

# PLEASE READ FIRST

EFFECTIVE JANUARY 1, 2026 THE IUPAT WELFARE FUND OF WESTERN PENNSYLVANIA WILL CONTINUE TO OFFER TWO INSURANCE PLANS

HIGHMARK BLUE CROSS AND BLUE SHIELD

OR

UPMC HEALTH PLAN

IF YOU DO NOT CHOOSE A NEW HEALTH PLAN DURING OPEN ENROLLMENT YOU WILL STAY IN THE PLAN YOU PREVIOUSLY ELECTED FOR THE ENTIRE YEAR OF 2026

**IF YOU ARE CURRENTLY OPTED OUT OF THE INSURANCE AND WANT TO REMAIN OPTED OUT YOU MUST COMPLETE AND RETURN THE OPT-OUT ENROLLMENT FORM**

- REVIEW THE RATE CHANGES IN THE ENROLLMENT LETTER EFFECTIVE JANUARY 1, 2026.
- If you wish to stay in the Plan that you are currently enrolled in with Highmark or UPMC with the High or Low option for insurance effective January 1, 2026, you **DO NOT** need to send back any of the information in this packet. You will automatically be enrolled as you were for the prior year of 2025.
- If you were opted out of the plan or are changing to the opt out benefit you **MUST timely** complete and return the **WAIVER OF PARTICIPATION AND PROOF OF OTHER COVERAGE** form.
- If you wish to change your current enrollment in any way you **MUST** complete the included enrollment form with your changes as well as the Highmark or UPMC enrollment form and return both to the Fund Office in the envelope provided.
- **THERE HAVE BEEN NO BENEFIT CHANGES FOR 2026.**

**REMEMBER ALL ENROLLMENT INFORMATION MUST BE RETURNED TO THE FUND OFFICE BY NOVEMBER 30, 2025.**

# 2026 OPEN ENROLLMENT

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Welcome to the 2026 open enrollment. Each year, during open enrollment, you have the opportunity to review your medical coverage options and change your option (or opt out) based on you and your family's health care needs for the upcoming year.

It's important that you read the Enrollment Guide carefully.

In your enrollment packet you will also find:

- Highmark PPOBLUE High Plan Summary Of Medical Benefits;
- Highmark PPOBLUE Low Plan Summary Of Medical Benefits;
- UPMC Health Plan High Plan Summary Of Medical Benefits;
- UPMC Health Plan Low Plan Summary Of Medical Benefits;
- Enrollment Application;
- Dental Enrollment Form;
- IUPAT of Western Pennsylvania Enrollment Form and envelope.

Please keep the contents of your enrollment packet in a safe place, as you may need to refer to it throughout the year.

## **Important! Open Enrollment November 1, 2025 – November 30, 2025**

You must enroll for health care coverage **November 1, 2025 – November 30, 2025**. If you do not enroll by the deadline, you and your dependents will automatically be covered under the current plan you are enrolled in.

*\*\*If you opted out of coverage for the 2025 plan year, YOU MUST complete opt out paperwork again for 2026, or you & your dependents will be enrolled in the default coverage.\*\**

## **HOW TO ENROLL**

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Open enrollment is **November 1, 2025 – November 30, 2025**, for coverage effective January 1, 2026 – December 31, 2026.

**Step 1:** Review this Guide and the Summary Of Benefits for both the High Plan and the Low Plan carefully.

**Step 2:** Consider your options and evaluate your medical coverage needs for the upcoming year.

**Step 3:** Complete the Enrollment Application and the IUPAT of Western Pennsylvania Enrollment Form. Be sure to complete all requested information. **If you opt out of medical coverage, complete the IUPAT Enrollment Form and complete the WAIVER OF PARTICIPATION & PROOF OF OTHER COVERAGE form. This form MUST be completed each year.**

Remember, your coverage level is automatically based on your family status on file with the Fund Office. In addition, you and any eligible dependents will be covered under the same medical option.

**IF YOU ENROLLED IN COVERAGE IN 2025 AND YOU DO NOT CHOOSE A NEW HEALTH PLAN DURING OPEN ENROLLMENT, YOU WILL BE ENROLLED IN THE SAME PLAN YOU WERE ENROLLED IN FOR 2025, FOR THE ENTIRE YEAR OF 2026.**

**Step 4:** Send the completed enrollment form(s) to the Fund Office **by November 30, 2025**. **If your form is not returned by the deadline, you, your spouse, and eligible dependents will receive coverage under the current plan you are enrolled in, or if you opted out for 2025, you and your dependents will be enrolled in the default coverage.**

Please note that open enrollment is only held once each year. However, if you decline enrollment for medical coverage for yourself (and dependents including your spouse) because of other medical coverage, and you had completed the Waiver of Participation and Proof of Other Coverage form during open enrollment, you may be able to enroll yourself and your dependents if you or your dependents lose eligibility for the other medical coverage (or the employer stopped contributing towards the coverage for you or your dependents). However,

If you have any questions about enrolling, please contact the Fund Office at 1-833-697-1294.

you must request enrollment by contacting the Fund Office **within 30 days** after the other coverage ends (or the employer stops contributing towards the coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment by contacting the Fund Office **within 30 days** after the marriage, birth, adoption, or placement for adoption.

If you or your eligible dependent are covered under a state Medicaid or Child Health Insurance Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you and/or your eligible dependent may enroll in this plan. Or, if you or your eligible dependent become eligible through Medicaid or CHIP for premium assistance to pay for medical coverage under this plan, you and/or your eligible dependent may enroll in this plan. You must request enrollment by contacting the Fund Office within 60 days after losing Medicaid or CHIP or becoming eligible for premium assistance under Medicaid or CHIP.

### **Loss Of Dependent Status**

Keep in mind that you must notify the Fund immediately if your dependent is no longer eligible for coverage (either because your dependent child reaches the limitation age or you and your spouse divorce). If you do not inform the Fund Office within 60 days of when your spouse or dependent is no longer eligible for coverage under the Plan, your spouse or dependent may lose his or her right to elect COBRA continuation of coverage.

If you have any questions about enrolling, please contact the Fund Office at 1-833-697-1294.

## **MEDICAL OPTIONS**

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Recognizing that our participants have different needs, the Fund offers four different medical coverage options – a High Plan of medical coverage, and a Low Plan of medical coverage with either Highmark or UPMC. Each medical coverage option covers the same range of services, including prescription drugs; however, your out-of-pocket expenses are different.

Effective January 1, 2026 the medical coverage options are:

- **HIGHMARK High Plan:** This option allows you to pay the least out of your pocket for medical expenses. However, in exchange for this higher level of coverage a higher monthly charge is deducted from your Health Care Account (or higher self-pay contribution).
- **HIGHMARK Low Plan:** This option has a lower monthly charge (or lower self-pay contribution) than the High Plan option does; but your out-of-pocket medical expenses including coinsurance, deductible, and out-of-pocket maximums are higher.
- **UPMC High Plan:** This option allows you to pay the least out of your pocket for medical expenses. However, in exchange for this higher level of coverage a higher monthly charge is deducted from your Health Care Account (or higher self-pay contribution).
- **UPMC Low Plan:** This option has a lower monthly charge (or lower self-pay contribution) than the

### **Deductible**

The calendar deductible is the amount of covered expenses that you pay each calendar year before the Plan begins to pay benefits. There are separate network and non-network deductibles and amounts do not apply toward each other. In addition, flat dollar copayments do not apply toward the deductible.

The deductible applies to each covered person each calendar year. The family deductible is met once two or more covered members of a family meet the amount as shown on the Summary Of Benefits for the family maximum. Once an individual and/or family deductible is met, no further deductibles are required for that year.

High Plan option does; but your out-of-pocket medical expenses including coinsurance, deductible, and out-of-pocket maximums are higher.

## ID Cards

**Be sure to keep your ID cards with you and show your ID card each time you receive services.**

## MEDICAL COVERAGE LEVELS

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We recognize that everyone's family composition may vary; therefore, there are four different coverage levels. The coverage levels ensure that your health care costs accurately reflect the amount of eligible dependents you cover. The coverage levels are:

- Member only;
- Member + spouse;
- Member + child(ren); and
- Member + family.

You will be automatically enrolled in the coverage level that matches your family status on file with the Fund Office as listed in the following chart:

<b>If You Have...</b>	<b>You Will Automatically Be Enrolled In...</b>
No spouse or eligible child(ren)	Member only
A spouse and no eligible child(ren)	Member + spouse
Eligible child(ren) and no spouse	Member + child(ren)
A spouse and eligible child(ren)	Member + family

If you sign the WAIVER OF PARTICIPATION AND PROOF OF OTHER COVERAGE, you may opt out of the medical coverage; otherwise, you will be enrolled in the medical coverage level that matches your family composition on file. You must cover yourself and all of your eligible dependents or opt out of coverage for all (with required signed Waiver of Participation and Proof of Other Insurance). As an exception, you may enroll in Member Only coverage if your spouse and all dependents are enrolled in your spouse's plan, but you are ineligible for coverage on your spouse's plan (proof of other coverage and your ineligibility for that coverage will be required).

### Examples

#### Example 1

*If you are married and have one eligible child, you will automatically be enrolled for member + family medical coverage under the Fund. Or, if your spouse has other medical coverage available through his or her employer, you and your family can elect medical coverage under your spouse's employer, and you may opt out of Fund coverage (with required proof). However, you could not elect member only coverage under the Fund and have your spouse and child covered under your spouse's employer unless you are not eligible for coverage under your spouse's plan.*

#### Example 2

*If you are married and do not have a child, you will automatically be enrolled for member + spouse coverage under the Fund. Or, if your spouse has other coverage available through his or her employer, you and your spouse can elect coverage under your spouse's employer, and you may opt out of Fund coverage (with required proof). However, you could not elect member*

only coverage under the Fund and have your spouse covered under your spouse's employer unless you are not eligible for coverage under your spouse's plan.

## PERSONAL ACCOUNTS

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Contributions made to the Welfare Fund on your behalf (minus the administrative fee and the \$25 monthly fee) will be deposited into two Personal Accounts – the Health Care Account and the Wage Account.

### Health Care Account

The balance in your **Health Care Account**:

- Determines your monthly eligibility for medical coverage;
- Is used to pay the monthly charge for medical coverage; and
- May be used to reimburse out-of-pocket medical, dental, and vision expenses.

Any contributions made on your behalf throughout the year (minus the administrative fee and the \$25 monthly fee) will be deposited to your Health Care Account until you reach a balance of \$1,000. A \$1,000 balance must be maintained in your Health Care Account at all times. After reaching the \$1,000 balance in your Health Care Account, future contributions will be split between your Health Care and Wage Accounts. The percentage contributed to each Account will be based on your medical coverage level as follows:

Health Care And Wage Account Contribution Percentages		
If Your Medical Coverage Level Is...	This Percentage Will Be Deposited To Your Health Care Account...	This Percentage Will Be Deposited To Your Wage Account...
Member Only	50%	50%
Member + Spouse	80%	20%
Member + Child(ren)	80%	20%
Member + Family	90%	10%
No Coverage (Opt Out)	20%	80%

Contributions made on your behalf will be credited to your Accounts as they are received. **You must have at least \$1,000 in your Health Care Account to be eligible for medical coverage.**

Eligibility is determined on a month-to-month basis. If there are not sufficient contributions in your Health Care Account to pay the monthly charge for medical coverage, you may self-pay the amount needed to continue medical coverage and to receive other Fund benefits. Self-payment amounts, if any, will be shown on your monthly statement that will be mailed on approximately the 10<sup>th</sup> of each month. If you do not have enough in your Health Care Account to continue coverage and you decide not to self-pay for coverage, you cannot self-pay for coverage for any other month until at least one hour of contributions have been made to the Fund on your behalf.

If no contributions are received during the month, and your Health Care Account is at the \$1,000 minimum balance, you may self-pay the full monthly charge amount for a maximum of nine consecutive months. If you do not make self-payments to maintain eligibility and have six months of no contribution activity, you may draw from your \$1,000 balance after the six months for reimbursement of medical expenses.

## Monthly Charges

The monthly charges for medical coverage are:

If You Elect...	Monthly Charge
Member + Family High Plan	\$1,650.00 + administration fee
Member + Child(ren) High Plan	\$1,423.00 + administration fee
Member + Spouse High Plan	\$1,464.00 + administration fee
Member Only High Plan	\$911.00 + administration fee
Member + Family Low Plan	\$1,432.00 + administration fee
Member + Child(ren) Low Plan	\$1,237.00 + administration fee
Member + Spouse Low Plan	\$1,262.00 + administration fee
Member Only Low Plan	\$828.00 + administration fee

**All self-payments are due on the 24<sup>th</sup> of the month. If payment is not received, coverage will end as of the last day of the month in which they are due. There will be no grace period for late payments. Once coverage ends for the month, you must meet the Plan's eligibility requirements to regain eligibility.**

## Reimbursement For Health Care Expenses

In general, you may be reimbursed for medical expenses for yourself, spouse, and eligible dependent children that would otherwise be deductible for federal income tax purposes (regardless of whether those expenses exceed 7.5% of your adjusted gross income). For example, you may be able to use the contributions in your Health Care Account for reimbursement of out-of-pocket medical, dental, and vision expenses for you and your eligible dependents.

You may not be reimbursed for any medical expense:

- That is reimbursable by insurance or otherwise;
- For which you have taken a deduction; or
- That was incurred before the Health Care Account started or before you are enrolled in the Health Account.

When you incur an eligible expense, you may either pay for it with your WEX debit card, or complete a Medical Reimbursement Request Form for the expense and submit an itemized bill of services received as well as the proof of payment. **Claims must be submitted within 12 months of the date the expense was incurred.** For more information about expenses that are eligible for reimbursement, contact the Fund Office.

## Wage Account

The **Wage Account** provides:

- PTO Days – Paid Time Off

For PTO (Paid time Off) pay, you are allowed up to 75 days of paid time off at \$200 per day. You are

eligible for up to 75 days of PTO per calendar year.

PTO will not be paid unless there are sufficient funds to pay all applicable taxes on the PTO pay. Therefore, your net vacation pay will be \$200 per day after taxes are withheld.

To request PTO, simply complete a PTO Pay Request Form. For forms submitted by the 10<sup>th</sup> of the month, a check will be mailed to you on the 15<sup>th</sup> of that month. Any balance remaining in your Wage Account as of November 15<sup>th</sup> each year will automatically be paid out to you, so you do not need to submit a Form for PTO after October 31<sup>st</sup>.

## Continuing Coverage During A Lay-Off

If you are laid-off, you may use your Health Care Account to maintain your eligibility for coverage. If there is a sufficient balance to pay the monthly charge, your coverage under the Fund will continue. If there is not enough in your Health Care Account to cover the monthly charge, you will receive a bill to self-pay the difference.

Remember, you must keep a \$1,000 minimum in your Health Care Account. However, if no employer contributions have been reported on your behalf for six months, you can use the balance in your Account for reimbursement of medical expenses (not for continuing medical coverage), even if it will drop below the \$1,000 minimum balance.

## If You Die Or Leave Covered Employment

If you die or leave covered employment, any remaining Health Care Account balance can be used by your eligible dependents to continue coverage or for reimbursement of allowable health care expenses. Balances cannot be provided as a death benefit to your beneficiary for any reason other than continuation of coverage or reimbursement of allowable expenses.

## **WEEKLY ACCIDENT AND SICKNESS BENEFITS AND LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

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If you are receiving medical coverage, then you are eligible for weekly accident and sickness benefits and life and accidental death and dismemberment (AD&D) insurance as follows:

<b>Benefit</b>	<b>Coverage</b>
Weekly Accident & Sickness Benefit	\$324.85 for 13 Weeks
Life Insurance	\$15,000
Accidental Death & Dismemberment Insurance	\$30,000

\*\$30,000 Accidental Death Payment is in lieu of the \$15,000 Life Insurance (beneficiaries do not get both).

To be eligible for these benefits, you must be eligible for and receiving medical coverage under the Fund. If you opt out of medical coverage under the Fund, you will not be eligible for these three benefits.

If you opt out of medical coverage under the Fund, you will not be eligible for weekly accident and sickness benefits and life and accidental death and dismemberment (AD&D) insurance.

Retirees who have reached age 65 are eligible for a \$5,000 or \$10,000 death benefit if they meet the eligibility conditions. Members are required to send in their retirement certificate and quarterly premium. The amount of the premium is available from the Fund Administrator. Coverage ends when you no longer meet the eligibility requirements or fail to make timely payments for the benefit. For more information contact the Fund Administrator.

*This Enrollment Guide contains only highlights of certain features of the IUPAT of Western Pennsylvania Welfare Fund. Full details are contained in the documents that establish the Fund provisions. If there is a discrepancy between the wording here and the documents that establish the Fund, the document language will govern. The Trustees reserve the right to amend, modify, or terminate the Fund at anytime.*

# IUPAT OF WESTERN PENNSYLVANIA WELFARE FUND 2026 ENROLLMENT FORM

3660 Stutz Drive, Suite LL101, Canfield, OH 44406 • Phone: (330) 779-8865/ (833) 697-1294

• Email: [dgroup\\_youngstown\\_eligibility@benesys.com](mailto:dgroup_youngstown_eligibility@benesys.com)

**MEMBER INFORMATION** – Please provide all requested information.

Member Name (Last, First, MI)	Member Social Security No.
Street Address	Date of Birth
City, State Zip Code	Home Telephone No. (      )

**MEDICAL OPTION ELECTION** – Please indicate your medical option choice by marking an “X” in the box by the program you are electing (choose only one). *If you do not elect a medical option and you had coverage in 2025, you will be enrolled in the same plan option you were enrolled in for 2025. If you do not elect a medical option and you did not have coverage in 2025, default coverage is medical coverage for yourself and all your eligible dependents under the High Plan with Highmark Blue Cross Blue Shield.* Your dependents will be covered under the same program as you. You will be automatically enrolled in the coverage level (member only, member + spouse, member + child(ren), or member + family) that matches your family status on file with the Fund Office.

- High Plan – Highmark Blue Cross Blue Shield
- Low Plan – Highmark Blue Cross Blue Shield
- High Plan – UPMC Health Plan
- Low Plan – UPMC Health Plan
- Opt out. I certify that I understand that by opting out of medical coverage under the Fund:

- I am not eligible for weekly accident and sickness, life, or accidental death and dismemberment (AD&D) insurance benefits under the Fund; and
- I (and my spouse and all eligible dependent children) must be covered under another medical plan. **(Note: You must complete the WAIVER OF PARTICIPATION AND PROOF OF OTHER COVERAGE FORM EVERY YEAR.)\***

**AUTHORIZATION** – Please read the paragraph below, then sign and date.

I understand that the election on this form will remain in effect until the next enrollment period, provided I remain eligible for coverage. In addition, I agree that my dependents and I will abide by the provisions of the program under which we are covered and understand that the Plan provisions may be changed. I have read the materials describing the Fund. I certify that the information on this form is correct and elect coverage as indicated.	
Member Signature	Date

**Return completed forms to the Fund Office at the address above no later than November 30, 2025.**

*\*You may be able to request a special enrollment during the year if you are declining medical coverage for yourself (and your spouse and eligible dependent children) because of other medical coverage, and you or your dependents lose eligibility for the other medical coverage; or, you have a family status change (for example marriage, divorce, birth, adoption, or placement for adoption). For more information, contact the Fund Office within 30 days of the change or the date you lose coverage.*



# IUPAT OF WESTERN PENNSYLVANIA WELFARE FUND 2026 ENROLLMENT APPLICATION

3660 Stutz Drive, Suite LL 101, Canfield, OH 44406 • Phone: (330) 779-8865/ (833)697-1294  
 • Email: [dgroup\\_youngstown\\_eligibility@benesys.com](mailto:dgroup_youngstown_eligibility@benesys.com)

## MEMBER INFORMATION – Please provide all requested information.

Member Name (Last, First, MI)	Member Social Security No.
Street Address	Date of Birth
City, State Zip Code	Home Telephone No. (       )       )

## DEPENDENT INFORMATION – Please provide all requested information.

Name – First – Last – Middle Initial	Social Security Number	Date of Birth xx/xx/xxxx	Sex FM	Relationship – Spouse/Child	If You Have Other Insurance List Carrier and Policy Holder Name and ID Information
Name – First – Last – Middle Initial	Social Security Number	Date of Birth xx/xx/xxxx	Sex FM	Relationship – Spouse/Child	If You Have Other Insurance List Carrier and Policy Holder Name and ID Information
Name – First – Last – Middle Initial	Social Security Number	Date of Birth xx/xx/xxxx	Sex FM	Relationship – Spouse/Child	If You Have Other Insurance List Carrier and Policy Holder Name and ID Information
Name – First – Last – Middle Initial	Social Security Number	Date of Birth xx/xx/xxxx	Sex FM	Relationship – Spouse/Child	If You Have Other Insurance List Carrier and Policy Holder Name and ID Information
Name – First – Last – Middle Initial	Social Security Number	Date of Birth xx/xx/xxxx	Sex FM	Relationship – Spouse/Child	If You Have Other Insurance List Carrier and Policy Holder Name and ID Information

Member Signature

Date



I.U.P.A.T. WELFARE FUND OF WESTERN PENNSYLVANIA

WAIVER OF PARTICIPATION AND PROOF OF OTHER COVERAGE

CURRENT EMPLOYER OF PARTICIPANT: \_\_\_\_\_

PARTICIPANT NAME: \_\_\_\_\_ PARTICIPANT SS# \_\_\_\_\_

EFFECTIVE DATE OF THIS WAIVER: **January 1, 2026**

**I. WAIVER OF PARTICIPATION (check one)**

\_\_\_\_\_ **Newly Eligible Employee.** I am an employee of the Employer and am newly eligible to participate in the I.U.P.A.T. Welfare Fund of Western Pennsylvania. The terms, conditions and costs involved in enrollment in the Fund have been fully explained to me. However, I hereby waive enrollment in the Fund for myself and all eligible dependents because I/we are covered by the medical coverage listed in section II below.

\_\_\_\_\_ **Current Participant in the Fund.** I am an employee of the Employer and am currently participating in the I.U.P.A.T. Welfare Fund of Western Pennsylvania. Effective at the beginning of the next plan year, I elect to terminate myself and my eligible dependents' coverage under the Fund because I/we have (or will have immediately upon termination of coverage under the Fund) the medical coverage listed in section II below.

\_\_\_\_\_ **Spouse and Dependents of the Employee.** I am an employee of the Employer and am newly eligible or currently participating in the I.U.P.A.T. Welfare Fund of Western Pennsylvania. I am waiving coverage for my spouse and dependents, but not myself, because I am ineligible for my spouse's plan. Please contact the Fund office if this is your situation at (330) 779-8865 or 1-833-697-1294.

**II. PROOF OF OTHER COVERAGE**

I certify that I, and all of my eligible dependents, are enrolled in the following medical coverage, which is considered to be "minimum value" coverage under the Healthcare Reform laws (check with the plan administrator of your medical coverage if you are not sure if the plan provides "minimum value" coverage). Further, I understand that I must notify the Fund Office within 30 days if I am no longer covered under the medical plan listed below. If I do not have other coverage at the time I terminate the coverage listed below, I understand that I and all of my eligible dependents will be enrolled in the I.U.P.A.T. Welfare Fund of Western Pennsylvania as soon as I meet the eligibility requirements of the Fund.

Name of Policy Holder or Subscriber: \_\_\_\_\_

Employer/Plan Sponsor: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy/Group/Member Numbers: \_\_\_\_\_

**III. CERTIFICATION**

I certify that the above information is true and correct as of the date indicated below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date





**UPAT DC 57 of Western PA**  
**Box 99459**  
**Troy, MI 48099-9998**  
**(330)779-8865 Toll (833)697-1294**  
**[www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org)**

## VITAL INFORMATION FORM

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 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

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone Number: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Date of Hire: \_\_\_\_\_

**Medicare Claim Number: (including the letter(s) that follows the number)**

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

<b>Member #</b> _____	<b>Spouse #</b> _____	<b>Dependent # and Name</b> _____
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**DEPENDENTS: - Include Spouse (Marriage/Birth Certificates are needed to add any new dependents to the plan)**

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**BENEFICIARY INFORMATION:**

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.*

\_\_\_\_\_  
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: \_\_\_\_\_

\_\_\_\_\_

### **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.*

*Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. 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 such material in any matter.*

**I Have No Other Insurance:** \_\_\_\_\_

Initial Here/Sign Below

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Instructions for completing the

### Authorization for Release of Protected Health Information

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

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#### Participant 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 our 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.**

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#### Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (participant/retiree)** authority to inquire about our 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.**

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#### 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 our health information, please enter their name and relationship (father, mother).  
**If you 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 I.U.P.A.T Welfare Fund of Western Pennsylvania (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:

**Fund Office, 3660 Stutz Dr., Suite LL101, Canfield, OH 44406**

I understand that my health information that is disclosed pursuant to this authorization may be redisclosed by the persons I have identified above, and the Plan cannot prevent or protect such redisclosures, 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.





IUPAT Welfare Fund of Western PA  
3660 Stutz Drive, Suite 101  
Canfield, OH 44406  
Phone (330) 779-8865  
Toll Free 1-833-697-1294  
[www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org)

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October, 2025

### **VOLUNTARY DENTAL PLAN**

Dear Participant:

We are pleased to announce that the Trustees have renewed the Fund's contract with United Concordia to provide a Voluntary Dental Plan for the calendar year 1/1/2026 through 12/31/2026. As in the past, this Plan is being offered on a voluntary basis and will require a quarterly self-payment from you.

**The quarterly premiums effective 1/1/2026 through 12/31/2026 are as follows:**

- **Quarterly Single Coverage is \$99.45**
- **Quarterly Family Coverage is \$259.23**

Should you be interested in participating in the Voluntary Dental Plan, please complete the enclosed enrollment form and return it to the Fund Office no later than **11/30/2025**. **Please be aware that even if you are a current enrollee, you must still complete a new enrollment form for the calendar year beginning 1/1/2026. Additionally, if you are a new enrollee, the waiting periods will apply to your coverage.**

As always, if you have any questions, please do not hesitate to contact the Fund Office.

Sincerely,

IUPAT of Western PA  
Welfare Fund Office  
Enclosure

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PO Box 99459 • Troy MI 48099-9998  
Phone (330) 779-8865  
Toll Free 1-833-697-1294  
[www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org) • [staff@IUPATDC57Benefits.org](mailto:staff@IUPATDC57Benefits.org)







## Program Availability

- Products are not available in any state where prohibited by law or where United Concordia does not have regulatory approval.
- Domestic partner coverage is not permitted in Idaho.

## State Mandated Provisions

- CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
- FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
- AZ, GA, KY, NE & NH: All statements made by a Policyholder or by any Insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.
- KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.
- LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
- NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
- OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.
- OR: Contestability is limited to two years as stated in the Group Policy.
- TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- UT: Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the Rules of (the American Arbitration Association or other recognized arbitrator), a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction.
- VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

## United Concordia operates as a wholly owned subsidiary under the name listed below in the following states:

- United Concordia Dental Corporation of Alabama—AL
- United Concordia Dental Plans, Inc.—DC, MD, NJ
- United Concordia Dental Plans of California, Inc.—CA
- United Concordia Dental Plans of Florida, Inc.—FL
- United Concordia Dental Plans of Kentucky, Inc.—KY
- United Concordia Dental Plans of the Midwest, Inc.—MI, MO, OH
- United Concordia Dental Plans of Pennsylvania, Inc.—PA
- United Concordia Dental Plans of Texas, Inc.—TX
- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY



## **Discrimination is Against the Law**

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: [CivilRightsCoordinator@highmark.com](mailto:CivilRightsCoordinator@highmark.com). 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>.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos servicios gratuitos de asistencia lingüística. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu u quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số 1-800-332-0366 (TTY: 711).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-0366 (TTY: 711) 번으로 전화해 주십시오.
Tagalog (Tagalog - Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-0366 (TTY: 711).
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, вам доступны бесплатные услуги перевода. Звоните 1-800-332-0366 (телетайп: 711).
العربية (Arabic)	يرجى الانتباه: إذا كنت تتحدث العربية، تتوفر خدمات المساعدة للغوية المجانية. اتصل على 1-800-332-0366 (TTY: 711)
Kreyòl Ayisyen (French Creole)	ATANSYON: Si ou pale Kreyòl Ayisyen, gen sèvis èd nan lang ki disponib gratis pou ou. Rele nimewo 1-800-332-0366 (TTY: 711).
Français (French)	ATTENTION : si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le 1-800-332-0366 (ATS: 711).
Polski (Polish)	UWAGA: jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-0366 (TTY: 711).
Português (Portuguese)	ATENÇÃO: se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-332-0366 (TTY: 711).
Italiano (Italian)	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-332-0366 (TTY: 711).
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Dienste für die sprachliche Unterstützung zur Verfügung. Rufnummer: 1-800-332-0366 (TTY: 711).
日本語 (Japanese)	注意事項：日本語をお使いの方は、言語面でのサポートを無償でご利用いただけます。1-800-332-0366 (TTY: 711) まで、お電話にてご連絡ください。
فارسی (Farsi)	توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-0366 (TTY: 711) تماس بگیرید.

## Dental Benefits Summary for IUPAT DISTRICT COUNCIL NO 57

Group Number: 834303000, 070

Network: Advantage

Benefit Category <sup>1</sup>		
	In-Network <sup>2</sup>	Non-Network <sup>2</sup>
<b>Class I – Diagnostic/Preventive Services</b>		
Exams	100%	100%
Bitewing X-rays		
Cleanings & Fluoride Treatments		
Sealants		
<b>Class II – Basic Services</b>		
All Other X-rays	80%	80%
Palliative Treatment		
Space Maintainers		
Basic Restorative (Fillings)		
Simple Extractions		
<b>Class III – Major Services</b>		
Endodontics	50%	50%
Complex Oral Surgery		
General Anesthesia		
Nonsurgical Periodontics		
Surgical Periodontics		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Inlays, Onlays, Crowns		
Prosthetics (Bridges, Dentures)		
<b>Orthodontics for dependent children to age 19</b>		
Diagnostic, Active, Retention Treatment	50%	50%
<b>Included Plan Features</b>		
Smile for Health <sup>®</sup> --Wellness <sup>3</sup> <i>Provides periodontal care for people with certain chronic medical conditions: diabetes, heart disease, lupus, oral cancer, organ transplant, rheumatoid arthritis and stroke Pregnancy is also a covered condition</i>	<ul style="list-style-type: none"> <li>Covers 1 additional periodontal maintenance per year and all are covered at 100%</li> <li>Scaling and root planing are covered at 100%</li> <li>4 periodontal surgery procedures are covered at 100%</li> </ul>	
Pregnancy Benefit <sup>3</sup>	Covers 1 additional cleaning during pregnancy in addition to the benefits listed for Smile for Health <sup>®</sup> --Wellness <sup>3</sup>	
<b>Maximums &amp; Deductibles (applies to the combination of services received from network and non-network dentists)</b>		
Calendar Year Deductible (per person/per family)	\$50/\$150 Excludes Class I & Orthodontics	
Calendar Year Maximum (per person)	\$1,000 Excludes Orthodontics	
Lifetime Orthodontic Maximum (per person)	\$1,000	
<b>Reimbursement</b>	<b>Advantage</b>	<b>Advantage</b>

Representative listing of covered services. For underwritten plans, your certificate of insurance/coverage provides complete details on covered services and exclusions and limitations which may affect benefits payable. For self-funded plans, see your employer's Summary Plan Description for a detailed description of benefits.

Dental plans are administered by United Concordia Companies, Inc. Fully insured plans are underwritten by United Concordia Insurance Company. For more information please visit the "Disclaimers" link at [www.UnitedConcordia.com](http://www.UnitedConcordia.com). Administrative and claims offices located at 1800 Center Street Suite 2B 220, Camp Hill, PA 17011. Call 1-800-332-0366. For additional plan details or questions, contact your account representative or visit [www.ucci.com](http://www.ucci.com) for more information.

1. Unmarried dependent children covered to age 19. Unmarried dependent students covered to age 23.
2. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee (also known as balance billing). We evaluate our MACs and OON percentile allowances annually based on proprietary claim experience and data purchased from independent sources such as FAIR Health. United Concordia Dental's standard exclusions and limitations apply.
3. Members (subscribers or covered dependents) with certain medical conditions must sign up for this program through **My Dental Benefits** on **UnitedConcordia.com**.

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-332-0366 (TTY: 711).
Español (Spanish)	ATENCIÓN: Si habla español, le ofrecemos de ayuda lingüística gratuita. Llame al 1-800-332-0366 (TTY: 711).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-0366 (TTY: 711)。

## ***IUPAT - High option – Groups numbers 11656-00,01,70***

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

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Benefit Period</b> (1)	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	\$250	\$500
Family	\$500	\$1,000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	80% after deductible	60% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
<b>Total Maximum Out of Pocket</b> (Includes deductible, prescription drug expenses and coinsurance, network only. Once met, plan pays 100% for the rest of the benefit period)		
Individual	\$1,750	Not Applicable
Family	\$3,500	
<b>Lifetime Maximum</b> (per person)	Unlimited	
<b>Primary Care Provider Office Visits</b>	100% after \$20 copayment	60% after deductible
<b>Specialist Office Visits</b>	100% after \$40 copayment	60% after deductible
<b>Urgent Care Center Visits / Retail Clinic Visits</b>	100% after \$50 copayment	60% after deductible
<b>Telemedicine</b> (7)	100% (no copayment)	Not Covered
<b>Preventive Care</b> (3)		
<b>Routine Adult</b>		
Physical exams	100% (deductible does not apply)	Not Covered
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Speech Therapy</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Allergy Extracts and Injections</b>	80% after deductible	60% after deductible
<b>Ambulance</b>	80% after network deductible	
<b>Applied Behavior Analysis for ASD</b> (2)	80% after deductible	60% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	80% after deductible	60% after deductible
<b>Diabetes Treatment</b>	80% after deductible	60% after deductible
<b>Diagnostic Services</b>		
<i>Advanced Imaging</i> (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after deductible	60% after deductible
<b>Enteral Formulae</b>	80% (deductible does not apply)	60% (deductible does not apply)
<b>Home Infusion Therapy</b>	80% after network deductible	
<b>Home Health Care</b>	80% after deductible	60% after deductible
<b>Hospice</b>	80% after deductible	60% after deductible
<b>Hospital Services</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
<b>Infertility Counseling, Testing and Treatment</b> (4)	80% after deductible	60% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	80% after deductible	60% after deductible
<b>Medical/Surgical Expenses</b> (except office visits)	80% after deductible	60% after deductible
<b>Mental Health</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient	100% after \$20 copayment	60% after deductible
<b>Private Duty Nursing</b>	80% after network deductible	
<b>Respiratory Therapy</b>	80% after network deductible	
<b>Skilled Nursing Facility Care</b>	80% after deductible	60% after deductible
<b>Substance Abuse</b>		
Inpatient Detoxification	80% after deductible	60% after deductible
Inpatient Rehabilitation	80% after deductible	60% after deductible
Outpatient	100% after \$20 copayment	60% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
<b>Transplant Services</b>	80% after deductible	60% after deductible
<b>Precertification Requirements</b> (5)	Yes	
<b>Prescription Drug Deductible</b>		
Individual	None	
Family	None	
<b>Premier Prescription Drug Program</b> Mandatory Generic(6) <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<p align="center"><b>Retail Drugs 34-day Supply (Mandatory Generic)</b>  \$10 generic copayment  \$20 brand copayment - formulary  \$40 brand copayment – non-formulary  Specialty Drugs – \$100 brand copayment</p> <p align="center"><b>Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic)</b>  \$20 generic copayment  \$40 brand copayment - formulary  \$80 brand copayment – non-formulary</p>	

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (5) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (6) The member is responsible for the payment differential when a generic drug is authorized by the physician and the **patient** elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to brand 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 the Outpatient Mental Health/Substance abuse benefit

*This is not intended as a contract of benefits. It is designed purely as a reference of the many benefits available under your program.*  
09/22/2025 138 W-PPO



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, \_\_\_\_\_ or call \_\_\_\_\_ or other underlined terms see the Glossary. You can view the Glossary at [www.HealthCare.gov/sbc-glossary/](http://www.HealthCare.gov/sbc-glossary/) or call \_\_\_\_\_ to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$250 individual/\$500 family network. \$500 individual/\$1,000 family out-of-network.	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, preventive care services, emergency room care, urgent care, outpatient mental health, outpatient substance abuse, rehabilitation services, and prescription drug benefits are covered before you meet your network deductible.  Copayments and coinsurance 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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?	\$1,500 individual/\$3,000 family network out-of-pocket limit, up to a total maximum out-of-pocket of \$1,750 individual/\$3,500 family. \$3,000 individual/\$6,000 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.
What is not included in the out-of-pocket limit?	Network: Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.  Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

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

<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. See _____ or call _____ 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 charge</u> 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><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></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><b>If you visit a health care <u>provider's</u> office or clinic</b></p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.</p>	<p>40% <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><u>Specialist</u> visit</p>		<p>\$40 <u>copay/visit</u> <u>Deductible</u> does not apply.</p>	<p>40% <u>coinsurance</u></p>	<p>Please refer to your <u>preventive</u> schedule for additional information.</p>
<p><u>Preventive care/screening/immunization</u></p>		<p>No charge <u>Deductible</u> does not apply.</p>	<p>No coverage for <u>preventive care visits</u> 40% <u>coinsurance</u> for <u>screening services</u> 40% <u>coinsurance</u> for <u>immunizations</u></p>	
<p><b>If you have a test</b></p>	<p><u>Diagnostic test</u> (x-ray, blood work) Imaging (CT/PET scans, MRIs)</p>	<p>20% <u>coinsurance</u> 20% <u>coinsurance</u></p>	<p>40% <u>coinsurance</u> 40% <u>coinsurance</u></p>	<p>Copayments, if any, do not apply to <u>diagnostic services</u> prescribed for the treatment of mental health or substance abuse. Pre-certification may be required.</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 _____.</p>	Generic drugs	\$10 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	<p>Up to 34-day supply retail pharmacy.</p> <p>Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.</p>
	<u>Formulary</u> Brand drugs	\$20 <u>copay</u> /prescription (retail) \$40 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	Non- <u>Formulary</u> Brand drugs	\$40 <u>copay</u> /prescription (retail) \$80 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Specialty</u> drugs	\$100 <u>copay</u> /prescription (retail) <u>Deductible</u> does not apply.	Not covered	
<p>If you have outpatient surgery</p> <p>If you need immediate medical attention</p>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification may be required.
	Physician/surgeon fees <u>Emergency room care</u>	20% <u>coinsurance</u> \$100 <u>copay</u> /visit <u>Deductible</u> does not apply.	40% <u>coinsurance</u> <u>Deductible</u> does not apply.	Pre-certification may be required. <u>Copay</u> waived if admitted as an inpatient.

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)	
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of-network: Subject to <u>network deductible</u> .
	<u>Urgent care</u>	\$50 <u>copay/visit</u> <u>Deductible</u> does not apply.	40% <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>	40% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</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 <u>Preventive Schedule</u> for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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	Home health care	20% coinsurance	40% coinsurance	Prerecertification may be required.
	Rehabilitation services	\$40 copay/visit Deductible does not apply.	40% coinsurance	Combined network and out-of-network: 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. Prerecertification may be required.
	Habilitation services	Not covered	Not covered	-----none-----
	Skilled nursing care	20% coinsurance	40% coinsurance	Prerecertification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prerecertification may be required.
	Hospice services	20% coinsurance	40% coinsurance	Prerecertification may be required.
	Children's eye exam	Not covered	Not covered	-----none-----
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	-----none-----
	Children's dental check-up	Not covered	Not covered	-----none-----

## Excluded Services & Other Covered Services:

<b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>	
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• <u>Habilitation services</u></li><li>• Hearing aids</li><li>• Long-term care</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>	
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Non-emergency care when traveling outside the U.S. See <a href="http://www.bcbsglobalcare.com">http://www.bcbsglobalcare.com</a></li><li>• Private-duty nursing</li></ul>

**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](http://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.ccoio.cms.gov](http://www.ccoio.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:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### **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.

About these Coverage Examples:



**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 \$40
- 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	\$250
Copayments	\$0
Coinsurance	\$1,500
<b>What isn't covered</b>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,810</b>

### 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 \$40
- 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	\$250
Copayments	\$600
Coinsurance	\$100
<b>What isn't covered</b>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$970</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$250
- Specialist copayment \$40
- 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	\$250
Copayments	\$400
Coinsurance	\$300
<b>What isn't covered</b>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$950</b>

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: \_\_\_\_\_.

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](http://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](mailto: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 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://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  
 Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

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**ATTENTION:** If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksèsib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

**ВНИМАНИЕ:** Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

**ATTENZIONE:** se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

**ATTENTION :** si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

**ÀKÍYÈSÍ:** Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ itumọ ati ògbufọ èdè wà ní àrọwọtọ lófẹfẹ fún ọ. Awọn iṣẹ itọjú ati irànlọwọ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati iwé afọjú) lati pèsè iwífúnni ni awọn ọna irááyè si wà pẹlu lófẹfẹ. Pe nọmba tó wà lẹhin kaádi idánimọ rẹ (TTY: 711) fún irànlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזוויי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقات يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدون على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的ID卡背面的号码（听障人士专用号码：711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિ:શુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેલ) પણ નિ:શુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કોલ કરો.

**CHÚ Ý:** Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई नि:शुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि नि:शुल्क उपलब्ध छन्। मददतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदीभाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी नि:शुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용하실 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

## IUPAT - Low option

## Group #'s 13164-00,01,70

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

Benefit	Network	Out-of-Network
<b>Benefit Period</b> (1)	Calendar Year	
<b>Deductible</b> (per benefit period)		
Individual	\$1,000	\$2,000
Family	\$2,000	\$4,000
<b>Plan Payment Level</b> – Based on the provider's reasonable charge (PRC)	80% after deductible	60% after deductible
<b>Out-of-Pocket Maximums</b> (Once met, plan payment level becomes 100%)		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
<b>Total Maximum Out of Pocket</b> (Includes deductible, prescription drug expenses and coinsurance, network only. Once met, plan pays 100% for the rest of the benefit period)		
Individual	\$6,000	Not Applicable
Family	\$12,000	
<b>Lifetime Maximum</b> (per person)	Unlimited	
<b>Primary Care Provider Office Visits</b>	100% after \$20 copayment	60% after deductible
<b>Specialist Office Visits</b>	100% after \$40 copayment	60% after deductible
<b>Urgent Care Center Visits / Retail Clinic Visits</b>	100% after \$50 copayment	60% after deductible
<b>Telemedicine</b> (7)	100% (no copayment)	Not Covered
<b>Preventive Care</b> (3)		
<b>Routine Adult</b>		
Physical exams	100% (deductible does not apply)	Not Covered
Adult immunizations	100% (deductible does not apply)	60% after deductible
Colorectal cancer screening	100% (deductible does not apply)	60% after deductible
Routine gynecological exams	100% (deductible does not apply)	60% (deductible does not apply)
Mammograms, annual routine and medically necessary	100% (deductible does not apply)	60% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
<b>Routine Pediatric</b>		
Physical exams	100% (deductible does not apply)	Not Covered
Pediatric immunizations	100% (deductible does not apply)	60% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	60% after deductible
<b>Emergency Room Services</b>	100% after \$100 copayment (waived if admitted)	
<b>Spinal Manipulations</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Physical Medicine</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Speech Therapy</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Occupational Therapy</b>	100% after \$40 copayment	60% after deductible
	Limit: 20 visits/benefit period	
<b>Allergy Extracts and Injections</b>	80% after deductible	60% after deductible
<b>Ambulance</b>	80% after network deductible	
<b>Applied Behavior Analysis for ASD</b> (2)	80% after deductible	60% after deductible
<b>Assisted Fertilization Procedures</b>	Not Covered	
<b>Dental Services Related to Accidental Injury</b>	80% after deductible	60% after deductible
<b>Diabetes Treatment</b>	80% after deductible	60% after deductible
<b>Diagnostic Services</b>		
Advanced Imaging (MRI, CAT, PET scan, etc.)	80% after deductible	60% after deductible

<b>Benefit</b>	<b>Network</b>	<b>Out-of-Network</b>
<i>Basic Diagnostic Services</i> (standard imaging, diagnostic medical, lab/pathology, allergy testing)	80% after deductible	60% after deductible
<b>Durable Medical Equipment, Orthotics and Prosthetics</b>	80% after deductible	60% after deductible
<b>Enteral Formulae</b>	80% (deductible does not apply)	60% (deductible does not apply)
<b>Home Infusion Therapy</b>	80% after network deductible	
<b>Home Health Care</b>	80% after deductible	60% after deductible
<b>Hospice</b>	80% after deductible	60% after deductible
<b>Hospital Services</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient	80% after deductible	60% after deductible
<b>Infertility Counseling, Testing and Treatment<sup>(4)</sup></b>	80% after deductible	60% after deductible
<b>Maternity</b> (non-preventive facility & professional services)	80% after deductible	60% after deductible
<b>Medical/Surgical Expenses</b> (except office visits)	80% after deductible	60% after deductible
<b>Mental Health</b>		
Inpatient	80% after deductible	60% after deductible
Outpatient	100% after \$20 copayment	60% after deductible
<b>Private Duty Nursing</b>	80% after network deductible	
<b>Respiratory Therapy</b>	80% after network deductible	
<b>Skilled Nursing Facility Care</b>	80% after deductible	60% after deductible
<b>Substance Abuse</b>		
Inpatient Detoxification	80% after deductible	60% after deductible
Inpatient Rehabilitation	80% after deductible	60% after deductible
Outpatient	100% after \$20 copayment	60% after deductible
<b>Therapy Services</b> (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	80% after deductible	60% after deductible
<b>Transplant Services</b>	80% after deductible	60% after deductible
<b>Precertification Requirements<sup>(5)</sup></b>	Yes	
<b>Prescription Drug Deductible</b>		
Individual	None	
Family	None	
<b>Premier Prescription Drug Program</b> Mandatory Generic <sup>(6)</sup> <i>Defined by Premier Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</i>	<p align="center"><b>Retail Drugs</b>  Generic \$10 copayment  Brand Formulary 20% coinsurance \$20 minimum  Brand Nonformulary 30% coinsurance \$40 minimum  Specialty Drugs – \$100 brand copayment  Mandatory Generic  34 day supply or 100 units whichever is greater</p> <p align="center"><b>Maintenance Drugs through Mail Order</b>  Generic \$20 copayment  Brand Formulary 20% coinsurance \$40 minimum  Brand Nonformulary 30% coinsurance \$80 minimum  Mandatory Generic  Up to 90-day supply</p>	

- (1) Your group's benefit period is based on a Calendar Year which runs from January 1 to December 31.
- (2) Coverage for eligible members to age 21. Services will be paid according to the benefit category (e.g. speech therapy). Treatment for autism spectrum disorders does not reduce visit/day limits.
- (3) Services are limited to those listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply.
- (4) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
- (5) Highmark Healthcare Management Services (HMS) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs not covered.
- (6) The formulary is an extensive list of Food & Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. The member is responsible for the payment differential when a generic drug is authorized by the physician and the patient elects to purchase a brand drug. The member payment is the price difference between the brand drug and generic drug in addition to the brand drug copayment or coinsurance amounts, which may apply.
- (7) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health/Substance abuse benefit

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



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, \_\_\_\_\_ or call \_\_\_\_\_.

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/](http://www.HealthCare.gov/sbc-glossary/) or call \_\_\_\_\_ to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$1,000 individual/\$2,000 family <u>network</u> . \$2,000 individual/\$4,000 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> .
<b>Are there <u>services covered before you meet your deductible</u>?</b>	Yes. Office visits, preventive care services, <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 <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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$5,000 individual/\$10,000 family <u>network out-of-pocket limit</u> , up to a total maximum out-of-pocket of \$6,000 individual/\$12,000 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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.  <u>Out-of-network</u> : <u>Copayments</u> , <u>deductibles</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><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. See _____ or call _____ 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 charge</u> 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><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></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 <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>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.	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply.	No coverage for <u>preventive care</u> 40% <u>coinsurance</u> for <u>screening services</u> 40% <u>coinsurance</u> for <u>immunizations</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work) Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> 20% <u>coinsurance</u>	40% <u>coinsurance</u> 40% <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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at _____	Generic drugs	\$10 <u>copay</u> /prescription (retail) \$20 <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	Greater of 34-day supply or 100 units retail pharmacy. Up to 90-day supply maintenance <u>prescription drugs</u> through mail order.
	<u>Formulary</u> Brand drugs	20% <u>coinsurance</u> \$20 minimum <u>copay</u> /prescription (retail) 20% <u>coinsurance</u> \$40 minimum <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Non-Formulary</u> Brand drugs	30% <u>coinsurance</u> \$40 minimum <u>copay</u> /prescription (retail) 30% <u>coinsurance</u> \$80 minimum <u>copay</u> /prescription (mail order) <u>Deductible</u> does not apply.	Not covered	
	<u>Specialty</u> drugs	\$100 <u>copay</u> /prescription (retail) <u>Deductible</u> does not apply.	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
	<u>Emergency room care</u>	\$100 <u>copay/visit</u> <u>Deductible</u> does not apply.	\$100 <u>copay/visit</u> <u>Deductible</u> does not apply.	<u>Copay</u> waived if admitted as an inpatient.
If you need immediate medical attention	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Out-of-network</u> : Subject to <u>network deductible</u> .
	<u>Urgent care</u>	\$50 <u>copay/visit</u> <u>Deductible</u> does not apply.	40% <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.
	Facility fees (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
	Outpatient services	\$20 <u>copay/visit</u> <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Precertification may be required.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for preventive services.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you are pregnant				<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. 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)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-certification may be required.
	Rehabilitation services	\$40 copay/visit Deductible does not apply.	40% coinsurance	Combined network and out-of-network: 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. Pre-certification may be required.
	Habilitation services	Not covered	Not covered	-----none-----
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-certification may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-certification may be required.
	Hospice services	20% coinsurance	40% coinsurance	Pre-certification 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-----

## Excluded Services & Other Covered Services:

<b>Services Your Plan Generally Does NOT Cover (Check your policy or <u>plan document</u> for more information and a list of any other <u>excluded services</u>.)</b>	
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• <u>Habilitation services</u></li><li>• Hearing aids</li><li>• Long-term care</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan document</u>.)</b>	
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Non-emergency care when traveling outside the U.S. See <a href="http://www.bcbsglobalcare.com">http://www.bcbsglobalcare.com</a></li><li>• Private-duty nursing</li></ul>

**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](http://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.ccio.cms.gov](http://www.ccio.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:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### **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.

About these Coverage Examples:



**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 \$1,000
- Specialist copayment \$40
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$10
Coinsurance	\$2,300
<b>What isn't covered</b>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,370</b>

**Managing Joe's type 2 Diabetes**

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$900
Copayments	\$400
Coinsurance	\$600
<b>What isn't covered</b>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

**Mia's Simple Fracture**

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- 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:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$70
<b>What isn't covered</b>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,470</b>

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: \_\_\_\_\_.

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](https://www.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](mailto: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 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://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  
 Phone: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

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**ATTENTION:** If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

**ATANSYON:** Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòm aksèsib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

**ВНИМАНИЕ:** Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

**ATTENZIONE:** se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

**ATTENTION :** si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

**ÀKÍYÈSÍ:** Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ itumọ ati ògbufọ èdè wà ní àrọwọtọ lófẹ́ẹ́ fún ọ. Àwọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíí títẹ́wé nla, gbígbọ ohùn, ati iwé afọ́jú) lati pèsè iwífúnni ni àwọn ọ̀nà ìràáyè si wà pẹ̀lu lófẹ́ẹ́. Pẹ nọmba tó wà lẹhin kaádi idánimọ rẹ (TTY: 711) fún ìrànlọ́wọ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזוויי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقات يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدون على ظهر بطاقة هويتك (TTY: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的ID卡背面的号码（听障人士专用号码：711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિ:શુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેલ) પણ નિ:શુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કોલ કરો.

**CHÚ Ý:** Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई नि:शुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि नि:शुल्क उपलब्ध छन्। मददतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी नि:शुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용하실 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

IUPAT Welfare Fund of Western Pennsylvania High Option	
PPO - Premium Network	
Deductible	\$250 /\$500
Coinsurance	20%
Total Annual Out-of-Pocket	\$1,750 /\$3,500
Primary care provider	You pay \$20 Copayment per visit
Specialist office visit	You pay \$40 Copayment per visit
Emergency Department	You pay \$100 Copayment per visit
Urgent Care Facility	You pay \$50 Copayment per visit
Rx	\$10 /\$10 /\$20 /\$40 /\$100

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

**For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary. They must also meet all other criteria described in your COC. Criteria may include Prior Authorization requirements.**

Please note that your plan may not cover all of your health care expenses, such as Copayments and Coinsurance. To understand what your plan covers, review your COC. You may also have Riders and Amendments that expand or restrict your benefits. Please note that UPMC Health Plan reserves the right to reduce or waive your cost-sharing for certain services, if necessary for compliance with the Mental Health Parity and Addiction Equity Act.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit [www.upmchealthplan.com](http://www.upmchealthplan.com). You can also call UPMC Health Plan Member Services at the phone number on your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Prior Authorization Requirements	Provider Responsibility	Member Responsibility
If you fail to obtain Prior Authorization for certain services, you may not be eligible for reimbursement under your plan. Please see additional information below.		

Member Cost Sharing	Participating Provider	Non-Participating Provider
<b>Annual Deductible</b>		
Individual	\$250	\$500

# UPMC Health Plan

# Schedule of Benefits

Member Cost Sharing	Participating Provider	Non-Participating Provider
Family	\$500	\$1,000
<p>Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios - whichever comes first:</p> <p>*When an individual within a family reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR</p> <p>*When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.</p>		
<p>Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.</p>		
<b>Coinsurance</b>		
	You pay 20% after Deductible	You pay 40% after Deductible
<p>Copayments may apply to certain Participating Provider services.</p>		
<p>Any Covered Services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.</p>		
<b>Annual Coinsurance Limit</b>		
Individual	\$1,500	\$3,000
Family	\$3,000	\$6,000
<p>The Annual Coinsurance Limit is the maximum amount you will have to pay in Coinsurance before your benefits are covered without a Coinsurance cost share. Any amount paid in Coinsurance during the plan year will be applied towards the satisfaction of your plan's Total Annual Out-of-Pocket Limit.</p>		
<b>Total Annual Out-of-Pocket Limit</b>		
Individual	\$1,750	Not Applicable
Family	\$3,500	Not Applicable
<p>Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways- whichever comes first:</p> <p>*When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have Covered Services paid at 100% for the remainder of the Benefit Period; OR</p> <p>*When a combination of a family member's expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.</p>		
<p>Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits. NOTE: For Covered Services rendered by Non-Participating Providers, only Coinsurance applies toward this Limit.</p>		

# UPMC Health Plan

# Schedule of Benefits

Member Cost Sharing	Participating Provider	Non-Participating Provider
<b>Preventive Services</b>		
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.		
Pediatric preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Pediatric immunizations	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Adult preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Screening gynecological exam	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Mammograms, annual routine and medically necessary	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Screening services and procedures required by the ACA	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
<b>Hospital Services</b>		
Hospital inpatient	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient/Ambulatory surgery	You pay 20% after Deductible.	You pay 40% after Deductible.
Observation stay	You pay 20% after Deductible.	You pay 40% after Deductible.
Maternity - facility services associated with delivery	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Emergency Services</b>		
Emergency department	You pay \$100 Copayment per visit.	
Copayment waived if you are admitted to hospital.		
Emergency transportation	You pay 20% after Deductible.	
<b>Surgical Services</b>		
Surgical services (professional provider services)	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Provider Medical Services</b>		
Inpatient medical care visits, intensive medical care, and consultation	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 20% after Deductible.	You pay 40% after Deductible.
Primary care provider office visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Specialist office visit	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Convenience care visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Urgent care facility	You pay \$50 Copayment per visit.	You pay 40% after Deductible.

# UPMC Health Plan

# Schedule of Benefits

Member Cost Sharing	Participating Provider	Non-Participating Provider
<b>Virtual Visits</b>		
UPMC AnywhereCare - Virtual Care and Children's AnywhereCare	Covered at 100%; you pay \$0.	
Virtual visit - Primary Care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Specialist	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Behavioral Health	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
<b>UPMC MyHealth 24/7 Nurse Line</b>		
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC MyHealth 24/7 Nurse Line at 1-866-918-1591(TTY:711) 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a> and a nurse will respond within 24 hours.		
<b>Allergy Services</b>		
Treatment, injections, and serum	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Diagnostic Services</b>		
Advanced imaging (e.g., PET, MRI)	You pay 20% after Deductible.	You pay 40% after Deductible.
Other imaging (e.g., x-ray, sonogram)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic testing	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Rehabilitation/Habilitation Therapy Services</b>		
Note: See the Behavioral Health Services section below for Rehabilitation/Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical Therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Occupational Therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Speech Therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Cardiac rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
Covered up to 12 visits per Benefit Period.		
Pulmonary rehabilitation	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 24 visits per Benefit Period.		
<b>Medical Therapy Services</b>		
Chemotherapy, radiation therapy, dialysis therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Medical Therapy Services-Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 20% after Deductible.	You pay 40% after Deductible.
Respiratory therapy	You pay 20% after Deductible.	You pay 20% after Deductible.

Member Cost Sharing	Participating Provider	Non-Participating Provider
<b>Pain management</b>		
Pain management program	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
<b>Behavioral Health (Mental Health and Substance Use Disorder) Services (Rehabilitative or Habilitative)</b>		
Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.		
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay 20% after Deductible.	You pay 40% after Deductible.
Office visits, including psychotherapy, counseling, and urgent care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Outpatient Services (includes intensive outpatient, partial hospitalization, and other medically necessary outpatient services)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay 20% after Deductible.	You pay 40% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health Condition	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Visit limits do not apply.		
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Other Medical Services</b>		
Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below. Visit limits do not apply for medically necessary services provided for treatment of a Behavioral Health condition.		
Corrective appliances	You pay 20% after Deductible.	You pay 40% after Deductible.
Dental services related to accidental injury	You pay 20% after Deductible.	You pay 40% after Deductible.
Durable medical equipment	You pay 20% after Deductible.	You pay 40% after Deductible.
Home health care	You pay 20% after Deductible.	You pay 40% after Deductible.
Hospice care	You pay 20% after Deductible.	You pay 40% after Deductible.
Medical nutrition therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Nutritional counseling	You pay 20% after Deductible.	You pay 40% after Deductible.
Covered up to 2 visits per Benefit Period.		
Nutritional formulas	You pay 20%. Deductible does not apply.	You pay 40%. Deductible does not apply.
Nutritional formulas for the treatment of PKU and related disorders are not subject to Deductible.		
Oral surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.

<b>Member Cost Sharing</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
Podiatry services	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Skilled nursing facility	You pay 20% after Deductible.	You pay 40% after Deductible.
Therapeutic manipulation/chiropractic care	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Home Infusion therapy	You pay 20% after Deductible.	You pay 20% after Deductible.
Private duty nursing	You pay 20% after Deductible.	You pay 20% after Deductible.
<b>Diabetic Equipment, Supplies, and Education</b>		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.	
Diabetic education	You pay 20% after Deductible.	You pay 40% after Deductible.

**Prescription Medication Coverage**

For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).

Not subject to Plan Deductible

**Retail prescription medication**

- Prescriptions must be dispensed by a participating pharmacy.
- 34-days supply.

Select Generic Medications Tier	You pay \$10 Copayment for select generic medications.
Preferred Generic Medications Tier	You pay \$10 Copayment for preferred generic medications.
Preferred Brand Medications and Generic Medications (Brand and Generic) Tier	You pay \$20 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay \$40 Copayment for preferred brand medications and generic medications (brand and generic).

**Specialty prescription medication**

- Specialty medications are limited to a 34-day supply. See Prescription Medication Schedule of Benefits for additional information.
- Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request).
- Your prescription medication benefit includes coverage of certain specialty medications in the SaveOnSP program. See Prescription Medication Schedule of Benefits for additional information.

Specialty Medications (Brand and Generic) Tier	You pay \$100 Copayment for specialty medications (brand and generic).
34-day maximum supply	

**Prescription Medication Coverage**

For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).

Not subject to Plan Deductible

**Mail-order prescription medication**

- **A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy.**

Select Generic Medications Tier	You pay \$20 Copayment for select generic medications.
Preferred Generic Medications Tier	You pay \$20 Copayment for preferred generic medications.
Preferred Brand Medications and Generic Medications (Brand and Generic) Tier	You pay \$40 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay \$80 Copayment for nonpreferred medications (brand and generic).
90-day maximum mail-order supply	
If a provider demonstrates that the brand-name medication is Medically Necessary and appropriate, you will pay only the nonpreferred brand-name medication copayment.	

## Services that require Prior Authorization

Certain services and items must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization before receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at [www.upmchealthplan.com](http://www.upmchealthplan.com). You can also contact Member Services by calling the phone number on your member ID card. Your provider may also access this list at [www.upmchealthplan.com](http://www.upmchealthplan.com) or your provider may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of your receiving services in order for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your COC. Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations, and, if applicable, subject to approval by the Pennsylvania Insurance Department. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail and UPMC Health Plan reserves the right to update this document accordingly.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into the UPMC Health Plan member site to view these documents. If you have questions, call Member Services.

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC for You Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

UPMC Health Plan

U.S. Steel Tower

600 Grant Street

Pittsburgh, PA 15219

[www.upmchealthplan.com](http://www.upmchealthplan.com)

**!** 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, call 1-888-876-2756 or see [www.upmchealthplan.com](http://www.upmchealthplan.com). 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](http://www.healthcare.gov/sbc-glossary) or call 1-888-876-2756 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Plan Year deductible Participating Provider: \$250 Individual/ \$500 Family Non-Participating Provider: \$500 Individual/ \$1,000 Family	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.
<b>Are there services covered before you meet your deductible?</b>	Yes. Deductible does not apply to Preventive care, Primary Care provider office visit, Specialist office visit, Emergency Department.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment (copay) 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Participating Provider: (Coinsurance only) \$1,500 Individual/ \$3,000 Family Non-Participating Provider: (Coinsurance only) \$3,000 Individual/ \$6,000 Family  Participating Provider: (All Inclusive) \$1,750 Individual/ \$3,500 Family Non-Participating Provider: (All Inclusive) Not Applicable	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 limit until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan does not cover.	Even though you pay these expenses they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a> or call 1-888-876-2756 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	<p>You can see the <u>specialist</u> you choose without a referral.</p>



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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.	\$20 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	\$40 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None.
	<u>Preventive care/screening/immunization</u>	No cost. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Please see your Schedule of Benefits for details. You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a>	Generic drugs	\$10 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Retail) \$20 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Mail Order)	Not covered	Please see your Prescription Medication Rider for details.
	Preferred brand drugs	\$20 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Retail) \$40 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Mail Order)	Not covered	Please see your Prescription Medication Rider for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Non-preferred brand drugs	\$40 copayment per prescription. <u>Deductible</u> does not apply. (Retail) \$80 copayment per prescription. <u>Deductible</u> does not apply. (Mail Order)	Not covered	Please see your Prescription Medication Rider for details.
	<u>Specialty drugs</u>	\$100 copayment per prescription. <u>Deductible</u> does not apply.	Not covered	Please see your Prescription Medication Rider for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 copayment per visit. <u>Deductible</u> does not apply.	\$100 copayment per visit. <u>Deductible</u> does not apply.	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	<u>Urgent care</u>	\$50 copayment per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None.
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Outpatient services	\$20 copayment per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Office visit and outpatient therapy. Other services (including intensive outpatient and partial hospitalization) may have additional cost sharing. Please see your Schedule of Benefits for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	Office visits	\$20 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Depending on the type of services, other cost shares may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Office visit cost share applies to first visit only.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	<u>Rehabilitation services</u>	\$40 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Occupational Therapy - Combined: Covered up to 20 visits per Benefit Period for both therapies combined. Physical Therapy - Combined: Covered up to 20 visits per Benefit Period for both therapies combined. Speech Therapy - Combined: Covered up to 20 visits per Benefit Period. <i>Visit limits do not apply for mental and behavioral health services.</i>
	<u>Habilitation services</u>	\$40 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If your child needs dental or eye care	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- Weight loss programs

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

- Acupuncture only covered for specific diagnosis
- Bariatric surgery subject to medical review
- Chiropractic care covered with limitations
- Private-duty nursing subject to medical review
- Routine foot care only covered for specific diagnoses

**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](http://www.dol.gov/ebsa/healthreform) or the insurer at 1-888-876-2756. 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 [www.HealthCare.gov](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: your plan at 1-888-876-2756 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact 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.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-876-2756.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-876-2756.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-876-2756.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-876-2756.

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

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## About these Coverage Examples:



**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 \$40
- 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:**

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$1,820</b>

### 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 \$40
- 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:**

Cost Sharing	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,300</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$250
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

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

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

Cost Sharing	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$5
<b>The total Mia would pay is</b>	<b>\$755</b>

## Discrimination is Against the Law

**UPMC Health Plan** complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. **UPMC Health Plan** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

### UPMC Health Plan:

- Provides people with disabilities reasonable modifications and free and timely appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified interpreters
  - Written information in other formats (large print, Braille, other formats).
- Provides free and timely language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.
- If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact **UPMC Health Plan Member Services at 1-844-220-4785**. Help is available Monday to Friday 8 a.m. to 6 p.m.

If you believe that **UPMC Health Plan** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint/ grievance with:

#### Complaints/Grievances/Appeals

Attn: Chief Risk, Compliance & Ethics Officer  
PO Box 2939

Pittsburgh, PA 15230-2939

Phone: 1-844-220-4785

TTY: 711

Fax: 412-454-7920

Email: [HealthPlanCompliance@upmc.edu](mailto:HealthPlanCompliance@upmc.edu)

You can file a complaint/grievance in person or by mail, fax, or email. If you need help filing a complaint/ grievance, **UPMC Health Plan Member Services** 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/smartscreen/main.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>.

This notice is available at **UPMC Health Plan's** website: <https://www.upmchealthplan.com/members/>

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products, or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

### Translation Services

**ATTENTION:** If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-869-7228 (TTY: 711) or speak to your provider.

### Spanish

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-869-7228 (TTY: 711) o hable con su proveedor.

### Chinese; Mandarin

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-869-7228（文本电话：711）或咨询您的服务提供商。

### Nepali

सावधानः यदी तपाईं नेपाली भाषा बोलनुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-869-7228 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

### Russian

**ВНИМАНИЕ:** Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-869-7228 (TTY: 711) или обратитесь к своему поставщику услуг.

### Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتيسقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-869-7228 (711) أو تحدث إلى مقدم الخدمة.

### Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-869-7228 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

### Ukrainian

**УВАГА:** Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-855-869-7228 (TTY: 711) або зверніться до свого постачальника».

### Portuguese

**ATENÇÃO:** Se você fala inserir idioma, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-855-869-7228 (TTY: 711) ou fale com seu provedor.

## French

**ATTENTION :** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-869-7228 (TTY : 711) ou parlez à votre fournisseur.

## Korean

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-869-7228 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

## Pennsylvania Dutch

**ACHTUNG:** Wann du Pennsylvaniaisch Deutsch schwetzsch, sin Hilfsdienst fer die Sprooch fer dich gratis verfügbar. Passende Hilfsmittel un Diensch, fer Informatione in zugängliche Formate ze gebbe, sin aa gratis verfügbar. Ruf 1-855-869-7228 (TTY: 711) oder schwelz mit dein Anbieter.

## German

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-869-7228 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

## Igbo

**NLEBARA ANYA :** O buru na i na-asu asusu Igbo, enwere oru enyemaka asusu n'efu maka gi. A na-enyekwa lke enyemaka na oru ndi kwesiri ekwesị jji nye ihe omuma n'udi ndi di mfe inweta n'efu. Kpoo 1-855-869-7228 (TTY: 711) ma o bu gwa ndi na-ahụ maka ahụike gi okwu.

## Hindi

**ध्यान दें:** यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-869-7228 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

## Italian

**ATTENZIONE:** se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama il 1-855-869-7228 (TTY: 711) o parla con il tuo fornitore.

IUPAT Welfare Fund of Western Pennsylvania Low Option	
PPO - Premium Network	
Deductible	\$1,000 /\$2,000
Coinsurance	20%
Total Annual Out-of-Pocket	\$6,000 /\$12,000
Primary care provider	You pay \$20 Copayment per visit
Specialist office visit	You pay \$40 Copayment per visit
Emergency Department	You pay \$100 Copayment per visit
Urgent Care Facility	You pay \$50 Copayment per visit
Rx	\$10 /\$10 /\$20 /\$40 /\$100

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

**For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary. They must also meet all other criteria described in your COC. Criteria may include Prior Authorization requirements.**

Please note that your plan may not cover all of your health care expenses, such as Copayments and Coinsurance. To understand what your plan covers, review your COC. You may also have Riders and Amendments that expand or restrict your benefits. Please note that UPMC Health Plan reserves the right to reduce or waive your cost-sharing for certain services, if necessary for compliance with the Mental Health Parity and Addiction Equity Act.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit [www.upmchealthplan.com](http://www.upmchealthplan.com). You can also call UPMC Health Plan Member Services at the phone number on your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Prior Authorization Requirements	Provider Responsibility	Member Responsibility
If you fail to obtain Prior Authorization for certain services, you may not be eligible for reimbursement under your plan. Please see additional information below.		

Member Cost Sharing	Participating Provider	Non-Participating Provider
<b>Annual Deductible</b>		
Individual	\$1,000	\$2,000

# UPMC Health Plan

# Schedule of Benefits

Member Cost Sharing	Participating Provider	Non-Participating Provider
Family	\$2,000	\$4,000
<p>Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios - whichever comes first:                      *When an individual within a family reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR                      *When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.</p>		
<p>Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.</p>		
<b>Coinsurance</b>		
	You pay 20% after Deductible	You pay 40% after Deductible
<p>Copayments may apply to certain Participating Provider services.</p>		
<p>Any Covered Services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.</p>		
<b>Annual Coinsurance Limit</b>		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
<p>The Annual Coinsurance Limit is the maximum amount you will have to pay in Coinsurance before your benefits are covered without a Coinsurance cost share. Any amount paid in Coinsurance during the plan year will be applied towards the satisfaction of your plan's Total Annual Out-of-Pocket Limit.</p>		
<b>Total Annual Out-of-Pocket Limit</b>		
Individual	\$6,000	Not Applicable
Family	\$12,000	Not Applicable
<p>Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways- whichever comes first:                      *When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have Covered Services paid at 100% for the remainder of the Benefit Period; OR                      *When a combination of a family member's expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.</p>		
<p>Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits. NOTE: For Covered Services rendered by Non-Participating Providers, only Coinsurance applies toward this Limit.</p>		

<b>Member Cost Sharing</b>	<b>Participating Provider</b>	<b>Non-Participating Provider</b>
<b>Preventive Services</b>		
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.		
Pediatric preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Pediatric immunizations	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Adult preventive/health screening examination	Covered at 100%; you pay \$0.	Not Covered
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Screening gynecological exam, including a Pap test	Covered at 100%; you pay \$0.	You pay 40%. Deductible does not apply.
Mammograms, annual routine and medically necessary	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Screening services and procedures required by the ACA	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
<b>Hospital Services</b>		
Hospital inpatient	You pay 20% after Deductible.	You pay 40% after Deductible.
Outpatient/Ambulatory surgery	You pay 20% after Deductible.	You pay 40% after Deductible.
Observation stay	You pay 20% after Deductible.	You pay 40% after Deductible.
Maternity - facility services associated with delivery	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Emergency Services</b>		
Emergency department	You pay \$100 Copayment per visit.	
Copayment waived if you are admitted to hospital.		
Emergency transportation	You pay 20% after Deductible.	
<b>Surgical Services</b>		
Surgical services (professional provider services)	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Provider Medical Services</b>		
Inpatient medical care visits, intensive medical care, and consultation	Covered at 100%; you pay \$0.	You pay 40% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay 20% after Deductible.	You pay 40% after Deductible.
Primary care provider office visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Specialist office visit	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Convenience care visit	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Urgent care facility	You pay \$50 Copayment per visit.	You pay 40% after Deductible.

# UPMC Health Plan

# Schedule of Benefits

Member Cost Sharing	Participating Provider	Non-Participating Provider
<b>Virtual Visits</b>		
UPMC AnywhereCare - Virtual Care and Children's AnywhereCare	Covered at 100%; you pay \$0.	
Virtual visit - Primary Care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Specialist	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Virtual visit – Behavioral Health	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
<b>UPMC MyHealth 24/7 Nurse Line</b>		
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC MyHealth 24/7 Nurse Line at 1-866-918-1591(TTY:711) 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a> and a nurse will respond within 24 hours.		
<b>Allergy Services</b>		
Treatment, injections, and serum	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Diagnostic Services</b>		
Advanced imaging (e.g., PET, MRI)	You pay 20% after Deductible.	You pay 40% after Deductible.
Other imaging (e.g., x-ray, sonogram)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services	You pay 20% after Deductible.	You pay 40% after Deductible.
Diagnostic testing	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Rehabilitation/Habilitation Therapy Services</b>		
Note: See the Behavioral Health Services section below for Rehabilitation/Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical Therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Occupational Therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Speech Therapy	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Cardiac rehabilitation	You pay 20% after Deductible.	You pay 40% after Deductible.
Covered up to 12 visits per Benefit Period.		
Pulmonary rehabilitation	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 24 visits per Benefit Period.		
<b>Medical Therapy Services</b>		
Chemotherapy, radiation therapy, dialysis therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Medical Therapy Services-Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay 20% after Deductible.	You pay 40% after Deductible.
Respiratory therapy	You pay 20% after Deductible.	You pay 20% after Deductible.

Member Cost Sharing	Participating Provider	Non-Participating Provider
<b>Pain management</b>		
Pain management program	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
<b>Behavioral Health (Mental Health and Substance Use Disorder) Services (Rehabilitative or Habilitative)</b>		
Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.		
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay 20% after Deductible.	You pay 40% after Deductible.
Office visits, including psychotherapy, counseling, and urgent care	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Outpatient Services (includes intensive outpatient, partial hospitalization, and other medically necessary outpatient services)	You pay 20% after Deductible.	You pay 40% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay 20% after Deductible.	You pay 40% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health Condition	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Visit limits do not apply.		
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay 20% after Deductible.	You pay 40% after Deductible.
<b>Other Medical Services</b>		
Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below. Visit limits do not apply for medically necessary services provided for treatment of a Behavioral Health condition.		
Corrective appliances	You pay 20% after Deductible.	You pay 40% after Deductible.
Dental services related to accidental injury	You pay 20% after Deductible.	You pay 40% after Deductible.
Durable medical equipment	You pay 20% after Deductible.	You pay 40% after Deductible.
Home health care	You pay 20% after Deductible.	You pay 40% after Deductible.
Hospice care	You pay 20% after Deductible.	You pay 40% after Deductible.
Medical nutrition therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Nutritional counseling	You pay 20% after Deductible.	You pay 40% after Deductible.
Covered up to 2 visits per Benefit Period.		
Nutritional formulas	You pay 20%. Deductible does not apply.	You pay 40%. Deductible does not apply.
Nutritional formulas for the treatment of PKU and related disorders are not subject to Deductible.		
Oral surgical services	You pay 20% after Deductible.	You pay 40% after Deductible.

Member Cost Sharing	Participating Provider	Non-Participating Provider
Podiatry services	You pay \$20 Copayment per visit.	You pay 40% after Deductible.
Skilled nursing facility	You pay 20% after Deductible.	You pay 40% after Deductible.
Therapeutic manipulation/chiropractic care	You pay \$40 Copayment per visit.	You pay 40% after Deductible.
Covered up to 20 visits per Benefit Period.		
Home Infusion therapy	You pay 20% after Deductible.	You pay 40% after Deductible.
Private duty nursing	You pay 20% after Deductible.	You pay 40% after Deductible.
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable Prescription Schedule of Benefits for coverage information.	
Diabetic education	You pay 20% after Deductible.	You pay 40% after Deductible.

**Prescription Medication Coverage**

For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).  
Not subject to Plan Deductible

**Retail prescription medication**

- Prescriptions must be dispensed by a participating pharmacy.
- 34-day supply.

Select Generic Medications Tier	You pay \$10 Copayment for select generic medications.
Preferred Generic Medications Tier	You pay \$10 Copayment for preferred generic medications.
Preferred Brand Medications and Generic Medications (Brand and Generic) Tier	You pay \$20 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay \$40 Copayment for preferred brand medications and generic medications (brand and generic).

**Specialty prescription medication**

- Specialty medications are limited to a 34-day supply. See Prescription Medication Schedule of Benefits for additional information.
- Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request).
- Your prescription medication benefit includes coverage of certain specialty medications in the SaveOnSP program. See Prescription Medication Schedule of Benefits for additional information.

Specialty Medications (Brand and Generic) Tier	You pay \$100 Copayment for specialty medications (brand and generic).
34-day maximum supply	

**Prescription Medication Coverage**

For additional information on your pharmacy benefits, refer to your Prescription Medication Schedule of Benefits. Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.

The Your Choice pharmacy program will apply (mandatory generic).

Not subject to Plan Deductible

**Mail-order prescription medication**

- **A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy.**

Select Generic Medications Tier	You pay \$20 Copayment for select generic medications.
Preferred Generic Medications Tier	You pay \$20 Copayment for preferred generic medications.
Preferred Brand Medications and Generic Medications (Brand and Generic) Tier	You pay \$40 Copayment for preferred brand medications and generic medications (brand and generic).
Nonpreferred Medications (Brand and Generic) Tier	You pay \$80 Copayment for nonpreferred medications (brand and generic).
90-day maximum mail-order supply	
If a provider demonstrates that the brand-name medication is Medically Necessary and appropriate, you will pay only the nonpreferred brand-name medication copayment.	

## Services that require Prior Authorization

Certain services and items must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization before receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at [www.upmchealthplan.com](http://www.upmchealthplan.com). You can also contact Member Services by calling the phone number on your member ID card. Your provider may also access this list at [www.upmchealthplan.com](http://www.upmchealthplan.com) or your provider may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of your receiving services in order for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your COC. Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations, and, if applicable, subject to approval by the Pennsylvania Insurance Department. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail and UPMC Health Plan reserves the right to update this document accordingly.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into the UPMC Health Plan member site to view these documents. If you have questions, call Member Services.

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UPMC Health Plan  
U.S. Steel Tower  
600 Grant Street  
Pittsburgh, PA 15219  
[www.upmchealthplan.com](http://www.upmchealthplan.com)

 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, call 1-888-876-2756 or see [www.upmchealthplan.com](http://www.upmchealthplan.com). 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](http://www.healthcare.gov/sbc-glossary) or call 1-888-876-2756 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Plan Year deductible Participating Provider: \$1,000 Individual/ \$2,000 Family Non-Participating Provider: \$2,000 Individual/ \$4,000 Family	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.
<b>Are there services covered before you meet your deductible?</b>	Yes. Deductible does not apply to Preventive care, Primary Care provider office visit, Specialist office visit, Emergency Department.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment (copay) 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Participating Provider: (Coinsurance only) \$5,000 Individual/ \$10,000 Family Non-Participating Provider: (Coinsurance only) \$10,000 Individual/ \$20,000 Family  Participating Provider: (All Inclusive) \$6,000 Individual/ \$12,000 Family Non-Participating Provider: (All Inclusive) Not Applicable	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 limit until the overall family out-of-pocket limit has been met.
<b>What is not included in the out-of-pocket limit?</b>	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan does not cover.	Even though you pay these expenses they don't count toward the out-of-pocket limit.
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a> or call 1-888-876-2756 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	<p>your plan pays (<u>balance billing</u>). Be aware, your network provider 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 referral.</p>



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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.	\$20 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	\$40 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None.
	<u>Preventive care/screening/immunization</u>	No cost. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Please see your Schedule of Benefits for details. You may have to pay for services that aren't <u>preventive</u> . Ask your provider if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certain Diagnostic Services may have additional cost sharing. Please see your Schedule of Benefits for details.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.upmchealthplan.com">www.upmchealthplan.com</a>	Generic drugs	\$10 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Retail) \$20 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Mail Order)	Not covered	Please see your Prescription Medication Rider for details.
	Preferred brand drugs	\$20 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Retail) \$40 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Mail Order)	Not covered	Please see your Prescription Medication Rider for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Non-preferred brand drugs	\$40 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Retail) \$80 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. (Mail Order)	Not covered	Please see your Prescription Medication Rider for details.
	<u>Specialty drugs</u>	\$100 <u>copayment</u> per prescription. <u>Deductible</u> does not apply. \$100 <u>copayment</u> per prescription. <u>Deductible</u> does not apply.	Not covered	Please see your Prescription Medication Rider for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	\$100 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
	<u>Urgent care</u>	\$50 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Office visit and outpatient therapy. Other services (including intensive outpatient and partial hospitalization) may have additional cost sharing. Please see your Schedule of Benefits for details.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you are pregnant	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	Office visits	\$20 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Depending on the type of services, other cost shares may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Office visit cost share applies to first visit only.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u>	\$40 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Occupational Therapy - Combined: Covered up to 20 visits per Benefit Period for both therapies combined.
	<u>Habilitation services</u>	\$40 <u>copayment</u> per visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u>	Physical Therapy - Combined: Covered up to 20 visits per Benefit Period for both therapies combined.
				Speech Therapy - Combined: Covered up to 20 visits per Benefit Period. <i>Visit limits do not apply for mental and behavioral health services.</i>
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required. If <u>preauthorization</u> is not obtained, benefits could be denied.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If your child needs dental or eye care	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	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.)

- Cosmetic surgery
- Infertility treatment
- Dental care (Adult)
- Long-term care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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

- Acupuncture only covered for specific diagnosis
- Chiropractic care covered with limitations
- Bariatric surgery subject to medical review
- Private-duty nursing subject to medical review
- Routine foot care only covered for specific diagnoses

**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](http://www.dol.gov/ebsa/healthreform) or the insurer at 1-888-876-2756. 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 [www.HealthCare.gov](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 your plan at 1-888-876-2756 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact 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.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-876-2756.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-876-2756.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-876-2756.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-876-2756.

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

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## About these Coverage Examples:



**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 \$1,000
- Specialist copayment \$40
- 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:**

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,370</b>

### Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- 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:**

Cost Sharing	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

### Mia's Simple Fracture

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

- The plan's overall deductible \$1,000
- Specialist copayment \$40
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

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

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$5
<b>The total Mia would pay is</b>	<b>\$1,375</b>

## Discrimination is Against the Law

**UPMC Health Plan** complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. **UPMC Health Plan** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

### UPMC Health Plan:

- Provides people with disabilities reasonable modifications and free and timely appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified interpreters
  - Written information in other formats (large print, Braille, other formats).
- Provides free and timely language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.
- If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact **UPMC Health Plan Member Services at 1-844-220-4785**. Help is available Monday to Friday 8 a.m. to 6 p.m.

If you believe that **UPMC Health Plan** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a complaint/ grievance with:

#### Complaints/Grievances/Appeals

Attn: Chief Risk, Compliance & Ethics Officer  
PO Box 2939

Pittsburgh, PA 15230-2939

Phone: 1-844-220-4785

TTY: 711

Fax: 412-454-7920

Email: [HealthPlanCompliance@upmc.edu](mailto:HealthPlanCompliance@upmc.edu)

You can file a complaint/grievance in person or by mail, fax, or email. If you need help filing a complaint/ grievance, **UPMC Health Plan Member Services** 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/smartscreen/main.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>.

This notice is available at **UPMC Health Plan's** website: <https://www.upmchealthplan.com/members/>

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products, or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

### Translation Services

**ATTENTION:** If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-869-7228 (TTY: 711) or speak to your provider.

### Spanish

**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-869-7228 (TTY: 711) o hable con su proveedor.

### Chinese; Mandarin

注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-855-869-7228（文本电话：711）或咨询您的服务提供商。

### Nepali

सावधानः यदी तपाईं नेपाली भाषा बोलनुहुन्छ भने तपाईंका लागि निःशुल्क भाषिक सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायता र सेवाहरू पनि निःशुल्क उपलब्ध छन्। 1-855-869-7228 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।

### Russian

**ВНИМАНИЕ:** Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-869-7228 (TTY: 711) или обратитесь к своему поставщику услуг.

### Arabic

تنبيه: إذا كنت تتحدث اللغة العربية المجانية، كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتسقيت يمكن الوصول إليها مجانًا. اتصل على الرقم 1-855-869-7228 (711) أو تحدث إلى مقدم الخدمة.

### Vietnamese

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-869-7228 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

### Ukrainian

**УВАГА:** Якщо ви розмовляєте українська мова, вам доступні безкоштовні мовні послуги. Відповідні допоміжні засоби та послуги для надання інформації у доступних форматах також доступні безкоштовно. Зателефонуйте за номером 1-855-869-7228 (TTY: 711) або зверніться до свого постачальника».

### Portuguese

**ATENÇÃO:** Se você fala inserir idioma, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-855-869-7228 (TTY: 711) ou fale com seu provedor.

## French

**ATTENTION :** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-869-7228 (TTY : 711) ou parlez à votre fournisseur.

## Korean

주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-855-869-7228 (TTY: 711) 번으로 전화하거나 서비스 제공업체에 문의하십시오.

## Pennsylvania Dutch

**ACHTUNG:** Wann du Pennsylvaniaisch Deutsch schwetzsch, sin Hilfsdienst fer die Sprooch fer dich gratis verfügbar. Passende Hilfsmittel un Diensch, fer Informatione in zugängliche Formate ze gebbe, sin aa gratis verfügbar. Ruf 1-855-869-7228 (TTY: 711) oder schwelz mit dein Anbieter.

## German

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-869-7228 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

## Igbo

**NLEBARA ANYA :** O buru na i na-asu asusu Igbo, enwere oru enyemaka asusu n'efu maka gi. A na-enyekwa lke enyemaka na oru ndi kwesiri ekwesị jji nye ihe omuma n'udi ndi di mfe inweta n'efu. Kpoo 1-855-869-7228 (TTY: 711) ma o bu gwa ndi na-ahụ maka ahụike gi okwu.

## Hindi

**ध्यान दें:** यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-869-7228 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

## Italian

**ATTENZIONE:** se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama il 1-855-869-7228 (TTY: 711) o parla con il tuo fornitore.

## **NOTICE OF THE PRIVACY PRACTICES OF THE IUPAT DC 57 of Western PA**

**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) 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.

## 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](http://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](http://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](http://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 March 17, 2025. Contact your State for more information on eligibility –**

<b>ALABAMA – Medicaid</b>	<b>CALIFORNIA – Medicaid</b>
Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a> Phone: 1-855-692-5447	Health Insurance Premium Payment (HIPP) Program Website: <a href="https://dhcs.ca.gov/hipp">https://dhcs.ca.gov/hipp</a> Phone: 916-445-8322 Fax: 916-440-5676 Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>
<b>ALASKA – Medicaid</b>	<b>FLORIDA – Medicaid</b>
The AK Health Insurance Premium Payment Program Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a> Phone: 1-866-251-4861 Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a> Medicaid Eligibility: <a href="http://health.alaska.gov/dpa/Pages/default.aspx">http://health.alaska.gov/dpa/Pages/default.aspx</a>	Website: <a href="https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html">https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html</a> Phone: 1-877-357-3268
<b>ARKANSAS – Medicaid</b>	<b>GEORGIA – Medicaid</b>
Website: <a href="http://myarhipp.com/">http://myarhipp.com/</a> Phone: 1-855-MyARHIPP (855-692-7447)	GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a> Phone: 678-564-1162, Press 1 GA CHIPRA Website: <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a> Phone: 678-564-1162, Press 2
<b>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</b>	<b>INDIANA – Medicaid</b>
Health First Colorado Website: <a href="https://www.healthfirstcolorado.com/">https://www.healthfirstcolorado.com/</a> Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+: <a href="https://hcpf.colorado.gov/child-health-plan-plus">https://hcpf.colorado.gov/child-health-plan-plus</a> CHP+ Customer Service: 1-800-359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): <a href="https://www.mycohibi.com">https://www.mycohibi.com</a> HIBI Customer Service: 1-855-692-6442	Health Insurance Premium Payment Program All other Medicaid Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a> <a href="http://www.in.gov/fssa/dfr/">http://www.in.gov/fssa/dfr/</a> Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone 1-800-457-4584

<p><b>IOWA – Medicaid and CHIP (Hawki)</b></p> <p>Medicaid Website: <a href="#">Iowa Medicaid   Health &amp; Human Services</a>  Medicaid Phone: 1-800-338-8366  Hawki Website:  <a href="#">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a>  Hawki Phone: 1-800-257-8563  HIPP Website:  <a href="#">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a>  HIPP Phone: 1-888-346-9562</p>	<p><b>NEBRASKA – Medicaid</b></p> <p>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a>  Phone: 1-855-632-7633  Lincoln: 402-473-7000  Omaha: 402-595-1178</p>
<p><b>KANSAS – Medicaid</b></p> <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a>  Phone: 1-800-792-4884  HIPP Phone: 1-800-967-4660</p>	<p><b>NEVADA – Medicaid</b></p> <p>Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a>  Medicaid Phone: 1-800-992-0900</p>
<p><b>KENTUCKY – Medicaid</b></p> <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a>  Phone: 1-855-459-6328  Email: <a href="mailto:KIHIPPPROGRAM@ky.gov">KIHIPPPROGRAM@ky.gov</a>  KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a>  Phone: 1-877-524-4718  Kentucky Medicaid Website: <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p>	<p><b>NEW HAMPSHIRE – Medicaid</b></p> <p>Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a>  Phone: 603-271-5218  Toll free number for the HIPP program: 1-800-852-3345, ext 15218  Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a></p>
<p><b>LOUISIANA – Medicaid</b></p> <p>Website: <a href="http://www.medicaid.la.gov">www.medicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>  Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>	<p><b>NEW JERSEY – Medicaid and CHIP</b></p> <p>Medicaid Website:  <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a>  Phone: 1-800-356-1561  CHIP Premium Assistance Phone: 609-631-2392  CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a>  CHIP Phone: 1-800-701-0710 (TTY: 711)</p>
<p><b>MAINE – Medicaid</b></p> <p>Enrollment Website:  <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a>  Phone: 1-800-442-6003  TTY: Maine relay 711  Private Health Insurance Premium Webpage:  <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a>  Phone: 1-800-977-6740  TTY: Maine relay 711</p>	<p><b>NEW YORK – Medicaid</b></p> <p>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a>  Phone: 1-800-541-2831</p>
<p><b>MASSACHUSETTS – Medicaid and CHIP</b></p> <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a>  Phone: 1-800-862-4840  TTY: 711  Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>	<p><b>NORTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a>  Phone: 919-855-4100</p>
<p><b>MINNESOTA – Medicaid</b></p> <p>Website: <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a>  Phone: 1-800-657-3672</p>	<p><b>NORTH DAKOTA – Medicaid</b></p> <p>Website: <a href="http://www.hhs.nd.gov/healthcare">http://www.hhs.nd.gov/healthcare</a>  Phone: 1-844-854-4825</p>
<p><b>MISSOURI – Medicaid</b></p> <p>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a>  Phone: 573-751-2005</p>	<p><b>OKLAHOMA – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a>  Phone: 1-888-365-3742</p>
<p><b>MONTANA – Medicaid</b></p> <p>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a>  Phone: 1-800-694-3084  Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a></p>	<p><b>OREGON – Medicaid</b></p> <p>Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a>  Phone: 1-800-699-9075</p>
	<p><b>PENNSYLVANIA – Medicaid</b></p> <p>Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a>  Phone: 1-800-692-7462  CHIP Website: <a href="#">Children’s Health Insurance Program (CHIP) (pa.gov)</a>  CHIP Phone: 1-800-986-KIDS (5437)</p>
	<p><b>RHODE ISLAND – Medicaid and CHIP</b></p> <p>Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a>  Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>
	<p><b>SOUTH CAROLINA – Medicaid</b></p> <p>Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a>  Phone: 1-888-549-0820</p>

<b>SOUTH DAKOTA - Medicaid</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a> Phone: 1-888-828-0059	Website: <a href="https://www.coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://www.coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a> <a href="https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a> Medicaid/CHIP Phone: 1-800-432-5924
<b>TEXAS – Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a> Phone: 1-800-440-0493	Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a> Phone: 1-800-562-3022
<b>UTAH – Medicaid and CHIP</b>	<b>WEST VIRGINIA – Medicaid</b>
Utah's Premium Partnership for Health Insurance (UPP) Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a> Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a> Phone: 1-888-222-2542 Adult Expansion Website: <a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a> Utah Medicaid Buyout Program Website: <a href="https://medicaid.utah.gov/buyout-program">https://medicaid.utah.gov/buyout-program</a> CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a>	Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a> <a href="http://mywvhipp.com/">http://mywvhipp.com/</a> Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
<b>VERMONT– Medicaid</b>	<b>WISCONSIN – Medicaid and CHIP</b>
Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a> Phone: 1-800-250-8427	Website: <a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a> Phone: 1-800-362-3002
	<b>WYOMING – Medicaid</b>
	Website: <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a> Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 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](http://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](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)





IUPAT DC 57 Welfare Funds  
PO Box 99459  
Troy, MI 48099-9998  
Phone (330) 779-8865  
Toll Free (833) 697-1294  
[www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org)

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## **ANNUAL NOTICES FOR ELIGIBLE EMPLOYEES AND BENEFICIARIES OF THE IUPAT DC 57 WELFARE FUNDS**

This packet provides annual notices that must be issued by the IUPAT DC 57 Welfare Funds to eligible employees. Please review the information carefully. Depending on the type of plan and benefit coverage you have, the following information may or may not apply.

### **HIPAA Notice of Special Enrollment Rights**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your eligible dependent are covered under a state Medicaid or Child Health Insurance Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you and/or your eligible dependent may enroll in this plan. Or, if you or your eligible dependent become eligible through Medicaid or CHIP for premium assistance to pay for medical coverage under this plan, you and/or your eligible dependent may enroll in this plan. You must request enrollment by contacting the Fund Office within 60 days after losing Medicaid or CHIP or becoming eligible for premium assistance under Medicaid or CHIP.

To request special enrollment or obtain more information, contact the Fund Office at 3660 Stutz Drive, Suite LL101, Canfield, OH 44406, 1-833-697-1294.

### **Women's Health & Cancer Rights Act (WHCRA)**

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call or contact the Fund Office at 3660 Stutz Drive, Suite LL101, Canfield, OH 44406, 1-833-697-1294.

### **Newborn and Mother's Health Protection Act Annual Notice**

Group plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth.

The law provides that neither you nor your newborn baby may be sent home less than 48 hours following a natural childbirth. If you have a Caesarean section, you may remain at the hospital

for 96 hours. A longer stay is based on medical necessity, which is determined by your physician. However, the law does not prohibit either of you from going home in less than 48 hours, or 96 hours following a Caesarean section, provided that you and your physician agrees that is safe to do so. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Reminder of Availability of HIPAA Notice of Privacy Practices**

As you know, the IUPAT DC 57 Welfare Fund maintains a HIPAA Notice of Privacy Practices (“Privacy Notice”) describing how health information about individuals covered under the plan may be used and disclosed. While we previously distributed the Privacy Notice to all covered individuals, the HIPAA Privacy Rule requires that, every three years, we notify currently covered individuals of the availability of the Privacy Notice and how to obtain a copy of it.

You may obtain a copy of our Privacy Notice by writing to/contacting the Fund Office 3660 Stutz Drive, Suite LL101, Canfield, OH 44406, 1-833-697-1294.

**I.U.P.A.T. WELFARE FUND OF WESTERN PENNSYLVANIA**  
**SUMMARY ANNUAL REPORT**  
**DECEMBER 31, 2024**

This is a summary annual report of the I.U.P.A.T. Welfare Fund of Western Pennsylvania, E.I.N. 25-1010829, which is a welfare benefit plan, for the year ended December 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). The Plan Administrator, which is the Board of Trustees, has committed itself to pay all health, dental, prescription, death, wage replacement, and disability claims incurred under the terms of the Plan.

**Insurance Information**

During the plan year, the plan had contracts with Blue Cross/Blue Shield of Western Pennsylvania, UPMC Health Plan, and United Concordia to pay health/dental care claims incurred under the terms of the plan. The total claims and administrative fees paid for the plan year ended December 31, 2024 were \$ 10,367,767.

**Basic Financial Statements**

The value of plan assets, after subtracting liabilities of the plan, was \$ 29,718,445 as of December 31, 2024, compared to \$ 27,110,234 as of December 31, 2023. During the plan year, the plan experienced an increase (decrease) in its net assets of \$ 2,608,211. This increase (decrease) included unrealized appreciation or 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 during the year. The plan had a total income of \$ 23,978,395, including employer contributions of \$ 21,750,891 participant contributions of \$ 462,237 and earnings from investments of \$ 1,765,267. Total Plan expenses were \$ 21,370,184. These expenses included \$ 706,556 in administrative expenses and \$ 20,663,628 in benefits paid for participants and beneficiaries.

Your right 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. An accountant's report
2. Financial information and information on payments to service providers
3. Assets held for investment
4. Transactions in excess of 5% of Plan Assets
5. 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 I.U.P.A.T. Welfare Fund of Western Pennsylvania, 3660 Stutz Drive, Suite 101, Canfield OH 44406, (330) 270-0453. The charge to cover copying costs will be \$8.25 for the full annual report, or \$.25 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

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: U.S. Department of Labor, Employee Benefits Security Administration, Public Disclosure Room, 200 Constitution Avenue, N.W., Room N-1513, Washington, D.C. 20210.



**I.U.P.A.T. OF WESTERN PENNSYLVANIA**  
**ANNUITY FUND**  
**SUMMARY ANNUAL REPORT**  
**DECEMBER 31, 2024**

This is the summary of the annual report of the I.U.P.A.T. of Western Pennsylvania Annuity Fund (EIN - 25-1304459), which is a defined contribution pension plan, for the year ended December 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).

The Plan Administrator, which is the Board of Trustees, has committed itself to pay all pension benefits required under the terms of the Plan.

**Basic Financial Statement**

The value of the Plan assets, after subtracting liabilities of the Plan, was \$ 79,660,158 as of December 31, 2024, compared to \$ 76,314,133 as of December 31, 2023. During the year ended December 31, 2024, the Plan experienced an increase in its net assets of \$ 3,346,025. The increase included unrealized appreciation or depreciation in the value of the Plan assets; that is, the difference between the value of the Plan's assets at the end of the year and the price the Plan originally paid for those assets. The Plan had a total income of \$ 13,669,390 including employer contributions of \$ 6,093,570, earnings from investments of \$ 7,572,675 and other income of \$ 3,145. Benefits under the Plan are provided by the Trust Fund. Plan expenses were \$ 10,323,365. These expenses included \$ 9,854,429 in benefits paid to the participants and beneficiaries, and \$ 468,936 in other expenses. These other expenses included fees for auditing, administrative services, legal services, and other operating expenses.

**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. an accountant's report;
2. financial information and information on payments to service providers.
3. assets held for investment;
4. transactions in excess of 5% of plan assets

To obtain a copy of the full annual report, or any part thereof, write or call the I.U.P.A.T. of Western Pennsylvania Annuity Fund, 3660 Stutz Drive, Suite 101, Canfield OH 44406, (330) 270-0453. The charge to cover copying costs will be \$8.25 for the full annual report; or \$.25 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the Plan and accompanying notes, or a statement of income and expenses of the Plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without cost.

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## Paying for college just got easier.

### Save more. Worry less.

Are you or your family stressed over college costs? You're not alone. The debt it takes to pay for a degree is the biggest concern of parents and students.\* In fact, 80% of families think they'll need financial aid to afford tuition.\*\*

### Earn Tuition Rewards® through your dental plan

At United Concordia Dental, we care as much about your mental well-being as your oral well-being. That's why your dental plan includes the College Tuition Benefit® savings program.

Much like a frequent flier program, you earn Tuition Rewards® points that can be redeemed for tuition discounts at more than 400 participating private colleges and universities nationwide.

### Share the savings with your family

You can participate even if you don't have kids. Points can be shared among any eligible students in your extended family. You must sign up students and allocate their points before August 31 of the year they begin 12th grade.

- 1 Tuition Rewards point = \$1 in tuition discounts.
- Earn 2,000 points when you sign up. Then earn 2,000 points each year you're covered by United Concordia.
- Transfer points to your children, grandchildren, nieces, nephews, stepchildren, godchildren and adopted children.
- Each child enrolled receives a one-time bonus of 500 Tuition Rewards points.
- In year four, they receive an additional 2,500-point bonus.

### Sign up for Tuition Rewards

1. Log into your **MyDentalBenefits** account at **UnitedConcordia.com**.
2. Verify your email address is correct by **clicking your name** in the upper right corner. **SAGE Scholars** will use this email address to contact you.
3. Click the **More** tab and select **College Tuition Benefit**.
4. Click on the **Get Started** button and consent to participate.
5. Look for an email from **SAGE Scholars** to complete your sign up.

**Don't have a *MyDentalBenefits* account? Create one at [UnitedConcordia.com/GetMDB](https://UnitedConcordia.com/GetMDB).**



Sign up on or  
after your plan's  
effective date.

## Tuition Rewards FAQs

**Q: What are Tuition Rewards?**

A: Tuition Rewards points are discounts off of tuition and are never awarded in cash. Participating schools reduce their tuition by the amount of Tuition Rewards points you redeem. For example, one Tuition Rewards point = a \$1 tuition discount. So, 2,000 Tuition Rewards points is equal to a \$2,000 discount.

**Q: Who can use the Tuition Rewards points I accumulate?**

A: Even if you don't have children in your immediate family, you can allocate points to nieces, nephews, grandchildren, stepchildren, godchildren, adopted children and more.

**Q: How do I identify the students I'm saving for?**

A: Once your account is created with SAGE Scholars, you can begin adding eligible students. Each student you sign up immediately earns a one-time bonus of 500 points!

**Q: When should I sign up my students in the Tuition Rewards program?**

A: You can add future students as early as the day they're born. But students must be signed up prior to August 31 of the year they begin 12th grade.

**Q: When must I transfer Tuition Rewards points to a student?**

A: Points accumulate in your account until you transfer them to a student headed for college. Points must be transferred before August 31 of the student's 12th grade year. After August 31, students cannot earn or receive points.

**Q: Is there a cap on how many Tuition Rewards I can use per child?**

A: Yes, students can use Tuition Rewards to get a maximum 25% discount on their total tuition costs, divided evenly over four years of education. For example, if your student's total tuition is \$40,000 per year, you may redeem Tuition Rewards points for up to a \$10,000 discount per year.

**Q: When should I submit my student's Tuition Rewards points to a participating college?**

A: You must submit the student's Tuition Rewards points statement within 10 days of application.

**Q. Can Tuition Rewards be used for graduate school, summer school, evening classes or a part-time classes?**

A: No, Tuition Rewards can only be used for full-time, undergraduate education beginning with the freshman year at a participating private college or university.

**Q: Are there other ways to earn Tuition Rewards points?**

A: Yes, you can earn points through any participating organization such as a bank, credit union, fraternal organization, financial advisory firm or other college funding plan.

**Q: What if a student doesn't use his/her Tuition Rewards points?**

A: Tuition Rewards points can be refunded back to your account and transferred to a younger eligible student.

**Q: Can my student also receive points from other family members who have Tuition Rewards accounts?**

A: Yes. Students may receive Tuition Rewards points from multiple family members.





IUPAT DC 57 of Western PA  
PO Box 99459  
Troy, MI 48099-9998  
Local (330)779-8865 Toll (833)697-1294  
[www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org)

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Enhanced Member Benefit Website  
[www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org)

Dear Member:

The Trustees of the IUPAT Welfare Fund of Western PA are pleased to announce a new enhanced member benefit website, [www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org). This website has been fully updated to provide you with a more effective way to access and manage your benefits.

The website enables you to obtain basic benefit information about the Plan, review answers to frequently asked questions, access your personal benefit information, and communicate with the Benefit Office via e-mail. You can also find helpful links regarding benefits provided by the Plan.

To access your personal benefit information, such as your benefit elections, work history detail, forms, and Plan documents, you need to register as a new user by clicking the *Create an Account* link at the top right hand corner in the Login box. More detailed instructions are shown on the back of this letter. Once you are registered, you can access your personal benefit information by entering your *User Name* and *Password*, so please keep these confidential. **Please note, only one user name and password is permitted per email address.**

Please contact the Benefit Office at (330) 779-8865 or toll free at (833) 697-1294 if you encounter any difficulty retrieving your User Name and Password, or if you have any questions regarding the Member Benefit website. You can also email the Benefit Office directly by using the “Contact Us” section of the website.

Please visit the enhanced Member Benefit website soon and see all that it has to offer!

Board of Trustees,

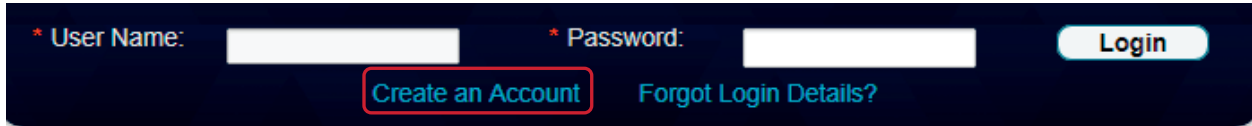
IUPAT Welfare Fund of Western PA



## HOW TO REGISTER ON THE WEBSITE

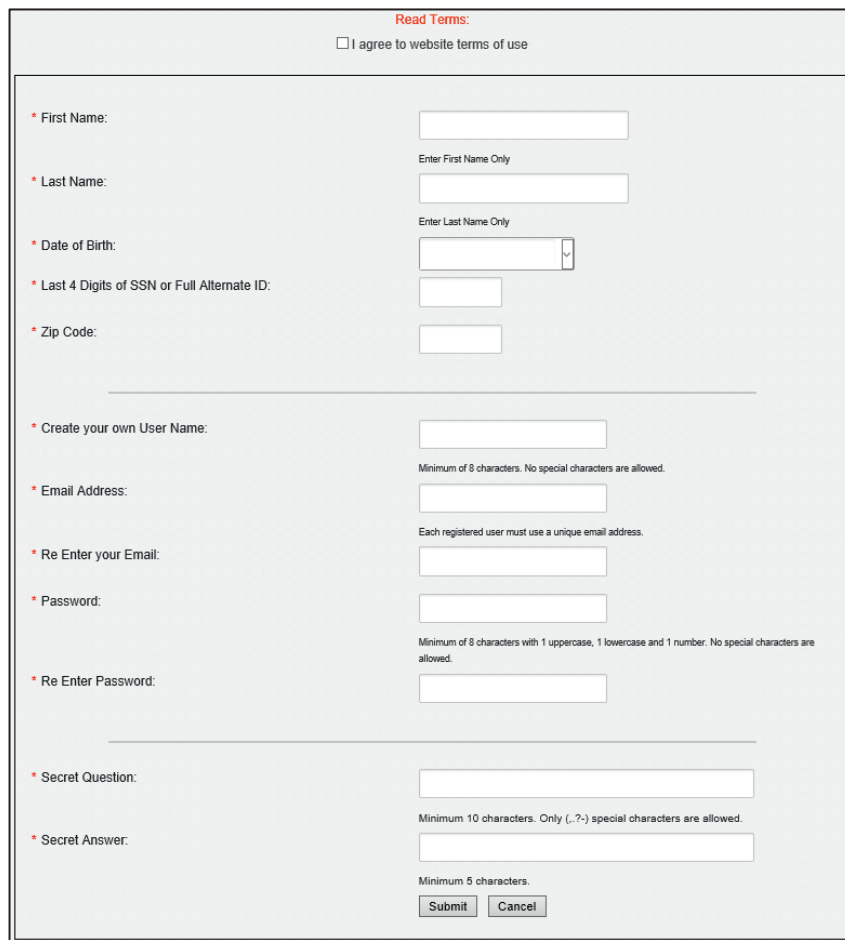
When registering for the first time, please follow these instructions:

- 1) From your computer or mobile device, enter [www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org) to connect to the website.
- 2) Locate the Login box in the upper right hand corner of the screen.
- 3) Click on “Create an Account” to get started.



A dark blue header bar containing a login form. On the left, there is a label "\* User Name:" followed by a white input field. To its right is a label "\* Password:" followed by another white input field. On the far right is a rounded button labeled "Login". Below the input fields, there are two links: "Create an Account" (highlighted with a red box) and "Forgot Login Details?".

- 4) The Registration Screen will display next. Please enter all information, as all fields are required. Once all information has been entered, please click “Submit” on the bottom of the screen.
- 5) After registering you will receive an email notification from [notifications@ourbenefitoffice.com](mailto:notifications@ourbenefitoffice.com) with a link to confirm your registration. Your email address will also be used in the event you forget your user name and password.



A registration form with a light gray background. At the top, there is a link "Read Terms:" and a checkbox "I agree to website terms of use". The form contains several fields with red asterisks indicating they are required:

- \* First Name: [input field]
- \* Last Name: [input field]
- \* Date of Birth: [dropdown menu]
- \* Last 4 Digits of SSN or Full Alternate ID: [input field]
- \* Zip Code: [input field]
- \* Create your own User Name: [input field]
- \* Email Address: [input field]
- \* Re Enter your Email: [input field]
- \* Password: [input field]
- \* Re Enter Password: [input field]
- \* Secret Question: [input field]
- \* Secret Answer: [input field]

Below the Secret Answer field, there are "Submit" and "Cancel" buttons.

### Profile Confirmation

Your authentication has been verified. Please login with your password. Please [Click here](#) to login.



IUPAT DC 57 of Western PA  
PO Box 99459  
Troy, MI 48099-9998  
Local (330)779-8865 Toll (833)697-1294  
[www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org)

Sitio Web Mejorado de Beneficios para Miembros  
<http://www.IUPATDC57Benefits.org>

Estimado Miembro:

Los Fideicomisarios del IUPAT DC 57 de PA Occidental se complacen en anunciar un nuevo sitio web mejorado de beneficios para miembros, [www.IUPATDC57Benefits.org](http://www.IUPATDC57Benefits.org). Este sitio web ha sido completamente actualizado para proveer una manera más efectiva to acceder y manejar sus beneficios.

El sitio web le habilita a obtener informacion de beneficios básica sobre el Plan, revisar las respuestas a preguntas hechas frecuentemente, acceder su informacion de beneficios personal, y a comunicarse con la Oficina de Beneficios por medio de correo electronico. Usted también encontrara enlaces útiles con respecto a beneficios provistos por el Plan.

Para acceder su informacion de beneficios personal, tal como sus elecciones de beneficio, detalle del historial laboral, formularios, y documentos del Plan, usted debe registrarse como un usuario nuevo por medio de hacer click en el enlace de “*Crear una Cuenta*” localizado en la esquina superior derecha en cuadro de Inicio de Sesión. Instrucciones más detalladas son exhibidas al reverso de esta carta. Una vez que esté registrado, puede acceder su informacion de beneficios personal ingresando su Nombre de Usuario y su Contraseña, así que por favor mantenga esto confidencial. **Por favor note, solo un nombre de usuario y contraseña es permitido por correo electronico. Si más de una persona en su familia requiere acceso al sitio web, cada persona debe usar un correo electronico diferente.**

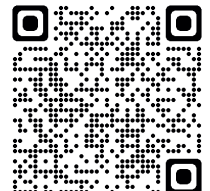
Cada miembro, cónyuge, y dependiente mayor de 18 años deberá crear su propio nombre de usuario y contraseña que le dará acceso a su propia Informacion de Salud Protegida (ISP). Cada persona que crea su propio nombre de usuario y contraseña no tendrá su ISP disponible a ser vista por ningún otro usuario.

Por favor contacte a la Oficina de Beneficios al (330) 779-8865 o llamada gratuita (833) 697-1294 si encuentra alguna dificultad para iniciar la sesión o si tiene alguna pregunta con respecto al Sitio Web de Beneficios para Miembros. Usted también puede enviar un correo electronico a la Oficina de Beneficios directamente utilizando la sección “Contáctenos” del sitio web.

¡Visite el sitio web mejorado de Beneficios para miembros pronto y vea todo lo que tiene para ofrecer!

Mesa Fideicomisaria,

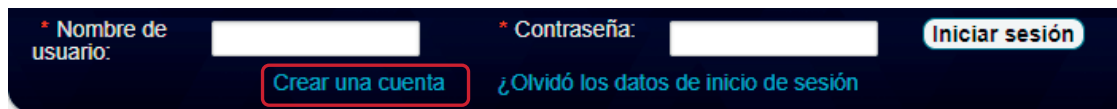
IUPAT DC 57 de PA Occidental



## COMO REGISTRARSE EN EL SITIO WEB

Cuando se registre por primera vez, por favor siga estas instrucciones:

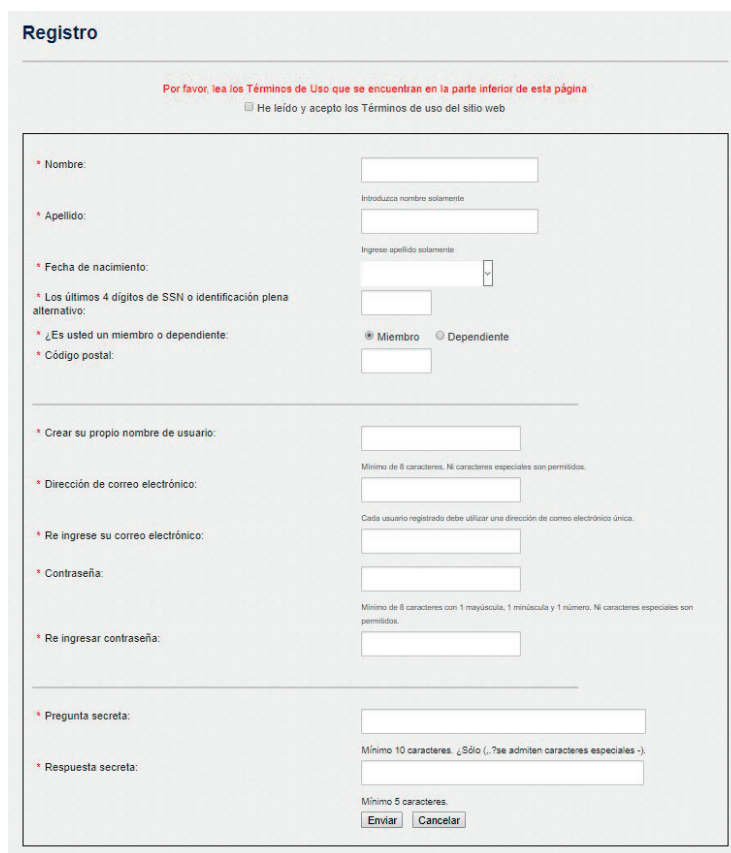
- 1) De su computadora o dispositivo móvil, conéctese al sitio web listado en la portada de esta carta.
- 2) Ubique cuadro de inicio de sesión en la esquina superior derecha de la pantalla.
- 3) Haga click en “Crear una cuenta” para empezar.



\* Nombre de usuario:  \* Contraseña:  **Iniciar sesión**

**Crear una cuenta** [¿Olvidó los datos de inicio de sesión?](#)

- 4) La pantalla de registro se mostrará a continuación. Por favor ingrese toda la información, ya que todos los campos son requeridos. Una vez que se haya ingresado toda la información, haga clic en "Enviar" en la parte inferior de la pantalla.



**Registro**

Por favor, lea los **Términos de Uso** que se encuentran en la parte inferior de esta página

He leído y acepto los Términos de uso del sitio web

\* Nombre:  Introduzca nombre solamente

\* Apellido:  Ingrese apellido solamente

\* Fecha de nacimiento:

\* Los últimos 4 dígitos de SSN o identificación plena alternativo:

\* ¿Es usted un miembro o dependiente:  Miembro  Dependiente

\* Código postal:

---

\* Crear su propio nombre de usuario:

\* Dirección de correo electrónico:  Mínimo de 8 caracteres. Ni caracteres especiales son permitidos.

\* Re ingrese su correo electrónico:  Cada usuario registrado debe utilizar una dirección de correo electrónico única.

\* Contraseña:

\* Re ingresar contraseña:  Mínimo de 8 caracteres con 1 mayúscula, 1 minúscula y 1 número. Ni caracteres especiales son permitidos.

---

\* Pregunta secreta:

\* Respuesta secreta:  Mínimo 10 caracteres. ¿Sólo (.?se admiten caracteres especiales -).

Mínimo 5 caracteres.

- 5) Después de registrarse, usted recibirá una notificación por correo electrónico con un enlace para confirmar su registración. Su correo electrónico también será utilizado en caso de que olvide su nombre de usuario y su contraseña.

¡Éxito! Gracias por registrarse para ver su información sobre sus beneficios. Su cuenta se activará y se enviará una notificación a su correo electrónico.