COUNTY OF WASHINGTON

Employee

2024 Benefits Guide

Salaried, Elected Officials, SEIU, PSSU, PDDA, AFSCME, DPSA, NCEU and Retirees Under Age 65

HIGHMARK.

UNITED CONCORDIA DENTAL

Colonial Life
The benefits of good hard work.™

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Table of Contents

This brochure summarizes the benefit plans that are available to County of Washington eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits. **V. 10.22**

A Message From County of Washington

At County of Washington we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each and every employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all of our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

Highlights

Medical:

Choosing the right health plan is probably one of the most important decisions you can make for you and your family. It is our objective to provide an employee benefit program with a high level of benefits, making it easy for you and your dependents to access the medical care you need. Please carefully consider the plan information provided in this document to make the best medical choices for you and your family. Always remember to eat right and get plenty of exercise to feel your best!

Prescription Drugs:

When you enroll in a medical plan, you and your eligible, enrolled dependents automatically receive prescription drug coverage. **Remember:** generic drugs have the same active chemical ingredients and therapeutic effect as their brand-name equivalents. These drugs are the least expensive.

Dental:

Our dental plan makes dental care more affordable for employees and their families. Remember to choose a dentist contracted with our plan for the biggest dental benefit. Taking care of your mouth, teeth and gums is a big part of making sure you feel your best. Healthy habits like brushing, flossing and seeing your dentist for regular cleanings help prevent problems.

Vision:

Eye doctors detect problems in vision, overall eye health, and detect signs of other health conditions like diabetic eye disease, high blood pressure and high cholesterol. We know your eyesight is precious to you and so we provide vision benefits to make sure your trip to the eye doctor is reasonably priced.

Flexible Spending Accounts:

If you elect to participate in the Flexible Spending Accounts, you can set aside tax-free dollars each year to cover your eligible out-of-pocket expenses and daycare expenses.

Life and AD&D:

Life/Accidental Death & Dismemberment protects employees and their families from financial hardship in the event of death or dismemberment. It provides the peace of mind you get when you know your loved ones will be protected if anything happens to you. See your Human Resources Department for your eligibility and for more information about this benefit.

Long-Term Disability:

One of the most important assets to you as an employee is the ability to earn an income. The long-term disability program is designed to continue providing you with income if you're unable to work due to sickness or injury. See your Human Resources department for more information and eligibility about this benefit.

Employee Assistance Program:

The Employee Assistance Plan (EAP) is an employer paid benefit providing resources for everyday living. Employee assistance professionals provide counseling and referral to continued therapy or treatment services anytime you or a family member are seeking to maintain mental and emotional well-being. The EAP can assist with a variety of life's issues.

Enrollment and Eligibility

Who is eligible for benefits:

All regular County of Washington employees working at least 30 hours per week may be eligible for benefits. If you are enrolling as a new employee, most benefits have a waiting period of 30 days of employment. You may also choose to enroll your eligible dependents in many of our benefits. Contact the Human Resources department for specific plan details.

Enrollment and Qualifying Events:

Each year you have the opportunity to make changes to your benefits package during open enrollment. With the exception of certain qualifying events, open enrollment is the only time benefit changes may be made. A qualifying event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying events include: a change in legal marital status, change in number or dependents, death of a child, change in employment status for you or your spouse, birth or adoption of a child.

If such a change occurs, you must make the changes to your benefits within 30 days of the Qualifying Event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the qualifying event may result in your having to wait until the next open enrollment period to make your change; this includes the enrollment of a newborn child. Please contact Human Resources to make these changes.

Plan Enrollment:

If you decide to enroll in benefit coverage, whether it is during your initial eligibility as a new hire or during open enrollment, you must complete the enrollment process.

Questions? Contact:

Regina Osko, Benefits Specialist
(724) 228-6746
oskoregi@co.washington.pa.us

Sonja Hatfield, Employee Wellness and Activities Coordinator
(724) 228-6933
s.hatfield@co.washington.pa.us

HRA Deductible Responsibility Notice

(Salaried, Elected Official, SEIU, PSSU, PDDA, AFSCME, DPSA, NCEU)

Your HRA deductible responsibility for plan year 2024 is $750 individual/$1500 family. However, the county is offering an opportunity to receive a discount on your deductible responsibility. To be eligible for the discount, **both** you and your spouse, if applicable, must be tobacco free.

You will be required to sign a self-certification during the open enrollment period in October/November 2023 for the 2024 plan year. If eligible for this discount, your 2024 deductible responsibility will be $500 individual/$1,000 family.

"Tobacco Free" for this purpose means the **non-use** of cigarettes (including e-cigarettes), pipes, cigars or any other tobacco products (snuff, chewing tobacco, etc.) regardless of the number of times, frequency or method of use.

The W.E.L.L. program continuously provides information on Tobacco Cessation programs available at no cost to you. Information is included in this guide should you wish to take advantage of this program.

HIGHMARK PPO WITH HRA

(HEALTH REIMBURSEMENT ARRANGEMENT)

Medical Insurance

HIGHMARK. | PPO Blue

Summary of County of Washington PPO Blue Customized Benefits

GROUPS 015518-00 01 02 04 06 07 08 12 13 14 15 16 17 18 19 20 22 23 24 25 26 28 29 30 32 33 34 35 36 37 39 40 42 43 44 46 50 51 52 53 54 55 56 57 58 59 60 61 62 64 65 66 67 68 69 70 71 72 74 76 77 78 79 80 81 82 84 86 87 88 89 90 91 92 93 94 95 96 97 98 (NGF)

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	**January 1, 2024**	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 $1,250 $2,500	 $2,500 $5,000
Plan Pays – payment based on the plan allowance	100% after deductible	70% after deductible
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 $3,500 $10,500
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $9,450 $18,900	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $30 copay	70% after deductible
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	70% after deductible
Specialist Office Visits & Virtual Visits	100% after $30 copay	70% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	70% after deductible
Urgent Care Center Visits	100% after $30 copay	70% after deductible
	Copayment does not apply to Urgent Care Center visits prescribed for the treatment of Mental Health or Substance Abuse	
Telemedicine Services (3)	100% after $5 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100% (deductible does not apply)	 not covered
Adult Immunizations	100% (deductible does not apply)	70% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	70% (deductible does not apply)
Mammograms, Annual Routine	100% (deductible does not apply)	70% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	70% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Routine Pediatric Physical Exams	 100% (deductible does not apply)	 not covered
Pediatric Immunizations	100% (deductible does not apply)	70% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	70% after deductible
Emergency Services		
Emergency Room Services (5)	100% after $100 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (6)	100% after deductible	100% after in-network deductible
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	$100 inpatient copay per admission, then 100% after deductible	$500 inpatient copay per admission, then 70% after deductible
Hospital Outpatient	100% after deductible	70% after deductible

Medical Insurance

Benefit	In Network	Out of Network
Maternity (non-preventive facility & professional services) including dependent daughter	$100 inpatient copay per admission, then 100% after deductible	$500 inpatient copay per admission, then 70% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100% after deductible	70% after deductible
Therapy and Rehabilitation Services		
Physical Medicine	100% after deductible	70% after deductible
	limit: 30 visits/benefit period **Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse*	
Respiratory Therapy	100% after deductible	70% after deductible
Speech Therapy	100% after deductible	70% after deductible
	limit: 30 visits/benefit period **Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse*	
Occupational Therapy	100% after deductible	70% after deductible
	limit: 30 visits/benefit period **Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse*	
Spinal Manipulations	100% after $30 copay	70% after deductible
	limit: $1,000/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	70% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$100 inpatient copay per admission, then 100% after deductible	$500 inpatient copay per admission, then 70% after deductible
Inpatient Detoxification / Rehabilitation	$100 inpatient copay per admission, then 100% after deductible	$500 inpatient copay per admission, then 70% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	70% after deductible
Outpatient Substance Abuse Services	100% after deductible	70% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	70% after deductible
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100% after deductible	70% after deductible
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100% after deductible	70% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	70% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	70% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	70% after deductible
Home Health Care	100% after deductible	70% after deductible
	limit: 180 visits/benefit period aggregate with visiting nurse	
Hospice	100% after deductible	70% after deductible
Infertility Counseling, Testing and Treatment (8)	100% after deductible	70% after deductible
Private Duty Nursing	100% after deductible	70% after deductible
Skilled Nursing Facility Care	$100 inpatient copay per admission, then 100% after deductible	$500 inpatient copay per admission, then 70% after deductible
	limit: 150 days/benefit period	
Transplant Services	100% after deductible	70% after deductible
Precertification Requirements (9)	Yes	Yes

Medical Insurance

Prescription Drugs	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (10) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Formulary Benefit Design **Select Specialty Drugs are limited to 31-day Supply**	**Retail Drugs (31-day Supply)** $10 generic copay $20 brand formulary copay $35 brand non-formulary copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $40 brand formulary copay $70 brand non-formulary copay

This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy/ plan documents, as limitations and exclusions apply. The policy/ plan documents control in the event of a conflict with this benefits summary.

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning on your employer's effective date. Contact your employer to determine the effective date applicable to your program.
(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7), must be performed by a Highmark approved telemedicine vendor. Additional services provided by an approved telemedicine vendor are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
(7) After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits.
(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use Accredo or Giant Eagle specialty pharmacy for select specialty medications. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details.

Health Reimbursement Account

Prepared for: County of Washington

Health Reimbursement Arrangement (HRA)

How your HRA works

Good news! Your plan comes with an HRA. That means budgeting for health expenses just got a whole lot easier.

How your HRA works

Be sure to show your Highmark ID card any time you receive care.

- Your provider will submit the claims to Highmark and they will process under your HRA.
- Your HRA pays for deductible expenses only, not copays.

How to Manage Your Account

You can check your account balance and payments at highmarkbcbs.com.

- Click Claims and Spending to see your HRA balance.
- Click Claims History for a list of your claims.
- Click See More and then EOP (Explanation of Payment) on a selected claim to find details of claims paid from your HRA.
- Click the blue access button on the Claims and Spending tab for additional HRA details.

Your Health Plan and Your HRA

	In-Network	
Benefit Level	Individual	Family
Medical Plan Deductible (Plan begins paying when claims total this amount.)	$1,250	$2,500
	Order of Payment	
Member Pays First (Before HRA begins paying)	$500	$1,000
HRA Pays Remaining	$750	$1,500

Notes on Family Coverage:

You or a covered member of your family has an amount you must pay first before the HRA begins paying.

- Once you pay $500, the HRA will begin to pay your claims.
- Once your payment plus the HRA payments add up to your plan's individual deductible of $1,250, your plan begins paying.
- The HRA will pay up to a total of $750 for other family members until the combined total reaches your plan's family deductible of $2,500.

If you have any questions about your HRA plan, **please call the Member Service phone number listed on the back of your medical insurance card.**

Health Reimbursement Account

Putting Health Care in Your Hands

Instant access to powerful mobile and online account tools — anytime and anywhere

Mobile Convenience

Get 24/7 account access from your smart phone or tablet

Download the free app

As a first-time user, you will need to download the app from the Apple App Store or Google Play.

- In the search field, enter Highmark Blue Shield $pending Account.
- Select the app and complete the download process.
- Once downloaded, reference the below information to help you complete the registration process:

Employee ID: This ID is located on the front of your member ID card. Enter only the number portion of your member ID, which is 12 digits.

Registration ID: You can enter your Employer ID or your debit card number linked to this account.

› **Employer ID** is SPA106473.

› **Card Number** is the 16-digit number on your debit card linked to this account.

Access Accounts
- Check balances
- View transaction history
- Get important plan details
- View a summary of all your accounts

Receive Notifications
- Get important messages about account activity and actions you may need to take

Track Account Activity
- Check claim and expense statuses
- View contributions and payments

Online Control

Your member website provides powerful self-service account tools to help make managing your spending easier than ever.

Getting started

- Log in at highmarkbcbs.com.
  - › First-time users must register before they can log in. Click **Register** and follow the simple instructions.
- Click the **Claims and Spending** tab and then click the blue **Access** button.

Take advantage of online educational videos and calculators that help you plan and make informed spending and saving decisions.

HIGHMARK.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

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.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

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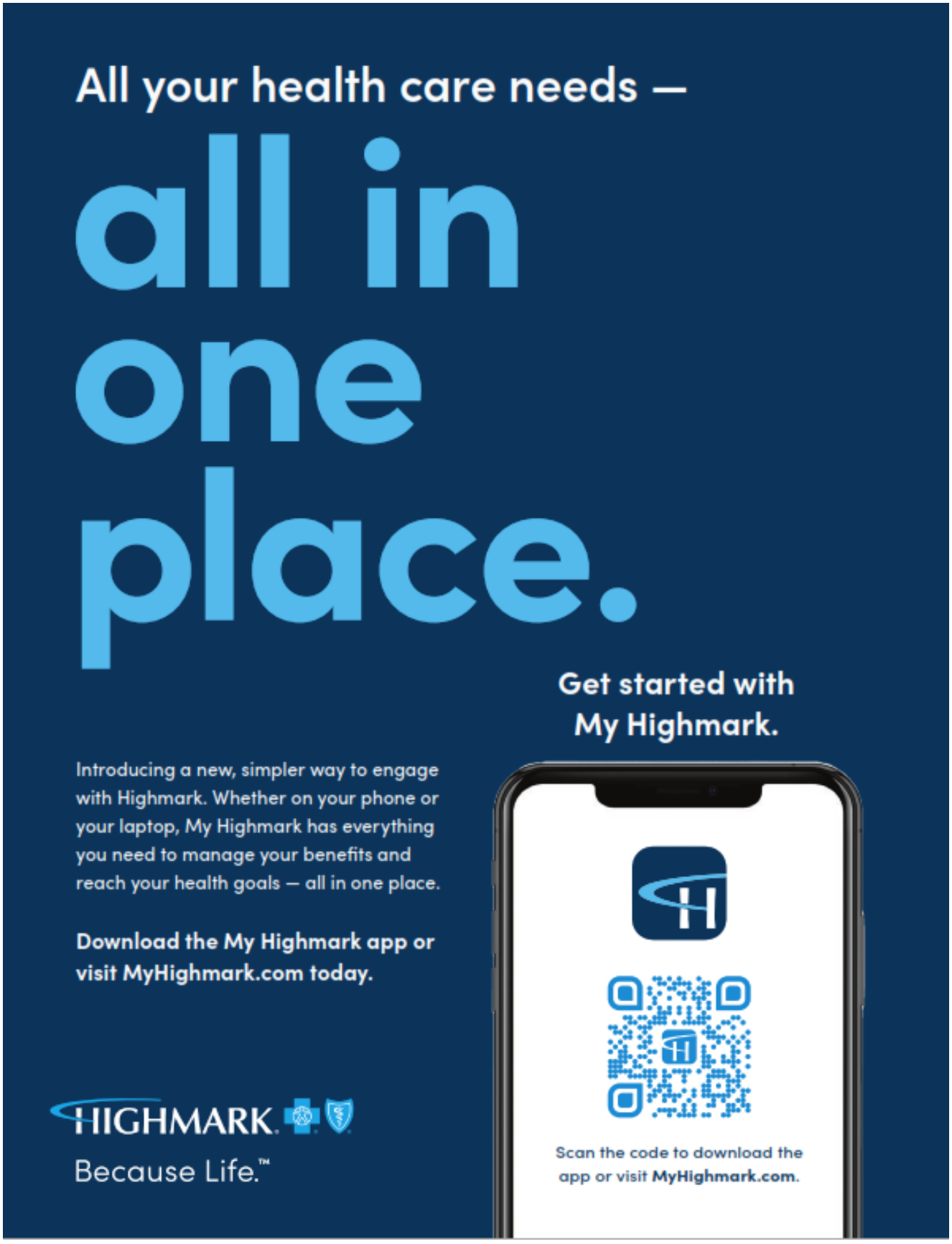
Highmark Mobile App



HIGHMARK PPO (No HRA)
(PERFORMANCE BLUE)

Medical Insurance

Highmark Performance Blue PPO

Summary of County of Washington Performance Blue PPO Benefits

Groups *107556-01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86*

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	**January 1, 2024**	
Benefit Period (1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 None None
Plan Pays – payment based on the plan allowance	100%	70%
Out-of-Pocket Limit (Includes coinsurance. Once met, plan pays 100% coinsurance for the rest of the benefit period) Individual Family	 None None	 None None
Total Maximum Out-of-Pocket (Includes deductible, coinsurance, copays, prescription drug cost sharing and other qualified medical expenses, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period. Individual Family	 $9,450 $18,900	 Not Applicable Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after $30 copay	70%
Primary Care Provider Office Visits & Virtual Visits	100% after $20 copay	70%
Specialist Office Visits & Virtual Visits	100% after $30 copay	70%
Virtual Visit Provider Originating Site Fee	100%	70%
Urgent Care Center Visits	100% after $30 copay	70%
	**Copayment does not apply to Urgent Care Center visits prescribed for the treatment of Mental Health or Substance Abuse*	
Telemedicine Services (3)	100% after $5 copay	not covered
Preventive Care (4)		
Routine Adult Physical Exams	 100%	 not covered
Adult Immunizations	100%	70%
Routine Gynecological Exams, including a Pap Test	100%	70%
Mammograms, Annual Routine	100%	70%
Mammograms, Medically Necessary	100%	70%
Diagnostic Services and Procedures	100%	70%
Routine Pediatric Physical Exams	 100%	 not covered
Pediatric Immunizations	100%	70%
Diagnostic Services and Procedures	100%	70%
Emergency Services		
Emergency Room Services (5)	100% after $100 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (6)	100%	100%
Hospital and Medical / Surgical Expenses (including maternity) (5)		
Hospital Inpatient	$100 inpatient copay per admission, then 100%	$500 inpatient copay per admission, then 70%
Hospital Outpatient	100%	70%

Medical Insurance

Benefit	In Network	Out of Network
Maternity (non-preventive facility & professional services) including dependent daughter	$100 inpatient copay per admission, then 100%	$500 inpatient copay per admission, then 70%
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	70%
Therapy and Rehabilitation Services		
Physical Medicine	100%	70%
	limit: 30 visits/benefit period **Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse*	
Respiratory Therapy	100%	70%
Speech Therapy	100%	70%
	limit: 30 visits/benefit period **Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse*	
Occupational Therapy	100%	70%
	limit: 30 visits/benefit period **Limit does not apply when Therapy Services are prescribed for the treatment of Mental Health or Substance Abuse*	
Spinal Manipulations	100% after $30 copay	70%
	limit: $1,000/benefit period	
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	70%
Mental Health / Substance Abuse		
Inpatient Mental Health Services	$100 inpatient copay per admission, then 100%	$500 inpatient copay per admission, then 70%
Inpatient Detoxification / Rehabilitation	$100 inpatient copay per admission, then 100%	$500 inpatient copay per admission, then 70%
Outpatient Mental Health Services (includes virtual behavioral health visits)	100%	70%
Outpatient Substance Abuse Services	100%	70%
Other Services		
Allergy Extracts and Injections	100%	70%
Applied Behavior Analysis for Autism Spectrum Disorder (7)	100%	70%
Assisted Fertilization Procedures	not covered	not covered
Dental Services Related to Accidental Injury	100%	70%
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	70%
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	70%
Durable Medical Equipment, Orthotics and Prosthetics	100%	70%
Home Health Care	100%	70%
	limit: 180 visits/benefit period aggregate with visiting nurse	
Hospice	100%	70%
Infertility Counseling, Testing and Treatment (8)	100%	70%
Private Duty Nursing	100%	70%
Skilled Nursing Facility Care	$100 inpatient copay per admission, then 100%	$500 inpatient copay per admission, then 70%
	limit: 150 days/benefit period	
Transplant Services	100%	70%
Precertification Requirements (9)	Yes	Yes

Medical Insurance

Prescription Drugs	
Prescription Drug Deductible Individual Family	 none none
Prescription Drug Program (10) Soft Mandatory Generic Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered. Your plan uses the Comprehensive Formulary with an Incentive Formulary Benefit Design **Select Specialty Drugs are limited to 31-day Supply**	**Retail Drugs (31-day Supply)** $10 generic copay $20 brand formulary copay $35 brand non-formulary copay **Maintenance Drugs through Mail Order (90-day Supply)** $20 generic copay $40 brand formulary copay $70 brand non-formulary copay

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(2) The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government. TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.
(3) Telemedicine Services (acute care for minor illnesses available on-demand 24/7), must be performed by a Highmark approved telemedicine vendor. Additional services provided by an approved telemedicine vendor are paid according to the benefit category that they fall under (e.g. PCP is eligible under the PCP Office Visit benefit, Behavioral Health is eligible under the Outpatient Mental Health Services benefit).
(4) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(5) Benefits for Emergency Care Services rendered by an Out-of-Network Provider will be paid at the Network services level. Benefits for Hospital Services or Medical Care Services rendered by an Out-of-Network Provider to a member requiring an inpatient admission or observation immediately following receipt of Emergency Care Services will be paid at the Network services level. The member will not be responsible for any amounts billed by the Out-of-Network Provider that are in excess of the plan allowance for such services.
(6) Medically necessary Air Ambulance services rendered by out-of-network providers will be covered at the highest network tier level of benefits.
(7) After initial evaluation, Applied Behavioral Analysis will be covered as specified above. All other Covered Services for the treatment of Autism Spectrum Disorders will be covered according to the benefit category (e.g. speech therapy, diagnostic services). Treatment for Autism Spectrum Disorders does not reduce visit/day limits.
(8) Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.
(9) If you receive services from an out-of-area provider or an out-of-network provider, you must contact Highmark Utilization Management prior to a planned inpatient admission, prior to receiving certain outpatient services or within 48 hours of an emergency or unplanned inpatient admission to obtain any required precertification. If precertification is not obtained and it is later determined that all or part of the services received were not medically necessary or appropriate, you will be responsible for the payment of any costs not covered by your health plan.
(10) The Highmark formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. The formulary was developed by Highmark Pharmacy Services and approved by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. All plan formularies include products in every major therapeutic category. Plan formularies vary by the number of different drugs they cover and in the cost-sharing requirements. Your program includes coverage for both formulary and non-formulary drugs at the copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, when you purchase a brand drug that has a generic equivalent, you will be responsible for the brand-drug copayment plus the difference in cost between the brand and generic drugs, unless your doctor requests that the brand drug be dispensed. Your plan requires that you use Accredo or Giant Eagle specialty pharmacy for select specialty medications. Your plan offers the Free Market Health program for select specialty medications. You will be contacted by one of the specialty network pharmacies who will provide quality service, care, and coordination of your specialty prescription fill and delivery. No enrollment necessary. Your plan requires that you use a specific specialty pharmacy for hemophilia medications. Please contact member services for more details.

Customized Fashion Advantage Option V

County of Washington

Fashion Advantage Option V Summary of Benefits

January 1, 2024

In-Network Benefits – Non-Voluntary		Fashion Advantage V
Frequency – Once Every:		
Eye Examination (including dilation when professionally indicated)		12 months
Spectacle Lenses		12 months
Frame		12 months
Contact Lenses (in lieu of eyeglass lenses)		12 months
Copayments		
Eye Examination		$0
Spectacle Lenses		$0
Contact Lens Evaluation, Fitting & Follow-Up Care		n/a
Eyeglass Benefit - Frame	**Average Retail Value**	
Non-Collection Frame Allowance (Retail):	Up to $130	Up to $130
Davis Vision Frame Collection[1] (in lieu of Allowance):		
- Fashion level	Up to $125	Included
- Designer level	Up to $175	$20 copayment
- Premier level	Up to $225	$40 copayment
Eyeglass Benefit - Spectacle Lenses	**Average Retail Value**	**Member Charges**
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)	$60-$120	Included
Oversize Lenses	$20	Included
Tinting of Plastic Lenses	$20	$11
Scratch-Resistant Coating	$25-$40	Included
Scratch Protection Plan Single Vision	$60-$120	$20
Scratch Protection Plan Multifocal	$60-$120	$40
Polycarbonate Lenses[2]	$60-$75	$0 or $30
Ultraviolet Coating	$25-$30	$12
Standard Anti-Reflective (AR) Coating	$50-$70	$35
Premium AR Coating	$65-$90	$48
Ultra AR Coating	$100-$125	$60
Standard Progressive Lenses	$150-$195	$50
Premium Progressives (Varilux®, etc.)	$195-$225	$90
Ultra Progressive Lenses	$225-$300	$140
Intermediate-Vision Lenses	$150-$175	$30
High-Index Lenses	$90-$150	$55
Polarized Lenses	$95-$110	$75
Plastic Photosensitive Lenses	$95-$150	$65
Contact Lens Benefit (in lieu of eyeglasses)		
Non-Collection Contact Lenses: Materials Allowance		Up to $130
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Not Covered
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Not Covered
Collection Contact Lenses[1] (in lieu of Allowance): Materials		
- Disposable		Covered In Full
- Planned Replacement		Covered In Full
- Evaluation, Fitting & Follow-up Care		Included
Medically Necessary Contact Lenses (with prior approval)		
- Materials, Evaluation, Fitting & Follow-Up Care		Included

Out-of-Network Reimbursement Schedule: up to			
Eye Examination: $32	Single Vision Lenses: $25	Trifocal Lenses: $46	Elective Contact Lenses: $85
Frame: $30	Bifocal/Progressive Lenses: $36	Lenticular Lenses: $72	Medically Necessary CL: $225

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

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

One-year eyeglass breakage warranty included

Customized Fashion Advantage Option V

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

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

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

Receiving services from a network provider:

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

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

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

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

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

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

VALUE-ADDED FEATURES

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

Information about laser vision correction services—You and your covered dependents can receive substantial discounts on laser correction procedures. You are entitled to savings of up to 25% off the provider's usual and customary fees, or a 5% discount on any advertised special through a network of credentialed physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equating to these discount levels.)

Call Member Service Monday through Friday, 8:00 am to 5:00 pm, Eastern Standard Time (EST) at 1-800-223-4795 (TTY users call 1-800-523-2847) to find a network provider, ask benefit questions, verify eligibility or request an out-of-network provider reimbursement form.

For information prior to enrolling, call 1-800-223-4795.

BASE DENTAL OPTION

Dental Benefits Summary

The County of Washington offers a base dental plan through United Concordia® Dental. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Dental Benefits Summary for County of Washington – Base Plan

Effective Date: January 1, 2024 **Network: Advantage *Plus***

Benefit Category[1]	CONCORDIA FLEX PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services		
Exams	100%	100%
Bitewing X-rays		
All Other X-rays		
Cleanings & Fluoride Treatments		
Space Maintainers		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative (Fillings)	50%	50%
Simple Extractions		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	50%	50%
Prosthetics (Bridges, Dentures)		
Implants		
Orthodontics		
Diagnostic, Active, Retention Treatment	Not Covered	Not Covered
Included Plan Features		
The College Tuition Benefit® – College Savings Program [3]	• Earn Tuition Rewards® points redeemable for tuition discounts • Receive 2,000 at signup, then 2,000 points/year • Each child enrolled receives a one-time bonus of 500 Tuition Rewards points • One Tuition Rewards point = $1 reduction in full tuition • Use Tuition Rewards points at participating private colleges and universities	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Calendar Year Program Deductible (per member/per family)	$25/$75 Excludes Class I	
Calendar Year Program Maximum (per member)	$1,000	
Reimbursement	**Advantage *Plus***	**Advantage**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

These policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your account representative for specific provisions and details of availability.

1. Dependent children covered to age 26.
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). United Concordia Dental's standard exclusions and limitations apply.
3. Tuition Rewards® is a Registered Trademark of and administered by SAGE Scholars, Inc. Participation in the program is contingent upon enrollment with SAGE Scholars, Inc. Tuition Rewards are not an underwritten benefit but a value-added program. Tuition Rewards not available in all jurisdictions (SAGE). SAGE is not a subsidiary or affiliate of United Concordia Insurance Company (UCIC). Subject to eligibility requirements and terms and conditions. Tuition Rewards are a value-added program and not an insured benefit. Program participation subject to enrollment with SAGE. "Points" are credits that may be used to discount the cost of Tuition and have no cash value. UCCI does not provide services related to this program. Tuition Rewards not available in all jurisdictions. Program subject to change without notice.

BUY-UP DENTAL OPTION

Dental Benefits Summary

The County of Washington offers a buy-up dental plan through United Concordia® Dental. The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

Dental Benefits Summary for County of Washington – Buy Up Plan

Effective Date: January 1, 2024 **Network: Advantage *Plus***

Benefit Category[1]	CONCORDIA FLEX PLAN	
	In-Network[2]	Non-Network[2]
Class I – Diagnostic/Preventive Services		
Exams	100%	100%
Bitewing X-rays		
All Other X-rays		
Cleanings & Fluoride Treatments		
Space Maintainers		
Palliative Treatment		
Class II – Basic Services		
Basic Restorative (Fillings)	80%	80%
Simple Extractions		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	50%	50%
Prosthetics (Bridges, Dentures)		
Implants		
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment	50%	50%
Included Plan Features		
The College Tuition Benefit® – College Savings Program [3]	• Earn Tuition Rewards® points redeemable for tuition discounts • Receive 2,000 at signup, then 2,000 points/year • Each child enrolled receives a one-time bonus of 500 Tuition Rewards points • One Tuition Rewards point = $1 reduction in full tuition • Use Tuition Rewards points at participating private colleges and universities	
Preventive Incentive®	Class I services do not count toward your calendar year program maximum	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Calendar Year Program Deductible (per member/per family)	$25/$75 Excludes Class I & Orthodontics	
Calendar Year Program Maximum (per member)	$1,500 Excludes Class I & Orthodontics	
Lifetime Orthodontic Maximum (per child dependent)	$1,500	
Reimbursement	**Advantage *Plus***	**Advantage**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

These policies have exclusions and limitations which may affect any benefits payable. See the actual policy or your account representative for specific provisions and details of availability.

1. Dependent children covered to age 26.
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). United Concordia Dental's standard exclusions and limitations apply.
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Making the Most of Your Benefits

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Making the Most of Your Benefits is as Easy as 1-2-3!

Beyond providing great dental insurance coverage, United Concordia Dental strives to provide the best-possible customer experience with easy-to-use tools. Here are three ways to get started:

Easy-to-use tools help you get more out of your dental benefits

1. Get *MyDental*Benefits

*MyDental*Benefits gives you personalized details about your United Concordia claims, coverage and available in-network dentists. Knowing this information *before* you see a dentist can help you prepare for any out-of-pocket costs, or even help you save money.

Create your account: Simply visit UnitedConcordia.com/GetMDB and click Create an Account. If you don't have access to the member ID number that's listed on your United Concordia card, contact Customer Service by visiting UnitedConcordia.com/Contact.

2. Stay Connected with Member Emails

United Concordia's member emails can help you better understand your dental coverage and improve your oral health. Each month, you'll get tools and tips to maximize your benefits, as well as oral wellness education for you and your family.

Sign up now:

- Login to *MyDental*Benefits
- Click the More tab, then My Profile

3. Find a Network Dentist

Seeing an in-network dentist can save you money, but how much you'll save can depend on your plan.

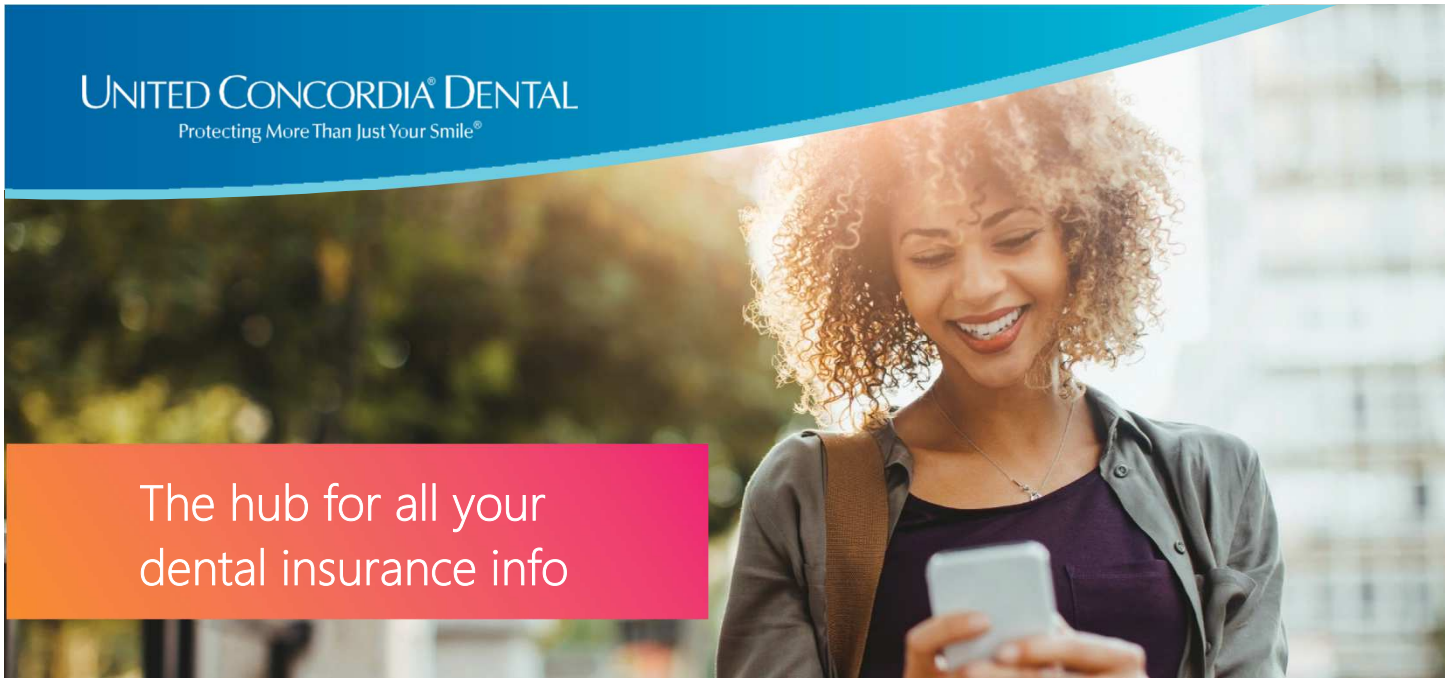
- With a PPO plan, you can visit any dentist and still have coverage, but you will save more money if you stay in-network.
- With a DHMO plan, you must visit your assigned dentist in your plan's network to receive coverage. This type of plan does not cover out-of-network dentists, which means you would be responsible for paying everything out-of-pocket.

Find *your* dentist: Visit UnitedConcordia.com/find-a-dentist to search for nearby in-network dentists. If you don't know your plan's network name, you can log into

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)。

My Dental Benefits



Create a *MyDentalBenefits*

With ***MyDental****Benefits*, you can find all your coverage info in one place online. You'll see a quick overview right when you log in.
Then just click to get details on everything from covered

You can create your own account after your plan's effective

MyDental*Benefits* **makes it easy**

- ✓ See what your plan covers and how much we'll pay
- ✓ Check the status of dental claims
- ✓ Find in-network dentists near you
- ✓ Chat live or upgrade to a phone call with customer
- ✓ service Print extra ID cards
- ✓ Rate your oral health with the My Dental Assessment quiz

How to create an account:

1. Go to **UnitedConcordia.com/GetMDB**
2. Enter your **Member ID** number and your **Birthdate** (You can also use the policyholder's SSN instead of the ID)

Chat live with customer service

Connect directly to a real person. Chat live while using your ***MyDental****Benefits* account.

Get the United Concordia Dental app

Sign in with your ***MyDental****Benefits* login info

Download on the App Store

GET IT ON Google Play

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College Tuition Benefits

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, 99% of families think they'll need financial aid to afford

COLLEGE TUITION BENEFIT®

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

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

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 register 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.

Sign up for Tuition Rewards

1. Log into your ***MyDental****Benefits* 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 *MyDental*Benefits account? Create one at

Predeterminations

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

What You Should Know About Predeterminations

When it comes to paying for dental treatment, no one likes surprises. Requesting a predetermination can prevent costly surprises by removing some of the guesswork regarding how much certain services will cost you, based on your dental insurance coverage.

What is a predetermination?

Predetermination is an estimate provided *before* dental treatment is started that tells you:

- If the treatment is covered
- The amount United Concordia Dental will pay
- The amount for which you will be responsible
- Alternate treatment options covered by your dental plan

It is a free, optional service provided to members to help you make an informed decision about your dental treatment and associated costs. A predetermination is not a guarantee of payment—it is an estimate of what you can expect to owe.

When should you ask for a predetermination?

You may want to ask your dentist to submit a predetermination for more expensive procedures or extensive treatment. Typically this would include procedures such as crowns, bridges, removal of wisdom teeth, periodontal

Why should you get a predetermination?

A predetermination estimate allows you to know in advance what is covered and what your share of the costs will be before you receive a service. Some dental services may be limited or not covered by your plan. It also shows you any deductible or maximums applied. Once you receive the predetermination, you can make an informed decision about whether you want to proceed with the treatment, or discuss alternate options with your dentist.

How do you submit a predetermination?

Your dentist will submit the predetermination request to United Concordia Dental on your behalf, either electronically or by mail. Once it is received, United Concordia carefully reviews the information provided against the details of your plan. Then, you and your dentist will be sent the estimated benefits for the planned services. This usually happens within 30 days, but your dentist can submit this request online for faster processing time. With My Dental Benefits, you can track the status of your predetermination, and review the results as soon as they are available. Get started at UnitedConcordia.com/MDB.

Knowing what your plan covers is just one factor to consider in your dental health. You and your dentist should always work together and choose the treatment that's best for you as an individual.

MEM-0372-1017

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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)。

MULTIPHASING TESTING

The County will provide 1% incentive toward your co-premium deducted from your paycheck if you **and** your spouse, if on the plan, have multiphasic testing performed each year. The County provides this at no charge to you if you have it completed at the County during the specified times announced.

We will honor bloodwork performed elsewhere according to the following guidelines.

1. Must be all 37 tests on the panel.
2. Testing must be performed for the current year between January 1st and October 31st.
3. You must provide a signed letter from the provider on their letterhead that the 37-test panel was performed and included all 37 tests on the panel. Do not submit lab reports or test results. These **will not** be accepted.
4. The letter must be received by Human Resources no later than October 31st. **No exceptions**.

The County will not reimburse any costs associated with the bloodwork, 37-test panel, physician's office visit and/or verification letter.

Please keep in mind the bloodwork is not required. This is only an incentive being offered by the County to help you save on the cost of your health insurance premium.

COUNTY OF WASHINGTON

MULTIPHASIC VERIFICATION FORM

This document is to certify that _____(Patient Name) has had the 37 tests performed as indicated below and, as their health care provider, I have received their results.

Tests Performed at the Multiphasic Screening

1. CBC	Complete blood count is used by physicians to rule out Infections, anemia, iron deficiencies, leukemia, etc.
2. WBC	White blood count
3. RBC	Red blood cell count
4. Hemoglobin	iron content
5. Hematocrit	% of red blood cells
6. MCV 7. MCH 8. MCHC	Detects various sizes and shapes of red blood cells
9. Platelet	Cells that are part of the clotting function
10 Lymphocytes 11. Mononuclear 12. Granulocytes	Types of white blood cells

Chemical Profile Tests (used to monitor various body functions)

13. Glucose	Diabetes
14. BUN 15. Creatinine 16. BUN/Creatinine Ratio	Kidney Function
17. Uric Acid	Gout/Arthritis
18. Calcium 19. Phosphorous 20. Ionized Calcium	Bone, Parathyroid, Thyroid
21. SGOT 22. LDH	Heart (ie. Myocardial infarction and various other diseases)
23. Cholesterol 24. Total & HDL 25. Triglycerides, Calculated LDL	Cardiac risk assessment and Lipids
26. SPGPT 27. Bilirubin-Total 28. Alkaline Phosphatase	Liver Function
29. Sodium (Na) 30. Potassium (K) 31. Chloride (Cl) 32. C02 33. Anion Gap	Electrolyte imbalance
34. Total Protein 35. Albumin 36. Globulin 37. *NG* Ratio	Monitors various conditions that effect protein excretion and metabolism

Physician Signature:_____Date:_____

Name of Practice:_____

2024 Employee Payroll Deductions - HRA

Salaried/EO, SEIU, PSSU, AFSCME, DPSA, PDDA, NCEU and Retirees Under Age 65 --- **13.5%**

Health	EE	EE + Spouse	EE + Child/Children	Family
Monthly	$110.82	$298.66	$266.94	$342.74
Bi-Weekly (24 pays)	$55.41	$149.33	$133.47	$171.37

Salaried/EO, SEIU, PSSU, AFSCME, DPSA, PDDA, NCEU and Retirees Under Age 65 --- **12.5%**
(Multiphasic Discount)

Health	EE	EE + Spouse	EE + Child/Children	Family
Monthly	$102.62	$276.56	$247.18	$317.36
Bi-Weekly (24 pays)	$51.31	$138.28	$123.59	$158.68

2024 Employee Payroll Deductions – Performance Blue

Salaried/EO, SEIU, PSSU, AFSCME, DPSA, PDDA, NCEU and Retirees Under Age 65 --- **13.5%**

Health	EE	EE + Spouse	EE + Child/Children	Family
Monthly	$102.22	$275.46	$246.22	$316.10
Bi-Weekly (24 pays)	$51.10	$137.73	$123.11	$158.05

Salaried/EO, SEIU, PSSU, AFSCME, DPSA, PDDA, NCEU and Retirees Under Age 65 --- **12.5%**
(Multiphasic Discount)

Health	EE	EE + Spouse	EE + Child/Children	Family
Monthly	$94.64	$255.08	$228.00	$292.68
Bi-Weekly (24 pays)	$47.32	$127.54	$114.00	$146.34

2024 Employee Payroll Deductions – Dental Coverage

BASE PLAN

Dental	EE	EE + 1 Dependent	EE + Family
Monthly	$0.00	$17.40	$37.70
Bi-Weekly (24 pays)	$0.00	$8.70	$18.85

BUY UP PLAN

Dental	EE	EE + 1 Dependent	EE + Family
Monthly	$7.76	$34.34	$73.70
Bi-Weekly (24 pays)	$3.88	$17.17	$36.85

Basic Life and Accidental Death and Dismemberment Benefits

Eligibility - Each Active Full-Time Salaried Employees.

- Life Benefit Amount: $50,000
- AD&D Benefit Amount: $5,000

Eligibility - Each Active Full-Time Elected Official.

- Life Benefit Amount: $50,000
- AD&D Benefit Amount: $5,000

Eligibility – Each Active Full-Time Washington Court Association of Professional Employees.

- Life Benefit Amount $50,000

Eligibility - Each Active Full-Time Service Employee International Union Local 585.

- Life Benefit Amount: $20,000

Eligibility - Each Active Full-Time Pennsylvania Social Service Union Local 668.

- Life Benefit Amount: $20,000
- AD&D Benefit Amount: $5,000

Eligibility - Each Active Full-Time National Corrections Employees Union.

- Life Benefit Amount: $25,000
- AD&D Benefit Amount: $5,000

Eligibility - Each Active Full-Time Deputy Sheriff Association.

- Life Benefit Amount: $25,000
- AD&D Benefit Amount: $5,000

Long-Term Disability Benefits Insurance Overview

Eligibility - Each Active Full-Time Salaried Employee, Elected Officials, and Probation Officers.

- LTD Benefit Amount: 60% of earnings to a maximum of $3,500 per month
- Elimination period: 90 days of disability

Travel Assistance

TheStandard®

Explore the world with confidence.

Rely on Travel Assistance when you're away from home.

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card
- Embassy locator

Reference Number:
01-AA-STD-5201

Download on the App Store | GET IT ON Google Play

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

1 Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

2 Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

3 Must be arranged by Assist America, Inc.

SI 14684

Travel Assistance EE
(6/20)

Employee Assistance Program (through The Standard)

A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,[1] which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to three counseling sessions per issue. Sessions can be done in person, on the phone, by video or text.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

Contact **EAP**

888.293.6948
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard3

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **healthadvocate.com/standard3** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

1 The EAP service is provided through an arrangement with Health Advocate℠, which is not affiliated with The Standard. Health Advocate℠ is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

Bereavement Support Services

The Life Services Toolkit

Resources and Tools to Support You and Your Beneficiary

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Health Advocate℠ to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard.

Services to Help You Now

Visit the Life Services Toolkit website at **standard.com/mytoolkit** and enter user name "assurance" for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and advance directives.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website for guidance on how to begin, to educate yourself on funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Death Benefit,[1] you may access the services for beneficiaries outlined on the next page.

The Life Services Toolkit is provided through an arrangement with Health Advocate℠ and is not affiliated with The Standard. Health Advocate is solely responsible for providing and administering the included service. This service is not an insurance product.

1 An Accelerated Death Benefit or Accelerated Benefit allows a covered individual who becomes terminally ill to receive a portion of the Life insurance proceeds while living, if all other eligibility requirements are met.

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | **standard.com**

Life Services EE
(8/21)

SI **17526**

Flexible Spending Account - TASC

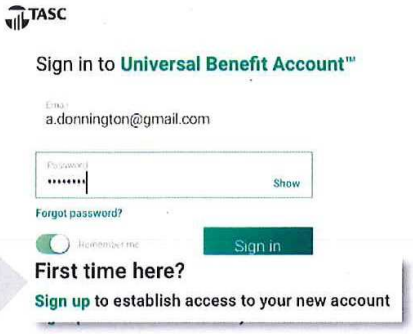
UNIVERSAL BENEFIT ACCOUNT Participant Access

TASC®

Let's get you signed in.

Visit **tasconline.com** and select **Sign in to Universal Benefit Account**

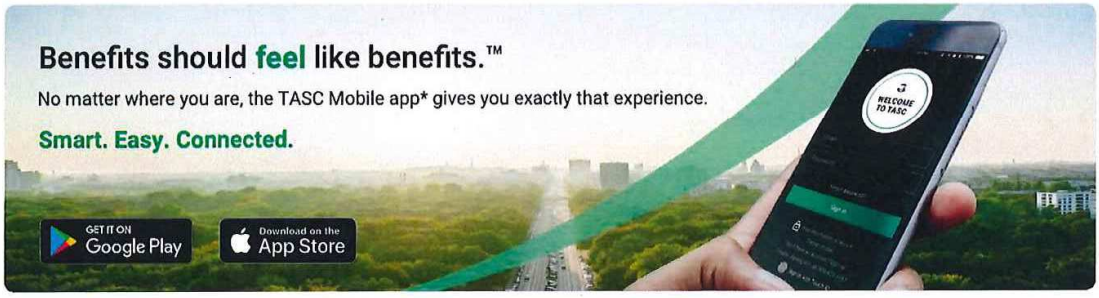
The first time you visit, select **Sign Up** and follow the directions to set up your account. All other times, simply **Sign In** with your established email and password.
Note: Chrome is the preferred browser.



TIPS

It is important to use the email address your employer has on file for you. If the one you entered is not recognized, please contact your employer to verify the email address on file.

Watch the **Accessing Your Account** tutorial!



*Standard message and data rates may apply.
The TASC Card is issued by MetaBank, Member FDIC, pursuant to license by Mastercard International Incorporated.
Mastercard is a registered trademark, and the circles design is a trademark of Mastercard International Incorporated.

Questions? Ask your employer or contact your plan administrator:
Total Administration Services Corporation • www.tasconline.com • 1-800-422-4661

TC-6213-052219

TASC®

TASC Eligible Expenses

EMPLOYEE EDUCATION

FlexSystem | Eligible and Ineligible Expenses for FSA

Expenses that qualify for reimbursement from FlexSystem

Healthcare FSA | Dependent Care FSA

Below is a partial list of permissible expenses reimbursable through a Flexible Spending Account (FSA) that are incurred by you, your spouse, or qualified dependents. Please note: a Limited Purpose Healthcare FSA only allows dental and vision expenses.

Medical Expenses

- Acupuncture
- Artificial limbs
- Bandages
- Birth control, contraceptive devices
- Birthing classes/Lamaze – only the mother's portion (not the coach/spouse) and the class must be only for birthing instruction, not child rearing
- Blood pressure monitor
- Blood sugar test kits/test strips
- Chiropractic therapy/exams/adjustments
- Contact lens and contact lens solutions
- Co-payments
- Crutches (purchased or rented)
- Deductible and co-insurance
- Diabetic supplies
- Eye exams
- Eyeglasses, contacts, or safety glasses, prescription only (warranties are not reimbursable)
- Flu shots
- Hearing aids and hearing aid batteries (warranties are not reimbursable)
- Heating pad
- Incontinence supplies
- Infertility treatments
- Insulin
- Lactation expenses (breast pumps, etc.)
- Laser eye surgery; LASIK
- Legal sterilization
- Medical supplies to treat an injury or illness
- Mileage to and from doctor appointments
- Nasal strips
- Optometrist's or ophthalmologist's fees
- Orthopedic inserts
- Physicals
- Physical therapy (as medical treatment)
- Physician's fee and hospital services
- Pregnancy test
- Prescription drugs and medications
- Psychotherapy, psychiatric and psychological service
- Reading glasses
- Sales tax on eligible expenses
- Services connected with donating an organ
- Sleep apnea services/products (as prescribed)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Vaccinations
- Wrist supports, elastic wraps
- X-ray fees

OTC Medicines and Drugs

Over-the-counter (OTC) medicines and drugs, except for insulin, require a prescription from your physician to be reimbursable. The prescription will need to be included with each request for reimbursement.

- Bengay, Flexall, pain relieving creams or gels
- Calamine lotion
- Canker/cold sore relievers
- Cold medicines
- Corn removal
- Diaper rash ointment
- GasX, baby gas drops
- Hemorrhoid creams and treatments
- Hydrogen Peroxide or rubbing alcohol
- Indigestion or anti-acid relievers
- Laxatives
- Nicotine patch
- Pain relievers (Tylenol, Advil, Aspirin, etc.)
- Sinus medicines
- Suppositories
- Teething gel
- Wart removal medication

Continued on next page...

TASC Total Administrative Services Corporation
2302 International Lane | Madison, WI 53704-3140

FX-4248-062316

TASC Eligible Expenses

For more information regarding FSA expenses, please review IRS Publication 502 or ask your employer for a copy of your Summary Plan Description (SPD).

Dental Expenses

- Braces and orthodontic services
- Cleanings
- Crowns
- Deductibles, co-insurance
- Dental implants
- Dentures, adhesives
- Fillings

Disability Expenses

- Automobile equipment and installation costs for a disabled person in excess of the cost of an ordinary automobile; device for lifting a mobility impaired person into an automobile
- Braille books/magazines in excess of cost of regular editions
- Note-taker for a hearing impaired child in school
- Seeing eye dog (buying, training, and maintaining)
- Special devices, such as a tape recorder or typewriter for a visually impaired person
- Visual alert system in the home or other items such as a special phone required for a hearing impaired person
- Wheelchair or autoette (cost of operating/maintaining)

Requiring Additional Documentation

The following expenses are eligible only when incurred to treat a diagnosed medical condition. Such expenses require a ***Letter of Medical Necessity*** from your physician, containing the medical necessity of the expense, diagnosed condition, onset of condition, and physician's signature.

- Ear plugs
- Massage treatments
- Nursing services for care of a special medical ailment
- Orthopedic shoes (excess cost of ordinary shoes)
- Oxygen equipment and oxygen
- Support hose
- Varicose vein treatment
- Veneers
- Vitamins and supplements
- Wigs (for mental health condition of individual who loses hair because of a disease)

Dependent Care Expenses

- Fees for licensed day care or adult care facilities
- Before and after school care programs for dependents under age 13
- Amounts paid for services (including babysitters or nursery school) provided in or outside of your home
- Nanny expenses attributed to dependent care
- Nursery school (preschool) fees
- Summer Day Camp – primary purpose must be custodial care and not educational in nature
- Late pick-up fees
- **Does not cover medical costs**; use Healthcare FSA for medical expenses incurred by you or your dependents

Ineligible Medical Expenses

- Athletic mouth guards
- Chapstick/lip balm
- Contributions to state disability funds
- Cosmetic surgery, dentistry, or other cosmetic procedures
- Cosmetic supplies (makeup, cleansers, moisturizers, etc.)
- Deodorant
- Dental floss
- Diet (cost of special foods as substitute for regular diet)
- Dietary and fiber supplements
- Electrolysis/hair removal
- Exercise equipment and fees
- Eye drops for general comfort
- Eyeglass cases
- Hand sanitizer
- Health club or athletic club membership fees
- Herbal supplements
- Insurance premiums, all types
- Lotions or skin moisturizers
- Marriage counseling
- Maternity clothes
- Mattress
- Medicare premiums
- Medicated shampoos, conditioners, and soaps
- Physical treatment unrelated to specific health problems (massage for general well-being, stress, depression, or chiropractic wellness)
- Safety glasses (non-prescription)
- Sunglasses (non prescription) and sun clips
- Teeth whitening products
- Toiletries
- Toothbrush (includes prescribed electronic) and toothpaste
- Vitamins and supplements for well-being
- Warranties
- Weight loss drugs/programs for general well being

TASC

TASC Identity Theft Protection

IDENTITY THEFT PROTECTION

TASC®

Offering peace of mind to Universal Benefit Account™ participants

Your identity has been stolen. You have called the police, your bank, and your credit card companies. There's one more call to make. TASC Identity Theft Protection is a feature of Universal Benefit Account that protects participants and the people important to them from the financial impact of identity theft.

Three Coverage and Service Components

Expense Reimbursement

- Covers out-of-pocket expenses incurred in identity restoration
- $25,000 annual aggregate limit with no deductible
- $5,000 sublimit for lost wages and child or elder care
- $1,000 sublimit for miscellaneous expenses

Fraud Loss

- Covers certain losses from the unauthorized use of credit or bank accounts when the participant is legally liable
- $5,000 sublimit

Help Line

- Report identity theft
- Learn how to respond
- Submit a claim

TASC Identity Theft Protection

Automatic Enrollment

- All active participants on Universal Benefit Account, their qualifying child(ren), relative, spouse, or civil union partners

Zero Cost

- TASC Identity Theft Protection is a value-added benefit of Universal Benefit Account

2302 INTERNATIONAL LANE, MADISON, WI 53704-3140 | 800-422-4661 | TASCONLINE.COM | TC-6248-060619

2024 Legal Notices

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

NOTICE REGARDING WELLNESS PROGRAMS

W.E.L.L. is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

2024 Legal Notices

Protections from Disclosure of Medical Information
We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and County of Washington may use aggregate information it collects to design a program based on identified health risks in the workplace, W.E.L.L. will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Regina Osko at 724-228-6746.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage
If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

2024 Legal Notices

Enforce your Rights
If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions
If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Regina Osko
95 West Beau Street, Suite 400
Washington, PA 15301
724-228-6746
oskoregi@co.washington.pa.us

2024 Legal Notices

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.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

2024 Legal Notices

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:

Marketing purposes
Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

2024 Legal Notices

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- October 12, 202□
- Regina Osko
  95 West Beau Street, Suite 400
  Washington, PA 15301

2024 Legal Notices

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE
NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from County of Washington About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with County of Washington and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **County of Washington has determined that the prescription drug coverage offered by Highmark BCBS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15thto December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current County of Washington coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current County of Washington coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through County of Washington changes. You also may request a copy of this notice at any time.

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For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 15, 2023
Name of Entity/Sender:	County of Washington
Contact--Position/Office:	Human Resources, Regina Osko
Address:	95 West Beau Street, Suite 400 Washington, PA 15301
Phone Number:	724-228-6746

CMS Form 10182-CC Updated April 1, 2011

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 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, 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.

2024 Legal Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

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KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

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WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

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

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

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

2024 Legal Notices

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMBNo.1210-

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your Team Member contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer - sponsored health plan meets the “minimum value standard” if the plan’s share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name County of Washington	4. Employer Identification Number (EIN) 25-6001043	
5. Employer address 95 West Beau Street, Suite 400	6. Employer phone number 724-228-6760	
7. City Washington	8. State PA	9. ZIP code 15301
10. Who can we contact about employee health coverage at this job? Regina Osko		
11. Phone number (if different from above)	12. Email address oskoregi@co.washington.pa.us	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are:
    - *Working at least 30 hours per week.*
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    - *Legal Spouses and Dependent Children to age 26.*
  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly Team Member or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

• An employer - sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

ADDITIONAL HIGHMARK MATERIALS

PPO Blue Facility Listing

Network hospitals in western Pennsylvania with PPO Blue

ALLEGHENY
- AHN Brentwood Neighborhood Hospital
- AHN McCandless Neighborhood Hospital
- Allegheny General Hospital
- Allegheny Valley Hospital
- Forbes Hospital
- Heritage Valley Kennedy
- Heritage Valley Sewickley
- Jefferson Hospital
- St. Clair Hospital
- West Penn Hospital
- Western Psychiatric Institute and Clinic
- UPMC Children's Hospital
- UPMC East
- UPMC Magee-Womens Hospital
- UPMC McKeesport
- UPMC Mercy
- UPMC Passavant
- UPMC Presbyterian Shadyside
- UPMC St. Margaret

ARMSTRONG
- Armstrong County Memorial Hospital

BEAVER
- Heritage Valley Beaver

BEDFORD
- UPMC Bedford

BLAIR
- Conemaugh Nason Medical Center
- Tyrone Hospital
- UPMC Altoona

BUTLER
- Butler Memorial
- UPMC Passavant-Cranberry

CAMBRIA
- Conemaugh Memorial Medical Center
- Conemaugh Miners Medical Center

CENTRE
- Mount Nittany Medical Center

CLARION
- Clarion Hospital

CLEARFIELD
- Penn Highlands Clearfield
- Penn Highlands DuBois

CRAWFORD
- Meadville Medical Center
- Titusville Area Hospital

ELK
- Penn Highlands Elk

ERIE
- Corry Memorial Hospital
- Millcreek Community Hospital
- Saint Vincent Hospital
- UPMC Hamot

FAYETTE
- Highlands Hospital
- Uniontown Hospital

GREENE
- Washington Health System Greene

HUNTINGDON
- Penn Highlands Huntingdon

INDIANA
- Indiana Regional Medical Center

JEFFERSON
- Penn Highlands Brookville
- Punxsutawney Area Hospital

LAWRENCE
- UPMC Jameson

MCKEAN
- Bradford Regional Medical Center
- UPMC Kane

MERCER
- AHN Grove City Hospital
- Edgewood Surgical Hospital
- Sharon Regional Medical Center
- UPMC Horizon

POTTER
- UPMC Cole

SOMERSET
- Chan Soon-Shiong Medical Center at Windber
- Conemaugh Meyersdale Medical Center
- UPMC Somerset

VENANGO
- UPMC Northwest

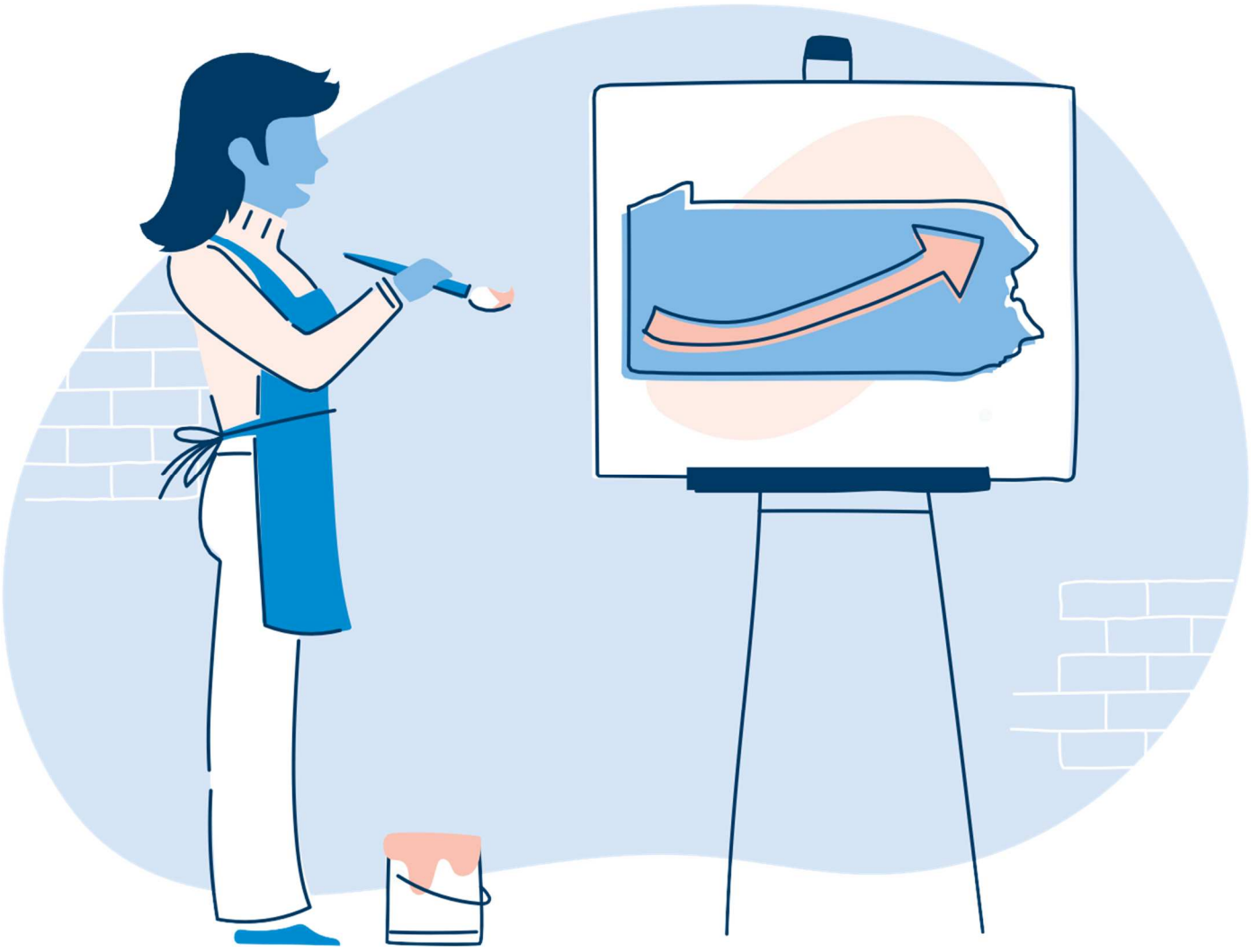
WARREN
- Warren General Hospital

WASHINGTON
- Advanced Surgical Hospital
- Canonsburg Hospital
- Monongahela Valley Hospital
- Washington Hospital

WESTMORELAND
- AHN Hempfield Neighborhood Hospital
- Excela Frick Hospital
- Excela Latrobe Hospital
- Excela Westmoreland Hospital

Lower costs and high-quality care, all across the state.

We thought you'd like the sound of that.



Performance Blue

HIGHMARK

Care all across the Keystone State.*

Talk about coverage.

Performance Blue has you covered across Pennsylvania.* That includes over 50 counties and over 100 facilities. So you're covered — no matter where you live or work in the state.

*Members have access to BlueCard® providers in Bucks, Montgomery, Philadelphia, Chester, and Delaware counties, as well as out of state.

Contents

Highlights you'll love.

Performance Blue has more than a few.

High-quality care

close to where you live and work

Nation-wide coverage

for wherever life takes you

Out-of-pocket savings

when you go to an in-network provider

That's the nutshell version.
Turn the page for more details.

How Performance Blue works.

With this plan, it will usually cost less to use in-network providers for medically necessary care. You also have access to high-quality community hospitals as well as doctors who offer all types of specialty care, from women's health to pediatrics, cancer care to neurology.

Plus, with a network this big, you can always find an in-network provider close by.

Plenty of choices

for being a Highmark Blue Cross Blue Shield member

In network

You'll have access to renowned providers including:

- Allegheny Health Network
- Conemaugh Health System
- Lehigh Valley Health Network
- Penn State Health
- WellSpan Health
- And more*

Out of network

For PPO plans, you can receive covered services from an out-of-network provider, but you'll pay the most out of pocket.

For EPO plans, there are no out-of-network benefits. The one exception is emergency care. In that case, it's always covered.

More benefits

- Routine checkups, immunizations, and a bunch of other preventive services are covered at 100%. **
- No referral? No problem. You don't need one to see a specialist.

Need help finding an in-network provider?

Just call My Care Navigator℠ at 1-888-258-3428, or visit highmarkbcbs.com and click **Find a Doctor**.

* Check the provider directory to find other in-network providers.

** Most plans cover many in-network preventive screenings with no out-of-pocket costs.

Performance Blue

With this plan, you have in-network access close to home and throughout the state at the following hospitals and facilities.*

*Members have access to BlueCard® providers in Bucks, Montgomery, Philadelphia, Chester, and Delaware counties, as well as out of state.

Performance Blue providers

ADAMS
- WellSpan Gettysburg Hospital

ALLEGHENY
- AHN Allegheny General Hospital
- AHN Allegheny Valley Hospital
- AHN Brentwood Neighborhood Hospital
- AHN Forbes Hospital
- AHN Harmar Neighborhood Hospital
- AHN Jefferson Hospital
- AHN McCandless Neighborhood Hospital
- AHN West Penn Hospital
- AHN Wexford Hospital
- Heritage Valley Kennedy
- Heritage Valley Sewickley
- St. Clair Memorial Hospital
- UPMC Children's Hospital of Pittsburgh
- UPMC Western Psychiatric Hospital

ARMSTRONG
- Armstrong County Memorial Hospital

BEAVER
- Heritage Valley Beaver

BEDFORD
- UPMC Bedford Memorial Hospital

BERKS
- Penn State Health St. Joseph
- Surgical Institute of Reading

BLAIR
- Conemaugh Nason Medical Center
- Penn Highlands Tyrone Hospital
- UPMC Altoona

BRADFORD
- Guthrie Robert Packer Hospital
- Guthrie Towanda Memorial Hospital
- Guthrie Troy Community Hospital

BUTLER
- Butler Memorial Hospital

CAMBRIA
- Conemaugh Memorial Medical Center
- Conemaugh Miners Medical Center

CARBON
- Lehigh Valley Hospital — Carbon (Opening 2022)

CENTRE
- Mount Nittany Medical Center

CLARION
- Clarion Hospital

CLEARFIELD
- Penn Highlands Clearfield
- Penn Highlands DuBois

CLINTON
- Bucktail Medical Center
- UPMC Lock Haven

COLUMBIA
- Berwick Hospital Center

CRAWFORD
- Meadville Medical Center
- Titusville Area Hospital

CUMBERLAND
- Penn State Health Hampden Medical Center
- Penn State Health Holy Spirit Medical Center

DAUPHIN
- Penn State Health Children's Hospital
- Penn State Health Milton S. Hershey Medical Center

ELK
- Penn Highlands Elk

ERIE
- AHN Saint Vincent Hospital
- Corry Memorial Hospital
- Millcreek Community Hospital

FAYETTE
- Penn Highlands Connellsville Hospital
- Uniontown Hospital

FRANKLIN
- WellSpan Chambersburg Hospital
- WellSpan Waynesboro Hospital

FULTON
- Fulton County Medical Center

GREENE
- Washington Health System Greene

But wait, that's not all.

Performance Blue providers (continued)

HUNTINGDON
- Penn Highlands Huntingdon

INDIANA
- Indiana Regional Medical Center

JEFFERSON
- Penn Highlands Brookville
- Punxsutawney Area Hospital

LACKAWANNA
- Lehigh Valley Hospital – Dickson City (Opening 2022)
- Moses Taylor Hospital
- Regional Hospital of Scranton

LANCASTER
- Lancaster General Hospital
- Lancaster General Women and Babies Hospital
- Penn State Health Lancaster Medical Center (Opening 2022)
- WellSpan Ephrata Community Hospital

LAWRENCE
- UPMC Jameson

LEBANON
- WellSpan Good Samaritan Hospital

LEHIGH
- Lehigh Valley Hospital — 17th Street
- Lehigh Valley Hospital — Cedar Crest
- Lehigh Valley Hospital — Coordinated Health Allentown

LUZERNE
- Lehigh Valley Hospital — Hazleton
- Wilkes-Barre General Hospital

LYCOMING
- Divine Providence Hospital
- Geisinger Jersey Shore Hospital
- UPMC Muncy
- UPMC Williamsport

MCKEAN
- Bradford Regional Medical Center
- UPMC Kane

MERCER
- AHN Grove City
- Edgewood Surgical Hospital
- Sharon Regional Medical Center
- UPMC Horizon

MIFFLIN
- Geisinger Lewistown Hospital

MONROE
- Lehigh Valley Hospital — Pocono

NORTHAMPTON
- Lehigh Valley Hospital — Coordinated Health Bethlehem
- Lehigh Valley Hospital — Hecktown Oaks
- Lehigh Valley Hospital — Muhlenberg

POTTER
- UPMC Cole

SCHUYLKILL
- Lehigh Valley Hospital — Schuylkill

SOMERSET
- Chan Soon-Shiong Medical Center at Windber
- Conemaugh Meyersdale Medical Center, LLC
- UPMC Somerset

Performance Blue providers (continued)

SUSQUEHANNA
- Barnes-Kasson County Hospital
- Endless Mountain Health System

TIOGA
- UPMC Wellsboro

UNION
- Evangelical Community Hospital

VENANGO
- UPMC Northwest

WARREN
- Warren General Hospital

WASHINGTON
- Advanced Surgical Hospital
- Canonsburg Hospital
- Penn Highlands Mon Valley Hospital
- The Washington Hospital

WAYNE
- Wayne Memorial Hospital

WESTMORELAND
- AHN Hempfield Neighborhood Hospital
- Excela Health Frick Hospital
- Excela Health Latrobe Hospital
- Excela Health Westmoreland Hospital

YORK
- OSS Orthopaedic Hospital
- WellSpan Surgery and Rehabilitation Hospital
- WellSpan York Hospital

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Your appointments, booked for you.

It's as simple as calling 1-888-BLUE-428. We'll help you find the in-network doctor you need and reserve some space on their calendar for a checkup. Which means less on-hold music for you.

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Personalized support for health goals.

Looking to lose weight? Quit smoking? Be more active?

Get guidance based on your lifestyle, trackers to measure your progress, and resources like Sharecare® to make healthy choices and keep you motivated.

Diagnostic Services

Accessible health care — anytime, anywhere.

When you or a loved one needs medical care — whether it's serious, routine, or somewhere in between — we want you to know you have options. Our guide can help you choose the one that's best for you.

HIGHMARK

Your care chart

Here's where to go when you need help. As you can see, the symptoms or condition you have determine your best destination for care.

Log in at **highmarkbcbs.com** and click on **Find a Doctor** to find the in-network option that's right for you.

	Telemedicine Convenient, at-home care for minor illnesses	Doctor's Office Sick visits, checkups, and care for chronic conditions	Urgent/Express Care Urgent but not life-threatening	Emergency Room (ER) Serious, life-threatening, or involving severe pain
Symptoms/conditions	Cold Flu Earaches Or other minor illnesses that don't require an office visit	Cold/sinus symptoms Stomach problems High blood pressure Behavioral health issues Other chronic conditions	Headaches/migraines Asthma/breathing conditions Flu and colds Urinary tract infections	Difficulty breathing Chest pain Uncontrolled bleeding Severe injury Stroke symptoms*
Estimated cost by comparison	Lowest	Lower	Moderate	Highest
Hours of operation	24/7	Business hours (generally)	Mornings, evenings, and weekends	24/7

Just so you know, you have a few different telemedicine options available to you. Contact your local provider or call the Member Service number on the back of your ID card to learn more.

If you believe you are having a medical emergency and you need immediate treatment, **go directly to any hospital emergency room or call 911.**

* Numbness or weakness in your face, arm, or leg, especially on one side. Confusion or trouble understanding other people. Difficulty speaking. Trouble seeing with one or both eyes. Telemedicine service availability is subject to state laws. Telemedical services are subject to the telemedicine services benefit. You may be responsible for the full cost of ineligible virtual medicine services. To determine the availability of services under your health plan, please review your Outline of Coverage for details on benefits, conditions and exclusions or call the number on the back of your ID card.

HIGHMARK

3/2021 MX502520 -

Find a PCP

Find In-Network Doctors and compare care costs.

It's easier than ever to find the care you need at the cost you want.

Log in at highmarkbcbs.com.

Select the **Find a Doctor** tab and choose **Medical**.

Search for a provider, tests, or procedure and compare costs.

Filter your search by:

Network • Location • Provider name & specialty • Common searches

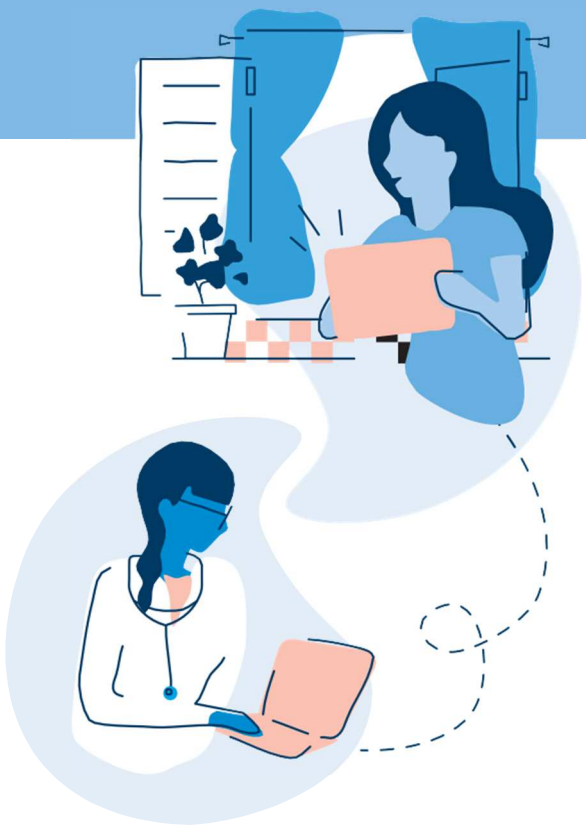
Estimate costs on:

- **Inpatient procedures**, such as C-section delivery and total knee replacement
- **Diagnostic procedures**, such as MRIs and CAT scans
- **Lab tests**, such as blood glucose and lipid panel
- **Outpatient procedures**, such as physical therapy and chiropractic treatments

HIGHMARK

Virtual Visits

Let the care come to you



Get quality care from the comfort of home with telemedicine.

With telemedicine, you have access to your doctor's office from your phone, tablet, or computer. Your doctor can treat most non-emergency illnesses and, in some cases, they can even prescribe medications. Pretty great, right? That's not all. Take a look:

Perks of telemedicine

- **It's safe.** No more sitting elbow-to-elbow in waiting rooms.
- **It's affordable.** A telemedicine visit will likely cost the same as a normal visit to the doctor.
- **It's convenient.** Save yourself a trip to the doctor's office and chat with your provider from the comfort of your couch.
- **It's accessible.** You can receive care from just about anywhere via video or phone.
- **It's versatile.** From a bad case of the sniffles to the seasonal flu, telemedicine can treat a variety of non-emergency health conditions.

HIGHMARK

Virtual Visits

Your telemedicine options

We want you to receive care in a way that's convenient and comfortable for you, which is why we give you access to telemedicine through your doctor's office or through a vendor. Though both of these options could work for you, there are specific perks to each that you may want to consider.

Telemedicine through your doctor's office

- You'll be chatting with someone you already know, which is sure to put your mind at ease.
- Your doctor is familiar with your medical history, which means your condition may be easier to diagnose.
- You can replace simple in-office follow-ups with your doctor with a convenient and quick telehealth appointment.
- Keep in mind that telemedicine may not be available to you, so make sure to check with your health care provider.

Telemedicine through a vendor

- When you use a vendor such as American Well (AmWell for short), you have access — day or night, seven days a week — to U.S. licensed, board-certified doctors.
- Setting up a telehealth appointment is quick and only takes a few steps.

How to get started with telemedicine

Contact your doctor to learn about the telemedicine options that are available to you.

If your doctor's office doesn't offer telemedicine services, **visit AmWell.com** and create an account using your member ID card.

From there, you'll be on your way to more convenient and comfortable care.

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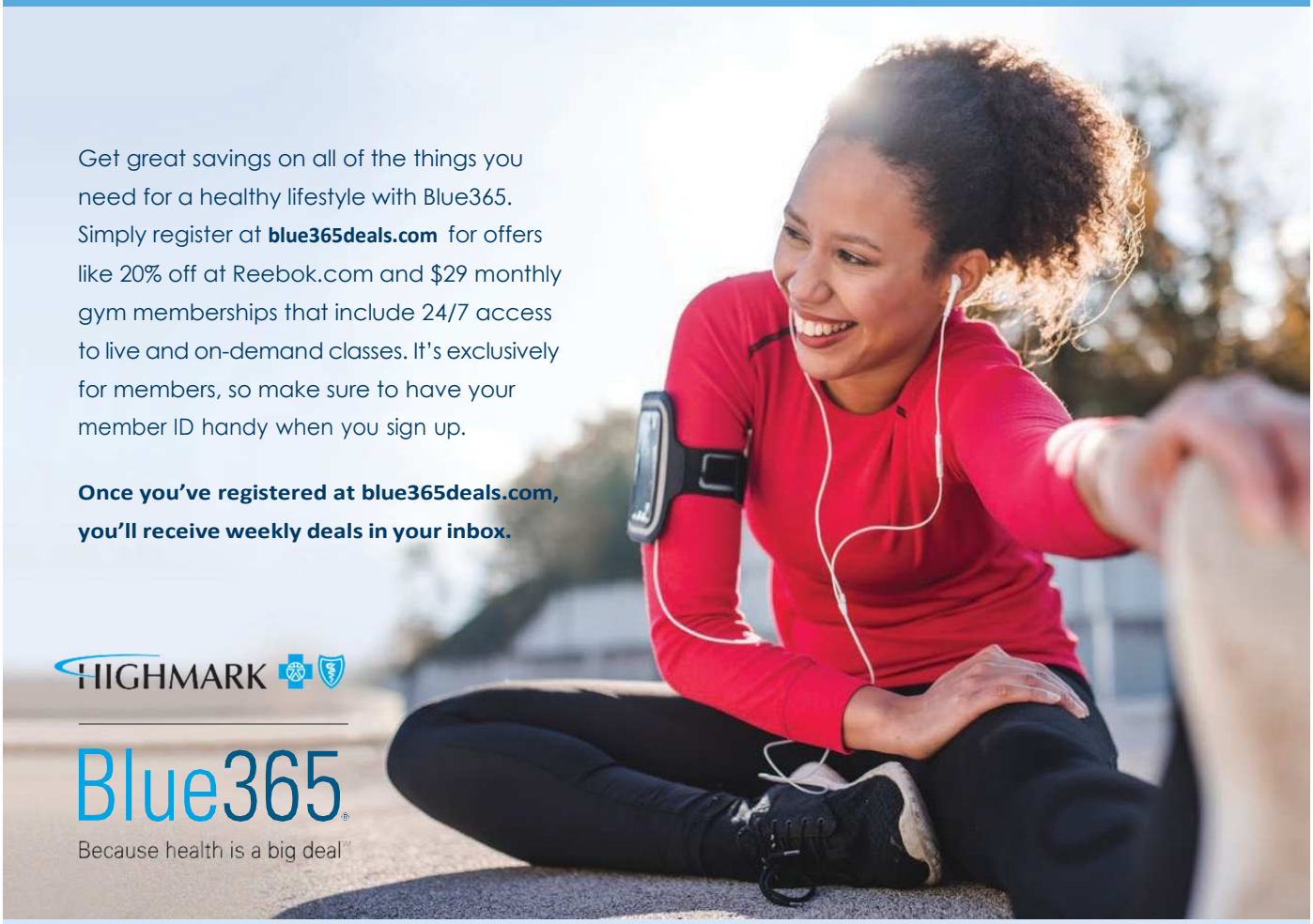

Get great savings on all of the things you need for a healthy lifestyle with Blue365. Simply register at **blue365deals.com** for offers like 20% off at Reebok.com and $29 monthly gym memberships that include 24/7 access to live and on-demand classes. It's exclusively for members, so make sure to have your member ID handy when you sign up.

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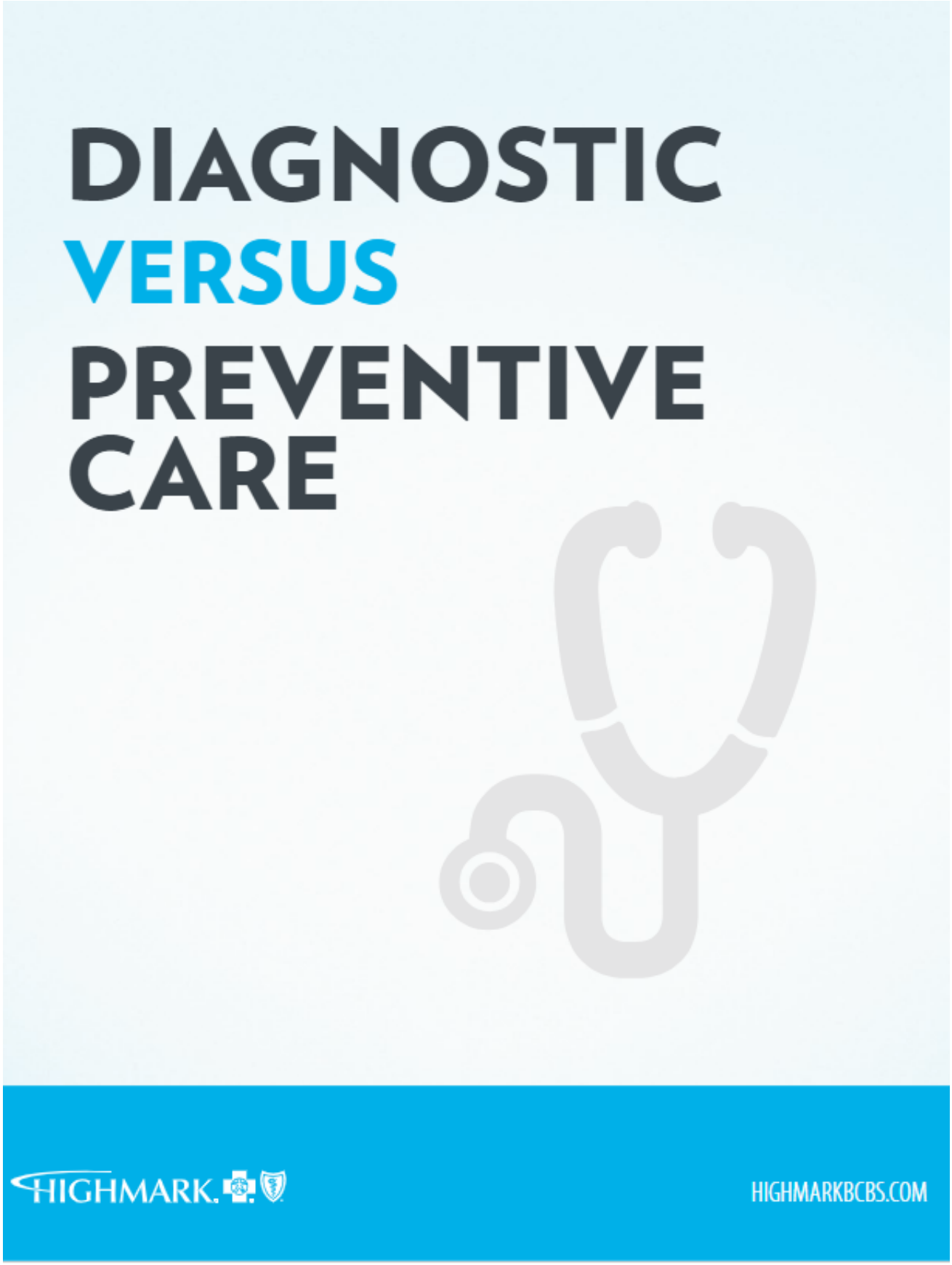
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How Can I Pay Two Different Amounts for the Same Procedure?

YOUR BENEFIT PAYMENT DEPENDS ON HOW YOUR DOCTOR CODES YOUR PROCEDURE

Preventive care, or routine care, is typically covered at 100%. Diagnostic tests — screenings performed for treating or diagnosing a medical condition — are typically covered at your plan's standard benefit level.

WHAT'S THE DIFFERENCE?

In general, the reason for the exam. When you see a doctor for routine care, you would not have symptoms or a previous medical history that would require the doctor to perform the procedure(s). When you receive diagnostic care, the doctor is performing the procedure(s) to find out what is wrong with you or to treat your condition.

QUESTIONS?

If you or your doctor have questions about the administration of the care as listed on the schedule, please call Member Service at the number listed on the back of your ID card.

TO ACCESS THE BLUE CROSS BLUE SHIELD PREVENTIVE SCHEDULE ON OUR WEBSITE:

Log on to **highmarkbcbs.com** (If you do not have a login ID, you'll need to click on the "Register Now" link). Click on the "Health & Wellness," "Healthy Living" and "Prevention" links. You can also call Member Service for a copy of the schedule.

If you are a 50-year-old male, you should have the following preventive care:

- ❑ Routine physical exam
- ❑ Colorectal cancer screening
- ❑ Cholesterol screening

If you are a 40-year-old female, you should have the following preventive care:

- ❑ Routine physical exam
- ❑ Pap test
- ❑ Mammogram
- ❑ Pelvic exam

If you are a 50-year-old female, you should have the following preventive care:

- ❑ Routine physical exam
- ❑ Colorectal cancer screening
- ❑ Pap test
- ❑ Mammogram
- ❑ Cholesterol screening

SEE THE FOLLOWING EXAMPLES:

John, Janice, and Judy have procedures performed by their network physicians. All three have the same PPO plan. However, they pay different amounts for their care because John is receiving preventive care, Janice is receiving diagnostic care, and Judy is receiving both.

John	Janice	Judy
Reason for exam: John turned 40 and figured he should have an annual exam and "once over" to see how his health is.	Reason for exam: Janice is a diabetic and is recovering from a near heart attack. The doctor put her on a strict diet and exercise regime and wants to perform follow-up tests to measure her improvement.	Reason for exam: Judy needs to follow up with her doctor to see if the cholesterol-reducing medication is working. While there, she decides to take care of her routine physical and get a flu shot, because flu season is coming.
Procedures performed: • Physical Exam • Blood Pressure • Cholesterol Screening • Lipid Panel • Fasting Blood Glucose • Urinalysis	Procedures performed: • Physical Exam • Blood Pressure • Cholesterol Screening • Lipid Panel • Fasting Blood Glucose • Urinalysis	Procedures performed: • Lipid Panel • Physical Exam • Flu Shot • Urinalysis
Doctor codes and submits as: Routine	Doctor codes and submits as: Diagnostic	Doctor codes and submits as: Some procedures as diagnostic, some as routine.
Benefit payment: All of these procedures are covered at 100%.	Benefit payment: All of these procedures and office visits are covered at the standard benefit level.	Benefit payment: Procedures billed as routine will be covered at 100%. Procedures billed as diagnostic will be covered at

What Preventive Care Do I Have Coverage For?

The Blue Cross Blue Shield Preventive Schedule is a list of general care guidelines. We encourage you to take a copy of the schedule with you when you or a family member visits their medical provider.

The schedule includes tests that are performed for both routine and diagnostic reasons. If you are seeing your doctor and have not been diagnosed with a medical condition, you should expect the services to be performed for routine/preventive care and covered at 100%, not subject to deductible or coinsurance. Only those procedures that are listed on the Preventive Schedule are covered at 100% with no deductible during a preventive exam. If your doctor orders other tests, those tests may be subject to your deductible and/or coinsurance, or they may be denied in certain instances. If you have a medical condition and the tests are being done to monitor the condition, then the services would be performed for diagnostic reasons and subject to your program's deductible and coinsurance.

Sample of Preventive Benefits

Benefits for adults	When submitted by your doctor as routine	When submitted by your doctor as diagnostic
Routine physical exams	100%	standard plan payment level
Routine gynecological exams, including a Pap Test	100%	standard plan payment level
Mammograms, as required*	100%	standard plan payment level
Colorectal Cancer Screening*	100%	standard plan payment level

Insurance carriers may differ in their preventive care schedules. If you or your doctor has questions about the administration of the care as listed on the schedule, please call Member Service at the number listed on the back of your ID card.

* See the Preventive Schedule for specific procedures and risk factors.

2024 Preventive Schedule

Effective 1/1/2024

Plan your care: Know what you need and when to get it

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. The preventive guidelines on this schedule depend on your age, gender, health, and family history. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. Make sure you know what is covered by your health plan and any requirements before you receive any of these services.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for you. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

Questions?

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

Adults: Ages 19+

Female Male

GENERAL HEALTH CARE	
Routine Checkup* (This exam is not the work- or school-related physical)	• Ages 19 to 49: Every 1 to 2 years • Ages 50 and older: Once a year
Depression Screening and Anxiety Screening	Once a year
Illicit Drug Use Screening	Once a year
Pelvic, Breast Exam	Once a year
SCREENINGS/PROCEDURES	
Abdominal Aortic Aneurysm Screening	Ages 65 to 75 who have ever smoked: One-time screening
Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
Cholesterol (Lipid) Screening	• Ages 20 and older: Once every 5 years • High-risk: More often
Colon Cancer Screening (Including Colonoscopy)	• Ages 45 and older: Every 1 to 10 years, depending on screening test • High-risk: Earlier or more frequently
Colon Cancer Screening	Ages 45 and older: Colonoscopy following a positive result obtained within 1 year by other mandated screening method
Certain Colonoscopy Preps With Prescription	• Ages 45 and older: Once every 10 years • High-risk: Earlier or more frequently
Diabetes Screening	High-risk: Ages 40 and older, once every 3 years
Hepatitis B Screening	High-risk

* Routine checkup could include health history; physical; height, weight, and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer, and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; age-appropriate guidance, and intimate partner violence screening and counseling for reproductive age women.

* USPSTF mandated Routine Labs

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Adults: Ages 19+

SCREENINGS/PROCEDURES	
Hepatitis C Screening	Ages 18 to 79
Latent Tuberculosis Screening	High-risk
Lung Cancer Screening (Requires prior authorization and use of authorized facility)	Ages 50 to 80 with 20-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
Mammogram	Ages 40 and older: Once a year including 3D. Screening follow up MRI or Ultrasound per doctor's recommendations.
Osteoporosis (Bone Mineral Density) Screening	Ages 65 and older: Once every 2 years, or younger if at risk as recommended by physician
Cervical Cancer Screening	• Ages 21 to 65 Pap: Every 3 years, or annually, per doctor's advice • Ages 30 to 65: Every 5 years if HPV only or combined Pap and HPV are negative • Ages 65 and older: Per doctor's advice
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	• Sexually active males and females • HIV screening for adults to age 65 in the general population and those at risk, then screening over age 65 with risk factors
IMMUNIZATIONS**	
Chicken Pox (Varicella)	Adults with no history of chicken pox: One 2-dose series
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines
Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
Flu (Influenza)	Every year (Must get at your PCP's office or designated pharmacy vaccination provider; call Member Service to verify that your vaccination provider is in the Highmark network)
Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia, and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
Hepatitis A	At-risk or per doctor's advice: One 2, 3 or 4-dose series
Hepatitis B	• Ages 19–59: 2 to 4 doses per doctor's advice • Ages 60 and older: High-risk per doctor's advice
Human Papillomavirus (HPV)	• To age 26: One 3-dose series • Ages 27 to 45, at-risk or per doctor's advice
Measles, Mumps, Rubella (MMR)	One or two doses
Meningitis*	At-risk or per doctor's advice
Pneumonia	High-risk or ages 65 and older: One or two doses, per lifetime
Shingles	• Shingrix - Ages 50 and older: Two doses • Ages 19 to 49: Immunocompromised per doctor's advice

* Meningococcal B vaccine per doctor's advice.

** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION	
Aspirin	Pregnant women at risk for preeclampsia
Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase* inhibitor**	At risk for breast cancer, without a cancer diagnosis, ages 35 and older
Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
Low to Moderate Dose Select Generic Statin Drugs for Prevention of Cardiovascular Disease (CVD)	Ages 40 to 75 years with 1 or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
Select PrEP Drugs and Certain Related Services for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis

PREVENTIVE CARE FOR PREGNANT WOMEN		
Screenings and Procedures	• Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum	• Rh typing at first visit • Rh antibody testing for Rh-negative women • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling • Nutritional counseling for pregnant women to promote healthy weight during the pregnancy

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE		
Adults with BMI 25 to 29.9 (overweight) and 30 to 39.9 (obese) are eligible for:	• Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity	• Recommended lab tests: – ALT – AST – Hemoglobin A1C or fasting glucose – Cholesterol screening
Adults with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling	
Adults with BMI 40 and over	Nutritional counseling and fasting glucose screening	

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

*** Aromatase inhibitors when the other drugs can't be used such as when there is a contraindication or they are not tolerated.

2024 Preventive Schedule

Plan your child's care:
Know what your child needs and when to get it

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

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

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations, depends on what the doctor thinks is right for your child.

Questions?

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

Children: Birth to 30 Months[1]

GENERAL HEALTH CARE	BIRTH	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Routine Checkup* (This exam is not the preschool- or day care-related physical.)	•	•	•	•	•	•	•	•	•	•	•
Hearing Screening	•										
SCREENINGS											
Autism Screening									•	•	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	•										
Developmental Screening						•			•		•
Hematocrit or Hemoglobin Anemia Screening							•				
Lead Screening**							•			•	
Newborn Blood Screening and Bilirubin	•										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines										
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)***					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

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

*** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years[1]

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	•	•	•	•	•	•	•	•	Once a year from ages 11 to 18			
Ambulatory Blood Pressure Monitoring**												•
Depression Screening										Once a year from ages 12 to 18		
Illicit Drug Use Screening												•
Hearing Screening***		•	•	•		•		•		•	•	•
Visual Screening***	•	•	•	•		•		•		•	•	
SCREENINGS												
Hematocrit or Hemoglobin Anemia Screening	Annually for females during adolescence and when indicated											
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9 to 11 and ages 17 to 21					
IMMUNIZATIONS												
Chicken Pox		Dose 2								If not previously vaccinated: Dose 1 and 2 (4 weeks apart)		
COVID-19 Vaccine	Per doctor's advice following CDC and Emergency Use Authorization Guidelines											
Dengue Vaccine							9–16 years living in dengue endemic areas in U.S. Territories AND have laboratory confirmation of previous dengue infection					
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5							One dose Tdap			
Flu (Influenza)****	Ages 3 to 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9 to 14. 3 doses, all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment.

** To confirm new diagnosis of high blood pressure before starting treatment.

*** Hearing screening once between ages 11-14, 15-17, and 18-21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4, and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit.

**** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

*****Meningococcal B vaccine per doctor's advice.

CARE FOR PATIENTS WITH RISK FACTORS			
BRCA Mutation Screening (Requires prior authorization)	Per doctor's advice		
Cholesterol Screening	Screening will be done based on the child's family history and risk factors		
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger		
Hepatitis B Screening		Per doctor's advice	
Hepatitis C Screening			•
Latent Tuberculosis Screening			High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)		For all sexually active individuals HIV routine check, once between ages 15 to 18	
Tuberculin Test	Per doctor's advice		

Children: 6 Months to 18 Years[1]

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

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE	
Children with a BMI in the 85th to 94th percentile (overweight) and the 95th to 98th percentile (obese) are eligible for:	• Additional annual preventive office visits specifically for obesity • Additional nutritional counseling visits specifically for obesity • Recommended lab tests: – Alanine aminotransferase (ALT) – Aspartate aminotransferase (AST) – Hemoglobin A1c or fasting glucose (FBS) – Cholesterol screening
Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome	Nutritional counseling

ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18	
Applies to Adults • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140-199mg/dl	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss

Women's Health Preventive Schedule

SERVICES	
Well-Woman Visits (Includes: preconception and first prenatal visit, urinary incontinence screening)	Up to 4 visits each year for developmentally and age-appropriate preventive services
Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy
SCREENINGS/PROCEDURES	
Diabetes Screening	• Screen for diabetes in pregnancy at 1st prenatal visit or at weeks 24-28 and after pregnancy in women with a history of diabetes
HIV Screening and Discussion	• All sexually active women: Once a year • Ages 15 and older, receive a screening test for HIV at least once during their lifetime • Risk assessment and prevention education for HIV infection beginning at age 13 • Screen for HIV in all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every 3 years
Domestic and Intimate Partner Violence Screening and Counseling	Once a year
Breast-feeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year
Screening for Anxiety	The Women's Preventive Services Initiative recommends screening for anxiety in adolescent girls and adult women, including those who are pregnant or postpartum.
Nutritional Counseling	Ages 40–60 with normal BMI and overweight BMI

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One or more forms of contraception in each of the 18 FDA-approved methods, as well as any particular service or FDA approved, cleared or granted contraceptive product that an individual's provider determines is medically appropriate, are covered without cost sharing. Exception Process: Your provider may request an exception for use of a prescribed nonformulary contraception drug due to medical necessity by completing the online request form. When approved, the prescribed drug will then be made available to you with zero-dollar cost share. [https://hbs.highmarkprc.com/Forms/Pharmacy-Prior-Authorization-Forms]Only FDA approved contraception apps, which are not part of the 18 method categories, and are available for download to a cell phone are reimbursable through the paper claim process with a prescription. Members need to submit three documents to obtain reimbursement; 1) completed the paper Claim Form: [https://www.highmarkbs.com/redesign/pdfs/mhs/Medical_Claim_Form.pdf] Under section DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – write "contraception app purchase" 2) receipt of payment for the FDA approved contraception app, 3) provider prescription for the FDA approved contraception app.

Information About the Affordable Care Act (ACA)

This schedule is a reference tool for planning your family's preventive care, and lists items and services required under the Affordable Care Act (ACA), as amended. It is reviewed and updated periodically based on the advice of the U.S. Preventive Services Task Force, laws and regulations, and updates to clinical guidelines established by national medical organizations. Accordingly, the content of this schedule is subject to change. Your specific needs for preventive services may vary according to your personal risk factors. Your doctor is always your best resource for determining if you're at increased risk for a condition. Some services may require prior authorization. If you have questions about this schedule, prior authorizations, or your benefit coverage, please call the Member Service number on the back of your member ID card.

Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.

Discrimination is Against the Law

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

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

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

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

[1]Information About Children's Health Insurance Program (CHIP)

Because the Children's Health Insurance Program (CHIP) is a government-sponsored program and not subject to ACA, certain preventive benefits may not apply to CHIP members and/or may be subject to copayments.

The ACA authorizes coverage for certain additional preventive care services. These services do not apply to "grandfathered" plans. These plans were established before March 23, 2010, and have not changed their benefit structure. If your health coverage is a grandfathered plan, you would have received notice of this in your benefit materials.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

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

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

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

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

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

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

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

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

HIGHMARK.

Because Life.™

Welcome to Sword

Your virtual physical care solution.

Get expert guidance at your fingertips with Sword.

Combining personalized support with the latest digital tools, Sword gives you the freedom to help overcome joint and muscle pain anytime, anywhere.

Sword can help relieve:

- Back pain.
- Elbow pain.
- Shoulder pain.
- Hip pain.
- Neck pain.
- Ankle pain.
- Knee pain.

Here's how it works:

Using a tablet and motion sensors that track and guide your movement, you're matched with a physical therapist who creates a customized, self-guided care plan, then monitors your progress while providing ongoing support.

Sword may also help you avoid surgery or reduce your need for medication.

To enroll online, scan this QR code with your phone.

The best part?

It's included in your health care plan at no cost to you.

sword

Mental health support that's exactly the right fit.

Starting in your new plan year, you'll have access to **Mental Well-Being,** powered by Spring Health. This mental health care option can help you or your family get the right care, right away, and make room for a brighter future. And it's all available on our app and website.

Mental Well-Being gives you the support you want.

Personalized care

Take a quick assessment that screens for different mental health conditions. Then you'll get a personalized care plan matched to your needs.

Care navigators

They can walk you through care plans for you or your child, help you find a therapist, and provide other support when you need it.

Fast access

You'll typically see a high-quality provider, in person or virtually, within five days or less. Treatment is available for everyone ages 6 and up.

Certified coaches

Build better habits, navigate life transitions, and improve communication skills with help from a coach. They can help you set and achieve goals, too.

Provider visits

Book therapy and medication management appointments in real time. Plus, you'll have a diverse national network of therapists to choose from.

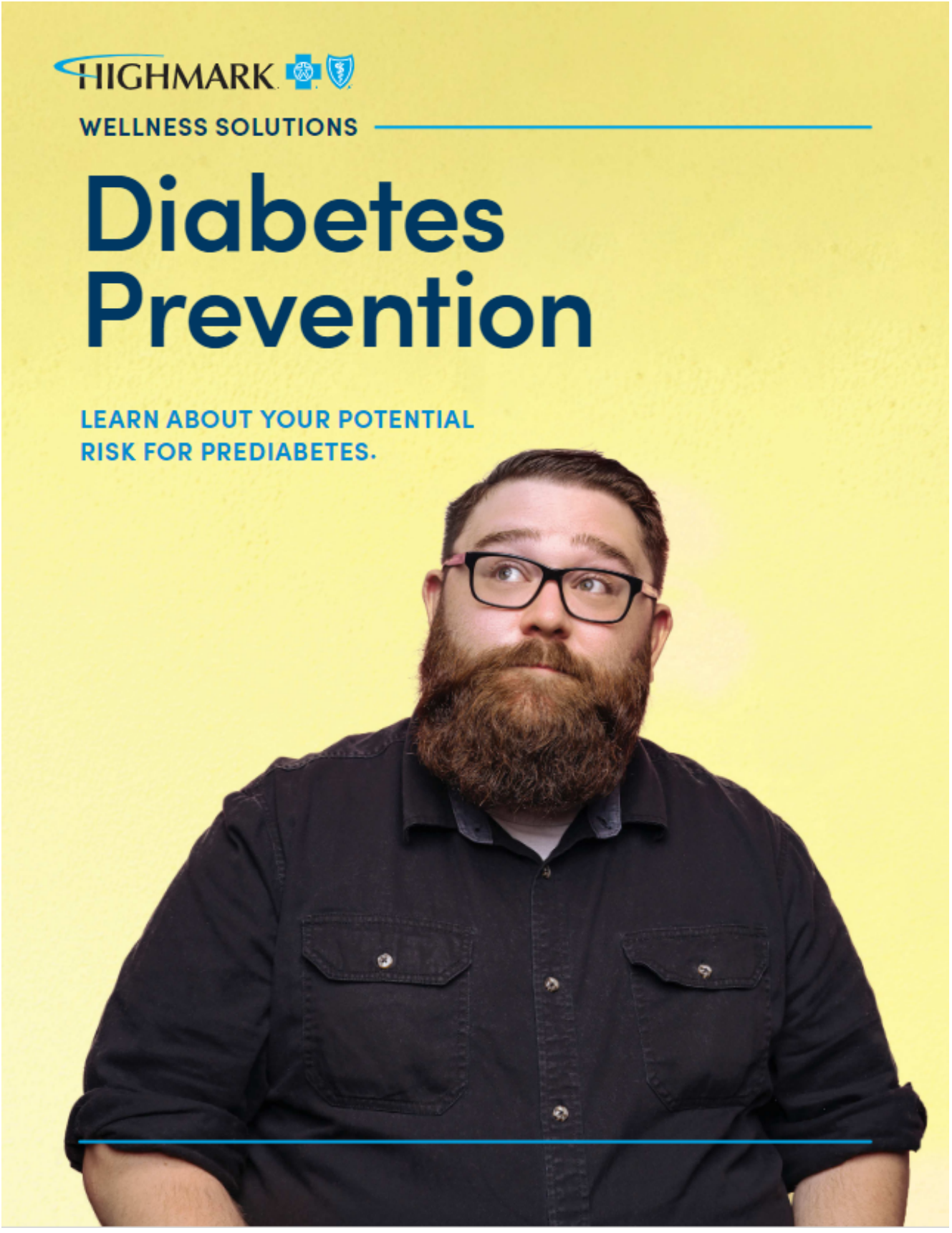
Digital exercises

These self-guided exercises can help you manage stress, calm anxiety, and improve sleep. Plus, they're available whenever you want.

HIGHMARK.

Because Life.™

Look for more details when your plan year starts.


HIGHMARK
WELLNESS SOLUTIONS
Diabetes Prevention
LEARN ABOUT YOUR POTENTIAL RISK FOR PREDIABETES.

Prediabetes is a reversible condition that affects millions of people — many of whom don't realize they have it.

Having prediabetes means your blood sugar levels are higher than normal, which can lead to type 2 diabetes. The good news is that it's reversible if discovered and managed early in your care.

To help you determine your risk, take our brief online questionnaire. We also offer these programs that provide support:

Online/mobile access

- Livongo® for prediabetes – gain access to digital tools and mobile access to a live coach and a community of support
- Case Specific Nutrition™ – virtual nutrition and online support programs

Log into highmarkbcbs.com and click on Diabetes Prevention to learn more.

And more. It's all included with your health insurance.

The Diabetes Prevention program is offered to members who screen positive for prediabetes and is covered if it is included as part of your health plan's preventive schedule.

Livongo is an independent company that provides a diabetes management program on behalf of Highmark.

Health benefits or health benefit administration may be provided by or through Highmark Blue Cross Blue Shield, Highmark Choice Company, First Priority Health or First Priority Life, all of which are independent licensees of the Blue Cross Blue Shield Association.

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.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

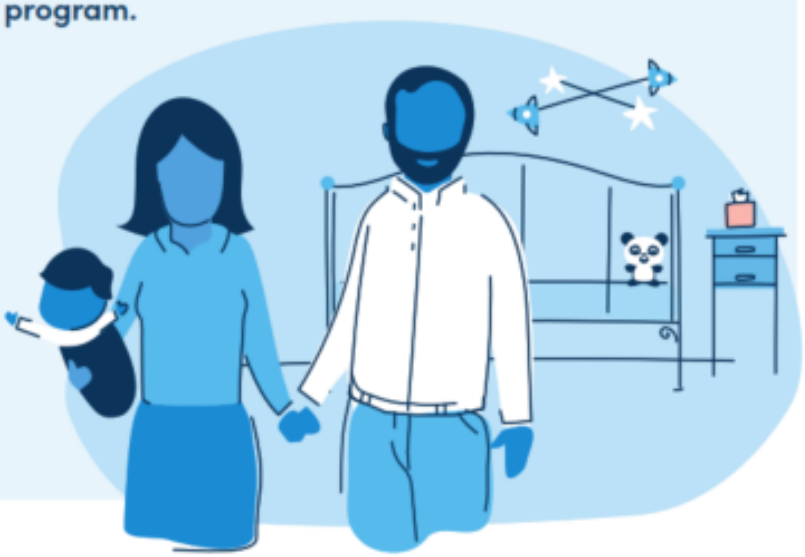
请注意：如果您说中文，可向您提供免费语言协助服务。请拨打您的身份证背面的号码（TTY：711）。

HIGHMARK

10/2021 MX830246MCC

Earn points for your family's education.

Enroll in the College Tuition Benefit Program (CTB), a rewards program offered through Highmark. If you have Highmark medical or dental coverage, you can automatically earn tuition reward points that can be converted into college tuition dollars with this program.



How it works

The College Tuition Benefit (CTB) works a lot like a scholarship program. Once you subscribe, you earn tuition reward points that can reduce your tuition obligations. Every tuition point equals $1 of tuition at one of over 400 participating private colleges and universities across the country. All you have to do to earn points is enroll in the program and keep your Highmark coverage.

One tuition reward point = **One dollar of college tuition**

HIGHMARK.

Dollars that add up

Just for being enrolled in an eligible Highmark medical or Blue Edge Dental plan, you can earn up to 2,000 Tuition Reward points per product automatically each year. If you enroll in more eligible plans, you can earn more points. And all of those points are tracked for you.

Who are we saving for?

Short answer: pretty much anyone in your family — children, nephews, nieces, grandchildren, stepchildren, god children, and more can all receive points. There's no limit to how many points you earn, and they never expire.

To see a list of participating schools and get more information on this program, visit TuitionRewards.com.

HIGHMARK.

VOLUNTARY BENEFITS

Voluntary Benefits for 2024

Voluntary benefits for 2024

Colonial Life

Medical Bridge

- Helps pay for your inpatient hospital deductible
- Will pay $500 or $1000 for each family member per one hospitalization per year
- Pays $250 for diagnostic testing and pays $1,500 for outpatient surgery per calendar year per family member
- Emergency room benefit of $150 per calendar year per family member

Critical Illness

- Helps maintain financial security during the lengthy, expensive recovery period of a critical illness
- Provides a lump sum benefit to help with the out-of-pocket expenses (employee amounts range from $10,000 to $50,000). **Premiums never increase!**
- **Subsequent Diagnosis-** a covered person received a benefit and is later diagnosed with a **different or same condition** this plan will pay 25% of face amount up to maximum benefit amount payable
- ***Includes $50 wellness/health screening benefit once per year per covered illness***

Disability Insurance

- Helps you pay everyday living expenses and out-of-pocket expenses due to loss of income
- Provides a monthly benefit to replace a portion of your income if you're unable to work due to a covered disability
- Variety of plan options available which includes maternity leave (6 and 12 month benefit periods)
- **Colonial Life disability pays in addition to your sick days**

Cancer Insurance

- Help pay out-of-pocket expenses not covered by health insurance plans
- Includes initial diagnosis benefit of $5,000, treatment, inpatient care, transportation, lodging, experimental treatment, and much more
- ***Pays $100 wellness benefit once per year per covered insured***

Accident Insurance

- Helps pay unexpected medical expenses from broken bones, lacerations and many other injuries
- Helps pay major medical deductibles and copayments if you're confined to a hospital from a covered accident
- **Pays $50 wellness benefit once per year per covered insured**

Life Insurance

- Annual opportunity to obtain additional life insurance above and beyond the county's group plan. This can be taken with you when you retire or change jobs. Keep in mind – your county provided life insurance will stay behind when you retire.
- **Whole Life is offered at a Guaranteed Issued basis regardless of past or current health issues**
- **Term Life offers coverage for 10, 20, or 30 years depending on the option picked**

***Premiums will vary based on employee preferences**

Please watch for Colonial Life reps to visit your work location.
For more information, please contact:
Alex Pihakis 724-575-0839 or alex.pihakis@coloniallifesales.com

All COVID-19 related office visits, illnesses, and treatments will be covered under all colonial products as normal

PLEASE NOTE: All Colonial Life benefits are independent and in addition to your County provided group benefits.

457(b) Deferred Compensation Plan

VOYA FINANCIAL

Many of you are aware of the advantages of deferred compensation plans. Available through payroll deduction, your deferred compensation plan is an excellent way to invest for retirement on a tax-deferred basis.

Washington County is continuing to offer a benefit for employees participating in Voya Financials 457 Savings Plan - Tuition Rewards from SAGE Scholars. There's **no charge** to participate and Tuition Reward points can be used for discounts off the "list price" of tuition at 225+ participating private U.S. colleges & universities. All participants earn Tuition Rewards based on their annual year ending account balances.

Please call Greg Jacobs, Voya Financial Consultant, at 412-967-2608 or email his assistant, Holly Kozer, at holly.kozer@voyafa.com if you are interested in scheduling a meeting time or if you are unable to meet with him on the scheduled date, but would like to speak with him.

Understanding your employer's plan

This information is not intended as tax advice. It is provided for your education only by Voya Financial®. For more information about the Voya companies, please contact your local office or representative.

Were you aware that the benefits available to you as a participant in a 457(b) deferred compensation plan have increased in recent years? Time passes quickly and, as your life changes, it is often difficult to keep track of all the benefits available – and how changes can affect you.

If you want to save more, you can save up to the plan's maximum annual contribution amount. If you wish you had started saving earlier, you may be able to "catch-up." Are you at least age 50? If so, you can contribute an additional amount over the regular contribution limits.

How do you know if you're taking full

Feature	What it means to you
Annual contribution amount	• Maximum annual contribution amount is shown below (or 100% of includible compensation, if less): Year: 2019 — Annual Maximum: $19,000 • Annual limit is not reduced for contributions you make to other plans (e.g., deferrals to a 403(b) or 401(k) plan). *Note: Includible compensation does not include pre-tax 414(h) contributions.*
Ability to catch-up	• The current catch-up provision, available during the three consecutive years prior to normal retirement age (as defined in your 457(b) plan), is shown below. The actual amount available under this catch-up will depend on the amount of your prior contributions to the 457 plan and (before 2002) to certain other retirement plans. Contact your local representative for additional information. Year: 2019 — Annual Maximum: up to $38,000 • Participants who are at least age 50 can contribute an additional amount over the regular annual limit, as follows: Year: 2019 — Annual Maximum: $6,000 *Note: Participants cannot use both catch-up provisions during the same year and must use the catch-up provision which gives the greater amount.*

457(b) Deferred Compensation Plan

Are you aware of the features available to you?

Your employer's 457(b) deferred compensation plan offers something for everyone. If you want more information on the options available to you, please contact your local representative.

Feature	What it means to you
Portability *You may wish to compare your options for differences in cost, benefits, charges and other important features before you roll over assets. You may want to consult your legal or tax advisors.*	• At retirement or severance from employment, rollovers to/from traditiona IRAs, 403(b), 401 and governmental 457(b) plans are permitted. Rollovers to a Roth IRA are also available. • Amounts rolled from a governmental 457(b) plan to a different plan type are subject to the IRS 10% premature distribution penalty tax when subsequently distributed from that other plan prior to the participant reaching age 59½ (unless another IRS exception applies). • Amounts rolled over from non-457(b) plans to a governmental 457(b) plan are subject to any applicable IRS 10% premature distribution penalty tax (unless an IRS exception applies) when distributed from that governmental 457(b) plan.
Election and distribution treatment	• There is no requirement to make a benefit payment election when you retire or sever employment if you are not yet age 70½. • Your benefit payment election is not required to be irrevocable. *Note: Some annuity options may be irrevocable. You should consider the tax consequences of your election, including required minimum distributions. Voya does not offer tax or legal advice. Seek the advice of a tax attorney or of a tax advisor prior to making a tax-related*
Tax treatment in the event of divorce	• Amounts awarded and paid to a former spouse as a result of a qualified domestic relations order are taxable to that former spouse. • The qualified domestic relations order can permit amounts to be paid to a participant's former spouse prior to the time that the participant is entitled to a plan distribution.
Ability to buy back service governmental employer's benefit plan	• Amounts accumulated under a governmental 457(b) plan can **under** be transferred tax-free to an employer's governmental defined **Defined** benefit plan to buy service credits. • Amounts used will not be taxable in the year transferred.
Tax credit for low- and middle-income participants	• This credit will be a percentage of contributions, up to $2,000. • Participant's adjusted gross income (AGI) and income tax filing status determines credit. • For 2019, AGI must not exceed $64,000 for joint filers; AGI must not exceed $32,000 for single filers.

USI Mobile App

MyBenefits2GO

Free Benefits App for iPhone & Android

You and your enrolled dependents can access benefit summaries and other important information about our group plans using MyBenefits2GO. View up-to-date plan information, store photos of ID cards, and easily locate carrier and HR contact information—all in one place.

Benefit Resource Center

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance.
Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution
- Medicare basics with your employer plan
- Coordination of benefits
- Finding in-network providers
- Access to care issues
- Obtaining case management services
- Group disability claims
- Filing claims for out-of-network services

Benefit Resource Center

BRCEast@usi.com | Toll Free: 855-874-6699

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

Tobacco Fact Sheet

County of Washington

Tobacco Awareness

Quitting smoking reduces your chances of getting cancer, heart disease, a stroke, emphysema, and other serious diseases. Quitting also lowers the risk of heart disease and lung cancer in nonsmokers exposed to your secondhand smoke.

Although there are benefits to quitting at any age, it's important to quit as soon as possible so your body can begin to heal from the damage caused by smoking. For instance, 12 hours after you quit smoking the carbon monoxide level in your blood drops to normal. Carbon monoxide is harmful because it deprives your heart, brain, and other vital organs of oxygen.

Are e-cigarettes less harmful than regular cigarettes?

While it's true that e-cigarette aerosol generally contains fewer toxic chemicals than the deadly mix of 7,000 chemicals in smoke from regular cigarettes, it does not mean that e-cigarettes are safe. E-cigarette vapor can contain harmful substances, including nicotine, heavy metals like lead, volatile organic compounds, and cancer-causing agents. E-cigarettes have recently been linked to thousands of cases of serious lung injury some resulting in death.

Help to Quit Smoking

Talk to your doctor about resources, strategies and nicotine replacement therapy. Utilize counseling and technology resources.

Call the Tobacco Quit Line

1-800-QUIT-NOW
Trained coaches in every state

National Cancer Institute (NCI) LiveHelp Service

Trained counselors provide free information and support for quitting in English and Spanish

877-44U-QUIT
877- 448-7848

Quit With a Free App

Download QUITGUIDE

- Track cravings by time and location
- Identify triggers and strategies to help you deal with them
- Cope with stress and bad moods
- Monitor your progress

Sources: 1. https://www.fda.gov/consumers/consumer-updates/want-quit-smoking-fda-approved-products-can-help 2. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/pdfs/Electronic-Cigarettes-Infographic-p.pdf 3. https://www.heart.org/en/healthy-living/healthy-lifestyle/quit-smoking-tobacco/is-vaping-safer-than-smoking
4.https://smokefree.gov/everytrycounts/

Employee Access Center

EMPLOYEE ACCESS CENTER

Log in by using the link below.

http://chseac/EAC51 /Login.aspx

If attempting to log-on while not on a county connection, use this link.

https://washcoeac.washcopa.org/EAC51/Login.aspx

Username is your **employee number** (assigned to you - also ID# in Kronos).

Password will be the **last four (4) digits of your Social Security Number.**

Please contact Payroll at x6800 or HR at x6738 with any questions or discrepancies.

Employee Assistance Program (through Washington County)

Washington EAP SERVICES

Instructions to access to EAP services via App, website, or telephone

Telephone:	For EAP Counseling Services: 1-800-EAP-LINK For Work-Life Services: 1-877-337-9553
Website:	1. From the internet, go to www.washingtoneapservices.com 2. Click "Work-Life" in the top right corner 3. Enter your company code: wc
App Directions:	This App will enable you to schedule an EAP appointment and access Work-Life services. 1. Go to either an iPhone or Android App store 2. Search for "washington eap ", then hit enter 3. Open our Icon when it appears, then follow instructions to download 4. Once installed you will be able to schedule an appointment by phone or by completing the "Appointment Request" form **Work-Life Services with the App** 1. Go to Work-Life on the App's menu 2. Enter your Work-Life login - "wceap" 3. Enter your password - "washeap". 4. To speak with a Work-Life Consultant about financial, legal, childcare, eldercare, nutrition, and fitness issues or for general information, press "Work-Life Consultation". 5. To reach the Work-Life website, open Work-Life Portal (your login is "wc").

Fitness Club

County Employees Fitness Club List

Listed below are facilities that have made special arrangements with our Wellness Committee to offer reduced fees for their services.

Name	Phone Number	Contact Name	Initiation Fee	Monthly Fee	Payroll Deduction	Column1	Column2
Anytime Fitness Contact Facility 3961 Washington Road McMurray, PA 15317	724-942-0024	Cory Huminsky	$35	Depends on length of time. Contact facility	No		
Aries CO-Ed Club 100 Almond Road Houston, PA 15342	724-239-4771	Raye Teluch *rayteluch@gmail.com*	50% off	starting @ $49	No		
California University of PA 250 University Avenue California, PA 15419	724-938-5907	Jamison Roth *roth-j@calu.edu*	0	**Alumni+Immediate Family Only** *$400 annual/$40 month*	Yes		
Cameron Wellness Center 240 Wellnes Way Washington, PA 15301	724-250-5230	Marissa Watson	$50	$64	Yes		
Eighty Four Fitness 1019 Route 519 Eighty Four, PA 15330	724-228-8855	Dia Walsh	--	Crossfit only (no discounts offered)	--		
Progressive Fitness 382 W. Chestnut Street Washington, PA 15301	724-228-9747	--	$0	$29	No		
Mon Valley Center for Fitness and Health 800 Plaza Drive Belle Vernon, PA 15012	724-379-5100	--	$119.25	$58.50	Yes		
Mon Valley YMCA 101 Taylor Run Road Monongahela, PA 15063	724-483-8077	--	$0	**Single**: $43 **Family**: $62			
Planet Fitness 901 Wildflower Drive Washington, PA `15301	480-536-6250	Wendy Cox	$0	**Classic**: *$39 annual/$10 month*	No	Corporate membership - employee	
w.cox@unitedpf.com			$0	**Black Card:** *$24.99 month*		Billing on the 17th a month/connect to bank account	
30 & Out Fitness for Women 887 Henderson Avenue Washington, PA 15301	724-222-1992	--	$0	**With Classes**: $24 **W/O Classes**: $31	Yes		


WASHINGTON COUNTY
Pennsylvania ☆ 1781 ☆