BENEFIT ENROLLMENT PACKET

Review the attached benefit packed and associated plans. Included in the packed is the following information:

- Highmark Plan Information
- Benefit Grid applicable to Administrators, Teachers and Administrative Support Staff
- Benefit Grid applicable to Food Service & Custodial Staff
- Delta Dental Plan Information
- Life Insurance Enrollment

Please refer to your group contract for specific benefit information including contributions for Dental. Additionally should you opt out of medical and dental insurance, there is an annual payment in December of each year for the full year opt out of medical.

Freedom Area School District provides an annual contribution of 55% of the plan deductible for employees employed as January 1 of each year to the HSA. The amount contributed on January 1 is $1,815 for family and $907.50 for individuals A form is also included for the employee to elect a contribution which combined with the District contribution cannot exceed $4,300 for individuals and $8,550 for family coverage.

Open enrollment is held annually with changes from open enrollment effective on January 1.

Benefit questions can be addressed to mlentz@freedomarea.org

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?	$1,650 individual/$3,300 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. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at 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. $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. Out-of-network: Copayments, deductibles, premiums, balance-billed charges, prescription drug expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

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). 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. 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 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. 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. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. 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	$1,650
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	$1,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,710**

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

The plan's overall deductible	$1,650
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	$1,650
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,670**

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

The plan's overall deductible	$1,650
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	$1,650
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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。 請致電 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 फ़ोन 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 níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' 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 تماس 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, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. కాల్ చేయండి 1-855-329-0729.

หากคุณพูด ไทย, มีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่มีค่าใช้จ่าย

โทร 1-855-329-0729.

توجہ 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.

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 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] (Employee Only Plan / Family Plan)	$1,600 / $3,200 Applies to Medical and Prescription Drug Benefits	
Co-Insurance (The Plan Pays:)	100% after deductible	80% after deductible
Annual Out-of-Pocket Maximum[4] (Employee Only Plan / Family Plan)	Not Applicable *Does not apply when the in-network co-insurance is 100% after deductible*	$1,500 / $3,000[5] (not including deductibles) (not including balance billing)
Total Maximum Out-of-Pocket (Employee Only Plan / Family Plan)[6] (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 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 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] Up to a 31 day supply National Pharmacy Network Open Formulary	
Prescription Drug (mail order)	100% after deductible[10] Up to a 90 day supply 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.

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 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] (Employee Only Plan / Family Plan)	$1,600 / $3,200 Applies to Medical and Prescription Drug Benefits	
Co-Insurance (The Plan Pays:)	100% after deductible	80% after deductible
Annual Out-of-Pocket Maximum[4] (Employee Only Plan / Family Plan)	Not Applicable *Does not apply when the in-network co-insurance is 100% after deductible*	$1,500 / $3,000[5] (not including deductibles) (not including balance billing)
Total Maximum Out-of-Pocket (Employee Only Plan / Family Plan)[6] (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 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 (Food Service & Custodians)

Overview of Current PPOBlue Qualified High Deductible Health Plan

Non-Grandfathered

BENEFIT	PPOBlue Qualified High Deductible Health Plan Group Numbers: 17108-02 (Active) & -03 (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] Up to a 31 day supply National Pharmacy Network Open Formulary	
Prescription Drug (mail order)	100% after deductible[10] Up to a 90 day supply 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.

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[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.

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

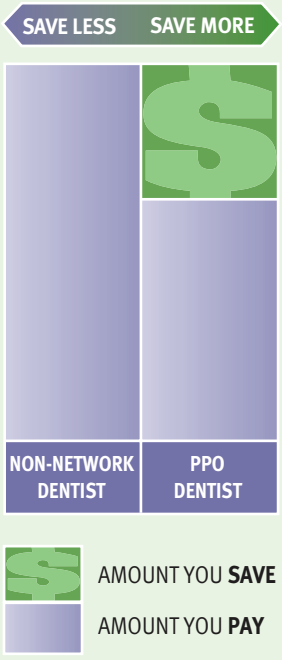

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

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

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.

DELTA DENTAL®

Delta Dental of Pennsylvania

FREEDOM AREA SCHOOL DISTRICT

Combined Evidence of Coverage and Disclosure Form

www.deltadentalins.com

Group No. 10002

Effective Date: 8/1/2011

Revised Date:

EVIDENCE OF COVERAGE

FREEDOM AREA SCHOOL DISTRICT

Group Number: 10002

Effective Date: 8/1/2011

Delta Dental
Administrative Offices
One Delta Drive
Mechanicsburg, PA 17055-6999
(717) 766-8500 Toll free: (800) 932-0783
TTY/TDD: (888) 373-3582
www.deltadentalins.com

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INTRODUCTION

Delta Dental is pleased to welcome you to the group dental plan for Freedom Area School District. Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the dentist, but to see him/her on a regular basis.

Using This Evidence of Coverage

This Evidence of Coverage discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this booklet completely and carefully. Keep in mind that YOU and YOUR mean the individuals who are covered. WE, US and OUR always refer to Delta Dental. In addition, please read the **Definition of Terms** section, which will explain any words that have special or technical meanings under the plan.

The benefit explanations contained in this booklet are subject to all provisions of the Group Dental Service Contract on file with your employer, trust fund, or other entity ("Plan Administrator") and do not modify the terms and conditions of that contract in any way, nor shall you accrue any rights because of any statement in or omission from this booklet.

Contact Us

If you have any questions about your coverage that are not answered here, please visit our web site at www.deltadentalins.com or call our Customer Service Center. A Customer Service Center representative can answer questions you may have about obtaining dental care, help you locate a Participating Dentist, explain benefits, check the status of a claim, and assist you in filing a claim.

Representatives are available by telephone Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time at (717) 766-8500 or toll-free at (800) 932-0783. If you are hearing impaired, you may call our toll-free TTY/TDD number at (888) 373-3582. You can also access Delta Dental's automated information line at (800) 932-0783 to obtain information about enrollee eligibility and benefits, group benefits, or claim status.

If you prefer to write Delta Dental with your question(s), please mail your inquiry to the following address:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

SELECTING YOUR DENTIST

Free Choice of Dentist

Delta Dental recognizes that many factors affect the choice of dentist and therefore supports your right to freedom of choice regarding your dentist. This assures that you have full access to the dental treatment you need from the dental office of your choice. You may see any licensed dentist for your covered treatment:

- Delta Dental PPO Participating Dentist ("PPO")
- Delta Dental Premier Participating Dentist ("Premier")
- Non-Participating Dentist

In addition, you may choose your own specialist, and you and your family members can see different dentists.

Remember, you enjoy the greatest savings when you choose a PPO Dentist. To take full advantage of your benefits, we highly recommend you verify a dentist's participation status within a Delta Dental network with your dental office before each appointment. Review the section titled "How Claims Are Paid" for an explanation of Delta Dental payment procedures to understand the method of payments applicable to your dentist selection and how that may impact your out-of-pocket costs.

Referrals to Specialists

Your dentist may refer you to another dentist for a consultation or specialized treatment or you may elect to see a specialist on your own. If this is done, be sure that the dentist you are referred to is a Participating Dentist. You can do this by simply asking the specialist when you make your appointment. Visiting a dentist who has agreed to participate in the Delta Dental network can save you money, time, and the hassle of paperwork. Remember, if the dentist is not a Participating Dentist, you may be required to pay all of the treatment cost at the time of service and submit a claim to Delta Dental for reimbursement.

Locating a Delta Dental Participating Dentist

There are several ways in which you can locate a Participating Dentist near you:

- You may access information about the plan through our web site at www.deltadentalins.com. This web site includes a dentist search function allowing you to locate Delta Dental Participating Dentists by location, specialty and network type; or

- You may also call Delta Dental and one of our representatives will assist you. He/she can provide you with information regarding a dentist's membership status, specialty and office location.

PLAN INFORMATION

Benefit Summary Charts

The services provided through the plan include all the benefits described in the Benefit Summary Charts on the following pages, depending on the participation status of the dentist providing the services, with the exception of those items presented in the **Limitations and Exclusions** section. The plan covers several categories of benefits when a licensed dentist provides the services and when they are within the standards of generally accepted dental practice. To help you understand the types of procedures that are included in each of the categories of services, examples and descriptions are provided in the charts. The enrollee's share may be higher than the percentages listed in the charts, depending on the applicability of deductibles, maximums, the difference between the Non-Participating Dentist's fee and the PPO Maximum Plan Allowance or charges for non-covered services.

The information in the following chart applies to services provided by Delta Dental PPO Dentists only.

Benefit Summary Chart

Category of Service	Paid by Delta Dental	Paid By Enrollee
Diagnostic (deductible waived) Periodic exams (once per 6-month period) Bitewing x-rays (once per 6-month period) Full-mouth x-ray (once per 3-year period) See note on additional benefits during pregnancy.	100%*	0%
Preventive (deductible waived) Prophylaxis (cleaning) (once per 6-month period) Fluoride treatments (once per 6-month period to age 19) Space maintainers (to age 14) See note on additional benefits during pregnancy.	100%*	0%
Basic Restorative Fillings (amalgam "silver" and composite "white" non-molar)	100%*	0%
Major Restorative Single crowns, inlays, onlays (excludes resin onlays)	100%*	0%
Oral Surgery Extraction and other oral surgery procedures, incl. pre- and post-operative care	100%*	0%
Endodontics Root canal, pulpal therapy	100%*	0%
Surgical Periodontics Surgical treatment of the gums and supporting structures of the teeth	100%*	0%
Non-Surgical Periodontics Non-surgical treatment of the gums and supporting structures of the teeth See note on additional benefits during pregnancy.	100%*	0%
Prosthodontics Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures	0%*	100%
General Anesthesia Covered when used in conjunction with covered oral surgical procedures	100%*	0%

	Deductibles	**Maximums**
Individual (Calendar year)	$10.00	$1,100.00
Family (Calendar year)	$30.00	$ n/a

*** For Delta Dental PPO Dentists, percentages are based on the PPO Allowed Amount, which is the lesser of the dentist's submitted fee or the PPO Maximum Plan Allowance.**

The information in the following chart applies to services provided by Delta Dental Premier Dentists and Non-Participating Dentists only.

Benefit Summary Chart

Category of Service	Paid by Delta Dental	Paid By Enrollee
Diagnostic (deductible waived) Periodic exams (once per 6-month period) Bitewing x-rays (once per 6-month period) Full-mouth x-ray (once per 3-year period) See note on additional benefits during pregnancy.	100%*	0%
Preventive (deductible waived) Prophylaxis (cleaning) (once per 6-month period) Fluoride treatments (once per 6-month period to age 19) Space maintainers (to age 14) See note on additional benefits during pregnancy.	100%*	0%
Basic Restorative Fillings (amalgam "silver" and composite "white" non-molar)	100%*	0%
Major Restorative Single crowns, inlays, onlays (excludes resin onlays)	100%*	0%
Oral Surgery Extraction and other oral surgery procedures, incl. pre- and post-operative care	100%*	0%
Endodontics Root canal, pulpal therapy	100%*	0%
Surgical Periodontics Surgical treatment of the gums and supporting structures of the teeth	100%*	0%
Non-Surgical Periodontics Non-surgical treatment of the gums and supporting structures of the teeth See note on additional benefits during pregnancy.	100%*	0%
Prosthodontics Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures	0%*	100%
General Anesthesia Covered when used in conjunction with covered oral surgical procedures	100%*	0%

	Deductibles	**Maximums**
Individual (Calendar year)	$10.00	$1,100.00
Family (Calendar year)	$30.00	$ n/a

*** For Delta Dental Premier Dentists and Non-Participating Dentists, percentages are based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance.**

Copayments

The plan will pay a percentage of the applicable allowed amount (PPO Allowed Amount for PPO Dentists and Premier Allowed Amount for Premier Dentists and Non-Participating Dentists) for each covered service, subject to certain limitations, and you are responsible for paying the balance. What you pay is called the copayment and is part of your out-of-pocket cost. You pay this even after a deductible has been met.

The amount of your copayment will depend on the type of service provided and the dentist providing the service (see section titled "Selecting Your Dentist"). Dentists are required to collect your copayment for covered services.

It is to your advantage to select PPO Dentists because they have agreed to accept the PPO Allowed Amount as payment, which typically results in lower copayments charged to you. Please read the sections titled "Selecting Your Dentist" and "How Claims Are Paid" for more information.

Deductible

Most dental plans have a specific dollar deductible. The Benefit Summary Charts show the individual and family deductibles that apply, depending on the participation status of the dentist providing the services. Deductibles apply to all benefits unless otherwise noted. Each enrolled family member must pay the individual deductible amount each calendar year to satisfy the plan deductible. You pay this directly to your dentist for completed services. The total deductible amount paid will not exceed the family deductible for all family members.

Maximum Benefit

Most dental programs have a maximum benefit. This is the maximum dollar amount a dental plan will pay toward the cost of dental care. The enrollee is personally responsible for paying costs above the maximum benefit. The Benefit Summary Charts show the maximum benefit amount that applies, depending on the participation status of the dentist providing the services. This is the maximum benefit amount that Delta Dental will pay for covered services per enrollee in a calendar year.

Note on Additional Benefits During Pregnancy

When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services while the Enrollee is covered under the Contract include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planing per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

Limitations and Exclusions

Dental plans are designed to help with part of your dental expenses and may not always cover every dental need. The typical program includes limitations and exclusions, meaning the program does not cover every aspect of dental care. This can relate to the type of procedures or the number of visits. These limitations and exclusions are carefully detailed in this booklet and you should make yourself familiar with them. Please read the **Limitations and Exclusions** section to help you understand the limitations and exclusions of this dental plan.

HOW CLAIMS ARE PAID

Payment by Delta Dental for any single procedure that is a covered service will be made upon completion of the procedure. Payment for care is applied to the calendar year deductible and maximum benefit based on the date of service. After you have satisfied your deductible requirement, Delta Dental will provide payment for covered services at the percentage indicated in the Benefit Summary Chart, up to a maximum for each enrollee in a calendar year.

Payment for Services — Delta Dental PPO Dentist

Payment for covered services performed for you by a PPO Dentist is calculated based on the PPO Allowed Amount. PPO Dentists have agreed to accept a PPO Allowed Amount as the full charge for covered services.

Delta Dental calculates its share of the PPO Allowed Amount ("Delta Dental Payment") using the applicable percentage from the Benefit Summary Chart and sends it directly to the PPO Dentist who has submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Enrollee Payment"). These charges are generally your share of the allowed amount ("Co-payment"), the deductible, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	= $100
PPO Maximum Plan Allowance	= $70
PPO Allowed Amount	= $70
Co-payment (50% of PPO Allowed Amount)	= $35
Delta Dental Payment	= $35
Enrollee Payment	= $35

Payment for Services — Delta Dental Premier Dentist

A Delta Dental Premier Dentist is a Participating Dentist, but is not a Delta Dental PPO Dentist. Premier Dentists have not agreed to accept a PPO Allowed Amount as full payment for services, but instead have agreed to accept a Premier Allowed Amount. Payment for covered services performed for you by a Premier Dentist is calculated based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance.

The portion of the Premier Allowed Amount payable by Delta Dental ("Delta Dental Payment") is limited to the applicable percentage shown in the Benefit Summary Chart. Delta Dental's Payment is sent directly to the Premier Dentist who submitted the claim. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Enrollee Payment"). These charges are generally your share of the Premier Allowed Amount, as well as any deductibles, charges where the maximum benefit has been exceeded, and/or charges for non-covered services.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	= $100
Premier Maximum Plan Allowance	= $80
Premier Allowed Amount	= $80
Co-payment (50% of Premier Allowed Amount)	= $40
Delta Dental Payment	= $40
Enrollee Payment	= $40

Payment for Services — Non-Participating Dentist

Non-Participating Dentists have not agreed to accept the PPO Allowed Amount as full payment for services. Payment for services performed for you by a Non-Participating Dentist is also calculated by Delta Dental based on the Premier Allowed Amount, which is the lesser of the dentist's submitted fee or the Premier Maximum Plan Allowance. The portion of the Premier Allowed Amount payable by Delta Dental ("Delta Dental Payment") is limited to the applicable percentage shown in the Benefit Summary Chart.

However, when dental services are received from a Non-Participating Dentist, Delta Dental's payment is sent directly to the primary enrollee. You are responsible for payment of the Non-Participating Dentist's total fee. Non-Participating Dentists will bill you for their normal charges, which may be higher than the Premier Allowed Amount for the service. You may be required to pay the dentist yourself and then submit a claim to Delta Dental for reimbursement. Since the Delta Dental payment for services you receive may be less than the Non-Participating Dentist's actual charges, your out-of-pocket cost may be significantly higher.

Example (assuming this is a procedure that is covered at a 50%/50% copayment level, the maximum benefit has not been exceeded and the deductible has been met):

Submitted Amount (Dentist Fee)	= $100
Premier Maximum Plan Allowance	= $80
Premier Allowed Amount	= $80
Co-payment (50% of Premier Allowed Amount)	= $40
Enrollee Payment	= $100
Enrollee Out-of-Pocket Payment	= $60
Delta Dental Payment to Enrollee	= $40
Enrollee Out-of-Pocket Payment	= $60

How to Submit a Claim

Delta Dental does not require any special claim forms. Most dental offices have standard claim forms available. Participating Dentists will fill out and submit your claims paperwork for you. Some Non-Participating Dentists may also provide this service upon your request. If you receive services from a Non-Participating Dentist who does not provide this service, you can submit your own claim directly to Delta Dental. For your convenience, you can print a claim form from our web site: www.deltadentalins.com.

Your dental office should be able to assist you in filling out the claim form. Fill out the claim form completely and mail it to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-6999

Payment Guidelines

Delta Dental does not pay Participating Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If you or your dentist files a claim for services more than twelve (12) months after the date you received the services, payment may be denied. If the services were received from a Non-Participating Dentist, you are still responsible for the full cost. If the payment is denied because your Participating Dentist failed to submit the claim on time, you may not be responsible for that payment. However, if you did not tell your Participating Dentist that you were an enrollee of the plan at the time you received the service, you may be responsible for the cost of that service.

We explain to all Participating Dentists how we determine or deny payment for services. We describe in detail the dental procedures covered as benefits, the conditions under which coverage is provided and the program's limitations and exclusions. If any claims are not covered, or if limitations or exclusions apply to services you have received, you may be responsible for the full payment.

If you have any questions about any dental charges, processing policies and/or how your claim is paid, contact Delta Dental.

Optional Treatment and Non-Covered Services

You must pay for any non-covered or optional dental benefits that you choose to have done. Refer to the **Limitations and Exclusions** section for information about excluded services and limitations.

Often there are several approaches or different methods that a dentist may use to treat dental needs. This program is designed to cover dental treatment using standards of care consistent with the delivery of quality, affordable dental treatment to the enrollee. If you request a treatment that is more costly than standard practice, you must pay for the charges in excess of the covered dental benefit.

Example: If a metal filling would fix the tooth and you choose to have the tooth crowned, you are responsible for paying the difference between the cost of the crown and the cost of the filling. You must pay this money directly to your dentist.

Pre-Treatment Estimates

If you and your dentist are unsure of your benefits for a specific course of treatment, or if treatment costs are expected to exceed $300, Delta Dental recommends that you ask for a pre-treatment estimate. You should ask your dentist to submit the claim form in advance of performing the proposed services. Pre-treatment estimate requests are not required but may be submitted for more complicated and expensive procedures such as crowns, wisdom tooth extractions, bridges, dentures, or periodontal surgery. You'll receive an estimate of your share of the cost and how much Delta Dental will pay before treatment begins. Delta Dental will act promptly in returning a pre-treatment estimate to you and the attending dentist with non-binding verification of your current availability of benefits and applicable maximums. The pre-treatment estimate is non-binding as the availability of benefits may change subsequent to the date of the estimate due to a change in eligibility status, exhaustion of applicable maximum benefit or application of frequency of procedure limitations.

Other Health Insurance

Be sure to advise your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the claim form, so that you will receive all benefits to which you are entitled. When you have coverage under more than one benefit program, the primary and secondary carriers coordinate the two programs, so that the primary carrier pays its portion first and then the secondary carrier pays its portion, not to exceed the dentist's fees for the covered services.

The following rules will be followed to establish the order of determining the liability of this or any other programs:

1. The program covering the enrollee as an employee will determine its benefits before the program covering the enrollee as a dependent.

2. The program covering the enrollee as a dependent of an employee whose birthday falls earlier in the calendar year will determine it benefits before the program covering the enrollee as a dependent of an employee whose birthday falls later in the calendar year. If both employees have the same birthday, the program covering the employee for the longest period will be primary over the program covering the employee for the shorter period.

3. The program covering the enrollee having custody of the dependent will determine its benefits first; then the program of the spouse of the parent with custody of the dependent; and finally, the program of the parent not having custody of the dependent. However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the dependent, the benefits of that program are considered first. The prior sentence will not apply with respect to any period during which any benefits are actually paid or provided before a program has actual knowledge of the court order.

4. The program covering the enrollee as an employee or as a dependent of an employee will determine its benefits before one that covers the enrollee as a laid-off or retired employee or as the dependent of such person. If the other plan does not have a rule concerning laid-off or retired employees, and as a result each plan determines its benefits after the other, then this paragraph will not apply.

5. If the other program does not have a rule establishing the same order of determining liability for benefits or is one which is "excess" or always "secondary," Delta Dental will determine its benefits first. If such determination indicates that Delta Dental should not have been the first program to determine its benefits, Delta Dental will be considered as not the first to determine its benefits.

6. In situations not described in items 1 through 5, the program under which the enrollee has been enrolled for the longest period of time will determine its benefits first.

When Delta Dental is the first to determine its benefits, benefits will be paid without regard to coverage under any other program. When Delta Dental is not the first to determine its benefits, and there are remaining expenses of the type allowable under this program, Delta Dental will pay only the amount by which its benefits under this plan exceed the amount of benefits payable under the other program or the amount of such remaining expenses, whichever is less.

ELIGIBILITY AND ENROLLMENT

Eligibility Requirement

You will become eligible to receive benefits on the date stated in the contract after completing any eligibility periods required by the group. Under this dental plan, the eligibility requirement for new hires is 90 days of employment. You may enroll for individual and family coverage.

If your dependents are covered, they will be eligible when you are or as soon as they become dependents. Dependents are your:

- Spouse.
- Unmarried children and/or dependent grandchildren until the day of their 19th birthday. Such children include: (a) your biological child, (b) your legally adopted child (including a child living with the adopting parents and/or grandparents during the period of probation), (c) a child for whom you have legal guardianship or temporary guardianship of more than 12 months duration and for a shorter period if the guardianship is of a dependent minor and granted by testamentary, (d) a stepchild, or child or grandchild who is the subject of a Court Order of support directed to you, without regard to the amount of support contributed by you, the amount of time the child spends in your home, or the custodial arrangement for the child. Documentation of the above must be furnished upon request by Delta Dental.
- Unmarried children and/or dependent grandchildren who are full-time students in a bona fide educational institution until the day of their 23rd birthday. In the event a full-time student is required, because of military duty, to take a military leave of absence for more than thirty (30) days for other than training, coverage will extend for a period equal to the duration of the eligible Dependent's service on active duty or active State duty or until the eligible Dependent is no longer a full-time student. Proof of continuing eligibility must be furnished as required by Delta Dental.
- Unmarried children and/or dependent grandchildren of any age who are incapable of self-support by reason of mental or physical incapacity that occurred before the age of 19 or 23 if full-time student and were covered prior to age 19 or 23 if full-time student. The dependent child must also be chiefly dependent on you for support and maintenance, but is not required to reside with a parent or legal guardian who is a primary enrollee. Eligibility of these dependent children and/or grandchildren will not be terminated while the contract remains in force and the dependent child and/or grandchild remains in such condition. Proof of physical or mental disability must be furnished as required by Delta Dental.
- Newborn children and/or dependent grandchildren of any enrollee for 31 days from: (a) the moment of birth, (b) the date of placement for adoption or upon placement in the foster home, or (c) the date of appointment for a minor for whom guardianship has been granted by court or testamentary appointment. Proof of birth or adoption or foster home placement must be furnished upon request by Delta Dental. In order for the coverage to continue beyond the 31-day period, you must notify the Plan Administrator of the birth, adoption, placement in the foster home, or appointment of guardianship.

Changes in Eligibility Status

Changes in eligibility status (i.e. marriage, divorce, birth, graduation, etc.) must be reported to the Plan Administrator within 31 days following the event causing the change. If you do not change coverage when first eligible, you may change later during a subsequent open enrollment period. Changes received from the 1st of the month through the 15th of the month become effective on the 1st of the month in which the notice is received. Changes received from the 15th of the month through the last day of the month become effective on the 1st of the following month.

Loss of Eligibility

Your coverage ends on the last day of the month in which termination of employment occurs or immediately when this program ends. Coverage for all dependents also ceases at that time, or when dependent status is lost. Your dependent children and/or grandchildren will be disqualified for benefits when they reach the disqualifying age.

COMPLAINTS, GRIEVANCES AND APPEALS

Our commitment to you is to ensure quality throughout the entire treatment process: from the courtesy extended to you by our customer service representatives to the dental services provided by our Participating Dentists. If you have questions about any services received, we recommend that you first discuss the matter with your dentist. However, if you continue to have concerns, please call Delta Dental's Customer Service Center.

Delta Dental attempts to process all claims within 30 days. If a claim will be delayed more than 30 days, Delta Dental will notify the enrollee in writing within 30 days stating the reason for delay.

Questions or complaints regarding eligibility, the denial of dental services or claims, the policies, procedures, or operations of Delta Dental, or the quality of dental services performed by the dentist may be directed in writing to Delta Dental or by calling Delta Dental at (717) 766-8500 or toll-free at (800) 932-0783. You can also e-mail questions by accessing the "Contact Us" section of Delta Dental's web site at www.deltadentalins.com.

A grievance is a written expression of dissatisfaction with the provision of services or claims practices of Delta Dental. When you write, please include the name of the enrollee, the primary enrollee's name and enrollee ID, and your telephone number on all correspondence. You should also include a copy of the claim form, Benefits Statement, Invoice or other relevant information.

Appeals

Any dissatisfaction with adjustments made or denials of payment should be brought to Delta Dental's attention, and if unresolved to your satisfaction, to the Plan Administrator. The Plan Administrator will advise you of your rights of appeal or other recourse.

Appeals on claims denied must be submitted in writing. The following section explains the claim review and appeal process and time limits applicable to such process. This information can also be found in your Benefits Statement.

If a post-service claim is denied in whole or in part, Delta Dental will notify you and your attending dentist of the denial in writing within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 14 days, for processing. If there is an extension, you and your attending dentist will be notified of the extension and the reason for the extension within the original 30-day period. If an extension is necessary because either you or your attending dentist did not submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You or your attending dentist will be afforded at least 45 days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent contract provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the enrollee's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by you or your attending dentist.

If you or your attending dentist wants the denial of benefits reviewed, you or your attending dentist must write to Delta Dental within 180 days of the date on the denial letter. In the letter, you or your attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice should accompany the request for review. You or your attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to you or your attending dentist on request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental will notify you and your attending dentist in writing of the decision on the request for review within 30 days of the date the request is received. Delta Dental will send to you or your attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific contract provisions on which the benefit determination is based. The notice shall state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, an explanation is available free of charge upon request by either you or your attending dentist. The notice shall also state that you have a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If in the opinion of you or your attending dentist, the matter warrants further consideration, you or your attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by you or your attending dentist. The Dental Affairs Committee will render a decision within 30 days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

Send your grievance, appeal, or claims review request to Delta Dental at the address shown below:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

GENERAL PROGRAM INFORMATION

Proof of Claim

Before approving a claim, Delta Dental will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist, or from hospitals in which a dentist's care is provided, such information and records relating to attendance to or examination of, or treatment provided to, an enrollee as may be required to administer the claim, or that an enrollee be examined by a dental consultant retained by Delta Dental, in or near the community or residence. Delta Dental will in every case hold such information and records confidential.

Physical Access

Delta Dental has made efforts to ensure that our offices and the offices and facilities of Participating Dentists are accessible to the disabled. If you are not able to locate an accessible dentist, please call our Customer Service Center and a representative will help you find an alternate dentist.

Access for the Hearing Impaired

The hearing impaired may contact the Customer Service Center through our toll-free TTY-TDD number at (888) 373-3582.

Privacy

Delta Dental values its relationship with you. Protecting your personal information is of great importance to us. Delta Dental will obtain from the enrollee only nonpublic information that relates to Delta Dental's administration of the dental benefits we provide. Information may include, but not be limited to name, address, social security number, enrollee ID, and date of birth. We do not disclose any nonpublic personal information about you to any affiliated or nonaffiliated third parties except as is necessary in order to provide our service to you or as we are required or permitted by law. Delta Dental maintains physical, electronic, and procedural security measures to safeguard your nonpublic personal information in our possession.

Web Site Security

Delta Dental employs security measures to control access to the eligibility and dental benefit information under our control. Delta Dental uses industry standards, such as firewalls and Secure Socket Layers, to safeguard the confidentiality of personal enrollee information.

There are areas of our web site that require a specific user ID and password for web site access. In order to receive a user ID and password, Delta Dental requires enrollees to contractually agree to not provide information they may access to other individuals. The user identification and password required for site access is internally validated to ensure this information cannot be viewed without proper authority and security authentication.

Reduction for Automobile Insurance Benefits *(For Pennsylvania Enrollees Only)*

Fees for services or supplies for injuries or conditions payable under this plan will be reduced by the amount of any first party benefits under automobile insurance and by any catastrophic loss benefits paid by the Catastrophic Loss Trust Fund. Fees not paid as first party benefits will be payable proportionately as the obligation of Delta Dental and enrollee in the percentages shown in the Benefit Summary Chart.

Any deductible will be considered satisfied to the extent of first party benefits under automobile insurance and by any catastrophic loss benefits paid by the Catastrophic Loss Trust Fund.

ENROLLEE RIGHTS AND RESPONSIBILITIES

We believe that you, as a Delta Dental enrollee, have the right to expect quality, affordable care that protects not only your dental health, but also your privacy and ability to make informed choices. We also believe that you have certain responsibilities to help protect these rights.

The Right to Choose

The Delta Dental system maintains some of the largest dentist networks in the industry — each with a full range of specialists — to give you the widest possible choice of dentists. Dentists are never penalized for referring you to a specialist. You can visit any dentist at any time, without prior notification or authorization from Delta Dental.

The Right to Quality Assurance

While we support the right of enrollees to choose their dentist, we recognize our responsibility to provide some assurances of quality care.

Therefore, each dentist who has contracted with Delta Dental agrees to provide care that meets the standards of the dental profession. Dentist contracts allow Delta Dental to audit dental offices in person — at random and for cause — to help ensure that these standards are met. If you should ever receive substandard care from a Delta Dental dentist, Delta Dental will fully investigate the matter and can arrange for you to be reimbursed and/or retreated as needed.

The Right to Affordability

Delta Dental contracts with dentists to provide fair and reasonable compensation. Those contracts also prohibit dentists from billing you for excess charges, "add-on" procedures that should already be included, or for any amount that is Delta Dental's responsibility.

Delta Dental benefit plans are designed to promote preventive care, avoiding dental disease before more costly treatment becomes necessary.

The Right to Full Disclosure

You have the right to clear and complete information about your dental benefits, including treatment that is subject to limitations or not covered. You are entitled to know what your share of costs will be before you receive treatment ("pre-treatment estimate"), and how your dentist is compensated by Delta Dental. Delta Dental provides materials to explain these features to you.

Delta Dental dentists are not subject to policies sometimes called "gag clauses." You are entitled to hear about all treatment options your dentist may recommend, whether covered or not, and to obtain a second opinion if you choose.

The Right to Fair Review and Appeal

Delta Dental supports your right, as well as your dentist's, to a fair and prompt review of any of Delta Dental's coverage decisions. We maintain effective complaint resolution systems in the event of disagreement over coverage or concern about the quality of care.

The Responsibility to Protect These Rights

Protection of the rights described above is possible only with your cooperation. In order to ensure the continued enjoyment of these rights, you share:

- The responsibility to participate in your own dental health — practicing personal dental hygiene and receiving regular professional care. You should avoid substances and behaviors that could jeopardize your oral health, and should cooperate with your dentist on his or her recommended treatment plans.

- The responsibility to become familiar with your coverage. This includes meeting any financial obligation incurred as a result of treatment (including the appropriate copayments or deductibles required by the program). It means cooperation with Delta Dental policies designed to protect against health care fraud schemes by fellow enrollees or dentists. It also means taking advantage of the information available on dental health and your dental program so that you can become a more informed consumer.

LIMITATIONS AND EXCLUSIONS

Excluded Benefits

The plan covers a wide variety of dental care expenses, but there are some services for which we do not provide benefits. It is important for you to know what these services are before you visit your dentist.

The plan does not provide benefits for:

1. Treatment or materials that are benefits to an enrollee under Medicare or Medicaid unless this exclusion is prohibited by law.

2. Treatment or materials to correct congenital or developmental malformations (including treatment of enamel hypoplasia) except for newborn children eligible at birth, so long as such eligible children continue to be enrolled. When services are not excluded under this provision congenital defects or anomalies specifically includes individuals born with cleft lip or cleft palate, and other limitations and exclusions of this section shall specifically apply.

3. Treatment that increases the vertical dimension of an occlusion, replaces tooth structure lost by attrition or erosion, or otherwise unless it is part of a treatment dentally necessary due to accident or injury.

4. Treatment or materials primarily for cosmetic purposes including but not limited to treatment of fluorosis (a type of discoloration of the teeth) and porcelain or other veneers not for restorative purposes, except as part of a treatment dentally necessary due to accident or injury. If services are not excluded as to particular teeth under this provision, cosmetic treatment of teeth adjacent or near the affected teeth are excluded.

5. Treatment or materials for which the enrollee would have no legal obligation to pay.

6. Services provided or materials furnished prior to the effective eligibility date of an enrollee under this plan, unless the treatment was a year in duration and completed after the enrollee became eligible if no other limitations shall apply.

7. Periodontal splinting, equilibration, gnathological recordings and associated treatment and extra-oral grafts.

8. Preventive plaque control programs, including oral hygiene instruction programs.

9. Fissure sealants.

10. Myofunctional therapy, unless covered by the exception in Item 2, above.

11. Temporomandibular joint dysfunction, unless covered by the exception in Item 2, above.

12. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesias, separate charges for local anesthetics, general anesthesia except as a covered benefit in conjunction with a covered oral surgery procedure.

13. Implants and related services, unless covered by the exception Item 2, above.

14. Experimental procedures that have not been accepted by the American Dental Association.

15. Services provided or material furnished after the termination date of coverage for which premium has been paid, as applicable to individual enrollees, except this shall not apply to services commenced while the plan was in effect or the enrollee was eligible.

16. Charges for hospitalization or any other surgical treatment facility, including hospital visits.

17. Dental practice administrative services including but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.

18. Replacement of existing restorations for any purpose other than restoring active carious lesions or demonstrable breakdown of the restoration.

Limitations

Benefits to enrollees are limited as follows:

Limitation on Optional Treatment Plan. In all cases in which there are optional plans of treatment carrying different treatment costs, payment will be made only for the applicable percentage of the least costly course of treatment, so long as such treatment will restore the oral condition in a professionally accepted manner, with the balance of the treatment cost remaining the responsibility of the enrollee. Such optional treatment includes, but is not limited to, specialized techniques involving gold, precision partial attachments, overlays, implants, bridge attachments, precision dentures, personalization or characterization such as jewels or lettering, shoulders on crowns or other means of unbundling procedures into individual components not customarily performed alone in generally accepted dental practice.

Limitation on Major Restorative Benefits. If a tooth can be restored with amalgam, synthetic porcelain or plastic, but the enrollee and the dentist select another type of restoration, the obligation of Delta Dental shall be only to pay the applicable percentage of the fee appropriate to the least costly restorative procedure. The balance of the treatment shall be considered a dental treatment excluded from coverage under this plan.

- Replacement of crowns, jackets, inlays and onlays (excluding resin onlays) shall be provided no more often than once in any five-year period and then only in the event that the existing crown, jacket, inlay or onlay is not satisfactory and cannot be made satisfactory. The five-year period shall be measured from the date on which the restoration was last supplied, whether paid for under the provisions of this plan, under any prior dental care contract, or by the enrollee.

Limitation on Prosthodontic Benefits. Replacement of an existing denture will be made only if it is unsatisfactory and cannot be made satisfactory. Services, including denture repair and relining, which are necessary to make such appliances fit will be provided as outlined in the section "Covered Benefits." Prosthodontic appliances and abutment crowns will be replaced only after five years has elapsed following any prior provision of such appliances and abutment crowns under any plan procedure.

Limitation on Oral Surgery Benefits. Benefits for specific oral surgery procedures, including but not limited to reduction of fractures, removal of tumors, and removal of impacted teeth payable under a medical insurance contract or a medical or hospital service contract by which the enrollee is covered shall be determined first under this plan. Delta Dental's obligation for these oral surgery services shall be limited to the difference between benefits paid under such other contracts up to the applicable allowed amount for the procedure less the applicable deductible and enrollee copayment. When there is no medical or hospital coverage, Delta Dental's obligation for oral surgery services shall be limited to the applicable allowed amount for those services provided under the contract less the applicable deductible and enrollee copayment.

Limitation on Periodontal Surgery. Benefits for periodontal surgery in the same quadrant are limited to once in any five-year period. The five-year period shall be measured from the date on which the last periodontal surgery was performed in that quadrant, whether paid for under the provisions of this plan, under any prior dental contract, or by the enrollee.

DEFINITION OF TERMS

The following are definitions of words that have special or technical meanings under the plan.

Attending Dentist Statement: The written report of a series of procedures recommended for the treatment of a specific dental disease, defect or injury, prepared for an enrollee by a dentist as a result of an examination made by such dentist.

Benefits Statement: The statement you receive after a claim is processed, detailing how your claim payment was calculated including the procedures and fees submitted and the amount for which you are responsible.

Calendar Year: The time period beginning on January 1st and ending on December 31st.

Claim Form: A written or electronically submitted document to request payment for completed dental treatment or to request a pre-treatment estimate for proposed dental treatment. The claim form is also sometimes called an Attending Dentist's Statement.

Company: The employer, union or other organization or group contracting to obtain benefits.

Contract: The written agreement between Delta Dental and Freedom Area School District to provide dental benefits. The contract, together with this Evidence of Coverage, forms the terms and conditions of benefits available to you under the dental plan.

Contract Year: The 12-month period beginning on the effective date and each yearly period thereafter.

Copayment: Your share of the cost of a covered service, usually expressed as a percentage of the applicable allowed amount.

Deductible: The dollar amount enrollees must pay toward completed treatment before Delta Dental's payment is applied to those services in a given period.

Delta Dental Payment: The portion of the PPO Allowed Amount or the Premier Allowed Amount payable by Delta Dental.

Delta Dental PPO ("PPO") Dentist: A Participating Dentist who is a member of the Delta Dental PPO Dentist network.

Delta Dental Premier ("Premier") Dentist: A Participating Dentist who is a member of the Delta Dental Premier Dentist network.

Delta Dental PPO ("PPO") Maximum Plan Allowance: The maximum amount, determined by Delta Dental, usually less than its Maximum Plan Allowance for Delta Dental Premier programs, from claim charges submitted on a regional basis for a given service by dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.

Delta Dental Premier ("Premier") Maximum Plan Allowance: The maximum amount payable for services of Participating and Non-Participating Dentists, calculated by Delta Dental, for use in payment by it and by its enrollees from claim charges submitted, on a regional basis, for a given service by dentists of similar training within the same geographical area blended by Delta Dental with dentist fee information from a number of other sources, including dentist fee filings, using various factors, subject to regulatory limitations and adjustment for extreme difficulty or unusual circumstances.

Dependent: Eligible family members as defined in the **Eligibility and Enrollment** section of this Evidence of Coverage.

Effective Date: The date the dental program begins. This date is given on the front cover of this Evidence of Coverage.

Employee: An employee of the company who meets the eligibility requirements, accepted by Delta Dental, for enrollment under the contract, and who is so specified for enrollment.

Enrollee: Collectively, the primary enrollee and all enrolled dependents.

Enrollee Payment: The amount the enrollee pays after calculation of the Delta Dental payment.

Exclusions: Services that are not covered under this dental plan.

Family: The primary enrollee and all enrolled dependents of the primary enrollee.

Limitations: The number of services allowed, frequency of services allowed, and the most affordable dentally appropriate service.

Maximum Benefit: The total maximum dollar amount Delta Dental will pay toward the cost of covered dental care incurred by an individual enrollee in a given period.

Network: A collective expression for all Participating Dentists who have contracted with Delta Dental to offer services to enrollees and who have agreed to abide by certain administrative guidelines.

Non-Participating Dentist: A dentist who has not contracted with Delta Dental and who is not contractually bound to abide by Delta Dental's administrative guidelines.

Out-of-Pocket Costs: The portion of dental fees that you pay. Out-of-pocket costs include your deductible, copayment, any amount exceeding the maximum benefit amount, and services not covered by the dental plan.

Participating Dentist: A dentist who contracts with Delta Dental and agrees to abide by certain administrative guidelines.

PPO Allowed Amount: For covered services, the PPO Allowed Amount is either the Delta Dental PPO Maximum Plan Allowance or the equivalent amount set for PPO Participating Dentists of other state Delta Dental Plans or the charged fee, whichever is less. For non-covered services, the PPO Allowed Amount is zero.

Premier Allowed Amount: For covered services, the Premier Allowed Amount is either the Delta Dental Premier Maximum Plan Allowance or the charged fee, whichever is less. For non-covered services, the Premier Allowed Amount is zero.

Pre-Treatment Estimate: A pre-treatment estimate gives a non-binding estimate of how much of a proposed treatment plan will be covered under an enrollee's dental program and what the enrollee's out-of-pocket cost will be.

Primary Enrollee: An employee who is enrolled in this dental plan.

Services: Treatment performed by a dentist or under his/her supervision and direction and when necessary, customary and reasonable, as determined by Delta Dental, using standards of generally accepted dental practice.

Single Procedure: A dental procedure to which a separate procedure number is assigned by Delta Dental.

Submitted Amount: The amount the dental office actually submits on the claim form. This is the fee normally charged by the dentist for services provided to all enrollees, regardless of insurance coverage.

Treatment: A caring for or dealing with an oral condition.

SWIFTMD
Talk to a doctor 24/7!

Welcome to SwiftMD

Eligible employees and family members can talk to a doctor 24/7 by phone or videoconference at **no cost for co-pays or consult fees!**

Some of the Benefits of SwiftMD:

- 24/7 nationwide access to U.S. Board-Certified physicians
- Convenient consults from your home, office, or on the road, usually within 30 minutes
- Doctor makes diagnosis and recommends treatment, and sends prescriptions to your preferred local pharmacy
- Avoid unnecessary visits to the ER and Urgent Care, or long waits for appointments at your doctor's office
- **No co-pays and no cost to you!** Freedom Area School District is paying for your membership!

Getting Started:

- You can use SwiftMD anytime simply by calling toll free **833-SWIFTMD (833-794-3863).** Your membership will be verified, and your appointment scheduled for a callback from a SwiftMD doctor.

- OR -

- Access your membership online (optional)
- Go to **SwiftMD.com** member login and click "Get Started"
- Click "Lookup Account with Group Passcode"
- Enter Group Passcode: "BCSHIC19", name, birthdate, email address and other info
- SwiftMD will email your username and password; be sure to log on to complete activation of your membership!

SwiftMD Physicians Are:

- U.S.-trained and Board Certified
- Experienced at diagnosing a range of illnesses and injuries, with a minimum of 10 years practicing medicine
- Excellent communicators with great bedside manners!

FREEDOM AREA SCHOOL DISTRICT

Group Passcode: **BCSHIC19**

Conditions we treat*

Allergies and rashes
Arthritis pain
Back pain or injury
Cold sores
Diarrhea
Earache
Conjunctivitis or pink eye
Fever and flu
Headache
Insect bites and stings
Lyme disease
Nasal or respiratory congestion
Sinusitis
Soft tissue and muscle injuries or pain
Sore throat
Stomach ache and nausea
Upper respiratory infections
Urinary tract infections
Vomiting
Your individual concerns

*SwiftMD does not replace your PCP or specialists managing chronic and serious conditions. SwiftMD doctors do not prescribe controlled substances, psychiatric, and certain other medications. For more info review the Exclusionary Criteria at mySwiftMD.com.

FREEDOM AREA SCHOOL DISTRICT
Medical Benefit Election or Opt out 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
	START DATE		

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, 2025

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 2025 contribution limits for HSAs are $4,300 for Employee Only Plans and $8,550 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.

Please make your election below, then sign and date your form and submit it via email to mlentz@freedomarea.org:

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.

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
1-800-553-5318 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* *(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.