Capital

Penn Medicine
Lancaster General Health

WELCOME TO CAPITAL BLUE CROSS

For employees of Penn Medicine Lancaster General Health

July 2024

MyHealthToolkitCapital.com

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Dear LG Health Colleagues,

Penn Medicine Lancaster General Health will host annual benefit enrollment April 22 to May 5, 2024. The selections made during the enrollment period will be valid July 1, 2024 to June 30, 2025.

Annual benefit offerings includes programs that reflect our desire to provide a total rewards package for staff which includes competitive base pay, health insurance and family support programs while at the same time, maintaining our commitment to financial sustainability. Please read the information below carefully.

What's new for July 1, 2024?

Health and Dental Premiums

- Premiums for medical* will increase slightly (3%) with the new rates reflected on the first pay in July dated July 12, 2024.
- Dental premiums will also be changing, allowing for alignment of these premiums across all UPHS entities (Philadelphia, Chester County, Lancaster General and Princeton). This will mean a reduction, or increase in dental premiums, dependent upon the level of coverage selected for July 1, 2024.
- Vision premiums will not be increasing.

*The premium changes only affect the LG Select Health Insurance Plan, where employees pay a bi-weekly premium for their health insurance. Employees who use the LG Consumer Health Insurance Plan will continue to not pay a premium for their health insurance.

Flexible Spending Accounts and Health Care Savings Account

- The maximum amount employees can contribute to a Health Care Flexible Spending Account (FSA) for the 2024 – 2025 benefit plan year will increase to $3,200 in pre-tax earnings. Previously, the limit was $3050
- The maximum amount employees can contribute, during the 2024-2025 benefit plan year, to their health savings account (HSA) is $4,150 or individual coverage or $8,300 for family coverage. Employees age 55 and older may make an additional "catch-up" contribution of $1,000.

Voluntary Short Term Disability

- Employees electing Voluntary Short-Term Disability, for the first time during annual benefit enrollment, will be required to answer medical questions to be approved for coverage.

Prescription Drug ID Cards

- Employees will be receiving new prescription drug ID cards that reflect the recent name change from Southern Scripts to LIviniti. This new ID card will arrive prior to the end of June from Liviniti.

Reminder! Benefits will rollover automatically for you with the exception of flexible spending and health savings accounts. You must re-elect the flexible spending and health savings accounts every year.

Questions? Contact your LG Health Benefits Team @ lgh-benefits@pennmedicine.upenn.edu .

Penn Medicine Lancaster General Health provides a comprehensive compensation package including group insurance benefits. The Capital Benefit Guide provides a general summary of these benefit options as a convenient reference. Please refer to Penn Medicine Lancaster General Health Policies, Benefits website and/or Certificates of Coverage for detailed descriptions of all available employee benefit programs and stipulations therein.

Important Notices for Plan Participants & Beneficiaries

The Federal Government has outlined several notices as Important Notices for our medical plan participants:

- Children's Health Insurance Program Reauthorization Act (CHIP)
- HIPAA Notice of Privacy Practices
- Medicare Part D Creditable Coverage Notice
- Summary of Benefits and Coverage
- Women's Health and Cancer Rights Act of 1998
- Health Insurance Marketplace Coverage Notice

All of the above notices can be viewed in their entirety on the employee benefits website at **https://www.lghealthbenefits.com/resources/required-notices/**

Summary Plan Descriptions

All Summary Plan Descriptions can be viewed on the employee benefits website at https://www.lghealthbenefits.com/resources/summary-plan-descriptions/

Complete, printed copies can also be mailed direct to your home. Please send requests to: Lgh-benefits@pennmedicine.upenn.edu

Employee Eligibility

• Employees are eligible to participate in the medical, dental and vision offerings if you are a FTE .5 or greater (20 hours per week).

• Coverage will be effective the 1st of the month following the date of hire.*Residents and Fellows please refer to your Benefit Summary Sheets For example, if you are hired on April 11th, your coverage will be effective on May 1st.

Termination

Benefits will end the end of the month of separation from employment.

Dependent Eligibility

Who are Eligible Dependents?

Dependents eligible for **Health, Dental, and/or Vision Plans** include your:

- Married spouse (opposite or same gender), as recognized by the state of Pennsylvania;
- Employee children under age 26; including natural children, stepchildren, and legally adopted children, regardless of marital status; and children for whom you are required to provide health coverage, under a Qualified Medical Child Support Order;

- Unmarried or married employee children of any age, who are incapable of self-support and who became mentally or physically handicapped before the limiting age of 26, and are dependent on you for over half of their maintenance and support.

Note: All Dependents must be enrolled using the name listed on their Social Security Card.

Eligible Spouse Rule*

Spouses are eligible to elect LG Consumer or LG Select Plan as primary if:

- Self-employed (Note: Work related injuries or illnesses are not covered)
- Unemployed
- Employed but employer does not offer health insurance
- Employed, but paying 50% or more of their employer's cost of single health insurance coverage

If spouse pays less than 50% of their employer's cost of single health insurance coverage, LG Health Insurance Plans will be available as secondary coverage, if desired.

*Eligible Spouse Rule only applies to Health Insurance Plans. Dental and Vision Plans are not governed by the Eligible Spouse Rule.

Dependent Eligibility Verification

After enrolling dependent(s), you will receive a "Review Documents" task in a Workday Inbox To-Do. This task will include a due date for enrollment and the uploading of documents. The documentation matrix link on the benefits website provides you with a documentation matrix and lists of acceptable documentation and verification forms. Note: The Spouse Eligibility Form must be completed if adding a spouse to your health insurance. If adding a spouse to your dental or vision insurances only, this form will not be required. The audit is used to verify Dependent identity, eligibility and the correct spelling of their name(s). All enrolled Dependents must be covered using the name listed on their Social Security Card.

Newly enrolled dependent(s) will not be eligible for coverage until their eligibility has been verified and documents accepted/approved in Workday. If verification is not received by audit deadline, your dependent(s) will not be covered by health, dental, and/or vision benefit plans.

Email questions to lgh-benefits@pennmedicine.upenn.edu

LG Select At-A-Glance

Plan Features	Tier 1 Providers	Tier 2 Providers	Non-Preferred Providers *
Annual Deductible (ded) – Embedded Individual Family	$250 $500	$750 $1,500	$900 $1,800
	In-network Co-payment	**In-network Co-payment**	**Out-of-network Co-Insurance**
Physician Services Personal Family Physician Specialist Personal Family Physician E-Visit Urgent Care Retail Health Care Clinics Penn Medicine OnDemand	$15 (No ded) $30 (No ded) $20 (No ded) $30 (No ded) $15 (No ded) $0 (No ded)	$40 (No ded) $50 (No ded) $20 (No ded) $50 (No ded) $40 (No ded) N/A	**After Deductible** Plan pays 60%* Plan pays 60%* Plan pays 60%* $50 (No ded) Plan pays 60%* N/A
	In-network Co-payment	**In-network Co-payment**	**Out-of-network Co-Insurance**
Inpatient Hospitalization Facility Services Physician Services	100% (after $200 copay per admission) After ded, Plan pays 90%	**After Deductible** Plan pays 80%* [1] Plan pays 80%*	**After Deductible** Plan pays 60%* Plan pays 60%*
Diagnostic Services and Supplies Inpatient or Outpatient Services Independent Lab	Plan pays 100% N/A	**After Deductible** Plan pays 80% Plan pays 80%	**After Deductible** Plan pays 60%* Plan pays 60%*
Outpatient Surgery Ambulatory or Surgical Center Facility Ambulatory or Surgical Center Services Physician's Office Services	Plan pays 100% After ded, Plan pays 90% After ded, Plan pays 90%	**After Deductible** Plan pays 80% Plan pays 80% Plan pays 80%	**After Deductible** Plan pays 60%* Plan pays 60%* Plan pays 60%*
Preventive/Wellness Adult and Child Well Exams	Plan pays 100%	Plan pays 100%	**After Deductible** Plan pays 60%*
Specialty RX Administration Inpatient, Physician Office, Outpatient Hospital or Facility	Plan pays 100%	**After Deductible** Plan pays 60%	**No coverage**
Emergency Room Care Emergency Care Non-Emergency Care	After Deductible Plan pays 80% Plan pays 80%	**After Deductible** Plan pays 80% Plan pays 80%	**After Deductible** Plan pays 80%* Plan pays 80%*
Rehabilitation Services Physical, Occupational, Speech and Respiratory Therapies	Plan pays 90% (No ded)	**After Deductible** Plan pays 80%	**After Deductible** Plan pays 60%*
Behavioral Health Services Outpatient Telemedicine Mental Health/Substance Use Inpatient Emergency Room/Crisis Evaluation	$15 copay, no deductible $15 copay, no deductible 100% after $200 copay Plan pays 80% after ded	$40 copay, no deductible $15 copay, no deductible Plan pays 80% after ded*[1] Plan pays 80% after ded	**After Deductible** Plan pays 60% Plan pays 60% Plan pays 60%* Plan pays 80%
	In-network	**In-network**	**Out-of-network**
Annual Out of Pocket Limit **Embedded** Individual Family	$1,500 $3,000	$3,750 $7,500	$6,400* $12,800*

[1] A $5,000 copayment will be applied for non-life threatening inpatient visits at the following hospitals: Penn State Milton S. Hershey Medical Center, WellSpan York Hospital, WellSpan Ephrata Community Hospital, Reading Hospital, UPMC Lititz, Penn State Health St. Joseph Medical Center, UPMC Harrisburg, Lebanon VA Medical Center, Nemours Children's Hospital, WellSpan Good Samaritan Hospital and Penn State Health Lancaster Medical Center. *paid at UCR (Usual, Customary and Reasonable) This document for summary purposes only, plan document will prevail if any discrepancy between this document and the plan document.

LG Consumer At-A-Glance

Plan Features	Tier 1 & Tier 2 Providers	Non-Preferred Providers *
Annual Deductible – Embedded **Individual Only **** **Family - Per Family Member**** **Family – Total****	 $2,000 $3,000 $4,000	
	In-network Co-payment	**Out-of-network Co-Insurance**
Physician Services Personal Family Physician Specialist Personal Family Physician E-Visit Urgent Care Retail Health Care Clinics Penn Medicine OnDemand	**After Deductible** $20 $35 $20 Plan pays 90% Plan pays 90% $49 before ded/$20 after ded	**After Deductible** Plan pays 60%* Plan pays 60%* Plan pays 60%* Plan pays 90%* Plan pays 90%* N/A
	In-network Co-Insurance	**Out-of-network Co-Insurance**
Inpatient Hospitalization Facility Services Physician Services	**After Deductible** Plan pays 90% [1] Plan pays 90%	**After Deductible** Plan pays 60%* Plan pays 60%*
Diagnostic Services and Supplies Inpatient Services Outpatient Services Independent Lab	**After Deductible** Plan pays 90% Plan pays 100% Tier 1 – N/A, Tier 2 – Plan pays 90%	**After Deductible** Plan pays 60%* Plan pays 60%* Plan pays 60%*
Outpatient Surgery Ambulatory or Surgical Center Facility Ambulatory or Surgical Center Services Physician's Office Services	**After Deductible** Plan pays 100% Plan pays 100% Plan pays 90%	**After Deductible** Plan pays 60%* Plan pays 60%* Plan pays 60%*
Preventive/Wellness Adult and Child Well Exams	 Plan pays 100%	**After Deductible** Plan pays 60%*
Emergency Room Care Emergency Care Non-Emergency Care	**After Deductible** Plan pays 80% Plan pays 80%	**After Deductible** Plan pays 80%* Plan pays 80%*
Specialty RX Administration Inpatient, Physician Office Outpatient Hospital or Facility	**After Deductible** Plan pays 60%	**No coverage**
Outpatient Rehabilitation Services Physical, Occupational, Speech and Respiratory Therapies	**After Deductible** Plan pays 90%	**After Deductible** Plan pays 60%*
Behavioral Health Services Outpatient Telemedicine Mental Health/Substance Use Inpatient Emergency Room/Crisis Evaluation	**After Deductible** $20 $15 Plan pays 90%[1] Plan pays 80%	**After Deductible** Plan pays 60% Plan pays 60% Plan pays 60%* Plan pays 80%
	In-network Co-Insurance	**Out-of-network Co-Insurance**
Annual Out-of-Pocket Limit – Embedded **Individual Only** **Family - Per Family Member** **Family - Total**	 $4,000 $4,000 $8,000	 $6,000* $12,000*

1 A $5,000 copayment will be applied for non-life threatening inpatient visits at the following hospitals: Penn State Milton S. Hershey Medical Center, WellSpan York Hospital, WellSpan Ephrata Community Hospital, Reading Hospital, UPMC Lititz, Penn State Health St. Joseph Medical Center, UPMC Harrisburg, Lebanon VA Medical Center, Nemours Children's Hospital WellSpan Good Samaritan Hospital and Penn State Health Lancaster Medical Center.

If you do not utilize a LG Health, Penn Care, CHOP, Eliance Health Solutions, Quest, PHC or Capital Preferred Provider, coverage will be reduced to the Non-Preferred Provider level of insurance. Preventive Services must be performed by a personal family physician,, obstetrics/gynecology, internist, or pediatrician; otherwise coverage will be reduced to the Non-Preferred Provider level of insurance, after deductible.

*Paid at UCR (Usual, Customary and Reasonable)

**The Plan begins to make payments for a family member as soon as that family member has reached his/her per family member deductible. Once a per family member deductible is met, as required by the IRS, the family total deductible can be met with combined expenses from all family members.

This document is for summary purposes only. The official plan document will prevail if any discrepancy exists between this document and the plan document.

Penn Medicine
Lancaster General Health

UNDERSTANDING DEDUCTIBLES
EMBEDDED

The Select Plan has an *embedded* deductible and an *embedded* out-of-pocket maximum.

The Consumer Plan has an *embedded* deductible and an *embedded* out-of-pocket maximum.

SELECT PLAN

Annual Deductible (Tier 1)

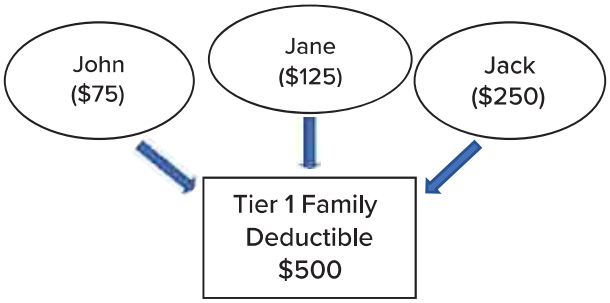
Employee Only Enrolled
- $250 Individual

Employee + 1 or More Enrolled
- $250 per Family Member (embedded)
- $500 Family Cumulative

Medical Expenses
- John: $75
- Jane: $125
- Jack: $250

Cumulative family expenses = $450

With an **embedded family deductible**, the plan begins to make payments for a family member as soon as that family member has reached his/her per family member deductible or the family deductible is met with cumulative expenses from all family members.



Jack sprains his wrist and must go to the emergency department. Will co-insurance apply immediately since he has already met the $250 individual deductible? ***YES.***

Jack only has to meet his individual deductible before co-insurance applies, which he did before he went to the hospital. With only $450 in family deductible expenses applied, if John or Jane had sprained his/her wrist, he/she would have to satisfy the remaining $50 toward the family deductible before coinsurance would apply.

CONSUMER PLAN

Annual Deductible (Tier 1)

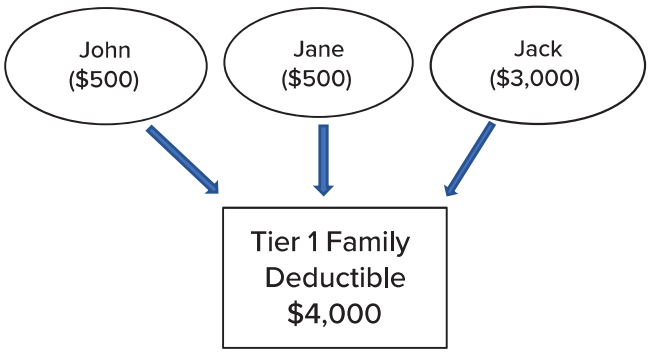
Employee Only Enrolled
- $2,000 Individual

Employee + 1 or More Enrolled
- $3,000 per Family Member* (embedded)
- $4,000 Family Cumulative

Medical Expenses
- John: $500
- Jane: $500
- Jack: $3,000

Cumulative family expenses = $4,000

With an **embedded family deductible**, the plan begins to make payments for a family member as soon as that family member has reached his/her per family member deductible or the family deductible is met with cumulative expenses from all family members.



Jane sprains her ankle and must go to the emergency department. Will co-insurance apply immediately since she has not met the $3,000 per family member deductible? ***YES.***

Jane did not have to meet her $3,000 per family member deductible because the family deductible of $4,000 had been met first with the combined expenses of each family member.

*Minimum per family member deductible as required for HSA compatible plans

Penn Medicine
Lancaster General Health

Health, Dental and Vision Insurance Premiums*

FULL TIME EMPLOYEE PREMIUMS PER PAY (Includes 0.9 FTE and Greater Employees)						
	LG Consumer	LG Select	LG Dental	LG Dental Plus	Vision	Vision Plus
Employee	$0.00	$ 55.16	$ 5.55	$7.79	$2.15	$4.11
Employee + Spouse	$0.00	$139.51	$10.32	$14.19	$4.30	$8.22
Employee + Child(ren)	$0.00	$113.56	$12.45	$16.52	$4.51	$8.63
Family	$0.00	$164.39	$18.40	$25.34	$6.66	$12.74

PART TIME EMPLOYEE PREMIUMS PER PAY (Includes 0.5 – 0.8 FTE Employees)						
	LG Consumer	LG Select	LG Dental	LG Dental Plus	Vision	Vision Plus
Employee	$0.00	$ 88.68	$9.06	$12.73	$2.15	$4.11
Employee + Spouse	$0.00	$201.16	$16.85	$23.16	$4.30	$8.22
Employee + Child(ren)	$0.00	$152.49	$20.32	$34.09	$4.51	$8.63
Family	$0.00	$231.44	$30.03	$41.37	$6.66	$12.74

*The premiums reflected above will be effective from July 1, 2024 – June 30, 2025

LIVINITI
formerly Southern Scripts

Penn Medicine
Lancaster General Health

Processing Information

Group Number: LGHRX4U

Member ID: Found on your Member ID Card

Bin Number: 015433

PCN: SSN (SSN is a network acronym – it does not refer to your social security number)

PBM: Liviniti formerly Southern Scripts

Find What's Covered

1. Visit liviniti.com/members
2. Log in to your PMLGH Page using your Group Number (LGHRX4U)
3. Under **Search For Medications**, type the name of your medication and click Search

Deductible Notes

LG Consumer:

- This plan has a deductible that applies to prescriptions and medical claims.
- After the deductible is met, the member pays the applicable copays.
- Once one active member of the family meets the $3,000 deductible, another family member only needs to meet an additional $1,000 to meet the family deductible.
  - EX: $3,000 + $1,000 = LG Consumer family deductible of $4,000.

LG Select:

- This plan does not have a deductible that applies to prescriptions.

Out-of-Pocket Notes

All prescription drug co-pays are attributable to annual out-of-pocket limits in the member's selected Health Insurance Plan.

LG Consumer Out-of-Pocket Maximum:

- Individual $4,000 / Family: $8,000

LG Select Out-of-Pocket:

- Tier 1 OOP: Individual $1,500 / Family $3,000
- Tier 2 OOP: Individual $3,750 / Family $7,500

You may fill your prescriptions at LGH's Convenience Pharmacies, UPHS Pharmacies, a Liviniti retail network pharmacy or through home delivery from a LGH Convenience Pharmacy.

Member copays are the same under both the LG Consumer and LG Select Plans.

		LG Health Convenience Pharmacy	Network Pharmacy
Up to 30 Day Supply	Generic	$5	$15
	Preferred Brand Name Drug	$15	$45
	Non-Preferrred Brand Name Drug	$30	$75
	Specialty Medication May only fill at a LG Health Convenience Phamacy	$0	N/A
Up to 90 Day Supply	Generic	$10	$30*
	Preferred Brand Name Drug	$30	$90*
	Non-Preferrred Brand Name Drug	$60	$150*

***Extended day supply (31 – 90 days) prescriptions are only available at LG Health Convenience Pharmacies or Mail Order.**

Cost Savings Tips!

Medications use to treat high blood pressure and high cholesterol may be filled at LG Health Convenience Pharmacies at no cost to you.

Filling medications at a **LG Health Convenience Pharmacy** saves you money! If you fill a generic medication every month, you can **save $120 a year** on one prescription by using a LG Health Convenience Pharmacy.

*Benefits above are only applicable to prescriptions filled at LG Health Convenience Pharmacies. For additional information regarding prescription drug benefits, email lgh-benefits@pennmedicine.upenn.edu

Maximizing your Value through LG Health Convenience Pharmacies

Opportunities to save on your prescriptions

Variable Copay™ reduces the cost of eligible specialty and brand medications by using manufacturer-provided coupons. This program is available through LGH Convenience Pharmacies.

Choose from a variety of pharmacy options.

- Place orders in person, at the pharmacy or over the phone.
- Get long-term medication (and savings) delivered right to your door or desk from Convenience Pharmacies
- The Lancaster General Health Convenience Pharmacies offer easy access to over-the-counter items and prescription fills/refills, including over- the- phone and on-line prescription refill services, home, and desk-side delivery services. Call 717-544-5929 or visit www.LGHealth.org/refill.

Personalized care for Specialty Medications.

- Medications that treat complex conditions are considered Specialty and need to be filled at a LGH Convenience Pharmacy.

Pharmacy Locations

- **Convenience Pharmacy**
  Lancaster General Hospital
  First Floor, 555 North Duke St. Lancaster, PA 717-544-5929
- **Convenience Pharmacy**
  Kissel Hill
  51 Peters Rd, Lititz, PA 717-627-7689
- **LG Health Convenience Pharmacy - Columbia**
  306 N 7th St, Columbia, PA 717-684-1450
- **LG Health Convenience Pharmacy - Suburban Outpatient Pavilion**
  Third Floor
  2108 Harrisburg Pike, Suite 314, Lancaster, PA 717-544-3154

Member Reference Guide

LIVINITI

Find What You Need

Activate your Member Portal:

1. Visit liviniti.com/members
2. Under Member Portal Login, select "Create Account"
   - Refer to your ID card for your credentials
   - Choose a password
   - Click "Register"
3. You will receive an email to confirm your registration before you can login

Take your pharmacy benefits on the go with the Liviniti Mobile App.

The mobile app has the same features and information as the Member Portal. You can find a free copy of the Liviniti Mobile App wherever you download apps for your phone. Get started today!

iPhone QR Code

Android QR Code

The Liviniti **Member Center** is your one-stop hub for all the information you need to maximize your pharmacy benefits.

The **Member Portal** is loaded with information about your pharmacy benefits and prescriptions. After you create your account and confirm your registration, you can login to the Member Portal from the Member Center.

On the Member Portal you can:

- View benefit details, including out-of-pocket and deductible information for you and your family
- Review your prescription history and share it with your physician
- Search for a nearby pharmacy based on your zip code
- Find and compare drug prices to find the best price at any network pharmacy in a few easy steps
- Search for medications by name and view formulary tier, whether it is a specialty or over-the-counter (OTC) drug, and any special programs such as prior authorization or quantity limits that apply to the medication
- Check the history or status of any prior authorization
- Locate the mail order pharmacy used by your plan
- Download a digital ID card

Your **Company Page** also has helpful information. You do not need to create a personal account but will need your Group Number. On the Member Center, scroll down to Your Company Page, enter your Group Number (LGHRX4U) and click "Visit Company Page."

On your PMLGH Page you can:

- Find your plan's Formulary or Drug List and look-up a drug or learn more about your coverage
  - Use your Group Number (LGHRX4U) to access your Company Page
  - Under **Search For Medications**, type the name of your medication

Your NEW ID Cards are coming in the mail

LG Select

LG Consumer

QUEST
EMPLOYEE ASSISTANCE PROGRAM

Summary of Benefits

Lancaster General Health

Professional Counseling Services

Professional Counseling – Employees and dependent family members are each eligible for **eight (8) free counseling sessions** per contract year. **Your benefits renew July 1st of each year**. To access these free services, call Quest at **1-800-364-6352**. The program is a professional, confidential service that helps employees and their dependent family members identify and resolve personal problems that may be affecting them at work or home.

You can access Quest's full provider network by visiting:

www.questbh.com/find-a-provider

Legal and Financial Resources

Legal – Each employee and dependent family member is entitled to **one (1) initial thirty-minute** office or telephone consultation per separate legal matter at no cost with a network attorney. If you wish to retain a participating attorney after the initial consultation, you will be provided with a preferred **rate reduction of 25%** from the attorney's normal hourly rate.

Financial – Each employee and dependent family member is entitled to **one (1) initial thirty-minute** office or telephone consultation per separate financial matter at no cost. Speak to professionals with experience in accounting, banking, and insurance; CPA's and Certified Financial Planners (CFP's). If you wish to retain a participating financial advisor after the initial consultation, you will be provided with a preferred **rate reduction of 25%** from the normal hourly rate.

Mediation – Each employee and dependent family member is entitled to **one (1) initial thirty-minute** office or telephone consultation per separate legal matter at no cost with a network mediator. Matters may include divorce and child custody, contractual and consumer disputes, real estate and landlord/tenant issues, car accidents and insurance disputes, etc. If you wish to retain a participating mediator after the initial consultation, you will be provided with a preferred **rate reduction of 25%** from the mediator's normal hourly rate.

To schedule your free consultation with a qualified network attorney, mediator, or financial advisor, **call 888-254-8104 and provide them with your Company Code: qeap-lgh.**

There's more →

Revised: April 13, 2023

Website – Employees and their dependent family members have unlimited access to the Legal & Financial Resources Website. Search through legal and financial topics, legal forms, financial calculators, professionally written articles, FAQ's, and much more. Visit www.worklifeservices.net

Registration – The first time you visit this confidential website, you will need to register using your **company code: qeap-lgh.** You will be prompted to create your own personal username and password. Keep your login information handy for future use.

"Do It Yourself" Legal Forms Document Preparation – Our simple process will enable members to download and complete their own legal document preparation from the comfort of their home without incurring the cost of an attorney or dealing with lengthy completion and delivery periods.

Eldercare Consultants

Caring for elderly loved ones - As we live longer, healthier lives, the demand for combining work along with care giving responsibilities for older family members becomes a greater challenge.

To help you meet these challenges, Quest offers **one (1) telephonic consultation** per family per contract year with our Eldercare Specialists. Call Senior Management Services at **717-881-4674** and tell them you are a member of Quest EAP. This is an excellent resource, whether you are seeking emotional support, counseling, guidance, or information regarding care and support of elderly loved ones. Some question topics include:

- What to look for and ask when selecting personal care facilities
- Medicare & Medicaid services
- Senior Transportation services
- Assisted Living facilities
- Nursing Home options
- In-Home Care services
- Senior Centers
- Adult Day Care facilities
- Alzheimer's Disease and other forms of dementia

Feel free to call us with any questions about your EAP benefits at 1-800-364-6352 or visit www.QuestEAP.com

WELL*focused*

LIFE IN BALANCE

The free, confidential, and voluntary wellness rewards program benefit for eligible employees. Support your personal well-being by accessing wellness program tools and resources through Limeade.

Employees who activate their Limeade account can participate in wellness activities and earn points for cash reward$ in their paycheck.

GET STARTED

- Visit LGH.Limeade.com or download the **Limeade ONE** app
- Activate your account
  Program Code: **LGH**
  Login Info: LG Health Credentials
- Agree to the prompted consent requests

Limeade®

Scan to download Limeade ONE

ADDITIONAL SUPPORT

Once signed on to the Limeade platform (app or online), you have access to the full meQuilibrium platform.

meQuilibrium is a clinically-validated tool harnessing behavioral psychology and neuroscience to create personalized training support around burnout, stress, purpose, performance, and well-being.

- Log into Limeade
- Click on **Services** in the top navigation bar
- Scroll down to **Lancaster General Tools**
- Click on **meQuilibrium**
- Scroll down and click **Access meQ HERE**

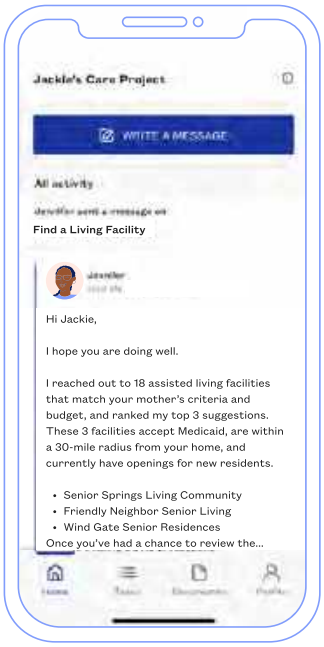
meQuilibrium

Penn Medicine
Lancaster General Health

Well*focused* Team
Wellfocused-LGH@pennmedicine.upenn.edu
StarNet ➔ Health & Wellness ➔ Wellfocused

CW/WF-240227

Wellthy

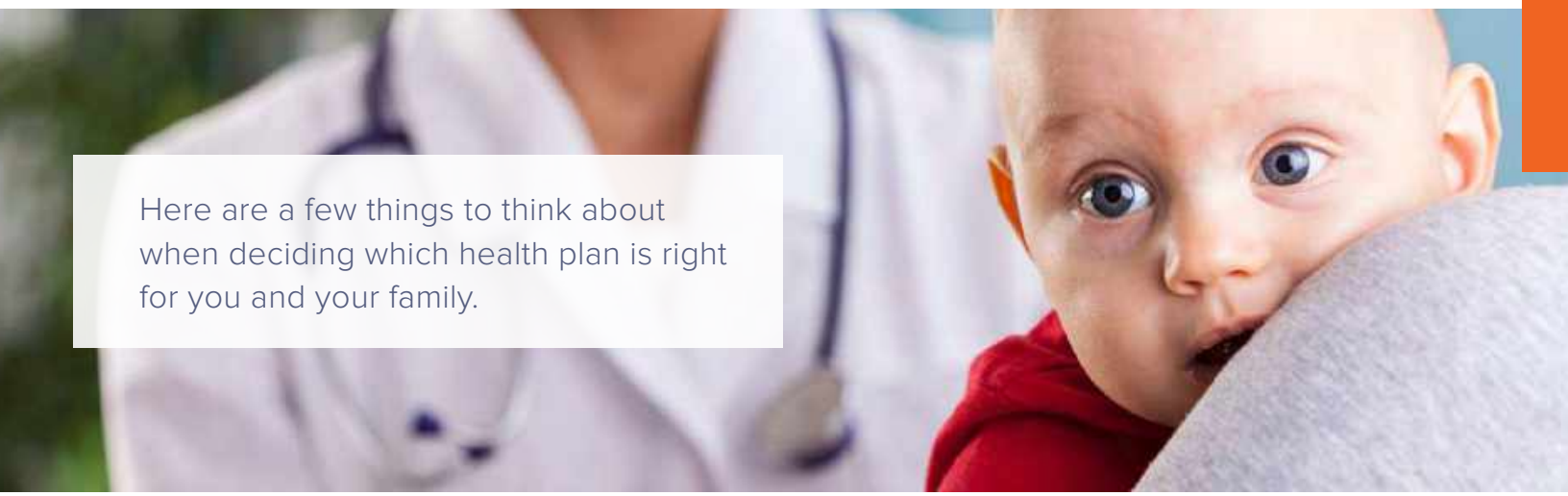


Benefits of care support from Wellthy

- **A skilled care professional dedicated to you**
  Your Care Coordinator will get to know your care story beginning to end. They'll identify priorities, design a personalized plan, tackle administrative tasks, and act as an advocate on your behalf.
- **Guidance from experts who know the care industry**
  Wellthy Care Coordinators are backed by specialized teams who are experts across every variable of care — from insurance to in-home care to mental health and beyond.
- **Family meetings, simplified**
  Keep siblings, relatives, neighbors, and anyone involved in care situation in the loop with streamlined communication — one email thread, one central channel, one voice of reason.
- **Help with immediate needs, or support for the long run**
  Create your account and open a Care Project to begin getting dedicated help now, or start by using the digital tools within the Care Dashboard so everything is set up for when you need it.
- **Everything you need, all in one place**
  The Care Dashboard keeps your information safe and accessible. Maintain all of your contacts, keep up with doctor appointments, track tasks, and store important documents.
- **A community of caregivers who can relate to what you're going through**
  Wellthy Community is a peer-to-peer space for family caregivers to find support, share experiences, and exchange knowledge across a range of care topics.

UPHS Benefit Eligible employees have access to Wellthy! Visit **join.wellthy.com/UPHS** and click 'GET STARTED.' Enter your UPHS email address and confirm your network credentials to create your account.

THINGS TO CONSIDER WHEN CHOOSING A HEALTH PLAN



Here are a few things to think about when deciding which health plan is right for you and your family.

Think about your doctors visits over the past year.

- Do you think you'll see the doctor more or less this year?
- How did your insurance work during your last appointment?
- Do you want a similar insurance plan this year?

Make a list of the prescription medications you're taking. If prescription drug coverage is part of your medical plan, you can look up the name of your prescriptions through your health plan's drug list to determine if they're covered.

What's most important to your budget?

How much cost variation are you comfortable with? Plans that have copays built in, like preferred provider organization (PPO) plans, typically cost more each month in premium, but less in coinsurance when you visit the doctor. High deductible plans typically cost less each month in premium, but your costs will vary when visiting the doctor or filling a prescription.

Be aware of what's not included in your plan.

Make sure you're familiar with the provider network for your plan and any excluded services.

Are you expecting any big changes in the coming year?

Is there a medical procedure you or a family member may need in the coming months?

Do you plan on expanding your family? There are qualifying life events, like marriage or having a baby, that allow you to add dependents to your plan during the benefits year. Make sure you know how your plan costs may change in those scenarios.

Remember, you're committed to your health plan selection until the next open enrollment opportunity unless you have a qualifying event.

Qualifying events include:

- Marriage, divorce or legal separation.
- When you or a dependent gets other coverage.
- Death of a spouse or dependent.
- Birth or adoption of a child.
- Enrollment in Medicare or Medicaid.

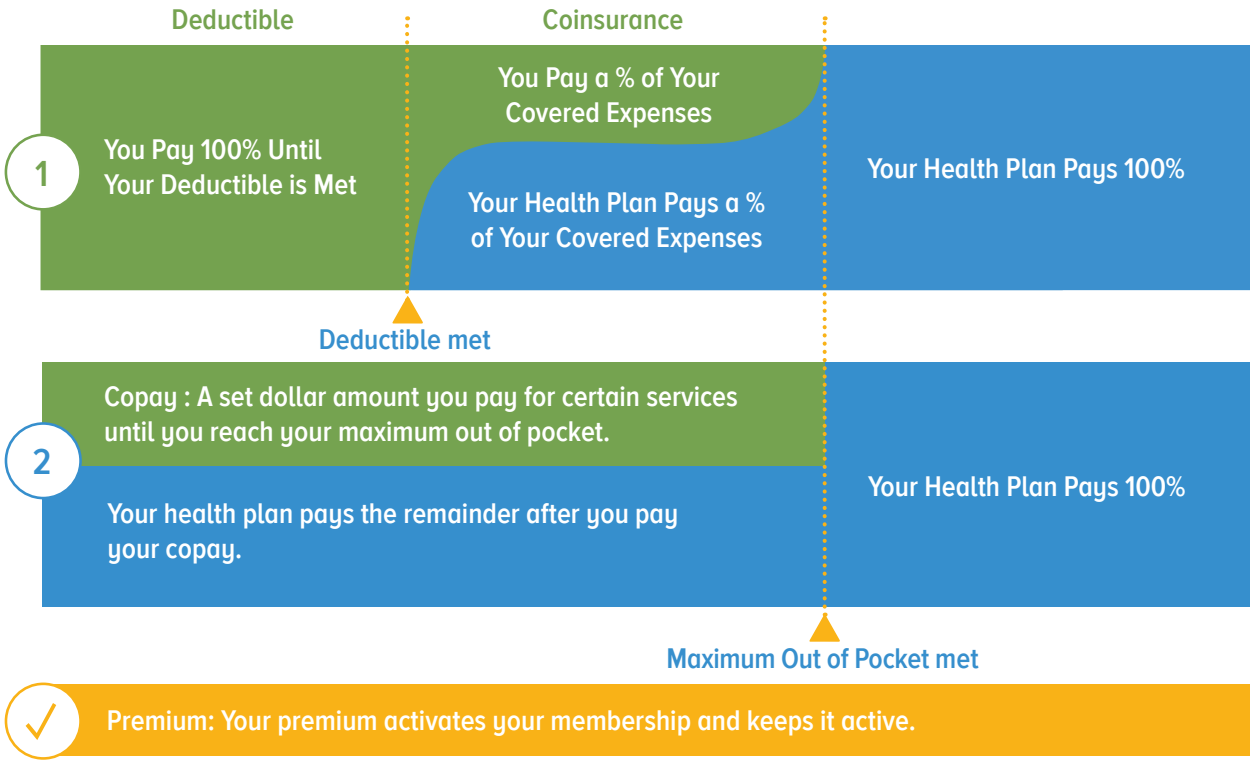
For information about your eligibility and benefits, log in to **My Health Toolkit®** and select **My Plan & Benefits**. Next, select **Health**, then **Health Benefits**. On the My Health Toolkit app, select **Benefits**, then **Health Benefits**. In this section, you can see your benefits at a glance, including the type of coverage you have and where you stand with your maximum out of pocket and deductible. You also can look up specific types of coverage such as hospital inpatient, surgery, urgent care and office visit. For questions about your deductible or out-of-pocket maximum amounts, please use the **Ask Customer Service** button on the Benefits page.

HOW YOU AND YOUR PLAN SHARE HEALTH CARE COSTS

Health insurance helps cover the cost of your medical expenses.

How your annual insurance benefits work: what you can expect to pay

Each service you receive gets paid through path 1 or path 2.



Terms you need to know

Your **deductible** is the set total amount you pay for medical services before your coinsurance kicks in. For example, you would meet your $1,000 deductible after your payments for covered medical services add up to $1,000. For most health plans, your copay does not count toward your deductible.

Coinsurance is the percentage of medical costs you pay after you've met your deductible. For example, you might pay 20 percent once you've met your deductible. Your health plan would pay 80 percent.

A **copay**, or copayment, is a set rate you pay for doctor visits, prescriptions and some other types of care. For example, you might pay $20 for an in-network doctor visit and $15 for a prescription.

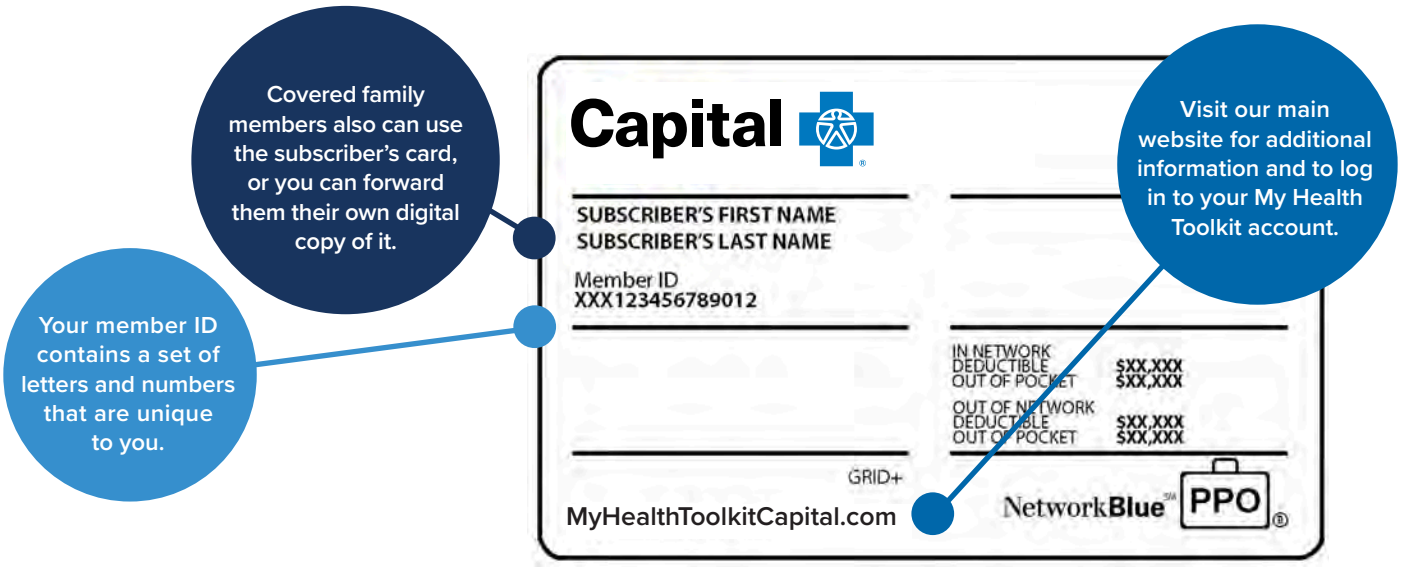
Your **maximum out-of-pocket amount** is the most you have to pay for covered services in one plan year. For example, let's say your maximum out-of-pocket amount is $4,000. Once your in-network payments for deductibles, copays and coinsurance add up to $4,000, your health plan then will pay 100 percent of the costs for covered services for the rest of that benefit year.

For more terms you'll see and hear in health insurance and health care, please see the Helpful Terms page near the end of this benefits guide.

To find your deductible, coinsurance, copay and maximum out-of-pocket amounts, review your summary of benefits or log in to **My Health Toolkit®**.

WE'VE GOT YOU COVERED WITH YOUR MEMBERSHIP CARD

Your Capital Blue Cross membership card contains important information that helps providers apply your benefits correctly. Keep it with you at all times or download a digital ID card to keep on your smartphone. A health care provider usually will ask to see your insurance card at the beginning of your visit.



Convenient option: your digital ID

It's all about convenience! Your digital ID card has the same information as the card you receive in the mail, but you can:

- View the digital ID on a smartphone, tablet or computer.
- Email the card to a spouse, child, doctor's office or pharmacy.
- Print the card from a smartphone, tablet or computer and use the printout just like a plastic card.

Accessing your digital ID

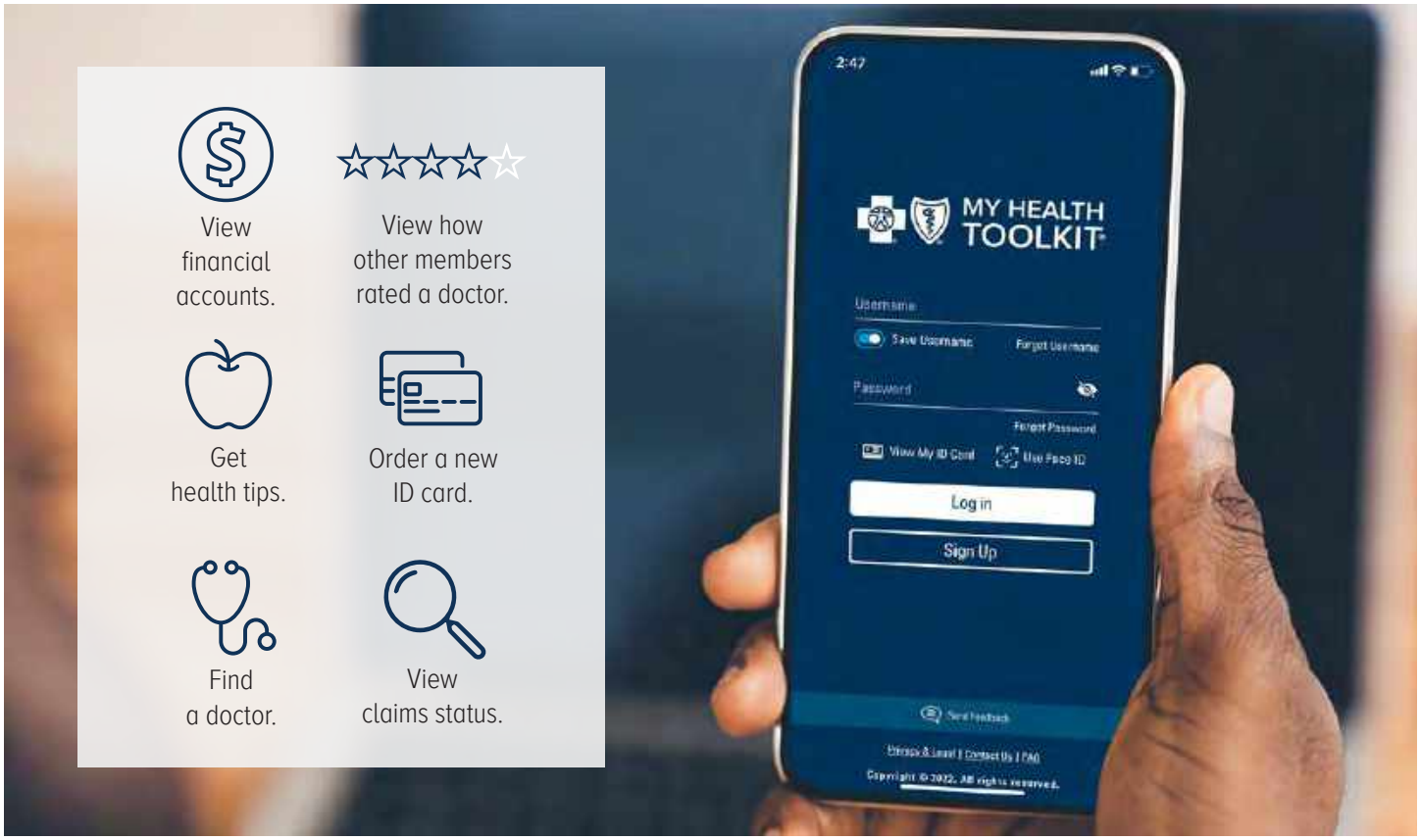
- From a computer or mobile device, log in to My Health Toolkit.
- Follow the prompts to select/view your insurance ID card.

TRY THIS SHORTCUT

Get easy access to your benefits information by downloading the My Health Toolkit® mobile app today! It's free on the App Store or Google Play.

Download on the App Store | GET IT ON Google Play

Register quickly through the app using your member ID number. Or just log in if you're already a My Health Toolkit user.



Your account homepage will link you to all of the helpful resources included with your health benefits plan.

Now you have anywhere, anytime access to your benefits information, including claims, discounts and how you prefer to be contacted.

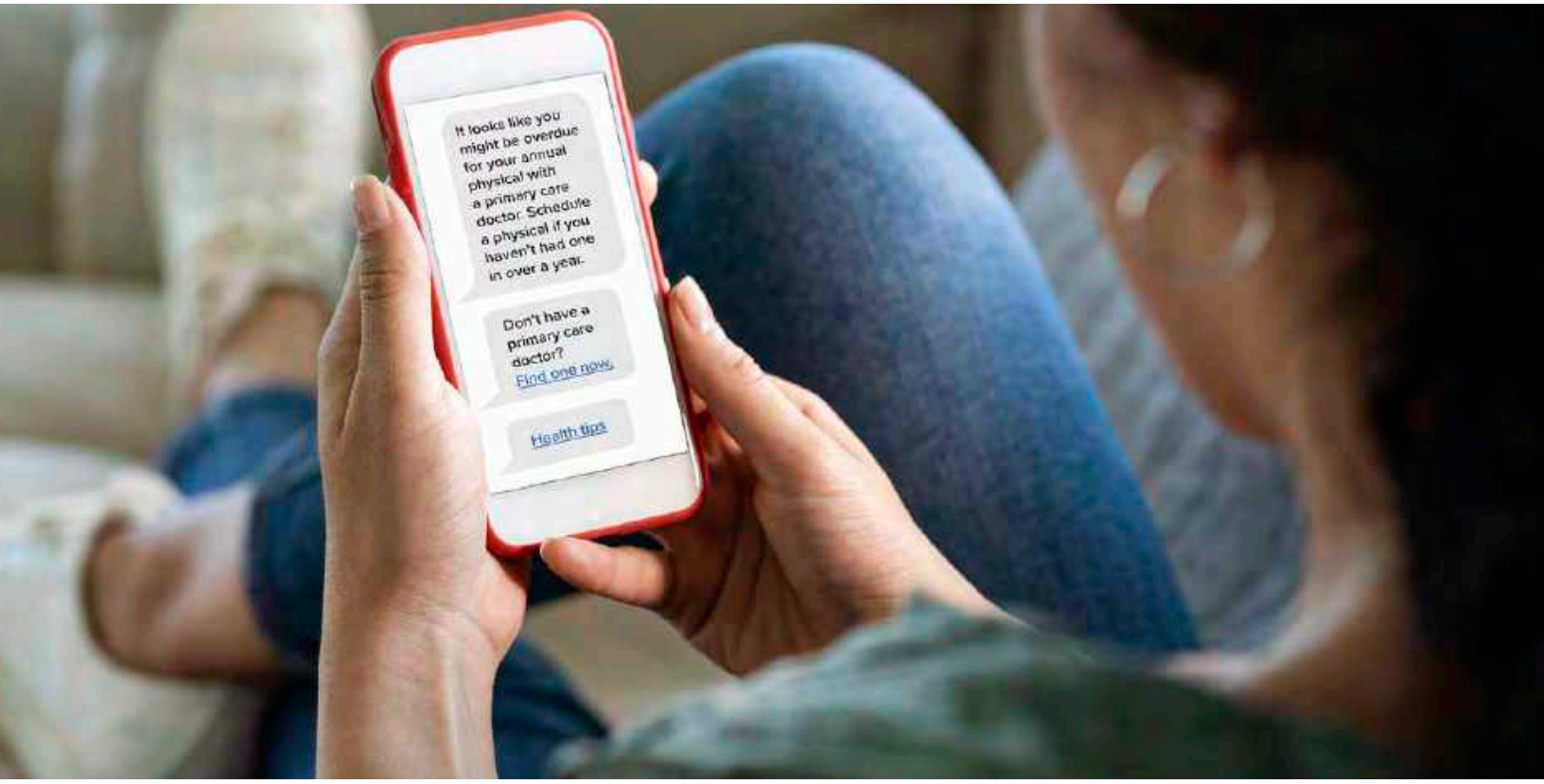
Rather get My Health Toolkit from a desktop or laptop computer?

Go to **www.MyHealthToolkitCapital.com** and then:

- Select **Create An Account** within the **Member Login** section.
- Enter your **member ID** (from your ID card).
- Follow the instructions to **create your profile**.

TELL US THE BEST WAY TO REACH YOU

Occasional communications from your health plan help you stay on top of your health, save money and make the most of your benefits. Just let us know which contact option is most convenient. We'll send a brief message when it's time for your annual checkup, for example, or there's an update on a prior authorization request.



Personalized member messages — by text, mail, app notification or email — help us keep in touch by providing useful information and tips. These could include wellness reminders or news on benefit changes.

You have great benefits; make sure you use them! Please take a minute to update your contact preferences in My Health Toolkit. Just let us know which channels and contacts you prefer. Check out the easy opt-in tips below.

Log in to My Health Toolkit, and under My Profile, select My Account, then My Contact Preferences. Update your contact information and tell us the best way to reach you.

You also can opt in to receive text messages by calling 844-206-0624.

SHOPPING FOR CARE

Find the best health care options just like you check out your choices in cars, hotels or restaurants.

"Know before you go." It's a smart idea before you make any important decision, including finding a new doctor or choosing a location for surgery.

Your health plan makes these decisions easier with Shopping for Care. Find it at your health plan's **My Health Toolkit®** website.

- Find health care providers and services within our vast provider network.
- Check out cost information to make sure you're getting the care you need at the best possible price.*
- See reviews from other patients who have rated a provider you're considering.
- Identify the highest-quality providers in your area, with Total Care and Blue Distinction® Specialty Care designations.
- View a detailed map to help you get where you need to go.

After you've registered with My Health Toolkit®:

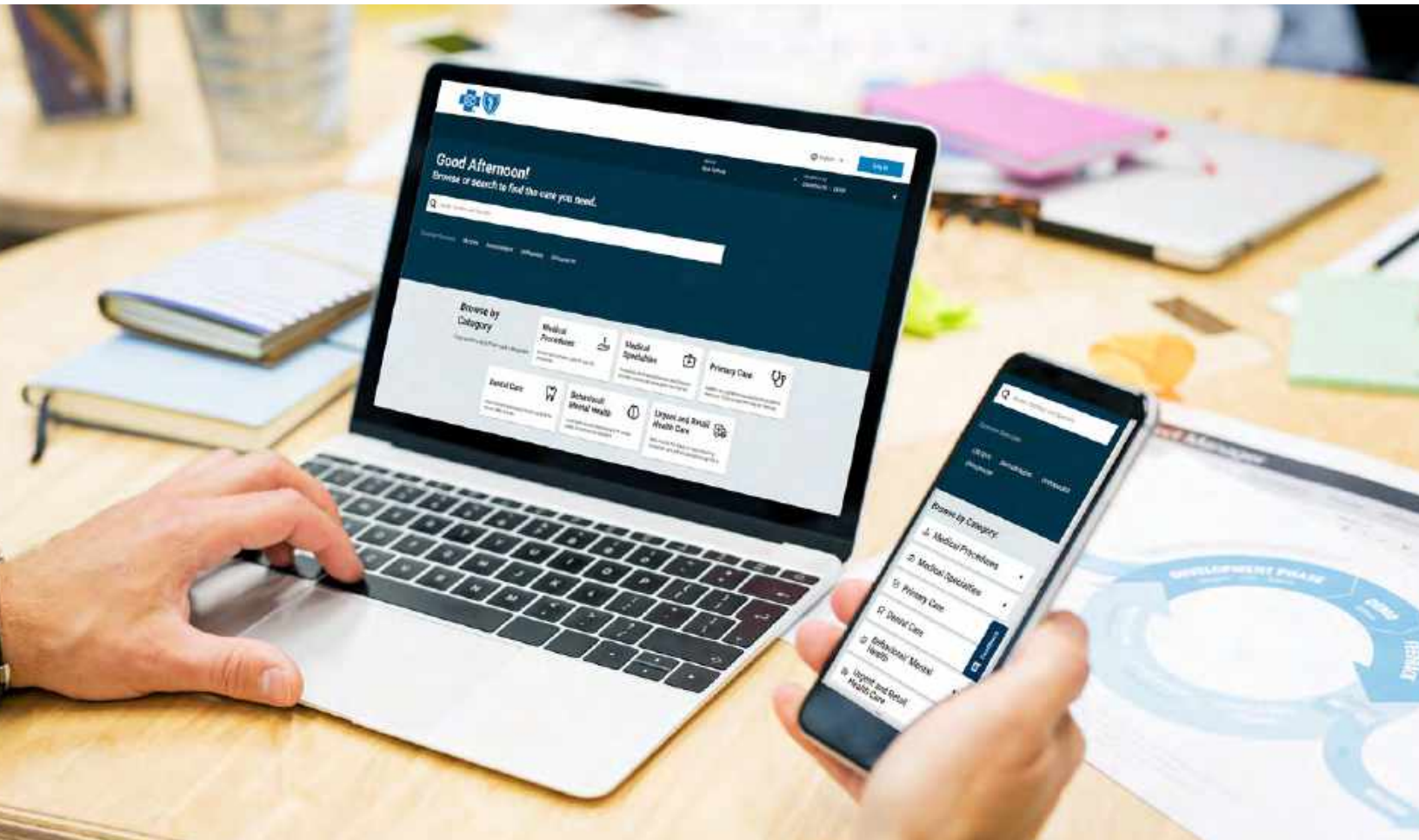
Access Shopping for Care from your computer:

- Visit your health plan's **My Health Toolkit** site.
- Log in to your account, select **Providers and Services**, then **Find Care.**
- We'll walk you through each step!

Or take it with you:

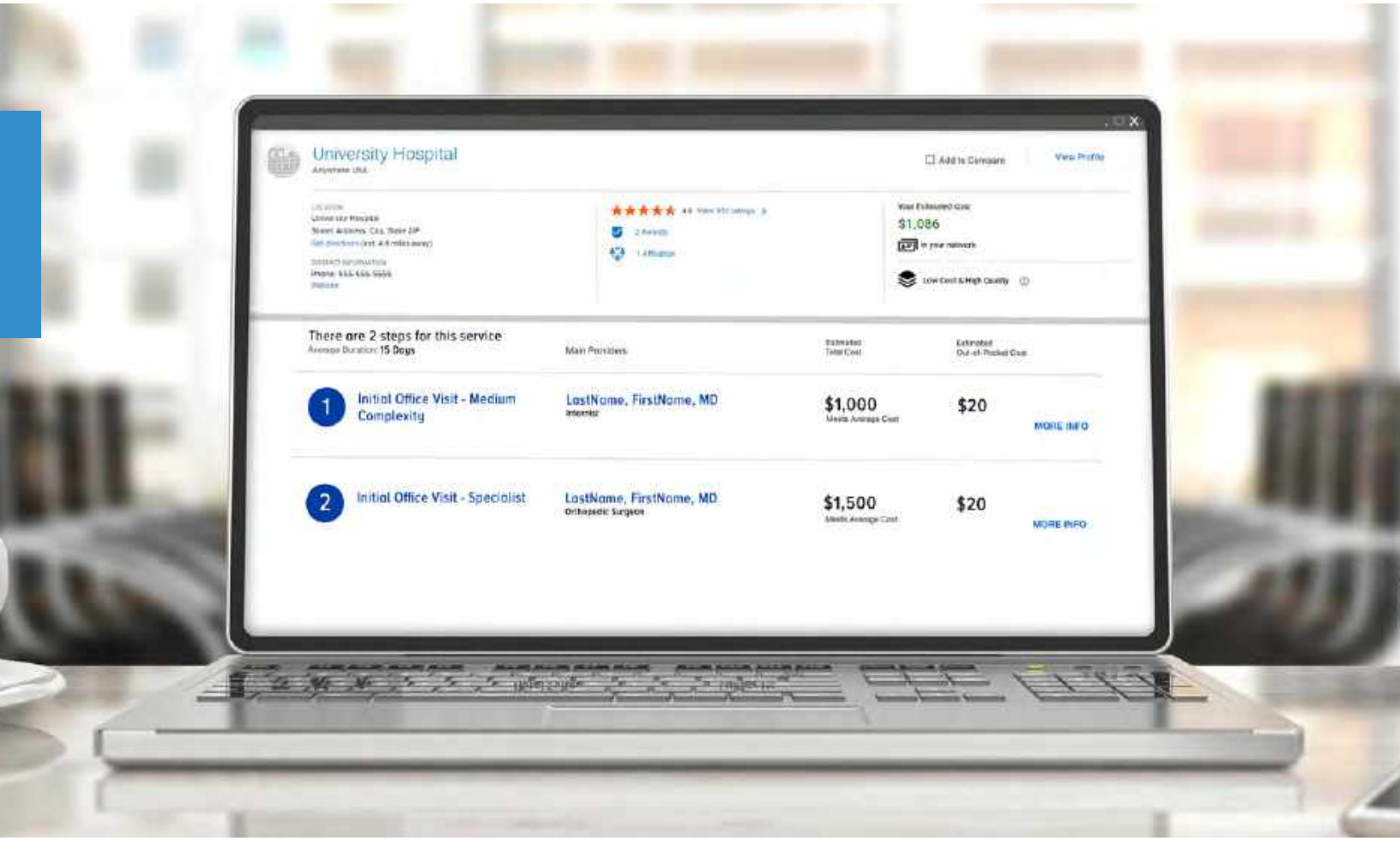
- Log in to the **My Health Toolkit** app from your mobile device.
- Select **Find Care**.

*Cost details might not be included with all plans.



“How much will it cost?”

Estimates help you avoid surprises when the bills come.



Costs for a medical procedure — like an ultrasound, a checkup, X-rays or joint replacement — can vary by hundreds of dollars. Our Shopping for Care feature includes cost estimates to help you find the right care at the right price. (Cost information might not be included for all plans.)

Estimate your out-of-pocket expenses for medical procedures — and compare pricing details that show you the most cost-efficient providers.

- At your health plan’s **My Health Toolkit** website, log in to your **My Health Toolkit** member account.
- Select **Providers and Services**, then **Find Care**.

As you explore the **Find Care** categories further, you’ll see a **Cost Estimates** tab that’s loaded with price information about hundreds of procedures, from mammograms and MRIs to allergy testing, sleep studies, physical therapy and various types of surgery.

TIP: When you get your member ID card, use your ID number to create your My Health Toolkit account. Then you’ll see cost information about copays and other details specific to your health plan.

WHERE SHOULD YOU GO WHEN YOU NEED CARE?

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? What if it's an emergency?

Here are tips to help you choose the right type of care for various situations.

Doctor's Office

Your primary care physician, or regular doctor, is the best option for routine medical care:

- Annual checkups and physicals
- Health screenings and immunizations
- Prescription refills

And unexpected health issues, if they can wait a day:

- Sprained muscles
- Minor cuts and bruises
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraine
- Rashes, insect bites, sunburn or other skin irritations

Urgent Care Center

If you can't wait for an appointment with your regular doctor, an urgent care center may be your best option for unexpected health issues:

- Minor fractures and sprains, especially if an X-ray is required
- Minor cuts and animal bites, especially if stitches may be required
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraine
- Rashes, insect bites, sunburn or other skin irritations

Emergency Room

Go to the emergency room or call 911 for potentially life-threatening conditions:

- Heavy, uncontrolled bleeding
- Signs of a heart attack, like chest pain that lasts more than two minutes
- Signs of stroke, such as numbness or sudden loss of speech or vision
- Loss of consciousness or sudden dizziness
- Major injuries, such as broken bones or head trauma
- Coughing up or vomiting blood
- Severe allergic reactions

WHEN AN EXPLANATION OF BENEFITS COMES, HERE'S WHAT TO DO WITH IT

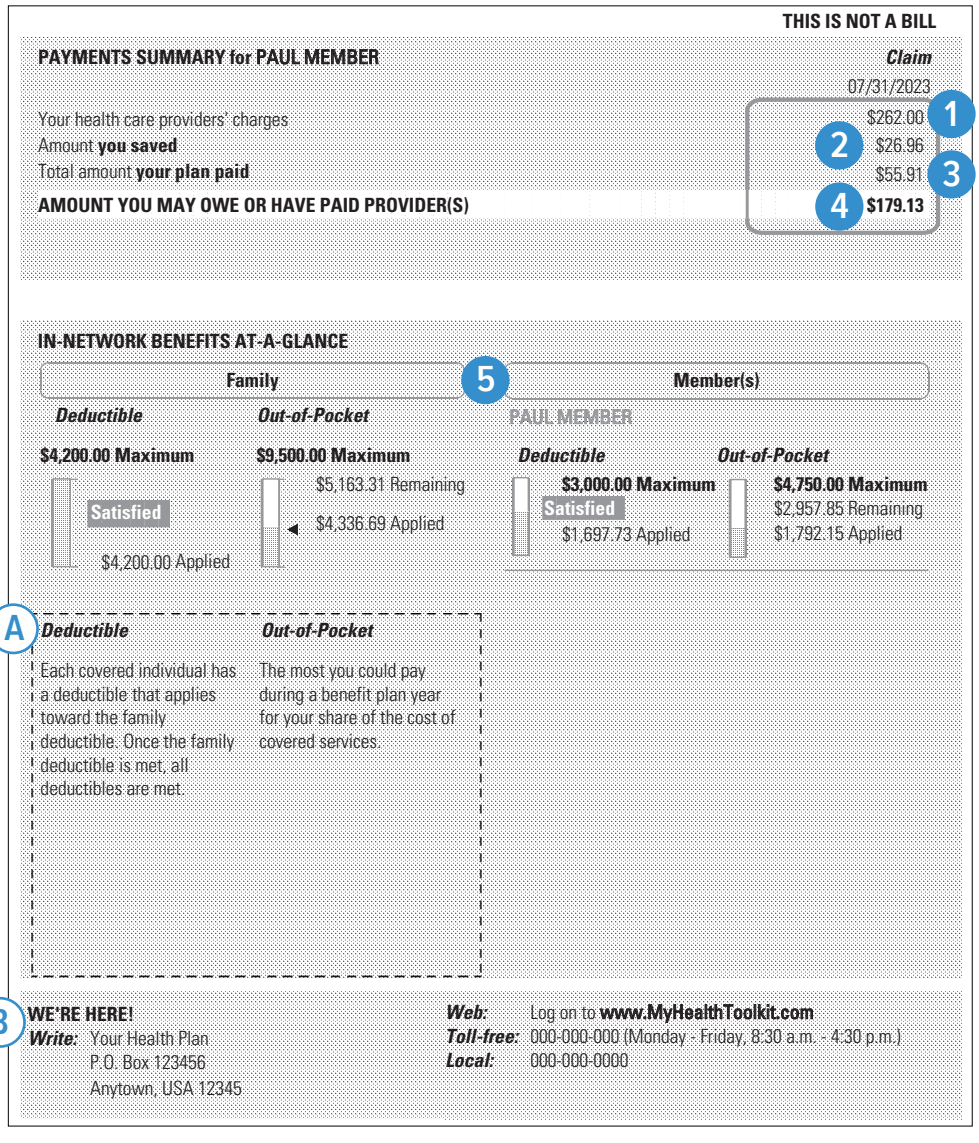
Whenever you use your health insurance, we send you an Explanation of Benefits (EOB). It shows you a breakdown of the services you received, the cost of those services and what you might have to pay your provider. **An EOB is not a bill**.

Your EOB shows you:

1. How much the doctor charged.
2. How much you saved through your health plan.
3. How much your health plan paid.
4. How much you may still owe.
5. How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your in-network benefits.

On page 1, you'll find:

- (A) Helpful definitions.
- (B) How to reach us if you have questions.
- (C) Your member ID number.



THIS IS NOT A BILL

PAYMENTS SUMMARY for PAUL MEMBER — ***Claim*** 07/31/2023

Your health care providers' charges	$262.00 (1)
Amount **you saved**	$26.96 (2)
Total amount **your plan paid**	$55.91 (3)
AMOUNT YOU MAY OWE OR HAVE PAID PROVIDER(S)	**$179.13** (4)

IN-NETWORK BENEFITS AT-A-GLANCE

Family		(5) Member(s)	
Deductible	***Out-of-Pocket***	PAUL MEMBER	
		Deductible	***Out-of-Pocket***
$4,200.00 Maximum	**$9,500.00 Maximum**	**$3,000.00 Maximum**	**$4,750.00 Maximum**
Satisfied	$5,163.31 Remaining	Satisfied	$2,957.85 Remaining
$4,200.00 Applied	$4,336.69 Applied	$1,697.73 Applied	$1,792.15 Applied

(A)

Deductible

Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.

Out-of-Pocket

The most you could pay during a benefit plan year for your share of the cost of covered services.

(B)

WE'RE HERE!

Write: Your Health Plan
P.O. Box 123456
Anytown, USA 12345

Web: Log on to **www.MyHealthToolkit.com**
Toll-free: 000-000-000 (Monday - Friday, 8:30 a.m. - 4:30 p.m.)
Local: 000-000-0000

Individual Claim Report

EXPLANATION OF BENEFITS

(C)

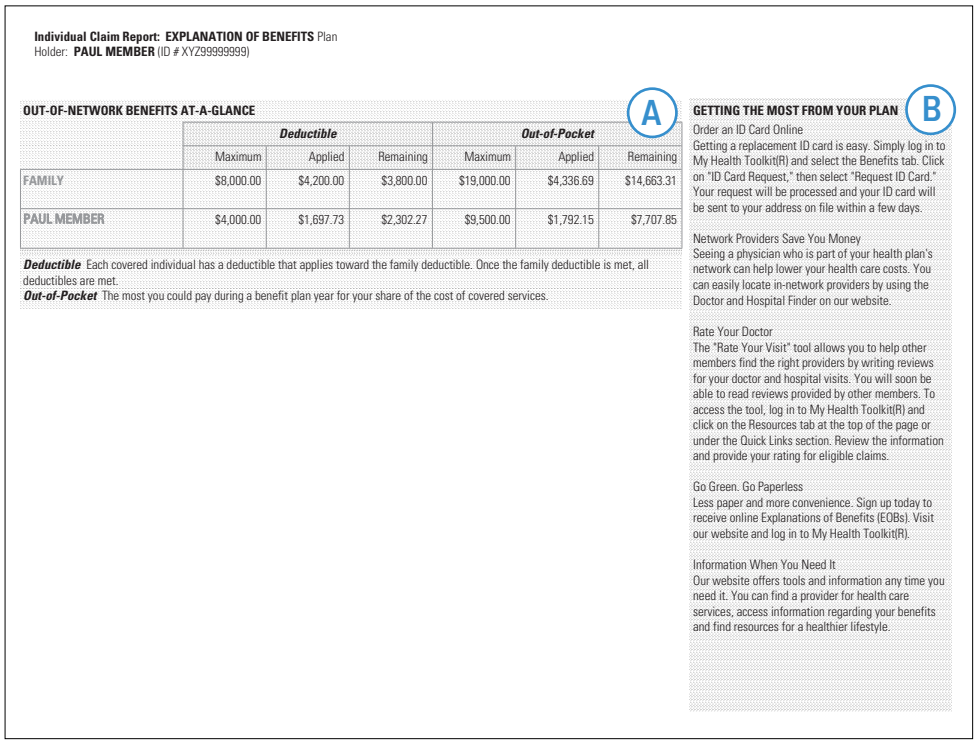
Plan Holder: PAUL MEMBER
(ID # XYZ999999999999)
Benefit Plan Year: 01/01/2023 - 01/01/2024
Notice Date: 08/07/2023

On page 2, you'll find:

- **A** How close you are to reaching your deductible and out-of-pocket maximum during this benefit period based on your out-of-network benefits.
- **B** Tips on using and making the most of your benefits.

On page 3, you'll find:

- **A** Details about your claim, including the claim number and provider.
- **B** When the visit took place and if the provider is in or out of network.
- **C** A breakdown of what your health plan paid and how much you might owe your provider. The amount you might owe does not reflect any amount you may have already paid the provider.
- **D** Additional details about your claim, including why a claim may have been denied.



Individual Claim Report: EXPLANATION OF BENEFITS Plan
Holder: **PAUL MEMBER** (ID # XYZ99999999)

OUT-OF-NETWORK BENEFITS AT-A-GLANCE (A)

	Deductible			Out-of-Pocket		
	Maximum	Applied	Remaining	Maximum	Applied	Remaining
FAMILY	$8,000.00	$4,200.00	$3,800.00	$19,000.00	$4,336.69	$14,663.31
PAUL MEMBER	$4,000.00	$1,697.73	$2,302.27	$9,500.00	$1,792.15	$7,707.85

Deductible Each covered individual has a deductible that applies toward the family deductible. Once the family deductible is met, all deductibles are met.
Out-of-Pocket The most you could pay during a benefit plan year for your share of the cost of covered services.

GETTING THE MOST FROM YOUR PLAN (B)

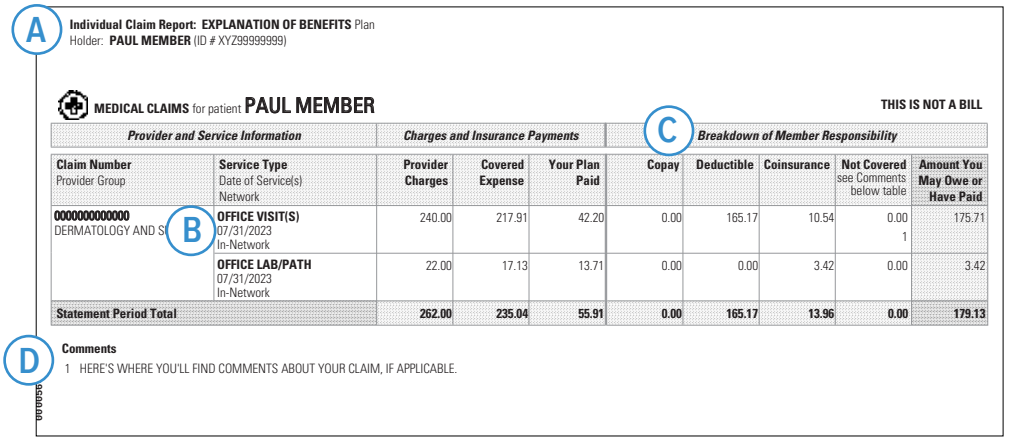
Order an ID Card Online
Getting a replacement ID card is easy. Simply log in to My Health Toolkit(R) and select the Benefits tab. Click on "ID Card Request," then select "Request ID Card." Your request will be processed and your ID card will be sent to your address on file within a few days.

Network Providers Save You Money
Seeing a physician who is part of your health plan's network can help lower your health care costs. You can easily locate in-network providers by using the Doctor and Hospital Finder on our website.

Rate Your Doctor
The "Rate Your Visit" tool allows you to help other members find the right providers by writing reviews for your doctor and hospital visits. You will soon be able to read reviews provided by other members. To access the tool, log in to My Health Toolkit(R) and click on the Resources tab at the top of the page or under the Quick Links section. Review the information and provide your rating for eligible claims.

Go Green. Go Paperless
Less paper and more convenience. Sign up today to receive online Explanations of Benefits (EOBs). Visit our website and log in to My Health Toolkit(R).

Information When You Need It
Our website offers tools and information any time you need it. You can find a provider for health care services, access information regarding your benefits and find resources for a healthier lifestyle.



(A) **Individual Claim Report: EXPLANATION OF BENEFITS** Plan
Holder: **PAUL MEMBER** (ID # XYZ99999999)

MEDICAL CLAIMS for patient **PAUL MEMBER** — **THIS IS NOT A BILL**

Provider and Service Information		Charges and Insurance Payments			(C) Breakdown of Member Responsibility				
Claim Number Provider Group	**Service Type** Date of Service(s) Network	**Provider Charges**	**Covered Expense**	**Your Plan Paid**	**Copay**	**Deductible**	**Coinsurance**	**Not Covered** see Comments below table	**Amount You May Owe or Have Paid**
0000000000000 DERMATOLOGY AND S (B)	**OFFICE VISIT(S)** 07/31/2023 In-Network	240.00	217.91	42.20	0.00	165.17	10.54	0.00 1	175.71
	OFFICE LAB/PATH 07/31/2023 In-Network	22.00	17.13	13.71	0.00	0.00	3.42	0.00	3.42
Statement Period Total		**262.00**	**235.04**	**55.91**	**0.00**	**165.17**	**13.96**	**0.00**	**179.13**

(D) **Comments**
1 HERE'S WHERE YOU'LL FIND COMMENTS ABOUT YOUR CLAIM, IF APPLICABLE.

0000000

Every EOB includes important information about how to appeal a denial of your claim. This will help you figure out what to do if you disagree with any of the benefits decisions made on this claim.

Check your EOBs through the **My Health Toolkit®** app or by logging in online. Select **Claims & Authorizations**, **Claims**, and then **Health Claims**.

Choose how you want to receive your EOBs — text, email or mail

You can set your contact preferences when you register for **My Health Toolkit**. Log in and select **Profile**, **My Account** and then **Contact Preferences**.

If you get paper EOBs, an EOB will be mailed to you after a claim has been finalized. If you've opted for online delivery, you'll get an email or text when your EOB is ready to view in **My Health Toolkit**.

MAKE SURE YOU'RE COVERED

Why coordination of benefits is important

Do you have other health insurance?

Coordination of benefits — COB, for short — affects your benefits when you or a family member also is covered under another health insurance plan. COB makes sure the right plan processes your claims first. It prevents overpayments and duplication of services. And that helps keep costs down for everyone.

Examples of other insurance: These may include coverage under a spouse's insurance plan, Medicaid or Medicare.

What you need to do: Be sure we have up-to-date information about your other insurance. That way, we can process your claims correctly and promptly.

- If you receive an Other Health Insurance Questionnaire in the mail, fill it out and return it right away. Even if you do not have coverage with another health plan, we need to know that, too.
- You also can give us this information by logging in to **My Health Toolkit®**. Select **My Plan Benefits**, **Health**, then **Other Health Insurance**.
- Or call the number on the back of your membership card and provide the information to a customer service advocate.

We appreciate your help with this.

Getting benefits after you have declined coverage

Special enrollment rights may apply to you, your spouse or other dependents even after you have declined coverage.

- For example, you might have declined coverage because other health insurance or another group health plan was in effect. Later, you may want to seek coverage with this plan if you or your dependents became ineligible for the other coverage or the employer stopped contributing to the other coverage. You must request our coverage within 30 days after this other coverage ends OR after the employer contribution stops.
- You also may be able to get coverage if you have a new dependent because of marriage, birth, adoption or placement for adoption. Again, you must request enrollment within 30 days of the event.

Please note that you may have been required to provide a written statement when you declined enrollment with us. If you did not provide this written statement, this health plan is not required to grant special enrollment rights to you or your dependents.

For more information, contact your employer's benefit department.

MEMBER PERKS

Discounts for you — just for being Blue!

In addition to superior health coverage, your membership provides access to exclusive discounts on a variety of products and services. The member discounts program includes items that generally are not covered byhealth insurance.

Log in to My Health Toolkit, select the **Resources** tab, then **Blue365® Discounts**. On a mobile device, select **Menu**, then **Blue365® Discounts**. You'll find details on discounts for:

Fitness

- Gym memberships
- Wearable fitness devices
- Activewear
- Magazine subscriptions
- 5K and obstacle course registration
- Home fitness equipment
- Vitamins and nutritional supplements

Excludes Silver Sneakers Program

Personal care

(please note that some restrictions may apply for these services.)

- Allergy relief
- Acupuncture
- Chiropractic services
- Massage therapy
- Hair restoration
- Teeth whitening

Healthy eating

- Weight loss programs
- Cookbooks and recipes
- Online cooking classes

Hearing and vision

- Hearing aids
- Eyewear

Lifestyle

- Travel clubs
- Vacation packages
- Pet care

YOU'VE GOT AN ADVOCATE IN YOUR CORNER

Managing your health care issues is easier if you don't have to do it alone. Care Connected links you with someone who's knowledgeable about the issues you face and about your benefits plan. Depending on your needs, this could be a dedicated customer service advocate or a dedicated nurse.

What is Care Connected?

Care Connected is a free program that can help you make informed health care decisions. Our team includes dedicated customer service advocates, registered nurses, pharmacists, social workers, physicians, licensed behavioral health specialists, maternity and NICU nurses, and other health and well-being professionals. Connect online or by phone!

Your Care Connected team can help you:

- Understand your insurance plan.
- Choose the right care.
- Navigate the system and review your bills.
- Deal with difficult health issues.

Your dedicated nurse can assist you with:

- Heart failure.
- Chronic obstructive pulmonary disease.
- Diabetes (adults and children).
- Cancer.
- End-stage renal disease.
- Maternity.
- Neonatal intensive care.
- Depression and other behavioral health conditions.

Connect with an app

The **My Health Planner**[SM] app is free for eligible members! It helps you keep track of what you need to do between doctor visits and stay in touch with your care team.

If you qualify for one of our care management programs, we will reach out to you with a phone call, email, text or letter to help you get started. You can also reach the Care Connected team at the phone number on the back of your ID card. The first time you call, you will be assigned a dedicated customer service advocate, someone who is familiar with your benefits plan and your personal health needs. Subsequent calls will be automatically routed to your dedicated advocate.

To learn more, log in to **My Health Toolkit**®, select **Wellness and Care Management**, then **Care Management**.

HELPFUL TERMS

Words commonly used in health care

Health care lingo can be confusing. Here are some terms you might need to know.

Claim: A request for payment that you or your health care provider submits to your health insurance company after you receive services.

Copay (or copayment): A set rate you pay for doctor visits, prescriptions and other types of care. For example, you might pay $20 for a doctor visit and $5 for a generic prescription.

Deductible: The set amount you pay for medical services and prescriptions before your coinsurance kicks in fully. For example, you'd meet a $1,000 deductible after your payments for various medical services add up to $1,000.

Coinsurance: The percentage of covered health care costs you pay after you've met your deductible. For example, you might pay 20 percent at that point, and your plan pays 80 percent.

Network: The facilities, providers and suppliers your health plan contracts with to provide health care services. You will typically pay less for services received in network versus out of network.

Out of pocket: Your costs for medical care expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance and copayments for covered services, plus costs for services that aren't covered.

Subscriber: The person who enrolls in a health plan. There is only one subscriber per health plan. The subscriber can add eligible dependents to a family health plan.

Prior authorization: A decision verifying that a service, prescription drug or type of treatment is medically necessary. Certain services and medications require prior authorization before you receive them, except in an emergency.

Premium: The amount you pay for your health plan's coverage, usually every two weeks or monthly.

Primary care physician (PCP): The main doctor and primary contact for your health care services.

Specialist: A doctor or health care professional who focuses on a specific area of medicine. For example, orthopedic surgeons, dermatologists and cardiologists are specialists.

Telehealth: Allows a patient to connect with a health care provider with virtual visits through an electronic device such as a smartphone or computer. Licensed telehealth providers offer nonemergency consultations for a variety of conditions and can prescribe medication when appropriate.

NON-DISCRIMINATION STATEMENT AND FOREIGN LANGUAGE ACCESS

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or when we provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice **(TDD 711)**.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing **contact@hcrcompliance.com** or by calling our Compliance area at **800-832-9686** or the U.S. Department of Health and Human Services, Office for Civil Rights at **800-368-1019** or **800-537-7697 (TDD)**.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ąąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

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