	
Endodontics	20%	
Periodontics (Surgical and Nonsurgical)	20%	
Inlays, Onlays, Crowns	20%	
Prosthetics (Bridges, Dentures)	20%	
Orthodontics (dependents to age 19)		
Diagnostic, Active, Retention Treatment	Not Covered	
Orthodontic Lifetime Maximum per covered dependent	Not Applicable	
Implants		
Implant Surgery, Supported Restoration	Not Covered	
Additional Features		
<input type="checkbox"/> TMD/TMJ*	<input checked="" type="checkbox"/> Smile for Health®--Wellness	<input checked="" type="checkbox"/> Pregnancy
<input type="checkbox"/> Annual Maximum Rollover*	<input checked="" type="checkbox"/> College Tuition Benefit	<input type="checkbox"/> Preventive Incentive*
<input type="checkbox"/> Occlusal Guard*		

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage, First Priority Life Insurance Company or First Priority Health, all of which are independent licensees of the Blue Cross and Blue Shield Association. United Concordia is a separate company that administers Highmark dental benefits.

Smile for Health--Wellness is a registered service mark of United Concordia Companies, Inc.

*These features are for Large Group only. Additional fees may apply.

In-Network Benefits – Non-Voluntary		Fashion Advantage V	
Frequency – Once Every:			
Eye Examination (including dilation when professionally indicated)		12 months	
Spectacle Lenses		12 months	
Frame		12 months	
Contact Lenses (in lieu of eyeglass lenses)		12 months	
Copayments			
Eye Examination		\$0	
Spectacle Lenses		\$0	
Contact Lens Evaluation, Fitting & Follow-Up Care		n/a	
Eyeglass Benefit - Frame		Average Retail Value	
Non-Collection Frame Allowance (Retail):		Up to \$130	
Davis Vision Frame Collection¹ (in lieu of Allowance):		Up to \$60	
- Fashion level		Up to \$125	
- Designer level		Up to \$175	
- Premier level		Up to \$225	
Eyeglass Benefit - Spectacle Lenses		Average Retail Value	
Lenses: Single Lined Bifocal Trifocal Lenticular		\$60-\$120	
Oversize Lenses		\$20	
Tinting of Plastic Lenses		\$20	
Scratch-Resistant Coating		\$25-\$40	
Scratch Protection Plan: Single Vision Multifocal Lenses		\$60 - \$120	
Polycarbonate Lenses ²		\$60-\$75	
Ultraviolet Coating		\$25-\$30	
Anti-Reflective Coating: Standard Premium Ultra Ultimate		\$100-\$175	
Progressive Lenses: Standard Premium Ultra Ultimate		\$230-\$440	
High-Index Lenses: 1.67 1.74		\$120-\$160	
Polarized Lenses		\$95-\$110	
Plastic Photosensitive Lenses		\$95-\$150	
Blue Light Filtering		\$25	
Contact Lens Benefit (in lieu of eyeglasses)		Member Charges	
Non-Collection Contact Lenses: Materials Allowance		Included	
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Included	
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		\$11	
		Included	
Collection Contact Lenses¹ (in lieu of Allowance): Materials		Included	
- Disposable		\$25 \$40	
- Planned Replacement		\$20 \$40	
- Evaluation, Fitting & Follow-up Care		\$0 or \$30	
Medically Necessary Contact Lenses (with prior approval)		\$12	
- Materials, Evaluation, Fitting & Follow-Up Care		\$35 \$48 \$60 \$85	
		\$50 \$90 \$140 \$175	
		\$55 \$120	
		\$75	
		\$65	
		\$15	
Out-of-Network Reimbursement Schedule: up to			
Eye Examination: \$32	Single Vision Lenses: \$25	Trifocal Lenses: \$46	Elective Contact Lenses: \$85
Frame: \$30	Bifocal/Progressive Lenses: \$36	Lenticular Lenses: \$72	Medically Necessary CL: \$225

¹Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

²Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

Network providers—The Davis Vision provider network is being used through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality and service are maintained.

Network retail locations—In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations, as noted in this benefit description. However, your value is comparable.

Locating a network provider—To find a network provider, go to www.highmarkbcbs.com and click on “Find a Doctor or Rx.” Click on “Find an Eyecare Provider”. Enter your zip code and mile radius then click on “Search” to see the most current listing of providers that will accept your vision plan.

Receiving services from a network provider:

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Highmark member, or eligible dependent, in a vision plan administered by Davis Vision.
- Provide the office with your identification (ID) number (located on your Highmark ID card), and the name and birth date of the covered dependent receiving services.

It's that easy! The provider's office will verify your eligibility for services. No claim forms are required!

Frame benefit—You may choose from 'The Collection' in most independent network provider offices or a program allowance will be applied toward a network provider's own frames. Many Collection frames are covered in full or have a nominal copayment which helps you select high-quality frames, while minimizing out-of-pocket expenses. Network retail providers typically do not display the Collection. You will instead be given a program allowance toward your frame purchase. If the chosen frame exceeds the allowance, you will be responsible for any remaining balance.

Contact lenses benefit—Contact lenses may be selected in lieu of eyeglass lenses. No copayment applies towards the initial supply of formulary contact lenses (many of the most popular standard, soft daily wear; disposable or planned replacement) including fitting/follow-up charges. A program allowance will be applied toward contact lenses from the provider's own supply (which may or may not include fitting/follow-up charges). At a network retail location, you will receive an allowance toward the cost of lenses from the retailer's supply. With prior approval, medically necessary contact lenses will be covered in full at all network provider locations.

Low vision services—You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up visits will be covered during the five-year period.

Exclusions—This vision program excludes coverage for certain items and services, including: medical treatment of eye disease or injury; vision therapy; special lens designs or coatings other than those previously described; replacement of lost or stolen eyewear; non-prescription (Plano) lenses; and services not performed by licensed personnel.

VALUE-ADDED FEATURES

Replacement contact lens program—Highmark offers a contact lens replacement program to members. This mail order program exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Visit www.davisvisioncontacts.com or call 1-855-589-7911 with a current prescription. Every order comes with a complimentary starter kit.

Laser Vision Correction

Highmark members enjoy lower prices on LASIK procedures than other carriers, along with flexible financing options - up to 12 months interest free. These savings are up to 40% - 50% off the national average price of traditional LASIK and are available at over 1,000 locations across our nationwide network of laser vision correction providers. Laser vision correction services are administered by QualSight, LLC. Terms and conditions are subject to change. Locate a participating provider by calling 1-855-502-2020.

Hearing Aid Discounts-Our members have access to exclusive discounts from Your Hearing Network to get started on the way to better hearing. Members receive a free hearing exam, and discounts of up to 40% off premium hearing aids. Each order includes:

- A Trial period - 60 day money back guarantee
- 1 year of follow-up care
- A 4-year service warranty, including 1 year of loss and damage
- A 4-year supply of batteries (included with each hearing aid purchase)

Call 1 (888) 809-0044 for more information, or to schedule your consultation with a local hearing aid professional.

Call Member Service at 1-800-223-4795 (TTY users call 1-800-523-2847).

Monday through Friday, 8:00 am to 5:00 pm, Eastern Standard Time (EST) to find a network provider, ask benefit questions, verify eligibility or request an out-of-network provider reimbursement form.

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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).

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Bricklayers & Allied Craftworkers Local 9 Welfare Fund of Western PA
PO Box 160
Troy, MI 48099-0160
Phone: (412) 317-6538 or Toll Free: (877) 270-1199
www.BACLocal9Benefits.org

Dear Participant,

The Trustees of the Bricklayers & Allied Craftworks Local 9 Welfare Fund of Western PA (Fund) are pleased to provide a summary update about the Medical Reimbursement Account (MRA).

Effective for hours worked on or after October 1, 2022, a portion of the hourly Employer Contributions received on your behalf will be credited to the MRA set up on your behalf. Plans A, B, D, or E will be eligible to receive MRA credits based at \$.50 per hour and Plan C will be eligible to receive MRA credits based at \$.75 per hour. The Opt-Out MRA Only Plan will be eligible to receive 50% of the hourly contribution rate of their hours to the MRA.

The MRA can be used to cover out-of-pocket expenses, including medical, dental, vision, and prescription copays and expenses not otherwise covered by the Plan, and which qualify as a medical expense under the Internal Revenue Code (IRS Pub 502 available at www.irs.gov). You will receive a "Benefit Reimbursement Credit Card" (referred to as a "WEX Card") to pay for eligible medical expenses. You may also submit receipts of medical expenses with a completed MRA form to the Fund and receive a reimbursement check. Make sure you retain all your receipts when you use the Benefit Reimbursement Credit Card, as you may need to prove that those expenses qualified as medical expenses (this is referred to as "substantiation"). If you cannot prove the expenses were medical, you may owe additional tax.

Included within this correspondence are:

- **Frequently Asked Questions (FAQ)** that we hope will answer most of your questions regarding eligible expenses, terms, and conditions of the MRA, and the reimbursement process. Due to IRS regulations, the Fund is required to verify your claims and, in certain circumstances, must obtain full itemization of expenses that you are claiming for reimbursement from your MRA.
- **MRA Claim Form** for use when manually submitting reimbursement requests.
- **Terms and Conditions of the MRA which include a Certification for Wex Card Use.** The Certification states your understanding and acceptance of the restrictions that apply to the Card's use. Please keep these material with your Summary Plan Description.
- **MRA Substantiation Overview** that explains how you can use the WEX Card while having your expenses automatically substantiated without a need for further documentation in certain situations.

Please read these documents carefully and be sure to keep these documents in a safe place for future reference.

If you have any questions, feel free to contact the Benefits Office at (877) 270-1199 or (412) 317-6538.

Sincerely,

The Benefits Office for the
Board of Trustees of the Bricklayers & Allied Craftworkers
Local 9 Welfare Fund of Western PA.

Important Information About Your Prepaid Benefits Card



Frequently Asked Questions

General Questions on Prepaid Benefits Card (WEX Card)

1. What is a Prepaid Benefits Card?

Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card (WEX Card) that gives participants an easy, automatic way to pay for qualified health care/benefit expenses. The Card lets participants electronically access the pre-tax amounts set aside in their respective employee benefits accounts such as your Medical Reimbursement Account (MRA).

2. How does the Prepaid Benefits Card work?

It works like a MasterCard® Card or Visa® Card (WEX Card), with the value of the participant's account(s) contribution stored on it. When participants have qualified eligible expenses at a business that accepts MasterCard debit cards or Visa debit cards, they simply use their Card. The amount of the qualified purchases will be deducted – automatically – from their account and the pre-tax dollars will be electronically transferred to the provider/merchant for immediate payment.

3. How does the Prepaid Benefits Card change how the participant is reimbursed for expenses?

With the Prepaid Benefits Card, participants simply swipe their Card, and the funds are automatically deducted from their respective employee benefit account(s) for payment. The Card eliminates most out-of-pocket cash outlays and paperwork, as well as the need to wait for reimbursement checks.

4. Is the Prepaid Benefits Card just like other MasterCard Cards or Visa® Cards (WEX Card)?

No. The Prepaid Benefits Card is a special-purpose MasterCard® Card or Visa® Card (WEX Card) that can be used **only** for qualified health care/benefits expenses. It cannot be used, for instance, at gas stations or restaurants. There are no monthly bills and no interest.

5. How many Prepaid Benefits Cards will the participant receive?

The participant will receive two cards. If participants would like additional Cards for other family members, they should contact their Benefit Office.

6. What if the Prepaid Benefits Card is lost or stolen?

Participants should call their Benefit Office to report a Card lost or stolen as soon as they realize it is missing, so the Administrator can turn off their current Card(s) and issue replacement Card(s). If the Benefit Office and the issuing bank are notified within two business days, the participant will not be responsible for any charges. If the notification is after 2 days, the participant may be responsible for the total amount of transactions applied to the lost or stolen card.

Getting Started and Activating Your Card

1. How do participants activate the Card?

Participants should call the toll-free number on the activation sticker on the front of the Card.

Participants requesting multiple cards can use all Cards once the first Card is activated – they do not need to activate all cards. They should wait one business day after activation to use their Cards. Each Card user should sign the Card with his or her own name.

2. What dollar amount is on the Prepaid Benefits Card when it is activated?

For Health Care MRA's, the dollar value on the Card will be the participant's MRA account balance. It is from that total dollar amount that eligible expenses will be deducted as you use the Card or submit manual claims.

Using the Card

1. Where may participants use the Prepaid Benefits Card?

The Prepaid Benefits Card can be used to pay for eligible goods and services at providers/merchants that offer these goods or services and accept MasterCard prepaid cards or Visa prepaid cards.

IRS regulations allow participants to use their Cards in participating pharmacies, discount stores and supermarkets that can identify MRA-eligible items at checkout. ***Participants cannot use their Cards at discount stores, department stores, and supermarkets that do not participate. The Card transaction may be declined. Participants can use their Cards at freestanding pharmacies and health care providers, such as hospitals, doctors, dentists, etc.***

2. Are there places where the Prepaid Benefits Card will not be accepted?

Yes. The Card will not be accepted at locations that do not offer eligible goods and services, such as hardware stores, restaurants, bookstores, gas stations and home improvement stores.

Cards will not be accepted at discount stores, department stores, and supermarkets that cannot identify MRA-eligible items at checkout.

3. If asked, should participants select "Debit" or "Credit"?

Prepaid Benefits Card is a prepaid card. But, since there is no "prepaid" selection available, participants should select **"Credit."** Participants do not need a PIN and cannot get cash with the Prepaid Benefits Card.

4. How will the Card work in participating discount stores and supermarkets?

- a. Bring prescriptions or vision products and other purchases to the register at the checkout to let the clerk ring them up.
- b. Present the Card and swipe it for payment.
- c. If the Card swipe transaction is approved (e.g., there are sufficient funds in the account and at least some of the products are MRA-eligible), the amount of the MRA-eligible purchases is deducted from the account balance. The clerk will then ask for another form of payment for the non-MRA-eligible items.
- d. If the Card swipe transaction is declined, the clerk will ask for another form of payment for the total amount of the purchase.
- e. The receipt will identify the MRA-eligible items and may also show a subtotal of the MRA-eligible purchases.
- f. In most cases, the participant will not receive requests for receipts for MRA-eligible purchases made in participating discount stores or supermarkets.

5. Why do participants need to save all their itemized receipts?

Participants should always save itemized receipts for MRA purchases made with the Prepaid Benefits Card. They may be asked to submit receipts to verify that their expenses comply with IRS guidelines. The need for you to retain copies of all receipts and records is an IRS requirement that the Trustees are required to enforce for you to receive and not lose tax-favored treatment. Each receipt must show: the merchant or provider's name, the service received, or the item purchased, the date and the amount of the purchase.

6. What if participants lose their receipts or accidentally swipe the Card for something that is not eligible?

Usually, the service provider can recreate an account history and provide a replacement receipt. If a receipt cannot be located, recreated, or if the expense is ineligible for reimbursement, the participant can send a check or money order to the Benefit Office for the amount so it can be credited back to the participant's MRA account.

7. May participants use the Prepaid Benefits Card for prescriptions ordered prior to activating the Card?

No. The Card must be activated prior to the order and/or purchase date of prescriptions. In some cases, participants need to wait one business day after activating the Card to purchase prescriptions at their pharmacy. For example, if the Card is activated on Tuesday, a prescription can be ordered and picked up on Wednesday.

8. May participants use the Prepaid Benefits Card if they receive a statement with a Patient Due Balance for a medical service?

Yes. If they have money in their account for the patient balance due and the provider accepts MasterCard debit cards or Visa debit cards, participants can simply write the Card number on their statement and send it back to the provider. Before providing your Prepaid Benefits Card number, be certain that the provider has submitted the charges to your health insurance, that your health insurance has considered and processed the claim, and that the remaining balance to be applied to your Prepaid Benefits Card represents only the patient's responsibility after any health insurance payments due.

9. How do participants know how much is in their account?

They can call the Benefit Office at the phone number on the back of the Card to obtain their current balance or follow the link to the "WEX Health Card" at the participant website, www.ourbenefitoffice.com/BacLocal9/Benefits that can be found under "Health Care" on the home page. You can also obtain your balance by downloading the app "BeneSys Member Reimbursement" from your mobile app store.

10. What if participants have an expense that is more than the amount left in their account?

By checking their account balance often, participants will have a good idea of how much is available in their MRA. To check your balance, refer to question #9 above for details. When incurring an expense that is greater than the amount remaining in their account, participants may be able to split the cost at the register. (Check with the merchant.) For example, participants may tell the clerk to use the Prepaid Benefits Card for the exact amount left in the account and then pay the remaining balance separately. Alternatively, participants may pay by another means and submit the qualified transaction manually via a claim form with the appropriate documentation to their Benefit Office.

11. What are some reasons that the Prepaid Benefits Card might not work at point of sale?

The most common reasons why a Card may be declined at the point of sale are:

- a. The Card has not been activated.
- b. The Card has been used before the 24-hour period after activation is over.
- c. The participant has insufficient funds in his or her employee benefit account to cover the expense.
- d. Non-qualified expenses have been included at the point of sale. (Retry the transaction with the qualified expense only.)
- e. The merchant is encountering problems (e.g., coding or swipe box issues).
- f. The discount store, department store, or supermarket cannot identify MRA-eligible items at checkout according to IRS rules on or after January 1, 2008.

12. Whom do participants call if they have questions about the Prepaid Benefits Card?

Call the Benefit Office at the phone number shown on the back of the Card.

13. How will a participant know to submit receipts to verify a charge?

The participant will receive a letter or notification from the Benefit Office if there is a need to submit a receipt. All receipts should be saved per the IRS regulations.

14. What if a participant fails to submit receipts to verify a charge?

If receipts are not submitted as requested to verify a charge made with Prepaid Benefits Card, then the Card may be suspended until receipts are received. The participant may be required to repay the amount charged. The Benefit Office will advise the participant that the Card has been suspended if a receipt is not received. Submitting a receipt or repaying the amount in question will allow the Card to become active again.

15. Why might my Wex Card be suspended?

The most common reason why your Wex Card might be suspended is because your Wex Card transactions have not been verified as qualified IRS expenses.



Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania MRA Reimbursement Form

BC00

Return completed documents to:

Bricklayers and Allied Craft Workers
Welfare Fund of Western Pennsylvania
P.O. Box 160
Troy, MI 48099-0160

Trust Fund Phone #: (877) 270-1199
Fax #: (248) 556-2597
Email: flexclaims@benesys.com

Instructions: To receive benefits from your MRA account, you must complete **ONE FORM** per patient, along with the following information:

Reimbursement for:

Medical Expenses

Dental Expenses

Vision Expenses

Prescription Expenses

Information Required:

Copy of your Explanation of Benefits Form (EOB).
Balance due statements are not acceptable.

Copy of your Explanation of Benefits Form (EOB).
Copy of Itemized Bill.
Orthodontic services will be paid for after services are rendered.

Copy of your Explanation of Benefits Form (EOB).
Copy of Itemized Bill.

Copy of the drug label stub or a printout from your pharmacy.
Cash register receipts are not acceptable.

PLEASE NOTE: You **MUST** allow up to **30 business days** for reimbursement. All reimbursements for claims will be made payable to the member. Claims must be filed within **12 months** from the date of service.

Member's Name: _____ Member's SS#: _____

Address: _____

Phone Number: (Home) _____ (Work) _____

Patient Name: _____ Relationship: _____

Type of Service (Medical, Dental, Vision or Prescription)	Providers Name	Date of Service	Amount of Claim
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____
_____	_____	___/___/___	_____

By signing this form, I understand that benefits shall be paid in accordance with the MRA Plan eligibility requirements and limitations established by the Board of Trustees

Member's Signature: _____ Date: _____



Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania MRA Reimbursement Form

BC00

What can I use the MRA account for?

Qualified medical expenses generally, but not always, are those that would qualify as tax-deductible medical, dental or vision expenses. These are explained in IRS Publication 502.

Also, a medicine or drug will be a qualified medical expense for MRA purposes only if the medicine or drug:

- requires a prescription;
- is available without prescription (an over-the-counter medicine or drug) and you get a prescription for it; or
- is insulin.

Qualified medical expenses reimbursable from your MRA include the following:

- amounts paid for health insurance premiums*;
- amounts paid for long-term coverage;
- amounts that are not covered under another health plan; and
- deductibles, copayments or coinsurance.

What expenses are not allowed?

- Expenses that are not for "medical care" as that term is defined by IRS Publication 502; Controlled substances that are in violation of federal law, even if a state allows its use with a physician's prescription (for example, marijuana prescribed to treat a specific medical condition);
- Cosmetic Surgery.
- Nutritional supplements, vitamins, herbal supplements, and natural medicines unless they are prescribed by a medical practitioner as treatment for a specific medical condition diagnosed by a physician;
- Weight-loss programs and drugs prescribed to induce weight loss, unless prescribed by a physician to treat a specific medical condition; and
- Special food and beverages, unless the food or beverages are prescribed by a medical practitioner to treat a specific illness or ailment and do not substitute for normal nutritional needs.

Is there a time limit to file for MRA Benefits?

Yes, claims must be received by the Fund office within 12 months from the date of service.

Return completed documents to:

Bricklayers and Allied Craft Workers
Welfare Fund of Western Pennsylvania
P.O. Box 160
Troy, MI 48099-0160

Trust Fund Phone #: (877) 270-1199
Fax #: (248) 556-2597
Email: flexclaims@benesys.com

Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania Certification for MRA Wex Card Use

NOTICE

It is important that you certify that you understand and agree to the following terms when you first receive the MRA Wex card (“Card”) and each year thereafter. According to IRS rules, you must follow these standards or return your Card. Unless you communicate to the Trustees of the Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania (“Fund”) to the contrary, you are certifying your understanding and acceptance of the following terms by accepting the Card:

1. You will only use the Card in connection with your payment of qualifying expenses under the Fund. You acknowledge that you have received and reviewed the guidelines regarding which expenses are qualifying expenses and agree to follow those guidelines.
2. You agree and affirm that any expense paid with the Card will not be submitted (and has not been submitted previously) for reimbursement under any other plan or program for health care coverage.
3. You agree to save all invoices and receipts for any expense paid with the Card and, upon request, to submit those documents to the Fund Administrator. You acknowledge that in order to process Card transactions, it may be necessary for the Fund Administrator to disclose information regarding your participation in Fund to third-party service providers (such as benefits administrators to determine pharmacy and/or other health care benefits).
4. You understand that by accepting the Card, you promise to comply with these representations and understand that this creates a binding contractual commitment to the Fund Administrator and Fund on your part regarding your use of the Card. You also understand that you renew and reaffirm these promises, which are printed on the back of the Card, each time you use or permit use of the Card.

BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA

MRA SUBSTANTIATION OVERVIEW

How to use your MRA

The Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania (Fund) has made using your MRA easy by offering a MRA Debit Card and giving you 24/7 access to your account online and on a mobile app. Having a debit card allows you to pay for your expenses upfront. The Card generally saves you from submitting your records but doesn't excuse you from keeping your receipts and other records. This is because in certain cases, you may still need to submit substantiation to the Fund Office. The MRA is a pre-tax benefit, and the IRS requires MRA debit card purchases be substantiated with itemized bills to verify the expense is allowed under the strict IRS rules.

- **For IIAS Retailers** - You can use the Card to pay for eligible expenses at any store that participates in the Inventory Information Approval System (IIAS). For example, if you use the Card at a pharmacy that participates in the IIAS, you may be able to use the Card to pay for a prescription and have the transaction automatically substantiate on your behalf without asking you to submit documentation. This is due to the IIAS technology generally being available at participating retailers. Most IIAS retailers include pharmacies, grocery stores and discount stores. Many merchants have implemented IIAS technology, but for a complete list of participating locations, please visit www.sig-is.org/storelocator.
- **For medical, dental and vision expenses** wait until the regular health plan pays its portion and sends you an EOB. Then use your MRA debit card to pay the balance due. If BeneSys asks you for documentation, please submit the EOB or other itemized documentation. Please see the documentation checklist enclosed for details on what's required.
- **Recurring debit card expenses** – if you are making regular payments or routinely seeking healthcare and paying the same amount at an eligible healthcare provider, you only need to submit substantiation once. When approved by the Fund office, future debit card payments of the exact same dollar amount at the same provider will be automatically verified for you for up to 12 months. Eligible healthcare providers include physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers.
- **Copay match** – your MRA card will automatically substantiate copayments, if the copayments are made at an eligible healthcare provider such as physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers. Copayment amounts are supplied by the Bricklayers Welfare Fund.

SAVE YOUR BILLS AND ITEMIZED RECEIPTS!

BeneSys may be required to request copies of your statements to verify that your purchase meets the Fund and IRS qualifications. While many MRA Card transactions are automatically verified, some require additional manual verification to make sure that the Card is being used to pay for an eligible expense.

If BeneSys asks for documentation, it is because the payment could not be verified for you. For example, if you have an office visit with Dr Jones, your cardiologist, the medical claim for that visit is billed to the health plan from "Dr Jones"; However, when you swipe your MRA debit card, the charge may show up as "Heart Practice" – therefore the two expenses may NOT automatically match up on your behalf and you may be asked to submit the EOB.

Timely Filing Requirements – Claims must be submitted/paid within 12 months after the incurred date.

Why has my MRA Card been suspended?

The most common reason why your MRA Card is suspended is because your MRA card transactions have not been verified as a qualified IRS expense. If asked to submit documentation or filing a claim for reimbursement, use this documentation checklist and submission tips to ensure your request is processed promptly.

BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA

MRA SUBSTANTIATION OVERVIEW

Claim & Card use Verification Documentation Checklist

All documentation MUST include these five key pieces of information:

- 1 Provider's Name** - Facility name or person who provided the service, or if a purchase, where item was purchased (i.e. hospital, doctor, pharmacy).
- 2 Service Date(s)** - Date services occurred, or date item was purchased.
- 3 Patient's Name** - Person who received the service or whom the item is for.
- 4 Type of Service** - Detailed description of the service provided or item purchased.
- 5 Amount Paid** - The amount charged for services or product and/or the portion not reimbursed by your insurance carrier.

Helpful Tips When Using Your MRA & Submitting Documentation

- Use an itemized bill from your provider or an Explanation of Benefits (EOBs), especially if your insurance paid a portion of the expense.
- Make sure documentation is legible; check that it isn't too dark, or light and that information is not cut off.
- Do not use highlighters on documentation.
- Handwritten documentation must include stamped provider information.
- Cash simple payment receipts alone do not have enough information; documentation must include description of services/supplies, date of service, patient name, provider name, and amount.
- For a list of IRS eligible expenses, please visit www.irs.gov/pub/irs-pdf/p502.pdf.
- Examples of common expenses that are NOT covered include dental teeth whitening, nitrous oxide, toiletries, eyewear protection plans, cosmetic surgery, marriage counseling, pre-payment of medical services, finance charges or "no show" fees.
- Some items require a Letter of Medical Necessity from your medical provider, such as vitamins/supplements and massage therapy.

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Member Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or- **If you are not married** or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an “X” in the box where it says “I do not want my Health Information released to anyone but myself”. **Please sign and date below the box.**

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse). **If you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an “X” in the box where it says “I do not want my Health Information released to anyone but myself”.

3. **Please sign and date form below the box.**
-

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother). **If want to give someone other than your parents** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

OR

If you do not want to give anyone other than yourself authority to inquire about your health information, then place an “X” in the box where it says “I do not want my Health Information released to anyone but myself”.

3. **Please sign and date form below the box.**

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____ authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

Bricklayers & Allied Craftworkers Local 9 Welfare Fund of Western PA
Attn: HIPAA Contact Person
PO Box 160, Troy, MI 48099-0160

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member _____ **Date Signed:** _____

-OR- I do not want my Health Information released to anyone but myself.

Signature of Member _____ **Date Signed:** _____

SPOUSE SECTION

I, the spouse (Name, Please Print) _____, (Spouse's Social Security #) _____ of the above named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse _____ **Date Signed:** _____

-OR- I do not want my Health Information released to anyone but myself.

Signature of Spouse _____ **Date Signed:** _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the dependent child(ren) over the age of 18 (Name, Please Print) _____, (Social Security #) _____ have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent _____ **Date Signed:** _____

OR- I do not want my Health Information released to anyone but myself.

Signature of Dependent _____ **Date Signed:** _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dftr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA

Fund Office: BeneSys Inc. P.O. Box 160 Troy, MI 48099-0160 /Phone: (412) 317-6538 / (877) 270-1199 /Fax: (412) 307-3691

PARTICIPANT NOTICE

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, the Fund is providing you with the following required annual notice:

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers all stages of reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The amount of benefits payable for this coverage is subject to the current medical plan provisions and also subject to the plan's normal annual deductibles and coinsurance provisions.

This notice is required to be distributed to you periodically for your information. No action is required by you with respect to this notice.

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact the customer service number listed on the back of your insurance card.

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NOTICE OF THE PRIVACY PRACTICES OF THE BRICKLAYERS AND ALLIED CRAFTWORKERS

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully and Contact the Plan Office If You Have Any Questions.

We are required by law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information that identifies you is kept private to the extent required by law. We are also required to give you this notice regarding (1) the uses and disclosures of medical information that may be made by the Plan, and (2) your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, we may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

For Payment.

We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the coordination of benefit payments.

For Health Care Operations.

We may use and disclose medical information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities.

As Required By Law.

We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action. When authorized by law to report information about abuse, neglect or domestic violence to public authorities, we may disclose medical information if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such a case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's health information.

To Avert a Serious Threat to Health or Safety.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

To Inform You About Treatment Alternatives or Other Health Related Benefits.

We may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. For instance, we may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.

Disclosure to Health Plan Sponsor.

Medical information may be disclosed to the Plan Sponsors, i.e. the Union and the Associations, or Plan Trustees, solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation.

If you are an organ donor, we may release medical information to organizations that handle organ procurement or transplantation.

Military and Veterans.

If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation.

We may release medical information about you for workers' compensation or similar programs.

Public Health Risks.

We may disclose medical information about you for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability.

Health Oversight Activities.

We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes.

We may disclose medical information in response to a court order or administrative tribunal. We may also disclose medical information in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if we receive satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if we have made a reasonable effort to notify you about the request.

Law Enforcement.

We may release medical information if asked to do so for law enforcement purposes so long as applicable legal requirements have been met.

Coroners, Medical Examiners and Funeral Directors.

We may release medical information to a coroner or medical examiner.

Research.

We may disclose medical information for research, subject to conditions.

National Security and Intelligence Activities.

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates.

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy.

You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity - that created the information is no longer available to make the

amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

Right to an Accounting of Disclosures.

You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures, other than disclosures made (1) to carry out treatment, payment or health care operations, (2) to individuals about their own medical information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for other national security or to correctional institutions or law enforcement officials, or (8) before April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions.

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan shall accommodate such a request if the participant clearly provides information that the disclosure of all or part of that information could endanger the participant. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice.

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Changes to This Notice

The effective date of this Notice is April 14, 2003. We reserve the right to (1) change this notice, and (2) to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If any changes are made, we will mail the revised Notice to participants. The Plan will comply with the terms of any such Notice currently in effect.

Complaints/Requests for Information

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, or to receive further information as required by the regulations, contact Sherry Verstraete at the Plan Office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

**SUMMARY ANNUAL REPORT FOR
BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA**

This is a summary of the annual report of the BRICKLAYERS AND ALLIED CRAFT WORKERS WELFARE FUND OF WESTERN PENNSYLVANIA, (Employer Identification Number 25-6103466, Plan Number 501), for the plan year 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Bricklayers And Allied Craft Workers Welfare Fund Of Western Pennsylvania has committed itself to pay certain claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with HIGHMARK INC. to pay all Health, Dental, Vision, and Prescription Drug claims incurred under the terms of the plan. The total premiums paid and self-paid claims for the plan year ending 12/31/2024 were \$13,047,533.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was \$18,418,356 as of the end of plan year, compared to \$17,041,083 as of the beginning of the plan year. During the plan year the plan experienced a change in its net assets of \$1,377,273. This change includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of \$14,973,256 including employer contributions of \$12,492,210, employee contributions of \$1,083,695 and earnings from investments of \$1,397,351. Plan expenses were \$13,595,983. These expenses included \$548,450 in administrative expenses, \$13,047,533 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Financial information and information on payments to service providers.
2. Insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of UNION TRUSTEE, who is a representative of the plan administrator, at 3660 STUTZ DRIVE, SUITE 101, CANFIELD, OH 44406 and phone number, 412-317-6538. The charge to cover copying costs will be \$5.00 for the full annual report, or \$0.25 per page for any part thereof.

You also have the legally protected right to examine the annual report at the main office of the plan: 3660 STUTZ DRIVE, SUITE 101, CANFIELD, OH 44406, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.