FRINGE BENEFITS

OPEN ENROLLMENT 2018-2019

Every year, the Allegheny County Schools Health Insurance Consortium (ACSHIC) makes changes to health benefit plans. To review the changes that have been made to your coverage, please visit www.bwschools.net. If you would like to make changes to any of your fringe benefits, you may do so during **Open Enrollment beginning May 15, 2018 thru June 8, 2018**. The Benefits you select will be in effect from July 1, 2018 through June 30, 2019. After July 1, 2018, you can only become eligible for or make changes to your health insurance by a "**qualifying event**" (i.e., marriage, birth of a child).

If you have questions regarding the Baldwin-Whitehall School District Open Enrollment, contact Georgann Helman at 412.884.6300, ext. 7461, Monday - Friday, 7:30 a.m. to 4:00 p.m.

All completed forms must be submitted no later than Friday, June 8, 2018
Attention: Georgann Helman, Administration Office.

The following forms are available in this packet:

MANDATORY ANNUAL COMPLETION

- Affordable Care Act **(All employees must complete and return this form annually.)**

ENROLLMENT

- Highmark Blue Cross Blue Shield Enrollment Application **(If you are satisfied with your existing coverages, no action is necessary.)**
- ACSHIC Audit Documentation
- 2018-2019 Monthly Rates For Health Benefits (July 1, 2018 – June 30, 2019)
- Summary of Community Blue Flex EPO Benefits
- Summary of Community Blue Flex PPO Blue Benefits
    - **Individuals selecting PPO coverage will be responsible for their premium plus the difference between the EPO and PPO rates. (Refer to Collective Bargaining Agreement)**
- ACSHIC Standard Dental Plan
- ACSHIC Vision Plan

OPTIONAL

- **INNOVA Benefit Services Enrollment Form: Part 1 – Plan Highlights (Flexible Spending)**
- **INNOVA Benefit Services Enrollment Form: Part 2 - Elections (Must complete annually, if applicable)**
- **Health Insurance Benefit Waiver/Opt Out Request** – A letter from your spouse's employer, stating you are enrolled in husband/wife or family coverage, must be included with this form. **(Must complete annually, if applicable)**

Baldwin-Whitehall School District

To: Employees in the Baldwin-Whitehall School District
From: Jennifer Seitzinger – HR/Risk Manager
Date: May 11, 2018
Topic: **Affordable Care Act- Health Insurance Benefits – ACTION REQUIRED**

ALL EMPLOYEES MUST COMPLETE AND RETURN THIS FORM ANNUALLY

The Baldwin-Whitehall School District provides health insurance coverage to its employees through the Allegheny County Schools Health Insurance Consortium (ACSHIC). Under the Affordable Care Act and the Baldwin-Whitehall School Board Resolution, all employees are now eligible to purchase health insurance, for themselves and their dependent children, at their own expense, starting on July 1, 2018. You may also purchase health insurance through the U.S. government's marketplace at https://www.healthcare.gov/. The District is sending this letter to all employees and requesting that you mark your enrollment decision in the appropriate box at the bottom of this letter and **return it to Georgann Helman - Administration - no later than June 8, 2018.**

The matrix below represents costs associated with different levels of Community Blue **EPO** coverage offered by the District and ACSHIC:

2018-2019 Baldwin-Whitehall School District/ACSHIC Monthly Benefit Premiums
(Rates in effect July 1, 2018 through June 30, 2019)

Tier	Monthly Premium
Employee	$560.56
Employee and Child	$1,257.35
Employee and Children	$1,383.06

This letter is not a guarantee for a specific number of hours of employment, but an offer for you to purchase health insurance at your own cost. If you choose to purchase health insurance through the District, you will be billed monthly for the full cost of the premium. Failure to pay the premium will result in your coverage being terminated by the District/ACSHIC.

Should you have any questions regarding this offer of insurance coverage, please contact the Human Resource Department at 412-884-6300 ext. 7461.

Return a signed copy to:
Baldwin-Whitehall School District
Attn: Georgann Helman
4900 Curry Road
Pittsburgh, PA 15236

Mark an 'X' in the box that applies to you.

☐ **I currently have health insurance coverage through the Baldwin-Whitehall School District**

☐ **I would like to purchase health insurance through BWSD/ACSHIC and I will contact Georgann Helman at (412) 884-6300 ext. 7461.**

☐ **I am declining to purchase health insurance coverage through the district.**

☐ **I currently have health insurance coverage.**

_____ _____ _____
Name (Print) **Name (Signature)** **Date**

The Baldwin-Whitehall School District is an Equal Opportunity Employer

HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

EMPLOYEE INFORMATION — Employee must complete items 1 through 17 and sign.

1) Employer Name		Reason for Application ☐New Hire ☐Rehire ☐Act 4 ☐Other: ☐Enrollment ☐COBRA	
2) Employee First Name / Middle Initial / Last Name			
3) Street Address	4) City	5) State	6) Zip
7) Social Security Number	8) Effective Date of Coverage Month / Day / Year	9) Employee Status ☐Active ☐Retired (Date) ☐Hourly ☐Salary	
10) Employee Phone #—Home ( )	11) Employee Phone #—Work ( )	12) Employee Hire Date Month / Day / Year	

13) Check Type of Coverage	MEDICAL	DENTAL	VISION	DRUG	COMMUNITY BLUE FLEX (select one) PPO	EPO (formerly HMO)
Employee Only	☐	☐	☐	☐	☐	☐
Insured & Spouse/Domestic Partner	☐	☐	☐	☐	☐	☐
Family	☐	☐	☐	☐	☐	☐
Parent & Child	☐	☐	☐	☐	☐	☐
Parent & Children	☐	☐	☐	☐	☐	☐

14) To be completed by Account Administrator only

Group Number	Report Code Qualifier	Report Code Value

Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)

	First Name / Middle Initial / Last Name	Social Security Number	Do you have other insurance?	Birth Date Mo / Dy / Yr	Sex F/M	Check If: Student Benefits Apply	Disabled	Act 4
15) Self			☐Yes ☐No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Are you an Established Patient? ☐Yes ☐No				
16) ☐Spouse ☐Dom. Part.*			☐Yes ☐No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Is Spouse/DP an Established Patient? ☐Yes ☐No				
17) ☐Child ☐Other*			☐Yes ☐No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Is Dependent an Established Patient? ☐Yes ☐No				
18) ☐Child ☐Other*			☐Yes ☐No If YES, then complete #19					
a) Full Name of Physician of Record (POR) Group Practice	b) POR Number from Provider Directory			c) Is Dependent an Established Patient? ☐Yes ☐No				

***If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner**

19) If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: _____

Group No: _____ Effective Date: _____

Name of Policy Holder: _____

Policy Number: _____

Relationship to Highmark Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Employment Status: ☐Active ☐Retired (Date) _____

MEDICARE INFORMATION: List any family member that is eligible for Medicare Benefits:

Name of Member Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare? ☐Age ☐Disability ☐End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ☐Yes ☐No

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Health Services may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Health Services' Notice of Privacy Practices is available on Highmark Health Services' Web site, or from the Highmark Health Services Privacy Office.

20) _____
Authorized Employer Signature — Date

21) _____
Employee Signature — Date

HIGHMARK.

HOW TO COMPLETE YOUR HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION

FOLLOWING ARE INSTRUCTIONS FOR COMPLETING THE HIGHMARK BLUE CROSS BLUE SHIELD ENROLLMENT APPLICATION.
ALL INFORMATION MUST BE COMPLETED AS INDICATED.

EMPLOYEE INFORMATION

The first thirteen (13) items ask for information regarding the employee. The information you must complete includes:

1) Employer Name and Reason for Application
2) Employee First Name, Middle Initial, Last Name.
3) Employee Street Address
4) City
5) State
6) Zip Code
7) Employee Social Security Number
8) Effective Date of Coverage
9) Employee Status: Please check (✓) the appropriate box indicating whether you are an Active, Retired, Hourly or Salary employee. If retired, please indicate retirement date.
10) Employee Home Phone Number (including area code) – Please provide so that we may contact you if we have questions about your application and to better serve you.
11) Employee Work Phone Number (including area code)
12) Employee Hire Date (i.e., date employee first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).
14) To be completed by Account/Administrator only

Items **15** through **18** ask for important information about yourself and each eligible member of your family (**15** yourself, **16** your spouse/ domestic partner, **17-18** your dependents). Please complete all requested information. If relationship is "other", please indicate the dependent's relationship to the employee according to the codes provided on the application.

- **First Name/Middle Initial/Last Name** — Complete the First Name, Middle Initial and Last Name for each eligible person listed.
- **Social Security Number** — Please include the Social Security Number of each person.
- **Do you have other insurance?** — If you or a family member have other medical insurance including Medicare, respond "yes". If not, you must respond "No".
- **Birth Date** (month/day/year)
- **Sex** (female or male)
- **Check if: Student over Maximum Regular Dependent Age, Disabled and/or Act 4 dependent** If your dependent is over the Maximum Regular Dependent Age and is a full time student or a disabled dependent of any age or an Act 4 dependent to the age of 30 (see your benefit administrator for eligibility), please check (✓) the appropriate column by that dependent's name.

Physician of Record (POR) Information — A Physician of Record is the physician selected by the member, who provides routine care and coordinates other specialized care. Please note that choosing a POR does not impact your benefits or claims payment in any way. Choosing a POR simply helps us to better serve you by connecting you to the practice where most of your health care is received.

a) **Full Name of Physician of Record (POR) Group Practice** — Indicate the name of the POR Group Practice selected from the Online Provider Directory for yourself and each of your dependents. You and your dependents can each choose a different POR.

b) **Physician of Record (POR) Number from Provider Directory** — Please indicate the corresponding number for the physician practice you or your dependent chose as a POR from the Online Provider Directory, Practice Information tab.

c) **Are you an existing Patient of this POR?** — Please check "Yes" or "No" to indicate if you are currently a patient of the POR you chose for yourself or your dependents.

For online provider lookup, go to www.highmarkbcbs.com and search under the "Find a Doctor or Rx" tab. If you need assistance with choosing a POR, please call Member Service at 1-800-241-5704.

Disclaimer: Please note that a provider number may not be available for providers that are located outside of the local servicing area. In this case, a POR cannot be chosen.

19) Needs to be completed if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Please complete all information requested. Refer to your Medicare card to complete the Medicare Information section.
20) Should be completed by your Account Administrator.
21) You must sign and date the form where indicated.

Once the form is completed, retain the last copy for your records.

ACSHIC Audit Documentation

Spouse:

- **Option 1:**
  - Marriage Certificate
  - Updated Social Security Card

    PLUS
  - Employees most recent Federal Tax Return
    Page 1 and 2 including signatures
    "Mark Out" all financial information & social security numbers

- **Option 2:**
  - Marriage Certificate
  - Updated Social Security Card

    PLUS
  - Proof of joint ownership
    Current copy of a mortgage statement; bank statement, utility bill or rental or lease agreement – Documents must show both the employee and spouse's names.

- **Option 3:**
  Newly married couples (less than 6 months)
  - Marriage Certificate
  - Updated Social Security Card

Children:

- Biological: Copy of Birth Certificate showing the employee as parent.
- Adopted: Copy of Court Order of Adoption listing the name of employee or spouse; name of the child, and Judge's signature and court seal.
- Stepchild: Copy of the birth certificate listing the spouse as parent. If the spouse is not on the Employer sponsored plan, a copy of the marriage certificate is also required.
- Permanent Legal Guardianship: Copy of court documents adoption listing the name of employee or spouse; name of the child, and Judge's signature and court seal.

2018-2019 Monthly Rates For Health Benefits
July 1, 2018 – June 30, 2019

- **The percentage an employee contributes is based on their Collective Bargaining Agreement or Contract for Community Blue Flex PPO and Community Blue Flex EPO**

- **Individuals selecting PPO coverage will be responsible for their premium plus the difference between the EPO and PPO rates.**

- **Part-Time employees pay full amount as shown**

CBF PPO

$ 600.05	Individual
$1,345.34	Parent/Child
$1,479.87	Parent/Children
$1,630.10	Husband/Wife
$1,694.85	Family

CBF EPO

$ 560.56	Individual
$1,257.35	Parent/Child
$1,383.06	Parent/Children
$1,522.81	Husband/Wife
$1,583.40	Family

United Concordia Dental

$26.71	Individual
$87.81	Family

Davis Vision

$ 4.88	Individual
$11.92	Family

HIGHMARK. Community Blue Flex EPO

Summary of Community Blue Flex EPO Benefits

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out of pocket. *You are responsible for paying for non-emergency services received from an out-of-network provider.* 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.

Allegheny County Schools Health Insurance Consortium

7/1/2018

Benefit	Enhanced Value	Standard Value
General Provisions		
Benefit Period(1)	Contract Year	
Deductible (per benefit period) Individual Family	 None None	 **$500** **$1,000**
Plan Pays – payment based on the plan allowance	100%	80% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	 None None	 $1,600 $3,200
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits	100% after $5 copayment	100% after $40 copayment
Primary Care Provider Office Visits	100% after $0 copayment	100% after $20 copayment
Specialist Office Visits	100% after $10 copayment	100% after $50 copayment
Urgent Care Center Visits	100% after $10 copayment	100% after $40 copayment
Telemedicine Services (6)	100% after $0 copayment	100% after $20 copayment
Preventive Care(2)		
Routine Adult		
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)
Adult immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Colorectal cancer screening	100% (deductible does not apply)	100% (deductible does not apply)
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)
Routine Pediatric		
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)
Pediatric immunizations	100% (deductible does not apply)	100% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)
Hospital and Medical/Surgical Expenses (including maternity)		
Hospital Inpatient	100%	80% after deductible
Hospital Outpatient	100%	80% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible
Medical Care (including inpatient visits and consultations)/**Surgical Expenses**	100%	80% after deductible
Emergency Services		
Emergency Room Services	100% after $100 copayment (waived if admitted)	
Ambulance	100%	
Ambulance – Non-Emergency	100%	
Therapy and Rehabilitation Services		
Physical Medicine	100%	100% after deductible
Respiratory Therapy	100%	80% after deductible
Speech & Occupational Therapy	100%	100% after deductible
Spinal Manipulations	100% after $25 copayment	100% after $50 copayment
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible
Mental Health/Substance Abuse		
Inpatient	100%	100%
Inpatient Detoxification/Rehabilitation	100%	100%
Outpatient	100%	100%

	Enhanced Value	Standard Value
Other Services		
Allergy Extracts and Injections	100%	80% after deductible
Assisted Fertilization Procedures	100%	80% after deductible
	$5,000 Family maximum per lifetime	
Dental Services Related to Accidental Injury	100%	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible
Home Health Care	100%	80% after deductible
Hospice	100%	80% after deductible
Infertility Counseling, Testing and Treatment(3)	100%	80% after deductible
Private Duty Nursing	100%	
Skilled Nursing Facility Care	100%	80% after deductible
Transplant Services	100%	80% after deductible
Precertification Requirements(4)	YES	
Prescription Drugs		
Prescription Drug Deductible Individual Family	None None	
Prescription Drug Program(5) *Defined by the **Advantage Pharmacy Network** - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.*	**Retail Drugs 34-day Supply (Mandatory Generic)** $8 generic copayment $35 brand copayment - formulary $60 brand copayment – non-formulary **Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic)** $12 generic copayment $50 brand copayment - formulary $90 brand copayment – non-formulary	

Questions? Call 1-800-215-7865
Reference Code: COMM030215
(Please have your Reference Code ready when you call.)

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning July 1st and ending June 30th.
(2) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(3) 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.
(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. 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 not covered.
(5) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
(6) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.

The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

Please be advised that most eligible consent decree services will process under the Standard Value level of benefits.

**The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions may apply. The policy / plan documents control in the event of a conflict with this benefit summary.*

REV 2.1.2018

Highmark. Community Blue Flex PPO

Summary of Community Blue Flex PPO Blue *Benefits*

On the chart below, you'll see what your plan pays for specific services. There are two levels of network benefits coverage for certain services: Enhanced Value and Standard Value*. When you receive services from providers at the Enhanced Value level of benefits, you will pay less out of pocket. 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.

Allegheny County Schools Health Insurance Consortium

7/1/2018

Benefit	Enhanced Value	Standard Value	Out-of-Network
General Provisions			
Benefit Period(1)	Contract Year		
Deductible (per benefit period) Individual Family	None None	$1,200 $2,400	$2,000 $4,000
Plan Pays – payment based on the plan allowance	100%	80% after deductible	50% after deductible
Out-of-Pocket Maximums (Once met, plan pays 100% for the rest of the benefit period) Individual Family	None None	$4,000 $8,000	$8,000 $16,000
Office/Clinic/Urgent Care Visits			
Retail Clinic Visits	100% after $5 copayment	100% after $40 copayment	50% after deductible
Primary Care Provider Office Visits	100% after 0 copayment	100% after $20 copayment	50% after deductible
Specialist Office Visits	100% after $10 copayment	100% after $50 copayment	50% after deductible
Urgent Care Center Visits	100% after $10 copayment	100% after $40 copayment	50% after deductible
Telemedicine Services (6)	100% after $0 copayment	100% after $20 copayment	Not Covered
Preventive Care(2)			
Routine Adult			
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Adult immunizations	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Colorectal cancer screening	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Routine gynecological exams, including a Pap Test	100% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Mammograms, annual routine and medically necessary	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	Routine: 100% (deductible does not apply) Medically Necessary: 100% (deductible does not apply)	50% after deductible
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Routine Pediatric			
Physical exams	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Pediatric immunizations	100% (deductible does not apply)	100% (deductible does not apply)	50% (deductible does not apply)
Diagnostic services and procedures	100% (deductible does not apply)	100% (deductible does not apply)	50% after deductible
Hospital and Medical/Surgical Expenses (including maternity)			
Hospital Inpatient	100%	80% after deductible	50% after deductible
Hospital Outpatient	100%	80% after deductible	50% after deductible
Maternity (non-preventive facility & professional services) including dependent daughter	100%	80% after deductible	50% after deductible
Medical Care (including inpatient visits and consultations)/Surgical Expenses	100%	80% after deductible	50% after deductible
Emergency Services			
Emergency Room Services	100% after $100 copayment (waived if admitted)		
Ambulance	100%		
Ambulance – Non-Emergency	100%		
Therapy and Rehabilitation Services			
Physical Medicine	100%	100% after deductible	50% after deductible
Respiratory Therapy	100%	80% after deductible	50% after deductible
Speech & Occupational Therapy	100%	100% after deductible	50% after deductible
Spinal Manipulations	100% after $25 copayment	100% after $50 copayment	50% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100%	80% after deductible	50% after deductible
Mental Health/Substance Abuse			
Inpatient	100%	100%	50% after deductible
Inpatient Detoxification/Rehabilitation	100%	100%	50% after deductible
Outpatient	100%	100%	50% after deductible

Benefit	Enhanced Value	Standard Value	Out-of-Network
Other Services			
Allergy Extracts and Injections	100%	80% after deductible	50% after deductible
Assisted Fertilization Procedures	100%	80% after deductible	50% after deductible
	$5,000 Family Maximum, per Lifetime		
Dental Services Related to Accidental Injury	100%	80% after deductible	Not Covered
Diagnostic Services			
Advanced Imaging (MRI, CAT, PET scan, etc.)	100%	80% after deductible	50% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100%	80% after deductible	50% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100%	80% after deductible	50% after deductible
Home Health Care	100%	80% after deductible	50% after deductible
Hospice	100%	80% after deductible	50% after deductible
Infertility Counseling, Testing and Treatment(3)	100%	80% after deductible	50% after deductible
Private Duty Nursing	100%		
Skilled Nursing Facility Care	100%	80% after deductible	50% after deductible
Transplant Services	100%	80% after deductible	50% after deductible
Precertification Requirements(4)	YES		
Prescription Drugs			
Prescription Drug Deductible Individual Family	None None		
Prescription Drug Program(5) *Defined by the Advantage Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.* *Your plan uses the Comprehensive Formulary with an Incentive Benefit Design.*	Retail Drugs 34-Day Supply (Mandatory Generic) $8 generic copayment $35 brand copayment - formulary $60 brand copayment – non-formulary Maintenance Drugs through Mail Order 90-day Supply (Mandatory Generic) $12 generic copayment $50 brand copayment – formulary $90 brand copayment – non-formulary		

Questions? Call 1-800-215-7865
Reference Code: COMM040215

(Please have your Reference Code ready when you call.)

(1) Your group's benefit period is based on a Contract Year. The Contract Year is a consecutive 12-month period beginning July 1st and ending June 30th.
(2) Services are limited to those listed on the Highmark Preventive Schedule (Women's Health Preventive Schedule may apply).
(3) 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.
(4) Highmark Medical Management & Policy (MM&P) must be contacted prior to a planned inpatient admission or within 48 hours of an emergency or maternity-related inpatient admission. Be sure to verify that your provider is contacting MM&P for precertification. 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 not covered.
(5) The formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians. Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed above. Under the soft mandatory generic provision, you are responsible for the payment differential when a generic drug is authorized by your provider and you purchase a brand name drug. Your payment is the price difference between the brand name drug and generic drug in addition to the brand name drug copayment or coinsurance amounts, which may apply.
(6) Services are provided for acute care for minor illnesses. Services must be performed by a Highmark approved telemedicine provider. Virtual Behavioral Health visits provided by a Highmark approved telemedicine provider are eligible under the Outpatient Mental Health benefit.

The Network Total Maximum Out-of-Pocket (TMOOP) is mandated by the federal government, TMOOP must include deductible, coinsurance, copays, prescription drug cost share and any qualified medical expense.

Please be advised that most eligible consent decree services will process under the Standard Value level of benefits.

**The terms "enhanced value" and "standard value" are not descriptors of the provider's ability. This is not a contract. This benefits summary presents plan highlights only. Please refer to the policy / plan documents, as limitations and exclusions may apply. The policy / plan documents control in the event of a conflict with this benefit summary.*

REV 2.1.2018

ACSHIC

Standard Dental Option

- A school must use this chart as the "Standard" Dental plan
- A "sunset" provision will apply that does not use this chart
- A school will use the "Building Block" approach of providing:
  i. Basic Services only
  ii. Basic and Specific Riders
  iii. Basic and All Riders
- But "Standard" Benefits Must be:
  - For the entire school or the entire CBA segment
  - There is no voluntary dental option, nor is there any optional cafeteria plan picking of the riders

Rider	Percentage	Individual	Family
Basic	100%	$11.73	$42.09
A	80%*	5.90	15.72
B	50%*	8.36	17.65
C	80%*	.72	2.17
D	50%**	N/A	10.18
		$26.71	**$87.81**
Rate Increase:		**0 %**	

* Unlimited yearly maximum
** $1,500 maximum

Dental Implants - $500 per implant

	Level of Coverage
BASIC SERVICES	
Diagnostic & Preventive	
✓ Routine Exam	100%
✓ Prophylaxis	100%
✓ Fluoride Treatments	100%
✓ Sealants	100%
✓ Bitewing X-Rays	100%
✓ Full Mouth X-Rays	100%
Endodontic Services	
✓ Root Canal Treatment	100%
Restorative Services (Under Local Anesthesia)	
✓ Fillings	100%
✓ Anesthesia	100%
✓ Consultation	100%
Oral Surgery Services	
✓ Simple Extractions	100%
Removable Prosthetics	
✓ Repairs	100%
Fixed Prosthetics	
✓ Repairs	100%
RIDER A SERVICES	
Endodontic Services	
✓ Apicoectomy	80%
Restorative Services (Under Local Anesthesia)	
✓ Single Unconnected Inlays, Onlays and Crowns	80%
Oral Surgery Services	
✓ Most Oral Surgery – excluding simple Extractions	80%
RIDER B SERVICES	
Removable Prosthetics	
✓ Full or Partial Dentures	50%
✓ Replacement	50%
✓ Relining and rebasing	50%
Fixed Prosthetics	
✓ Dental Implants	$500 per implant (limited to 3 - $1,500)
✓ Dental Implants – Related Services (crown over implant)	50%
✓ Fixed Bridgework	50%
✓ Replacement	50%
RIDER C SERVICES	
Periodontics	
✓ Non-Surgical	80%
✓ Surgical	80%
RIDER D SERVICES	
Orthodontics – Dependents to age 19	
✓ Diagnostic, Active and Retention Treatment	50%
✓ Lifetime Orthodontic Maximum – Per Child	$1,500
POLICY DEDUCTIBLES AND MAXIMUMS	
✓ Annual Program Maximum-Per Covered Individual	Unlimited
✓ Annual Program Deductible	None

DAVIS VISION
EYECARE REFRAMED™

Allegheny County Schools
Health Insurance Consortium
www.ACSHIC.com

Fashion Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. With the rising cost of eyewear you can't afford not to be covered through a managed vision care plan. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full.[1]

Contact Lens Collection: Select from the most popular contact lenses on the market today with Davis Vision's Contact Lens Collection.[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...

Just log on to the Open Enrollment section of our Member site at davisvision.com and click "Find a Provider" to locate a provider near you including:

Visionworks

For more details about the plan, just log on to the Open Enrollment section of our Member site at **davisvision.com** or call **1.877.923.2847** and enter Client Code **4230**.

IN-NETWORK BENEFITS	
Eye Examination	Every 24 months, every 12 months for dependents up to age 19, **Covered in full**
Eyeglasses	
Spectacle Lenses	Every 24 months, every 12 months for dependents up to age 19, **Covered in full** For standard single-vision, lined bifocal, or trifocal lenses
Frames	Every 24 months, **Covered in full** Any Fashion frame from Davis Vision's Collection[1] (value up to $100) OR $100 retail allowance toward any frame from provider supply OR $150 allowance to go toward any frame from a Visionworks family of store locations.[5]
Contact Lenses	
Contact Lens Evaluation, Fitting & Follow Up Care	Every 24 months, Collection Contacts: Covered in full
Contact Lenses (in lieu of eyeglasses)	Every 24 months, $80 retail allowance toward provider supplied disposable contact lenses, $110 retail allowance for specialty and non-disposable contact lenses

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in-network usage and average retail values.	Without Davis Vision	With Davis Vision
Scratch-Resistant Coating	$25	$0
Polycarbonate Lenses	$68	$0[2]-$35
Standard Anti-Reflective (AR) Coating	$83	$40
Standard Progressives (no-line bifocal)	$198	$0
Plastic Photosensitive (Transitions®[3])	$110	$70

Lower costs and more benefits! *See the savings!*

Service	Without Davis Vision	With Davis Vision
Eye Examination	$103	$0
Lenses		
Bifocals	$116	$0
Scratch-Resistant Coating	$25	$0
Transitions®[3]	$110	$70
Frame	$160	$0
Total	$514	$70

Savings up to: **$444**

[1] The Davis Vision Collection is available at most participating independent provider locations.
[2] For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
[3] Transitions® is a registered trademark of Transitions Optical Inc.
[4] Allowance is available at these Visionworks family of store locations: Davis Vision, Empire Vision Centers, Total Vision Care, EyeMasters, Cambridge Eye Doctors, Vision World, Dr. Bizer's Vision World, Eye Dr, Dr. Bizer's Valu Vision, Doctor's Valu Vision, Hour Eyes, Visionworks.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with Davis Vision, the terms of the contract or insurance policy will prevail.

OE00275 2/23/15

Davis Vision plans offer...

Value for our Members

A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations

A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice

Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:

- Mail Order Contact Lenses Replacement contacts (after initial benefit) through DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Web site for details.
- Laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact Info

For more details about the plan, just log on to the Open Enrollment section of our Member site at davisvision.com or call 1.877.923.2847 and enter Client Code 4230.

ADDITIONAL OPTIONS	WITHOUT DAVIS VISION	WITH DAVIS VISION
Fashion Frame (from the Davis Vision Collection)	$100	$0
Designer Frame (from the Davis Vision Collection)	$160	$20
Premier Frame (from the Davis Vision Collection)	$195	$40
All Ranges of Prescriptions and Sizes	$90	$0
Plastic Lenses	$78	$0
Oversized Lenses	$20	$0
Tinting of Plastic Lenses	$25	$15
Scratch-Resistant Coating	$25	$0
Polycarbonate Lenses	$66	$0[1] or $35
Ultraviolet Coating	$25	$15
Standard Anti-Reflective (AR) Coating	$83	$40
Premium AR Coating	$104	$55
Ultra AR Coating	$121	$69
Intermediate-Vision Lenses	$150	$30
Standard Progressive Addition Lenses	$198	$0
Premium Progressives Addition Lenses	$247	$40
Ultra Progressive Addition Lenses	$369	$90
High-Index Lenses	$120	$60
Polarized Lenses	$103	$75
Photochromic Lenses (i.e. Transitions®, etc.)[2]	$110	$70
Scratch Protection Plan (Single vision | Multifocal lenses)		$20 | $40

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

[2] Transitions® is a registered trademark of Transitions Optical, Inc.

Out-of-Network Benefits

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE
Eye Examination up to $40 | Frame up to $64 Spectacle Lenses (per pair) up to: Single Vision $30, Bifocal $40, Trifocal $60, Lenticular $80 Progressive Lenses $130 Dependents up to age 19 may receive: Single Vision Polycarbonate $70 | Bifocal Polycarbonate $80 | Trifocal Polycarbonate $95 Evaluation/Fitting $35 | Elective Contacts up to $80, Medically Necessary Contacts up to $225

INNOVA Benefit Services

ENROLLMENT FORM: PART 1 - PLAN HIGHLIGHTS
FSA - Medical Expenses and Dependent Care Expenses

General Information

Baldwin Whitehall School District Flexible Spending Account
July 1, 2018 through June 30, 2019

What is a Flexible Spending Account: A Flexible Spending Account (FSA) allows you to set aside a portion of earnings to pay for qualified medical and/or dependent care expenses. The benefit of a FSA is that the money deducted from your pay for a FSA is not subject to payroll taxes, resulting in substantial payroll tax savings.

Eligibility

Regular, full-time employees may begin participating on first of the month coinciding with or immediately following date of hire. You are considered a full-time employee for this benefit plan if you are regularly scheduled to work at least 10 hours per week and are over the age of 19.

Benefits

Important:

- Every eligible employee who wishes to participate in the FSA MED or FSA DEP must complete an enrollment form each year. If you fail to complete an enrollment form in any plan year's open enrollment period it will be assumed that you do NOT wish to participate for the applicable plan year.
- Once you make your election it cannot be changed for the remainder of the plan year without an eligible change in status (i.e. marriage/divorce, birth/adoption of a child). Please estimate carefully.

Medical Care Flexible Spending Account (FSA MED)	Your pre-tax contributions to this account can be used to reimburse eligible healthcare expenses incurred during the plan year or by your termination date. Your full account election will be available on the first day of the plan year.	Maximum Annual Election: $2,650 Minimum Annual Election: $120
Dependent Care Flexible Spending Account (FSA DEP)	Your pre-tax contributions to this account can be used to reimburse eligible daycare expenses incurred during the plan year. Your account will be funded as contributions are withheld from your paycheck.	Maximum Annual Election: $5,000 ($2,500 if married, filing separately) Minimum Annual Election: n/a

mySourceCard™ Enrollment / Reimbursements

Important:

- It is our recommendation that you review your account information periodically by logging into your participant portal via our website www.innovaben.com. If this is your first time logging in, please choose "Register". Your login ID is your Social Security Number and the Employer code is 75688832.

mySourceCard™ Enrollment	For your payment convenience, and as a participant in one or more of the Reimbursement Plans indicated on this form, you will be issued a *my*SourceCard™ MasterCard© Debit Card issued by Armstrong Bank, and agree to use it according to the terms of this Agreement and the Cardholder Agreement that will be provided to you with the Card.
Reimbursements	You may also be reimbursed for expenses that you have not used your debit card for by submitting a claim to INNOVA. Payments will be processed weekly via direct deposit. Minimum reimbursement amount (except at year end) is $25.

Unused Funds

This plan does not allow any unused contributions to be carried forward to the next Plan Year or to be refunded to you. You will have an additional 2 ½ months (September 15) Grace-Period in which to incur expenses. You will also have a period of time after the end of the Plan Year (September 30) to submit claims for expenses incurred during the Plan Year. This period of time is known as the "Run-Out Period." Any money left in your account after the end of the Run-Out Period will be forfeited to your employer in accordance with the Internal Revenue Code and Regulations. Your employer cannot refund this money to you but may use it to offset the cost of employee benefits.

INNOVA Benefit Services

ENROLLMENT FORM: PART 2 - ELECTIONS
FSA - Medical Expenses and Dependent Care Expenses

General Information

Baldwin Whitehall School District Flexible Spending Account
July 1, 2018 through June 30, 2019

Participant Information (*Please Print*)

Employee Name:	Social Security Number:
Street Address:	City, State, Zip:
Daytime Phone:	Email Address:

Benefits Election

Medical Expense Reimbursement Account

Maximum Plan Year Election: **$2,650** Minimum Plan Year Election: **$120**	$_____ Per Pay Amount	$_____ Total Plan Year Amount

Dependent Care Expense Reimbursement Account

Maximum Plan Year Election: **$5,000** Minimum Plan Year Election: **n/a**	$_____ Per Pay Amount	$_____ Total Plan Year Amount

*my*SourceCard™ Enrollment Agreement

☐ No, I do NOT want a *my*SourceCard™ debit card.

☐ Yes, I would like a *my*SourceCard™ debit card issued for payment of eligible FSA expenses. **I have read and understand fully that the *my*SourceCard is issued as a payment convenience only, and I am still responsible for verifying all card transactions via acceptable documentation when it is requested or my card may be blocked and payment may be due back to the Plan.** *(If you currently have a mySourceCard™, you can continue to use it in the new plan year.)*

Request for additional card(s)	Name	Relationship

Reimbursements

Reimbursements are made via **direct deposit**. *(If you are currently enrolled in direct deposit, your information will remain in effect.)*

Attach Voided Check Here *(Do NOT attach a deposit slip.)*

Joan Doe
Anywhere, USA

1234

PAY TO THE ORDER OF _____ $ ____

_____ DOLLARS

YOUR TOWN BANK
YOUR TOWN, AR 123456

FOR _____

⑈25550005⑈ 1234556789022⑆

VOID

Authorization/Declination

I have been made aware of and understand that all of the appropriate documents relating to the Baldwin Whitehall School District Flexible Spending Account ("Plan") including Page 1 – Plan Highlights of this two-page Enrollment Form, the Summary Plan Description, Privacy Notice, and any other relevant Plan Documents, or Notices are available to me electronically. I also understand that if I wish to receive a paper copy of any of the above documents, I may do so free of charge by contacting my Human Resource Department.

☐ **Authorization:** I elect to participate in the Plan and agree to have my gross salary reduced by the benefit amount(s) selected above. I understand this election is irrevocable for the plan year unless there is a change in family status and that any unused balance(s) may be forfeited pursuant to the rules of the Plan.

☐ **Declination:** I have been given the opportunity to enroll in the Plan, but I elect NOT to participate.

Signature of Employee	Date

According to the individual collective bargaining agreements, only qualified employees are eligible.

Baldwin-Whitehall School District
Health Insurance Benefit Waiver/Opt Out Request

Name_____ **Building**_____

Social Security Number_____-____-_____ **Job Assignment** _____

I hereby notify the Baldwin-Whitehall School District that I wish to waive my participation in the District's group insurance plans, as follows, in lieu of a supplemental payroll payment. Such payment will be made in accordance with the Compensation/Benefit Policy.

I waive my coverage in the following plans:

(Please check one) ☐ **Individual** ☐ **Parent/Child** ☐ **Parent/Children** ☐ **Husband/Wife or** ☐ **Family**

- ☐ **All Coverage**
- ☐ **Medical Coverage only**
- ☐ **Dental Coverage only**
- ☐ **Vision Coverage only**

This waiver will remain in effect for the entire **2018/2019** school year. I understand that during this period, I may not rejoin the plan for any reason except for the following non-medical instances as follows:

1. death, layoff, discharge or other loss of benefits by the person whom I am relying for benefits or
2. divorce or separation is shown to cause loss of benefits or
3. during any open enrollment period and
4. the prorated portion of savings must be returned upon re-enrollment in the plan.

Signature _____ **Date** _____

At the end of this waiver period, you may either rejoin the plan or waive your coverage for the next school year.

New waivers will be required each year. New letters from your spouse's employer showing what coverage you have (husband/wife or family) is also required.

Please return to Georgann Helman, Administration Office, by June 8, 2018.

Total Waiver Due: _____