## APPENDIX D

# FREEDOM AREA SCHOOL DISTRICT
# BENEFIT ELECTION FORM

You have the opportunity to participate in the Freedom Area School District Waiver of Health Care Coverage Plan (the "Plan") and elect to receive additional taxable compensation in lieu of health insurance coverage. Complete Section 1, sign at the bottom, and return this Election Form to the Business Manager. Your compensation will be increased in the amount as listed in Section 2. Only those employees who are eligible to participate in the Freedom Area School District Health Insurance Plan and are enrolled in another group medical plan, such as a spouse's plan, or covered by an individual policy, are eligible to participate in this Plan.

**Irrevocable Election** If you choose to participate in this Plan, you can not change or revoke your election until the next open enrollment period for the next Plan Year that runs from January 1 through December 31 unless you have a change in status as described in the Plan. Examples of a change in status are: marriage, divorce, death of your spouse or child, birth or adoption of a child, termination of employment of your spouse, switch from part-time to full-time employment or from full-time to part-time employment, beginning an unpaid leave of absence, or where there has been a significant change in your or your spouse's health coverage attributable to the spouse's employment. The election change must be requested within 30 days of the event, and must be on account of and consistent with the change in status as defined in the Plan.

### 1. Employee Information

Name: _____ SS#: _____

### 2. Election

For the Plan Year commencing January 1, _____, I hereby elect to receive the following benefit **(select only one):**

___ PPO Qualified High Deductible Health Plan

___ Waiver Compensation ($2,000 per Plan Year) ($1000 if half-time)

### 3. Waiver Compensation

By electing to receive Waiver Compensation, I am waiving participation in the Health Insurance Plan. I understand that I will receive additional taxable compensation during the Plan Year in the amount of $2,000 such (or $1000 for half-time employees, or prorated) such payment being made with the December payroll. (Such additional compensation does not qualify as "compensation" as defined by the Pennsylvania State Employee Retirement Code and, therefore, is not subject to member-paid or employer-paid contributions to the Pennsylvania State Employee Retirement System).

### 4. Employee Statement and Signature

I hereby certify my election as designated above under the Freedom Area School District Waiver of Health Care Coverage Plan for the duration of the Plan Year. If I elected the Waiver Compensation benefit, I certify that I am covered for health care under another group/individual health plan as documented by my submission of such coverage. I acknowledge that I have read and understand any material (including the Summary Plan Description) concerning the effect of my election. I further understand that if I elected to waive receiving health insurance from the Freedom Area School District, I agree to hold Freedom Area School District harmless from any medical claim expenses incurred subject to group/individual health insurance plan coverage on my eligible dependents or myself. My election on this Election Form revokes any prior election relating to the same matter under the Plan. Before the beginning of each Plan Year, I will be offered the opportunity to change my election for the following Plan Year.

This Election Form is subject to the terms of the Plan as in effect from time to time and shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania to the extent not superseded by Federal law.

_____ _____

Employee's Signature Date

_____

_

**Administrator Use Only:**

Proof of other coverage received Date: _____ Received by:_____

# FREEDOM AREA SCHOOL DISTRICT-INSURANCE ENROLLMENT/CHANGE FORM

☐ New Enrollment ☐ Name Change ☐ Address Change ☐ Change of Dependents ☐ Termination

☐ COBRA

| SOCIAL SECURITY NUMBER | LAST NAME | FIRST | MI | DATE OF BIRTH | SEX |
|---|---|---|---|---|---|
| | | | | | |

| ADDRESS | HIRE DATE | | PHONE NUMBERS |
|---|---|---|---|
| | | | |
| | | | |

COVERAGE OPTION

☐ Employee Only ☐ Parent/Child(ren)

☐ Employee/Spouse ☐ Family

NOTES:

**Other Insurance** ☐ YES ☐ NO

| NAME AND ADDRESS OF CARRIER(S) | GROUP NUMBER | POLICY HOLDER | RELATIONSHIP |
|---|---|---|---|
| | | | |
| | | | |

3. DEPENDENT CHANGE — CHOOSE ONE PLEASE

☐ ADD DEPENDENTS LISTED BELOW ☐ DELETE DEPENDENTS LISTED BELOW

| DEPENDENTS | LAST NAME | FIRST NAME | MI | STUDENT | SEX | DATE OF BIRTH | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|---|---|---|
| Spouse | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |

| EFFECTIVE DATE OF ABOVE CHANGE(S) | REASON FOR ABOVE CHANGE(S) |
|---|---|
| | |

EMPLOYEE SIGNATURE DATE

EMPLOYER SIGNATURE DATE

# FREEDOM AREA SCHOOL DISTRICT

## HSA ELIGIBILITY DETERMINATION / PRE-TAX SALARY REDUCTION ELECTION FORM – Coverage for January 1 – December 31, 2024

First Name MI Last Name

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

I understand that if I meet the eligibility standards as defined by the IRS, my employer may make a contribution to my Health Savings Account ("HSA"). I may also elect to make pre-tax contributions to my HSA through payroll reductions. These pre-tax contributions are available under my employer's Section 125 Plan. When making this election, I further understand the 2024 contribution limits for HSAs are $4,150 for Employee Only Plans and $8,300 for Family Plans (with a catch up provision for participants age 55 years and older of an additional $1,000 over the respective category limit). This maximum contribution level is the sum of employer and employee contributions.

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**Please make your election below, then sign and date your form and submit it to the Payroll Office:**

I certify that I meet the following requirements and thus am eligible to have a Health Savings Account ("HSA"):

- I am or will be enrolled in Qualified High Deductible Health Plan
- I am not enrolled as a dependent in a non-QHDHP coverage
- I am not enrolled in Medicare (Including active employees enrolled in Medicare Part A)
- I am not enrolled in TriCare
- I am not claimed as a dependent on another person's tax return
- I nor my spouse are enrolled in a Medical Flexible Savings Account (FSA) or Health Reimbursement Account (HRA)
- I am not receiving Social Security or Railroad Retirement Board Benefits and enrolled in Medicare Part A.

I understand that I must maintain the eligibility requirements for the current benefit period to remain eligible to ***receive and make contributions*** to my Health Savings Account.

☐ I am **not eligible**, as defined by the IRS, to be enrolled in a Health Savings Account.

☐ I **am eligible**, as defined by the IRS, to be enrolled in a Health Savings Account, and I elect to have deducted _____ per pay period, effective _____ and continuing until I change my election. I understand that my election is prospective only and that the contribution(s) I have elected will be made with pre-tax salary reductions and that such reductions reduce my compensation for Social Security benefit purposes.

☐ I **am eligible**, as defined by the IRS, to be enrolled in a Health Savings Account and to receive employer contributions to my HSA; however, I am declining the option to make pre-tax contributions to my HSA at this time.

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Employee Signature _____ Date _____

# Beneficiary Designation Under Group Life Insurance Policy

*Products and financial services provided by*
*American United Life Insurance Company®*
*a OneAmerica® company*
*One American Square, P.O. Box 6123*
*Indianapolis, IN 46206-6123*
*1-800-553-5313 Fax: 1-888-285-1565*
*www.employeebenefits.aul.com*

OneAmerica®

**IMPORTANT:** PLEASE READ INSTRUCTIONS AND SAMPLE DESIGNATIONS ON REVERSE SIDE BEFORE COMPLETING FORM.

CHECK IF BENEFICIARY FOR: ☑ All Policies or ☐ Basic Life ☐ Supplemental ☐ Voluntary Term Life ☐ AD&D ☐ List Other _____

| | | | |
|---|---|---|---|
| Group Policy/Participating Unit Number | 00622439-0000-000 | | |
| Name of Group Policyholder/Participating Unit | FREEDOM AREA SD | | |
| Name of Insured Person | | | |
| Insured Person's SSN | | Insured Person's Date of Birth | |

Subject to the provisions of the policy, applicable laws, and the rights of any valid assignee of record with American United Life Insurance Company® (AUL), it is requested the beneficiary of any policy proceeds payable at the death of the Insured Person be as follows:

**PRIMARY BENEFICIARY(S)**

| *Name* | *Relationship* | *Address* | *DOB* | *SSN* | *Percentage* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | **Total**[1] | | 0 |

**CONTINGENT BENEFICIARY(S) IF THE PRIMARY BENEFICIARY(S) PREDECEASES YOU**

| *Name* | *Relationship* | *Address* | *DOB* | *SSN* | *Percentage* |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | **Total**[2] | | 0 |

It is understood and agreed upon receipt of this beneficiary designation by AUL at its principal office, such beneficiary designation will become effective and shall relate back to the date this beneficiary designation is signed, but without prejudice to AUL on account of any payment made prior to the receipt of and acknowledgement of the validity of the beneficiary designation by AUL. AUL shall not be obligated to honor this beneficiary designation unless and until it has been received by AUL, acknowledged by the appropriate officer of AUL, and determined by AUL to comply with applicable law at the time a claim is made. This beneficiary designation supersedes and cancels all prior beneficiary designations by the Insured Person for the policy(s) indicated. If no beneficiary designation is named on any additional AUL coverage, the undersigned understands that this beneficiary designation will be used by AUL for any additional coverage.

The undersigned hereby declares that he/she has not been declared incompetent and no court order or laws prevent naming the above designee(s). It is agreed that AUL assumes no responsibility for the validity or effect of any purported beneficiary designation or transfer of rights under the policy. **The undersigned represents and warrants any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.** The undersigned understands and agrees: 1) any insurance coverage or benefits is contingent upon any statements made to AUL as being complete and correct and 2) benefits under any policy will be paid only if AUL decides the applicant is entitled to them under the policy.

| | |
|---|---|
| *Signature of Insured* | *Signature of Witness*<br>*(The Witness must have no interest in the policy/contract or be a named beneficiary)* |
| *Printed Name* | *Printed Name* |
| *Date* | *Date* |

Lack of Notice of Community Property Interest: If AUL has not previously received written notice of a community property interest and if the space for consent below is not signed by a person having such an interest, then AUL shall be entitled to rely upon its good faith that no such interest exists. AUL assumes no responsibility of inquiry regarding such interest and, in consideration of acknowledgement of this designation, the insured person listed above, for himself/herself and his/her estate, heirs, successors and assigns, agrees to indemnify AUL and hold it harmless from the consequences of acknowledging this beneficiary designation.

Spouse's signature and consent *(if applicable)*[3] _____ Date _____

1 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

2 Total percentage must equal 100%. If percentages do not equal 100%, then benefits will be paid on a pro-rata basis, according to the percentages shown. If no percentages are shown, benefits will be distributed equally.

3 Spouse's signature is needed only if Insured/Beneficiary lives in a community property state which currently include AZ, CA, ID, LA, NM, NV, TX, WA and WI.

# Freedom Area School District (Teachers, Administration, Support Staff)

## Overview of Current PPOBlue Qualified High Deductible Health Plan

### Non-Grandfathered

| BENEFIT | PPOBlue Qualified High Deductible Health Plan<br>Group Numbers - 17108-00 (Active) & -70 (Inactive) | |
|---|---|---|
| | In-Network Care[1] | Out-of-Network Care[1,2] |
| **Policy Provisions** | | |
| Benefit Period | January 1 - December 31 | |
| Benefit Period Deductible[3]<br>(Employee Only Plan / Family Plan) | $1,600 / $3,200<br>Applies to Medical and Prescription Drug Benefits | |
| Co-Insurance (The Plan Pays:) | 100% after deductible | 80% after deductible |
| Annual Out-of-Pocket Maximum[4]<br>(Employee Only Plan / Family Plan) | Not Applicable<br>*Does not apply when the in-network co-insurance is 100% after deductible* | $1,500 / $3,000[5]<br>(not including deductibles)<br>(not including balance billing) |
| Total Maximum Out-of-Pocket (Employee Only Plan / Family Plan)[6]<br>(Includes medical and prescription drug deductible, coinsurance, & copays) | $6,350 / $12,700 | Not Applicable |
| Lifetime Maximum Per Person | Unlimited | |
| Dependent Eligibility | Dependents to age 26 | |
| Precertification Requirements | Yes (provider responsibility) | Yes[7] |
| **Preventive Care Services** | | |
| Routine Physical Exams (adult & pediatric) | 100% (deductible does not apply) | 80% after deductible |
| Routine Gynecological Exams, including PAP Test | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Adult Immunizations | 100% (deductible does not apply) | 80% after deductible |
| Childhood Immunizations | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Mammograms - Routine | 100% (deductible does not apply) | 80% after deductible |
| Colorectal Cancer Screening - Routine | 100% (deductible does not apply) | 80% after deductible |
| **Hospital / Physician Services** | | |
| Physician Office Visits | 100% after deductible | 80% after deductible |
| Specialist Office Visits | 100% after deductible | 80% after deductible |
| Maternity Care (facility & professional) | 100% after deductible | 80% after deductible |
| Inpatient Hospital Services | 100% after deductible | 80% after deductible |
| Outpatient Hospital Services | 100% after deductible | 80% after deductible |
| Medical/Surgical Services (except office visits) | 100% after deductible | 80% after deductible |
| Diagnostic Services<br>Advanced Imaging (MRI, CAT Scan, PET Scan, etc) | 100% after deductible | 80% after deductible |
| Basic Diagnostic Services (Standard Imaging, Diagnostic Medical, Lab/Pathology, Allergy Testing) | 100% after deductible | 80% after deductible |
| Mammograms - Medically Necessary | 100% after deductible | 80% after deductible |
| Colorectal Cancer Screening - Medically Necessary | 100% after deductible | 80% after deductible |
| Allergy Extracts | 100% after deductible | 80% after deductible |
| Transplant Services | 100% after deductible | 80% after deductible |
| **Emergency Services** | | |
| Emergency Room Services[8] | $100 copayment per visit after deductible | |
| Ambulance | 100% after deductible | 80% after deductible |
| **Therapy Services** | | |
| Spinal Manipulation Services | 100% after deductible | 80% after deductible |
| Physical Therapy Services | 100% after deductible | 80% after deductible |
| Speech & Occupational Therapy Services | 100% after deductible | 80% after deductible |
| Cardiac Rehabilitation, Chemotherapy, & Dialysis Treatment | 100% after deductible | 80% after deductible |
| Infusion, Radiation, & Respiratory Therapy Services | 100% after deductible | 80% after deductible |

# Freedom Area School District (Teachers, Administration, Support Staff)

## Overview of Current PPOBlue Qualified High Deductible Health Plan

### Non-Grandfathered

| BENEFIT | PPOBlue Qualified High Deductible Health Plan<br>Group Numbers - 17108-00 (Active) & -70 (Inactive) | |
|---|---|---|
| | In-Network Care[1] | Out-of-Network Care[1,2] |
| **Behavioral Health Services** | | |
| Mental Health - Inpatient | 100% after deductible | 80% after deductible |
| Mental Health - Outpatient | 100% after deductible | 80% after deductible |
| Substance Abuse - Inpatient Detoxification | 100% after deductible | 80% after deductible |
| Substance Abuse - Inpatient Rehabilitation | 100% after deductible | 80% after deductible |
| Substance Abuse - Outpatient Rehabilitation | 100% after deductible | 80% after deductible |
| **Other Services** | | |
| Dental Services Related to Accidental Injury | 100% after deductible | 80% after deductible |
| Diabetes Treatment | 100% after deductible | 80% after deductible |
| Durable Medical Equipment | 100% after deductible | 80% after deductible |
| Enteral Formulae | 100% after deductible | 80% after deductible |
| Home Infusion Therapy | 100% after deductible | 80% after deductible |
| Home Health Care | 100% after deductible | 80% after deductible |
| Hospice Care | 100% after deductible | 80% after deductible |
| Infertility Counseling, Testing and Treatment[9] | 100% after deductible | 80% after deductible |
| Orthotics | 100% after deductible | 80% after deductible |
| Pediatric Extended Care Services | 100% after deductible | 80% after deductible |
| | *Combined Limit: 100 days per benefit period* | |
| Private Duty Nursing | 100% after deductible | 80% after deductible |
| Prosthetics | 100% after deductible | 80% after deductible |
| Skilled Nursing Facility | 100% after deductible | 80% after deductible |
| **Prescription Drugs** | | |
| Prescription Drug Deductible | Works In Conjunction with Medical Deductible | |
| Prescription Drug (retail) | 100% after deductible[10]<br>Up to a 31 day supply<br>National Pharmacy Network<br>Open Formulary | |
| Prescription Drug (mail order) | 100% after deductible[10]<br>Up to a 90 day supply<br>Open Formulary | |

[1] You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

[2] Precertification may be required for services rendered by out-of-network providers.

[3] Deductible levels are determined by the IRS and are subject to change.

[4] The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services and covered medications in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. In-network expenses are paid at 100% after satisfying the deductible; with 100% coverage there is no applicable coinsurance incurred; therefore, the out-of-pocket limit is not applicable.

[5] Non-participating providers or those who are not in the Highmark network can bill members for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services that are performed by the non-participating provider. This is referred to as balance billing and the member's liability is not limited by the health plan. Balance billing liabilities are above and beyond the out-of-pocket maximum listed on this benefit grid.

[6] The in-network total maximum out-of-pocket as mandated by the federal government must include medical and prescription drug deductible, coinsurance, & copays. If you are enrolled as an individual, the deductible, and Total Maximum Out-of-Pocket for the "Employee Only" plan apply. If you are enrolled in a "Family" plan, the entire family deductible and Total Maximum Out-of-Pocket apply.

[7] HMS must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs incurred.

[8] Emergency service is any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

[9] Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

[10] At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible.

***NOTE:*** *This grid is only provided as a brief overview of benefits. All services must be medically necessary and appropriate, as determined by Highmark Blue Cross Blue Shield, for benefits to apply.*
*For questions concerning your benefits, please contact The Reschini Group at 1-800-442-8047.*

The Reschini Group
January 2024

# Freedom Area School District (Food Service & Custodians)

## Overview of Current PPOBlue Qualified High Deductible Health Plan

## Non-Grandfathered

| BENEFIT | PPOBlue Qualified High Deductible Health Plan<br>Group Numbers: 17108-02 (Active) & -03 (Inactive) | |
|---|---|---|
| | In-Network Care[1] | Out-of-Network Care[1,2] |
| **Policy Provisions** | | |
| Benefit Period | January 1 - December 31 | |
| Benefit Period Deductible[3]<br>(Employee Only Plan / Family Plan) | $1,600 / $3,200<br>Applies to Medical and Prescription Drug Benefits | |
| Co-Insurance (The Plan Pays:) | 100% after deductible | 80% after deductible |
| Annual Out-of-Pocket Maximum[4]<br>(Employee Only Plan / Family Plan) | Not Applicable<br>*Does not apply when the in-network co-insurance is 100% after deductible* | $1,500 / $3,000[5]<br>(not including deductibles)<br>(not including balance billing) |
| Total Maximum Out-of-Pocket (Employee Only Plan / Family Plan)[6]<br>(Includes medical and prescription drug deductible, coinsurance, & copays) | $6,350 / $12,700 | Not Applicable |
| Lifetime Maximum Per Person | Unlimited | |
| Dependent Eligibility | Dependents to age 26 | |
| Precertification Requirements | Yes (provider responsibility) | Yes[7] |
| **Preventive Care Services** | | |
| Routine Physical Exams (adult & pediatric) | 100% (deductible does not apply) | 80% after deductible |
| Routine Gynecological Exams, including PAP Test | 100% (deductible does not apply) | 80% (deductible does not apply) |
| Adult Immunizations | 100% (deductible does not apply) | 80% after deductible |
| Childhood Immunizations | 100% (deductible does not apply) | 80% (deductible does not apply) |
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| Specialist Office Visits | 100% after deductible | 80% after deductible |
| Maternity Care (facility & professional) | 100% after deductible | 80% after deductible |
| Inpatient Hospital Services | 100% after deductible | 80% after deductible |
| Outpatient Hospital Services | 100% after deductible | 80% after deductible |
| Medical/Surgical Services (except office visits) | 100% after deductible | 80% after deductible |
| Diagnostic Services<br>Advanced Imaging (MRI, CAT Scan, PET Scan, etc) | 100% after deductible | 80% after deductible |
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| Allergy Extracts | 100% after deductible | 80% after deductible |
| Transplant Services | 100% after deductible | 80% after deductible |
| **Emergency Services** | | |
| Emergency Room Services[8] | $100 copayment per visit after deductible | |
| Ambulance | 100% after deductible | 80% after deductible |
| **Therapy Services** | | |
| Spinal Manipulation Services | 100% after deductible | 80% after deductible |
| Physical Therapy Services | 100% after deductible | 80% after deductible |
| Speech & Occupational Therapy Services | 100% after deductible | 80% after deductible |
| Cardiac Rehabilitation, Chemotherapy, & Dialysis Treatment | 100% after deductible | 80% after deductible |
| Infusion, Radiation, & Respiratory Therapy Services | 100% after deductible | 80% after deductible |

# Freedom Area School District (Food Service & Custodians)

## Overview of Current PPOBlue Qualified High Deductible Health Plan

### Non-Grandfathered

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| | In-Network Care[1] | Out-of-Network Care[1,2] |
| **Behavioral Health Services** | | |
| Mental Health - Inpatient | 100% after deductible | 80% after deductible |
| Mental Health - Outpatient | 100% after deductible | 80% after deductible |
| Substance Abuse - Inpatient Detoxification | 100% after deductible | 80% after deductible |
| Substance Abuse - Inpatient Rehabilitation | 100% after deductible | 80% after deductible |
| Substance Abuse - Outpatient Rehabilitation | 100% after deductible | 80% after deductible |
| **Other Services** | | |
| Dental Services Related to Accidental Injury | 100% after deductible | 80% after deductible |
| Diabetes Treatment | 100% after deductible | 80% after deductible |
| Durable Medical Equipment | 100% after deductible | 80% after deductible |
| Enteral Formulae | 100% after deductible | 80% after deductible |
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| Home Health Care | 100% after deductible | 80% after deductible |
| Hospice Care | 100% after deductible | 80% after deductible |
| Infertility Counseling, Testing and Treatment[9] | 100% after deductible | 80% after deductible |
| Orthotics | 100% after deductible | 80% after deductible |
| Pediatric Extended Care Services | 100% after deductible | 80% after deductible |
| | *Combined Limit: 100 days per benefit period* | |
| Private Duty Nursing | 100% after deductible | 80% after deductible |
| Prosthetics | 100% after deductible | 80% after deductible |
| Skilled Nursing Facility | 100% after deductible | 80% after deductible |
| **Prescription Drugs** | | |
| Prescription Drug Deductible | Works In Conjunction with Medical Deductible | |
| Prescription Drug (retail) | 100% after deductible[10]<br>Up to a 31 day supply<br>National Pharmacy Network<br>Open Formulary | |
| Prescription Drug (mail order) | 100% after deductible[10]<br>Up to a 90 day supply<br>Open Formulary | |

[1] You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

[2] Precertification may be required for services rendered by out-of-network providers.

[3] Deductible levels are determined by the IRS and are subject to change.

[4] The out-of-pocket limit refers to the specified dollar amount of coinsurance incurred for covered services and covered medications in a benefit period. When the specified dollar amount is attained, your program begins to pay 100% of all covered expenses. In-network expenses are paid at 100% after satisfying the deductible; with 100% coverage there is no applicable coinsurance incurred; therefore, the out-of-pocket limit is not applicable.

[5] Non-participating providers or those who are not in the Highmark network can bill members for the difference between the amount that the non-participating provider bills and the payment Highmark will make for the covered services that are performed by the non-participating provider. This is referred to as balance billing and the member's liability is not limited by the health plan. Balance billing liabilities are above and beyond the out-of-pocket maximum listed on this benefit grid.

[6] The in-network total maximum out-of-pocket as mandated by the federal government must include medical and prescription drug deductible, coinsurance, & copays. If you are enrolled as an individual, the deductible, and Total Maximum Out-of-Pocket for the "Employee Only" plan apply. If you are enrolled in a "Family" plan, the entire family deductible and Total Maximum Out-of-Pocket apply.

[7] HMS must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Some facility providers will contact HMS and obtain precertification of the inpatient admission on your behalf. Be sure to verify that your provider is contacting HMS for precertification. If not, you are responsible for contacting HMS. If this does not occur and it is later determined that all or part of the inpatient stay was not medically necessary or appropriate, you will be responsible for payment of any costs incurred.

[8] Emergency service is any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

[9] Treatment includes coverage for the correction of a physical or medical problem associated with infertility. Infertility drug therapy may or may not be covered depending on your group's prescription drug program.

[10] At a retail or mail order pharmacy, if your deductible has not been met, you pay the entire cost for your prescription drug at the discounted rate Highmark has negotiated. The amount you paid for your prescription will be applied to your deductible.

***NOTE:*** *This grid is only provided as a brief overview of benefits. All services must be medically necessary and appropriate, as determined by Highmark Blue Cross Blue Shield, for benefits to apply.*
*For questions concerning your benefits, please contact The Reschini Group at 1-800-442-8047.*

The Reschini Group
January 2024

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.freedomareaschools.org or call (724)775-7644. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call (724)775-7644 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $1,600 individual/$3,200 family, combined network and out-of-network. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Network deductible does not apply to preventive care services.<br><br>Coinsurance amounts don't count toward the network deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $0 individual/$0 family network out-of-pocket limit, up to a total maximum out-of-pocket limit of $6,350 individual/$12,700 family.<br><br>$1,500 individual/$3,000 family out-of-network. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. |
| **What is not included in the out–of–pocket limit?** | Network: Premiums, balance-billing charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket limit.<br><br>Out-of-network: Premiums, deductibles, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

| | | |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. For a list of network providers, see www.freedomareaschools.org or call (724)775-7644. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).<br>Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do I need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No charge | 20% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.<br><br>Please refer to your preventive schedule for additional information. |
| | Specialist visit | No charge | 20% coinsurance | |
| | Preventive care/Screening/Immunization | No charge for preventive care services; deductible does not apply | 20% coinsurance for preventive care services | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | 20% coinsurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | No charge | 20% coinsurance | ----------none---------- |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.highmarkbcbs.com. | Generic drugs | No charge (retail and mail order) | Not covered | Up to 31-day supply retail pharmacy.<br><br>Up to 90-day supply maintenance prescription drugs through mail order. |
| | Brand drugs | No charge (retail and mail order) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | 20% coinsurance | ----------none---------- |
| | Physician/surgeon fees | No charge | 20% coinsurance | ----------none---------- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need immediate medical attention** | Emergency room Care | $100 copay/visit | $100 copay/visit | ----------none---------- |
| | Emergency medical transportation | No charge | 20% coinsurance | ----------none---------- |
| | Urgent care | No charge | 20% coinsurance | ----------none---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | 20% coinsurance | Precertification may be required. |
| | Physician/surgeon fee | No charge | 20% coinsurance | ----------none---------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | No charge | 20% coinsurance | ----------none---------- |
| | Inpatient services | No charge | 20% coinsurance | Precertification may be required. |
| **If you are pregnant** | Office visits | No charge | 20% coinsurance | Precertification may be required for inpatient facility services.<br>Cost sharing does not apply for preventive services.<br>Depending on the type of services, a coinsurance or deductible may apply.<br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br>Network: The first visit to determine pregnancy is covered at no charge.<br>Please refer to the Women's Health Preventive Schedule for additional information. |
| | Childbirth/delivery professional services | No charge | 20% coinsurance | |
| | Childbirth/delivery facility services | No charge | 20% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | 20% coinsurance | ----------none---------- |
| | Rehabilitation services | No charge | 20% coinsurance | ----------none---------- |
| | Habilitation services | Not covered | Not covered | ----------none---------- |
| | Skilled nursing care | No charge | 20% coinsurance | Precertification may be required. |
| | Durable medical equipment | No charge | 20% coinsurance | ----------none---------- |
| | Hospice service | No charge | 20% coinsurance | ----------none---------- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's Eye exam | Not covered | Not covered | ----------none---------- |
| | Children's Glasses | Not covered | Not covered | ----------none---------- |
| | Children's Dental check-up | Not covered | Not covered | ----------none---------- |

## Excluded Services & Other Covered Services:

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

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

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

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

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

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

- Your plan administrator/employer (724)775-7644.
- Highmark Inc. at 1-800-241-5704.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

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

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

**To obtain language assistance, call (724)775-7644.**
SPANISH (Español): Para obtener asistencia en Español, llame al (724)775-7644.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (724)775-7644.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (724)775-7644.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (724)775-7644.

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

## About these Coverage Examples:

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

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,600 |
| Specialist coinsurance | 0% |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

| **Total Example Cost** | **$12,700** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,600 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,660** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,600 |
| Specialist coinsurance | 0% |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| **Total Example Cost** | **$5,600** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,600 |
| Copayments | $0 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,620** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,600 |
| Specialist coinsurance | 0% |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

| **Total Example Cost** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,600 |
| Copayments | $100 |
| Coinsurance | $0 |
| ***What isn't covered*** | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,700** |

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact (724)775-7644.

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

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

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

**Discrimination is Against the Law**
The claims administrator 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 does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The claims administrator:

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

***Please note that your employer – and not the claims administrator - is entirely responsible for determining member eligibility and for the design of your plan/program; including, any exclusion or limitation described in the benefit Booklet.***

If you speak English, language assistance services, free of charge, are available to you. Call 1-855-329-0729.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-855-329-0729.

如果您说中文，可向您提供免费语言协助服务。请致电 1-855-329-0729.

Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel 1-855-329-0729.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-855-329-0729.

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-855-329-0729.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-855-329-0729.

જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-855-329-0729 નંબર પર ફોન કરો.

यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। 1-855-329-0729 पर फोन करें।

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-855-329-0729.

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。1-855-329-0729 を呼び出します。

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-855-329-0729 로 전화.

បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ការហៅ 1-855-329-0729 ។

Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níik'eh, bee níká a'doowoł, éí bee ná'nhóót'i'. Koji' hodíilnih 1-855-329-0729.

यदि तपाई नेपाली भाषा बोल्नुहुन्छ भने, तपाईका लागि भाषा सहायता सेवाहरू निःशुल्क उपलब्ध हुन्छन्। 1-855-329-0729 मा फोन गर्नुहोस्।

Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-855-329-0729 uffrufe.

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با شما با شماره 1-855-329-0729.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-855-329-0729.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-855-329-0729.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-855-329-0729.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-855-329-0729.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-855-329-0729.

మీరు తెలుగు మాట్లాడితే, లాగీవేవ్ అనినటినన సరీవినిన, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉనసాయి. కాల్ చేయండి 1-855-329-0729.

หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย
โทร 1-855-329-0729.

نوٹ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-855-329-0729 پر کال کریں۔

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-855-329-0729.

# Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

## Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

## Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

## Balance Billing

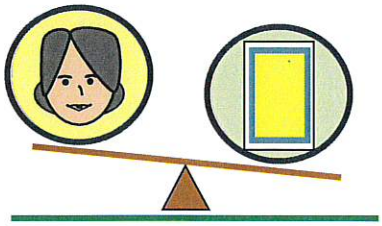
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

## Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

## Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance ***plus*** any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



Jane pays **20%** | Her plan pays **80%**

(See page 6 for a detailed example.)

## Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

## Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

## Cost Sharing

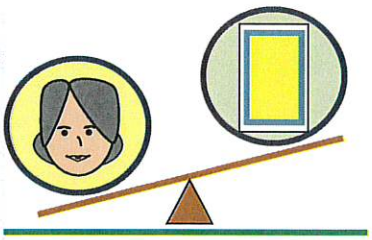
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

## Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

## Deductible




(See page 6 for a detailed example.)

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

## Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

## Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

## Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

## Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

## Excluded Services

Health care services that your plan doesn't pay for or cover.

## Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

## Grievance

A complaint that you communicate to your health insurer or plan.

## Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

## Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

## Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

## Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

## Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

## Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

## In-network Coinsurance
Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

## In-network Copayment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

## Marketplace
A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

## Maximum Out-of-pocket Limit
Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

## Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

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

## Minimum Value Standard
A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

## Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

## Network Provider (Preferred Provider)
A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

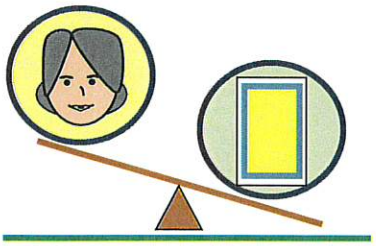
## Orthotics and Prosthetics
Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

## Out-of-network Coinsurance
Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

## Out-of-network Copayment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

## Out-of-network Provider (Non-Preferred Provider)
A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

## Out-of-pocket Limit




The most you ***could*** pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

(See page 6 for a detailed example.)

## Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

## Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan," "policy," "health insurance policy," or "health insurance."

## Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

## Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

## Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

## Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

## Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

## Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

## Referral
A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

## Rehabilitation Services
Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Screening
A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

## Skilled Nursing Care
Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is ***not*** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

## Specialist
A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

## Specialty Drug
A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

## UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

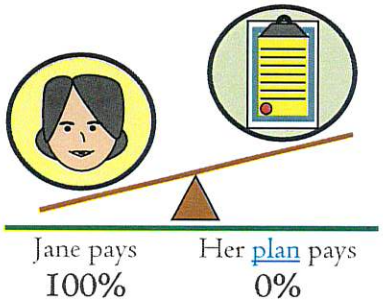
## Urgent Care
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

# How You and Your Insurer Share Costs - Example

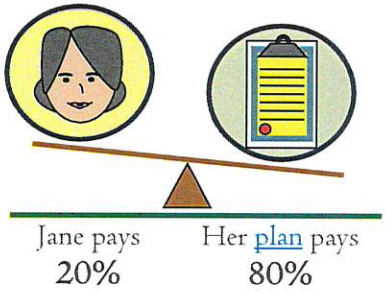
**Jane's Plan Deductible:** $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

***January 1st***
*Beginning of Coverage Period*

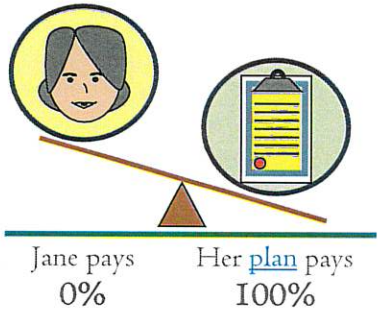
***December 31st***
*End of Coverage Period*




more costs




more costs




**Jane hasn't reached her $1,500 deductible yet**

Her plan doesn't pay any of the costs.

**Office visit costs:** $125
**Jane pays:** $125
**Her plan pays:** $0

**Jane reaches her $1,500 deductible, coinsurance begins**

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

**Office visit costs:** $125
**Jane pays:** 20% of $125 = $25
**Her plan pays:** 80% of $125 = $100

**Jane reaches her $5,000 out-of-pocket limit**

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

**Office visit costs:** $125
**Jane pays:** $0
**Her plan pays:** $125

# Delta Dental PPO℠— Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

## Greatest potential savings when you visit a Delta Dental PPO dentist

**OUT-OF-POCKET COSTS**

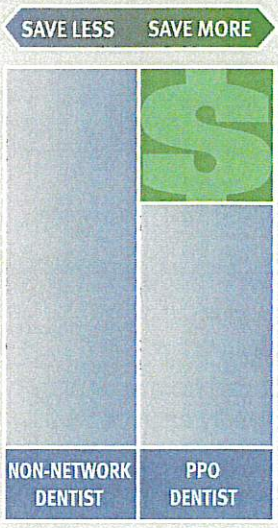



Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

** In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.*

DELTA DENTAL®

**WE KEEP YOU SMILING®**

HL_PPO_2col #63452 (6/11)

**Plan Benefit Highlights for:** Freedom Area School District

**Group No:** 10002

Delta Dental PPO℠

Benefit Highlights

| Eligibility | Primary enrollee, spouse and eligible dependent children to age 19 or to age 23 if dependent is full-time student |
|---|---|
| **Deductibles** | $10 per person / $30 per family each calendar year |
| Deductibles waived for Diagnostic & Preventive (D & P)? | Yes |
| **Maximums** | $1,100 per person each calendar year |
| D & P counts toward maximum? | Yes |

| Benefits and Covered Services* | Delta Dental PPO dentists** | Non-PPO dentists** (Delta Dental Premier® & Non-Delta Dental Dentists) |
|---|---|---|
| **Diagnostic & Preventive Services** Exams, cleanings, x-rays | 100 % | 100 % |
| **Basic Services** Fillings | 100 % | 100 % |
| **Endodontics** (root canals) Covered Under Basic Services | 100 % | 100 % |
| **Periodontics** (gum treatment) Covered Under Basic Services | 100 % | 100 % |
| **Oral Surgery** Covered Under Basic Services | 100 % | 100 % |
| **Major Services** Crowns, inlays, onlays and cast restorations | 100 % | 100 % |
| **Prosthodontics** Bridges and dentures | 0 % | 0 % |

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.


Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

**Customer Service**
800-932-0783
**(Business Hours: 8 am to 8 pm ET)**

**Claims Address**
P.O. Box 2105
Mechanicsburg, PA 17055-2105


**deltadentalins.com**

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

# Beneficiary Basics

Six steps to maximize your term life insurance and get your benefit into the right hands.

## 1. Choose wisely

You can name anyone a beneficiary of your life insurance, however, in nine states (AZ, CA, ID, LA, NV, NM, TX, WA, WI), your spouse must sign off on anyone else you choose. If you choose to have multiple primary beneficiaries and one dies before you, the benefit will go to your remaining primary beneficiaries. If there are no surviving beneficiaries then the benefit would go to your back-up, or contingent, beneficiaries. Keep in mind, you can't name a funeral home or your employer as beneficiaries. If you have term life insurance for your spouse or dependent, you will always be the beneficiary.

More than a quarter of U.S. households would feel the financial impact from the loss of their primary wage earner in a month or less.[1]

**$6 billion**

OneAmerica® paid out $6 billion in benefits in 2019.

**1. Source:** *2020 Insurance Barometer Study, LIMRA and Life Happens*





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## 2. Be thorough

When you choose your beneficiaries, be sure to list names, Social Security numbers, birth dates and addresses so we can easily find your beneficiary(ies) when we need to. The beneficiary designation form must be dated and witnessed by someone other than your beneficiary(ies).

## 3. Don't forget to update

Be sure to revisit your beneficiary designations whenever you have a big life event, such as marriage, divorce, new baby or if one of your beneficiaries dies.

## 4. Use extra care when your beneficiary is a child

We don't pay life insurance proceeds directly to minors. If you'd like to leave your benefit to someone under 18 (19 in AL and NE; and 21 in MS and Puerto Rico), work with an attorney or financial advisor to set up a trust. Or take steps to legally appoint a trustworthy adult to be responsible for managing the money on behalf of the minor. If you leave your life insurance benefit to a minor without a trust or guardianship, it can take longer and be more expensive to get your benefit into the right hands.

## 5. Avoid unnecessary taxes

Most of the time life insurance benefits are tax-free, but anyone who receives Supplemental Security Income or Medicaid can be disqualified from those benefits if they receive $2,000 or more as a gift or inheritance. If you want to give your death benefit to someone receiving those government benefits, work with an attorney to set up a special needs trust and name that trust as your beneficiary.

## 6. Save your loved ones time and money

Keep in mind that if you name your estate as your beneficiary, or if you list a beneficiary who's not living, your loved ones will likely spend valuable time collecting required documents and their own money on attorney and court fees.

**Note:** Products issued and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN, a OneAmerica company. Not available in all states or may vary by state. In all situations, the policy is the governing document and AUL pays benefits in accordance with policy provisions. Provided content is for overview and informational purposes only and is not intended as tax, legal, fiduciary, or investment advice.

To choose your beneficiary, visit the Forms section on **employeebenefits.aul.com**, click on the Life tab, download and complete the beneficiary designation form, and turn it into your employer.





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## Sample beneficiary designations

The beneficiary wording should be absolutely clear and without question as to whom the proceeds are to be paid. Listed below are sample beneficiary designations. Please note state laws may prohibit naming certain entities and individuals as a beneficiary. If you live in a community property state, you should obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NM, NV, TX, WA and WI.

To ensure the correct individual or entity receives the benefits and the intended benefit amount, please provide the following:

- The beneficiary's Social Security number or Tax Identification number and date of birth.
- Distribution of proceeds should be shown in fractions or percentages if multiple beneficiaries are designated, and should add up to 1 if using fractions or 100% if using percents. Do not list dollar amounts as the amount of the insured's life benefit may change. If no distribution is shown, benefits will be divided equally among the living beneficiaries.

### Acceptable beneficiary designations

1. One Beneficiary - State the full name and relationship to the insured. Sample: John Doe, husband
2. Two Beneficiaries in Equal Shares. Sample: Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
3. Three or More Beneficiaries in Equal Shares. Sample: Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
4. Two Beneficiaries in Succession - If the primary beneficiary dies, the second person named will receive the proceeds and is known as the contingent beneficiary. Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin.
5. Three or More Beneficiaries in succession - If the primary and secondary beneficiaries die, the third person named will receive the proceeds. Sample: Martha Doe, wife, or, in the event of her death, Richard Doe, cousin, or, in the event of his death, Jane Doe, niece.
6. One Beneficiary Followed by Two Beneficiaries in Equal Shares. Sample: Martha Doe, wife, or, in the event of her death, Jane Doe and Mary Doe, cousins, in equal shares, or their survivors.
7. One Beneficiary Followed by Three or More Beneficiaries in Equal Shares. Sample: John Doe, husband, or, in the event of his death, Jane Doe, Mary Doe, and Richard Doe, cousins, in equal shares, or their survivors.
8. Two Beneficiaries Shown in Percentages. Sample: John Smith, cousin 40%, Sally Smith, aunt 60%.
9. Two or More Beneficiaries Shown in Percentages. Sample: Mary Doe, wife 50%, Jane Doe, cousin 25%, John Doe, cousin 25%.
10. Estate Do not identify the name of the executor or executrix since this name may change as wills are updated. Sample: Estate of John Doe
11. Custodian for Minor Children - Please note any minor child beneficiary designation should nominate a custodian (i.e. bank, adult, trustee followed by the words "as custodian for (minor child's name) under the (child's residential state) uniform transfers to minors act." This designation may avoid a court appointed guardianship for the payment of the death benefit. Sample: John Doe as custodian for Jimmy Smith under the Indiana Uniform Transfers to Minors act.
12. Trust Agreement - State the name of the trust and the date of the trust agreement. Sample: John Doe Trust dated MM/DD/YY. Payment to trustee shall discharge the company.
13. Wife or Unnamed Children. Sample: Martha Doe, wife, or, in the event of her death, our children, if any, or their survivors.
14. Unnamed Children. Sample: Children, if any, in equal shares, or their survivors.
15. No Relationship. Sample: Mary Doe, friend
16. To a Church or Organization - It is preferable to indicate both the name and address and the wording "or its successors or assigns." Sample: Christ Lutheran Church or its successors or assigns
17. Irrevocable Beneficiary - This is acceptable, but not preferable, as the beneficiary must then approve any future beneficiary change. Sample: John Smith, husband, irrevocable beneficiary
18. Employee Unable to Sign - This designation must contain the person's mark and be signed by two disinterested witnesses.

### Unacceptable beneficiary designations

- Collateral assignments, e.g. to banks, finance companies, etc. as creditors on a loan.
- The Employer
- Funeral Homes