FULLY INSURED SMALL GROUP

ADMINISTRATOR'S GUIDE

An owner's manual for your health plan.

Congrats on choosing a terrific health plan for your employees. Now, let's go over how it all works.

Say hello to simpler coverage with Highmark.

We're glad you chose us. And when your employees find out everything that's included with their coverage, they will be, too.

Let's get into the good stuff. This guide should make administering your health plan as simple and streamlined as possible. It's divided into two main sections: one for employers (you) and one that's dedicated to supporting your employees.

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EMPLOYER SECTION

Coverage for your company. Confidence for you. How’s that for peace of mind?

We've got your back.

Here you'll find all the tools, services, contacts, and instructions you need to manage your group's coverage with Highmark on a daily basis. From enrollment and eligibility information to billing and payments, it's all right here.

Occasionally, you'll have questions or need support with your plan. Keep these contacts handy any time you need an answer.

WHERE TO START

Contact your Highmark Client Manager or broker — they can help point you in the right direction.

EMPLOYER PORTAL

Once you've worked with your Client Manager or broker to obtain a username, log in via **highmarkbcbsde.com** and click on **Resources** or **Assist Employees** to get help with employee inquiries or managing your group plan. For login and password reset issues, call **1-877-298-3918** and select **Option** 2. For assistance with portal navigation, call **1-866-306-1059** and select **Option** 2.

ENROLLMENT AND BILLING

Delaware (small group): **1-866-835-8977**

PAY BY MAIL

Contact your broker, Client Manager, or Client Service Manager for help obtaining the address and/or enrolling in eBill.

SPENDING ACCOUNTS

Members can use spending accounts to pay for medical, dental, and vision expenses, as well as prescriptions and other qualified medical costs now or in the future.

SATriage@Highmark.com
(Issue Resolution)

SAPInvoice@Highmark.com
(Invoicing) **or 1-888-334-4184**

HSAClientService@Highmark.com
(HSA Contribution Processes)
or **1-877-959-4161**

DENTAL AND VISION

Contact your broker, Client Manager, or Client Service Manager.

PHARMACY

Call Express Scripts at **1-800-282-2881.**

GLOBAL CORE

Call the BCBS Global Core Service Center at **1-800-810-2583**, email at **customerservice@bcbsglobalcore.com**, or visit **bcbsglobalcore.com**.

Wishing you had a hub for all things related to your plan? We're way ahead of you.

Welcome home(page).

The Employer Portal is your online home for the most important information concerning your group's plan. Your employees also have their own website for support (more on that later).

Getting started is as easy as contacting your broker or Client Manager. They'll request the needed credentials and a username. From there, you'll simply visit highmarkbcbsde.com and log in with your username and temporary password. Once you're there, here's how to find what you need.

ENROLLMENT TAB

Come here to view and make changes to who is enrolled in your group plan. This page also includes:

- **Enrollment tutorial**
- **Find an Employee tool**
  - You will need their last name, your group number, and the Employee's member ID or SSN.
- **Enrollments in Process window to show enrollment submitted, but not yet processed**
- **Add Employee link**
  - You'll need to fill out three sections (Subscriber and Dependents, Plan Coverage, Review and Submit). Within each section, you'll need to know the employee's SSN, contact information, etc.

ASSIST EMPLOYEES TAB

If your employees need assistance with their coverage, use this page to lend them a hand. Here, you'll find:

- Employee resources such as ID cards, benefit booklets, group contracts, and a list of preventive medications.
- Provider information, including how to find a provider and information on how to change a primary care physician.
- Educational tools such as the Second Opinion Health Education Series.

BILLING TAB

For resources related to paying for your group plan, the **Billing** tab has everything you need, including:

- Monthly premium invoices.
- Spending Account invoices.

RESOURCES

If it's forms or other helpful information you're after, the **Resources** tab has everything you need, including:

- Forms and applications such as the enrollment application, member change form, HIPAA Authorization, Rx Request forms, Dental Claim form, HRA Direct Deposit form, and Waiver Insurance form.
- Group bulletins, including catalogs and back issues of the Group Administrator's newsletter.
- Helpful information, such as FAQs, responses for benefit coordination, brochures, employee help, and government legislation.

Whew, that sure is a lot.

Then again, that's what the Employer Portal is all about — a comprehensive collection of resources concerning your coverage. And the best part? It's super easy to navigate.

ENROLLMENT AND ELIGIBILITY

Your group. Our plan. Sounds like the start of a healthy relationship.

Let’s talk eligibility.

To benefit from group coverage, there are a few simple requirements. First, your business must employ no more than 50 total employees in order to be considered a small group. Contact your Client Manager or broker to find out about the minimum number of employees required. At least 75% of the full-time employees who are eligible for coverage must be enrolled in your health plan.

An eligible employee is defined as an “individual who is actively employed by the group” (in an employee/employer relationship) and who meets all of the following requirements:

DELAWARE

- Works on a full-time basis and has a normal work week of 30 or more hours.
- An employee who is not a part-time, temporary or substitute employee, but for various reasons might work 30+hours/week for fewer than nine months, could still be considered an eligible employee if they are employed full time and the employee’s “normal work week” is 30+ hours.
- Coverage may also be offered to employees who routinely work 20 or more hours per week if the group clearly identifies their weekly hour requirements on the Small Group Business Application.
- Based on Delaware law, the definition of an “eligible employee” includes sole proprietors and partners. Independent (1099) contractors may also be considered eligible for coverage provided they meet the group’s weekly hour requirements and their income on their 1099 Forms and the group’s payroll records supports the group’s weekly hour requirements (as stated on the group application).

ALL REGIONS:

- Receives a verifiable, regular wage or income (appears on the payroll).
- Has satisfied the group’s probationary requirements.

OWNER ELIGIBILITY:

- **C Corporations** — Corporate officers/shareholders of C corporations will only be considered eligible for coverage provided **they appear as paid employees** on the group’s current UC tax report (or year-to-date payroll register) and wage/salary information must support the weekly hour requirement as stated on the Small Group Business Application.

Because managing plan participation should be a whole lot easier than managing a business.

Why you'd need to update your enrollment.

When your business changes, your coverage will likely need to change with it. Here's what would need to take place for you to make an adjustment.

LIFE EVENTS

When something significant takes place that affects a member's eligibility — marriage, newborn, divorce, or death in the family — be sure to notify Highmark within 90 days of the event in case the event affects your plan. Employers can notify Highmark directly by fax, email, or mail.

CHANGES OF ADDRESS

Whenever a member relocates, let us know by sending a member change form or by the **Assist Employees** tab of the Employer Portal — we'll make the necessary adjustments to your enrollment.

TERMINATIONS AND REINSTATEMENTS

When an employee leaves your company or is reinstated after an absence, it's easy to update coverage using either the **Assist Employees** tab or the member change form on the Employer Portal. Just visit **highmarkbcbsde.com** and let us know as soon as possible when you're adding or removing employees from your coverage.

OPTIONS FOR CONTINUING COVERAGE

When an employee loses access to your group plan because they are no longer employed by you, the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires they be given the option to continue coverage.

- An employee may lose access to your group plan because of reduction of hours, loss of employment, divorce, legal separation, or loss of dependent status.
- To determine which COBRA law applies, employers must calculate their full-time and full-time equivalent employees for the preceding calendar year (referring to the COBRA definition for counting employees and if applicable, the Internal Revenue Code Section 414 (aggregation) rules for multiple businesses that are to be treated as a "single employer"). Employers are encouraged to seek legal counsel in making their determinations.
- For employers with 20 or more full-time/full-time equivalent employees in the prior calendar year under any of these circumstances, COBRA gives the former employee and their eligible dependents the opportunity to continue coverage for up to 18 months.
- That 18-month period is extended to 29 months if the employee was disabled under Social Security standards as of the date of election of COBRA. The 36 months applies to former spouse, legally separated spouse, and former dependents if such triggering events result in a loss of coverage.
- **Mini-COBRA:**
  - Delaware: 1 to 19 total employees. However, unlike federal COBRA, covered individuals may only continue medical and prescription drug coverage up to nine months. For one-person groups, the provisions of law HB 170 apply only to dependents that lose coverage due to a qualifying event.
- A member has the option of moving to a conversion plan.

So how do you keep your plan up to date?

The process is simple. Any time you need to update your enrollment, visit the **Enrollment** tab within the Employer Portal at **highmarkbcbsde.com**. Not only will you find additional details about when it's appropriate to make changes, you'll also have quick and easy access to all the necessary forms.

Know what you owe.
Pay the easiest way.

An introduction to invoices.

Invoices for your coverage arrive on a monthly basis and will provide plenty of detail around what amount is due. While payments are due within 30 days, you have options for how to settle your balance.

PAY ONLINE

The Employer Portal makes it easy to pay your invoices via your bank account. Simply log into your account at **highmarkbcbsde.com** and click the **Billing** tab to get started.

My Invoices

Health Premium PAY NOW

Total amount due

$5,668.44

View Accounts

View Current Invoices

Current Invoice for: Health Premium

Invoice Number	Account Number	Invoice Type	Due Date	Payable Amount	Outstanding Balance	To Pay
1511XXXXXXXXX	1683XXXXXXXX	REG	07/24/2020	$2,921.10	$2,921.10	PAY
1509XXXXXXXXX	1656XXXXXXXX	REG	07/24/2020	$2,747.34	$2,756.86	PAY

1 /1 10 items per page 1 - 2 of 2 items

DOWNLOAD REPORTS

Recurring Payments

Add Recurring Payment

Payment Methods

Any Bank, x6789

Test 2, x3124

Test 1, x3123

PAY BY MAIL

Unless you choose otherwise, invoices are automatically mailed to you every month.
So if you're not keen on paying online, feel free to send us a check.

Contact your broker, Client Manager, or Client Service Manager for help obtaining the proper address.

Want to know more?

The **Billing** and **Reporting** tabs within the Employer Portal make it easy to search and manage all your invoices and adjustments.

Of course, if you have a question, you can contact your billing representative at:

Delaware: 1-866-835-8977

EBBilling@highmark.com

MANAGING YOUR COVERAGE

And now, everything you ever wanted to know about adding, changing, or terminating coverage.

Changes to your coverage option.

There are a few simple guidelines to follow if you're interested in adding or changing products. Here's what you need to know:

- **Adding a coverage type** – You can add a coverage type at any time throughout the year. For example, if you currently have medical coverage and want to add dental or vision coverage, you don't have to wait until your annual renewal period to get signed up. Contact your broker or Highmark Client Manager to get started.
- **Changing an existing coverage type** – You're able to make changes to your existing coverage upon renewal each year and under certain circumstances throughout the year. Changes that take place outside of the normal renewal time frame must be in accordance with any applicable federal and state guidelines and must be approved by Highmark Underwriting. For questions on changing existing coverage throughout the year, please contact your broker or Highmark Client Manager.
- **Terminating your coverage** – If you wish to cancel your policy/coverage, you're responsible for notifying us in writing prior to the requested cancellation date. Please contact your broker or Highmark Client Manager to assist in this process.

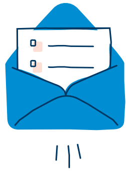
Changes to your organizational structure.

Existing groups are required to report ownership and/or other changes that affect their group health plan to their broker or Highmark Client Manager within 30 days from the change. These changes include, but are not limited to the following scenarios:

- **Ownership Change** – Group is sold and new owner wishes to assume the role of policyholder for the current group health plan.
- **Business Restructure** – e.g., a non-incorporated business incorporates, whereby a new Employer Identification Number (EIN) is assigned.
- **Acquisition or Merger** – Group acquires a new business or merges with another business.
- **Adding Other Affiliated Entities** – Group wishes to add other related entities (not currently insured by Highmark) that are to be treated as a "single employer" under the IRC Section 414 aggregation rules.
- **Asset Purchases** – Group acquires the assets/employees of another business and wishes to cover the new employees.
- **Spin-off Groups** – Group experiences ownership or business structure changes in which new companies are formed (or businesses are sold off) that do not qualify as a "single employer" and must be written separately.

Naturally, there's some fine print that applies to each of these guidelines. Feel free to reach out to your broker or Highmark Client Manager for more information.

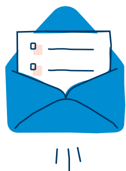
Here are some things you can expect from us throughout the year.



ATNE

Calculating your average number of employees.

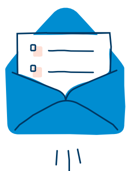
An important part of determining your annual eligibility is calculating your **Average Total Number of Employees (ATNE).** We'll send you a form each year to complete the process. We'll need this form whether you're applying for or renewing coverage.



Audits

Everything you need to know.

In the event of an audit, a letter and underwriting questionnaire will be mailed to you. Following your response, Underwriting will review your group for compliance with the Underwriting guidelines and will reach out directly if there's a need for additional information.



Renewing your coverage

The process is easy.

We'll send you a package roughly two months before your renewal date. Inside you'll find everything you need to keep your coverage current, or to change your plan if necessary. Of course, feel free to contact your broker or Highmark Client Manager with any questions.

SAMPLE FORM

Determining the average total number of employees for your business

For the purpose of determining the average total number of employees and proper market placement at renewal, count all employees for each month in the **preceding calendar quarter** leading up to the next renewal date. This includes full-time, part-time, seasonal/intermittent, in/out-of-area employees who were issued (or will be issued) a W-2; regardless of whether they were eligible to enroll, and/or participated in the group health plan. Exclude owners and working family members (who do not qualify as common law employees), 1099 independent contractors, and retirees.

Please review the example and enter the appropriate number of employees for each month in the chart below. Add each month's total to create an annual total, then divide the annual total by 12 to determine the average.

Company Name: ______________________ **Client Number:** ______________

Is the above company affiliated with other entities that are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules (e.g., (b) controlled group of corporations, (c) partnership or proprietorship, etc., under common control, (m) employees of an affiliated service group, or (o) other regulations)? ______ **Yes** ______ **No**

If you answered Yes, please count all employees collectively for all related entities that are to be treated as a "single employer" under the Internal Revenue Code Section 414 aggregation rules.

EXAMPLE	JAN 2019	FEB 2019	MAR 2019	APR 2019	MAY 2019	JUN 2019	JUL 2019	AUG 2019	SEP 2019	OCT 2019	NOV 2019	DEC 2019	Annual Total	Average (Total/12)
FULL TIME	5	5	5	5	5	5	5	5	5	5	5	5		
PART TIME	3	3	3	4	4	4	4	4	4	4	3	3		
SEASONAL	0	0	0	1	2	4	4	4	3	0	0	0		
TEMPORARY	0	0	0	0	1	1	1	0	0	0	0	0		
TOTAL	8	8	8	10	12	14	14	13	12	9	8	8	124	10.3

	JAN 2019	FEB 2019	MAR 2019	APR 2019	MAY 2019	JUN 2019	JUL 2019	AUG 2019	SEP 2019	OCT 2019	NOV 2019	DEC 2019	Annual Total	Average (Total/12)
FULL TIME														
PART TIME														
SEASONAL														
TEMPORARY														
TOTAL														

Group Policymaker (PRINT): ______________________ **Title (PRINT):** ______________

Signature & Date: ______________________ **Phone Number:** ______________

(ATNE sample form)

EMPLOYEE SECTION

Your employees will have questions. Let’s make sure you’re the person with all the answers.

Numbers worth knowing.

It's natural for your employees to want to understand their coverage. That's why we've made it easy for you to support them whenever they need it. In fact, they'll rely on many of the same resources you'll be using regularly. Nice, right?

If your employees need additional support with their plan, we're here to help.

MEMBER SERVICE:
1-888-510-1084

MEMBER PORTAL TECHNICAL SUPPORT:
1-877-298-3918

DENTAL AND VISION:
Employees should call the Member Service number on the back of their member ID card.

SPENDING ACCOUNTS:
Employees should call the Member Service number on the back of their member ID card, or use the Highmark app.

PHARMACY:
Employees should call the Member Service number on the back of their member ID card. They can also call Express Scripts® at **1-800-903-6228** or use the Highmark app.

BLUES ON CALL:
For access to a wellness coach and My Care Navigator℠, call 1-888-258-3428.

If there's another health plan that offers this much, we haven't found it.

The perks just keep coming.

Your group plan comes with heaps of benefits at no extra cost with membership. Let's take a look at everything your employees get.

BLUECARD® & GLOBAL® CORE ACCESS

Local, national, and global coverage.

Access to the largest physician and hospital networks in the U.S. with over 1.7 million providers, including 95% of all hospitals.*

And when you travel globally, you're covered in 190 countries through the Blue Cross Blue Shield Global® Core program.* Get more details at **bcbsglobalcore.com** or call the Service Center at 1-800-810-2583. Happy trails.

**The level of coverage depends on your chosen plan.*

HELP WHEN YOU NEED IT

Total support, day or night.

Whether it's 24/7 answers from registered nurses, access to video chat services for prescriptions or a diagnosis, or just some help booking your doctor visits, we're here for whatever comes up. Members can call the Member Service number on the back of their member ID card, or use the Highmark app.

FIND A DOC

Find quality care near you.

Locate an in-network physician or hospital near you, as well as finding mental health care resources, diagnostics, labs, and MRIs all with a simple search.

BLUE DISTINCTION®

Easy access to top-performing specialists.

Thousands of our network doctors and hospitals have Blue Distinction status for their exceptional safety and results. When you use our Find a Doctor tool on **highmarkbcbsde.com** after you enroll, a special logo will be by their name, so you can choose a top-performing specialist for any care you need.

*According to the Blue Cross Blue Shield Association.

BABY BLUEPRINTS®

Personalized support for expecting mothers.

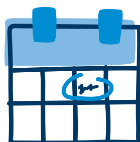
Pregnancy can be an overwhelming nine months for new moms. This free program provides a bit of clarity through educational online offerings and support from a health coach. You or your employees can call **1-866-918-5267** to take advantage of Baby Blueprints today.

BLUES ON CALL℠

Answers from a health pro, 24/7.

Medical concerns during off hours? You and your employees can call **1-888-BLUE-428** to get support from a registered nurse or a health coach at any time and put those worries to bed.

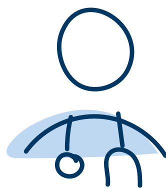
MY CARE NAVIGATOR℠



Appointments? Leave the booking to us.

It's as simple as calling Member Service at **1-888-510-1084** or using the Highmark app. We'll help you or anyone in your group find the in-network doctor they need and reserve some space on the calendar for a checkup.

VIRTUAL VISITS



Face to face with a doctor, 24/7.

It's never been easier to see a doctor. Now you and your employees can get a diagnosis, treatment plan, or prescription any time, right from a smartphone or computer. Members can register at **amwell.com**, via the mobile app, or over the phone using the Member Service number on the back of your member ID card or by calling 1-855-818-3627. Talk about laid-back-in-a-recliner easy.

HEALTH COACHES

Personalized support for your health goals.

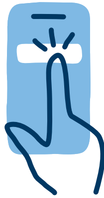
Are you or your employees looking to lose weight? Quit smoking? Be more active? A wellness coach can create a personalized plan right over the phone. Sessions are free and totally confidential. Members can call Member Service at 1-888-510-1084 or use the Highmark app.

BLUE365℠

Discounts for staying healthy.

From workout gear to gym memberships to healthy meal services, we'll take a little off the top for anyone on your plan who's looking to take a little off their middle. Member-only deals are at **blue365deals.com**.

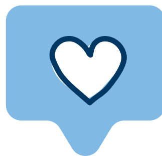
SHARECARE®



One-stop digital platform for wellness.

A tool that helps you and your employees learn their RealAge®, track health habits, and monitor sleep, stress, and fitness — all in real time. Enrollment is easy and starts at **mycare.sharecare.com**.

DIABETES PREVENTION PROGRAM



Tips on how to avoid diabetes.

Simple, effective, practical strategies to help your employees lower their risk. For more information on this program, call 1-888-BLUE-428.

DISEASE MANAGEMENT PROGRAM

Help managing chronic conditions.

One-on-one nurse support for employees with asthma, diabetes, heart disease, and other chronic conditions. For more information on this program, call 1-888-BLUE-428.

THE HIGHMARK APP

Your health plan in your pocket.

Get instant access to your digital member ID card, care-finding tools, claims updates, and more right on your mobile device. To start, just download the Highmark app from the App Store or Google Play and set up your profile.

MEMBER PORTAL

Help your employees make sense (and the most) of their coverage.

All roads lead to the Member Portal.

Much like the Employer Portal, the Member Portal is a one-stop-shop for anything your employees might need concerning their health plan. Access to the portal is as simple as visiting highmarkbcbsde.com and choosing **Register** if they are first-time users. And while the website is both easy to use and quite comprehensive, let's quickly go over what's there.

COVERAGE

Here's where your employees can review exactly what your plan covers:

- Deductibles, copays, and out-of-pocket maximums
- Prescription drug benefits
- Spending account information
- Wellness benefits

CLAIMS INFORMATION

Members are able to see everything about claims and spending accounts on one easy-to-follow dashboard.

- Paid and unpaid claims information
- Up-to-date out-of-pocket spending for the member and any dependents
- Progress toward meeting any deductibles
- Current spending account balances
- Access to previous statements and use of our Care Cost Estimator and Prescription Cost Comparison tool

FIND A DOCTOR

Whether they're looking for a specialist or a new primary care physician, members can come here to find the best option for them. Our Find a Doctor tool allows them to find in-network providers and pharmacies based on:

- Name
- Location
- Type of care (e.g., medical, dental, vision, emergency, urgent care, etc.)
- Specialty
- Specific medical procedures

HEALTH PLANS 101

Learn how plans work, check the health glossary, and find out how you can save.

ID CARDS

Check which individuals are covered by the plan, view, print, or order ID cards and see a snapshot of current plan information.

MEDICAL BENEFITS

Discover the details of the health plan, review the Summary of Benefits and Coverage, and view the preventive schedule. You can also use our Find a Doctor tool, as well as get prescriptions.

PRESCRIPTIONS

Highmark makes it easy to manage prescriptions online. Members have access to several helpful resources, including:

- Refills and order status
- History of medications and prescription claims
- Their plan's formulary (list of drugs the plan covers)
- A cost comparison tool for prescription drugs

WELLNESS

A Highmark health plan isn't about just caring for you when you're sick. We also provide resources to keep members well and promote a healthy lifestyle. Like Sharecare — an online and mobile tool to help members learn their RealAge and provide advice and activities to help them turn back the clock.

FILING CLAIMS

We’ve made sure that filing a claim is a painless process.

Leave the hard part to us.

When it comes to receiving services from an in-network provider, there's no need to submit a claim — we'll take care of everything. For out-of-network providers, however, your employees may need to submit a claim themselves. Fortunately, the process is still simple.

Here are the steps they'll need to follow to submit a claim for out-of-network services.

1. **Log in to the Member Portal.** Once logged in, it's easy to locate the needed forms.
2. **Locate and click on the Forms Library.** This will list all available form categories.
3. **Select Medical Forms.** From there, they can choose the needed form.
4. **Select the Member Submitted Health Insurance Claim Form.** Fill it out completely.
5. **Mail in the completed form.** The address is on the back of all member ID cards.

Need help with a claim?

Claims must be submitted within 90 days of the date of service. For assistance with any part of filing, we're here to lend a hand: **1-888-510-1084.**

Understanding the Explanation of Benefits.

Any time a claim is submitted, we mail an Explanation of Benefits (EOB) statement to the member who filed the claim. Basically, it's a summary of what was covered, what was charged, and any amount owed. Make sure your employees know to keep an eye out for an EOB after submitting a claim — just in case Highmark needs to mail a check to the member so they can pay the provider.

Here's what an EOB looks like:

HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

Explanation of Benefits
THIS IS NOT A BILL

Contract Holder Name: SAMUEL SAMPLE
Member ID: 012345678910
Group Name: ABC CORP.
Group ID: 123456 789
Claim Activity For: SAMUEL SAMPLE
Claim Number: 12345678910

EXPLANATION AT A GLANCE		
Date of Service: 01/28/14		
We Sent Payment To: PATHOLOGY PRACTICE A Network Provider		
Claim Payment Amount:	$	90.00
Provider May Bill You (If Not Already Paid) :	$	7.00

Member Responsibility					
Provider Date of Service Type of Service Service Code (Number of Services)	Provider's Charge	Non-Billable To Member	Plan Allowance (Covered Charges)	Your Deductible	Amount You Owe Provider (total of shaded columns)
PATHOLOGY PRACTICE 01/28/14 SURGICAL PATHOLOGY TEST 88305 (2)	284.00	187.00 J4047	97.00	7.00	7.00
TOTALS	284.00	187.00	97.00	7.00	7.00

Explanation of Remark Codes

J4047 - This is the difference between the provider's charge and our allowance. Since the provider is in-network, you are not responsible for this amount.
X5018 - The allowance for this service has been applied to the dollar deductible amount required under the patient's coverage.

PATIENT BENEFIT SUMMARY

Patient: SAMUEL SAMPLE Group Number: 123456-789
Benefit Period: 01/01/14 - 12/31/14
$2,350.00 has been applied to your $6,350.00 individual in network total maximum out-of-pocket amount. $2,350.00 has been applied to your $3,000.00 individual in network out-of-pocket limit.
You have satisfied $1,000.00 of your $1,000.00 individual in network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

PROGRAM BENEFIT SUMMARY

Benefit Period: 01/01/14 - 12/31/14 Group Number: 123456-789
$2,350.00 has been applied to your $12,700.00 program in network total maximum out-of-pocket amount. $2,350.00 has been applied to your $4,000.00 program in network out-of-pocket limit.
You have satisfied $1,000.00 of your $2,000.00 program in network deductible.

Please refer to your benefit booklet or agreement for further information. Amount(s) shown may include totals from claims which are still being processed and for which you have not been notified.

Health care lingo, translated.

When it comes to health care, you're bound to see certain terms over and over. Here's a cheat sheet for a few of the most important ones.

BLUECARD

A program that connects independent Blue Plans across the country and the world. It gives Blue Plan members access to in-network coverage while outside their plan area. The level of coverage depends on your chosen plan.

COINSURANCE

The percentage you may owe for certain covered services after reaching your deductible. For example, if your plan pays 80%, you pay 20%.

COPAY

The set amount you pay for certain covered services, this could be $20 for a doctor visit or $30 for a specialist.

DEDUCTIBLE

The set amount you pay for health services or drug costs before your plan starts paying.

EMERGENCY SERVICES

Care for a condition needing immediate attention to avoid severe harm.

FLEXIBLE SPENDING ACCOUNT (FSA)

An account an employee puts pre-tax money into that is used to pay for eligible medical expenses.

FORMULARY

The list of medicines covered by your plan, sorted by tier. Lower tiers usually mean lower copays.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

An employer-funded benefit used to reimburse employees for out-of-pocket medical expenses and personal health insurance premiums.

HEALTH SAVINGS ACCOUNT (HSA)

An account to set aside pre-tax money to pay for qualified medical expenses. You can only have an HSA if you have a Qualified High-Deductible Health Plan.

HIGH-DEDUCTIBLE HEALTH PLAN (HDHP)

A plan that usually comes with a lower premium because you pay more upfront before the insurance company starts to pay. Some of these plans are often combined with a health savings account.

IN-NETWORK PROVIDER

A doctor or hospital who has an agreement with your plan to charge no more than your plan allowance for their services

OUT-OF-NETWORK PROVIDER

A doctor or hospital who doesn't have an agreement with your plan and likely charges more than your plan allowance amount for the same services.

OUT-OF-POCKET MAXIMUM

The most you'd pay for covered care. If you hit this amount, your plan pays 100% after that.

PLAN ALLOWANCE

The set amount your plan will pay for a health service during a coverage period, even if your provider bills for more. Plans often pay a portion of the plan allowance, not the entirety. Plan allowance is the negotiated rate that network providers have agreed to accept as payment in full for covered services.

PREMIUM

The monthly amount paid so you have coverage.

PREVENTIVE CARE SERVICES

Routine care like screenings and checkups that help keep health issues from happening

PRIMARY CARE PROVIDER (PCP)

The medical professional you see for most of your basic care, like yearly preventive visits and screenings.

QUALIFIED HEALTH PLAN (QHP)

A plan that meets all ACA requirements. That includes providing the 10 essential health benefits and staying inside the limits for deductibles, copays, and out-of-pocket maximums.

RETAIL CLINIC

Walk-in centers for less complex health needs, generally open in the evenings and on weekends.

VIRTUAL HEALTH

Health care or guidance that you get from a doctor in real time via a smart device or computer.

URGENT CARE CENTER

A walk-in center for when you have a condition that's serious enough to need care right away, but not serious enough for a trip to the emergency room.

METAL LEVELS

Under the Affordable Care Act (ACA), insurance companies must define the level of health care costs a particular plan will pay (on average) for covered benefits. To make it easier to understand, the government established metal levels.

	OUT-OF-POCKET COSTS	ESTIMATED PLAN COSTS
PLATINUM PLANS	Lowest	$$$$
GOLD PLANS	Low	$$$
SILVER PLANS	Moderate	$$
BRONZE PLANS	High	$

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American Well service availability is subject to state laws. Medical services provided by American Well are subject to the telemedicine services benefit. Therapy and Psychiatry provided by American Well are subject to theoutpatient mental health benefit. Other than these mentioned services, all other service provided by American Well are not eligible. You are responsible for the full cost of ineligible 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.

Patients may receive a promotional offer for a free visit directly from American Well. These promotions are not part of your plan of benefits.

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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. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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