Welcome to FreedomCare

Employer Name: Technical Needs North, Inc.
Group ID#: C002312

Benefits Enrollment Guide

Disponible en Español, favor de comunicarse: 1.844.300.6497

Keeping you healthy

Your employer has chosen to offer an eligible employer-sponsored plan designed to promote the health and wellness of you and your family. This offer of coverage is your opportunity to enroll in an eligible employer-sponsored plan or to decline coverage. The benefits program offers a variety of valuable health coverage options. Choosing the right option is an important decision, so to help you make an informed choice this guide provides an overview of the benefits available.

Additional information about these benefits and a Summary of Benefits Coverage (SBC) can be found at www.freedomcarebenefits.com.

A paper copy of the SBC is also available, free of charge, by calling (toll-free) 1.844.657.1575.

IMPORTANT: You are required to make an election during your enrollment period, you must enroll or decline coverage.

You have 4 different ways you can make your elections!

1. Go Online

Visit: www.freedomcarebenefits.com. Click **Register** and set up your account using your group ID number and social security number. Review your options & choose your coverage.

2. Text Enroll to 367-655

You will receive a link to set up your account.

3. Give us a call

Call our Enrollment Center and one of our knowledgeable representatives will help you. Available Monday through Friday 9:00 am – 9:00 pm EST at **1.844.300.6497**.
Representantes que hablan Inglés y Español están disponible.

4. See your HR department

Your HR representative will give you a paper form to make your selections.

Minimum Essential Coverage Plan

The Minimum Essential Coverage (MEC) Plan provides Preventative and Wellness Benefits. These covered benefits have **no copays or out of pocket expenses** and may help reduce your risk of developing health conditions in the future.

Benefits include:

- Immunizations
- Blood pressure screenings
- Diabetes and cholesterol screenings
- Prenatal visits for pregnant women
- Diet counseling
- Oral health assessments
- Vision screenings
- Cancer screenings

You get to choose your doctor!

This plan utilizes an open network; this means you can choose any doctor. Your doctor will call the number on the back of your Member ID card to verify your eligibility and you will have no out of pocket expenses for covered services.

Includes unlmited 24/7 access to a doctor and hundreds of prescriptions under $10 through our FreedomMD+RX program.

This MEC Plan is designed to satisfy your obligations under the ACA and avoid individual tax penalties.

Under the ACA, all individuals must have Minimum Essential Coverage or face the penalty. The penalty is the greater of $695 per adult plus $347.50 per child or 2.5% of your adjusted household income.

See the MEC Plan Summary on the following page for additional details of covered services. Spouses and dependents can be added for an additional fee.

MEC Plan Summary

Preventative Health Services for Adults

- **Abdominal Aortic Aneurysm One-Time screening** *(Men of specified ages who have ever smoked)*
- **Alcohol Misuse screening and counseling**
- **Aspirin Use to Prevent Cardiovascular disease**
- **Blood Pressure screening**
- **Cholesterol screening** *(Adults of certain ages or at a higher risk)*
- **Colorectal Cancer screening** *(Adults over 50)*
- **Depression screening**
- **Diabetes (Type 2) screening** *(Adults with high blood pressure)*
- **Diet counseling** *(Adults at higher risk for chronic disease)*
- **HIV screening**
- **Hepatitis B screening** *(People at high risk)*
- **Hepatitis C screening** *(Adults at increased risk, and one time for everyone born 1945-1965)*
- **Immunization Vaccines**
- **Obesity screening and counseling**
- **Sexually Transmitted Infections counseling**
- **Syphilis screening**
- **Tobacco Use screening**

Preventative Health Services for Women

- **Anemia screening**
- **Breast Cancer Genetic Test Counseling (BRCA)**
- **Breast Cancer Mammography screenings** *(Every year for women over 40)*
- **Breast Cancer Chemoprevention counseling**
- **Breastfeeding support and counseling**
- **Cervical Cancer screening** *(Sexually active women)*
- **Chlamydia Infection screening**
- **Contraception** *(Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling)*
- **Domestic Violence screening and counseling**
- **Folic Acid Supplements**
- **Gestational Diabetes screening** *(Women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes)*
- **Gonorrhea screening**
- **Hepatitis B screening** *(Pregnant women at first prenatal visit)*
- **HIV screening and counseling**
- **Human Papillomavirus (HPV) DNA Test** *(Every 3 years for women with normal cytology results who are 30 or older)*
- **Osteoporosis screening** *(Women over age of 60 depending on risk factors)*
- **Rh Incompatibility screening** *(Pregnant Women)*
- **Sexually Transmitted Infections counseling**
- **Syphilis screening** *(Pregnant Women)*
- **Tobacco Use screening and interventions**
- **Urinary Tract or Other Infection screening**
- **Well-woman visits**

Preventative Health Services for Children

- **Alcohol and Drug Use Assessments**
- **Autism screening** *(Children at 18 & 24 months)*
- **Behavioral assessments** *(0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)*
- **Blood Pressure screening** *(0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)*
- **Cervical Dysplasia screening**
- **Depression screening**
- **Developmental screening** *(Children under age 3)*
- **Dyslipidemia screening** *(1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)*
- **Fluoride Chemoprevention supplements**
- **Gonorrhea Preventive Medication** *(Newborns)*
- **Hearing screening** *(Newborns)*
- **Height, Weight and BMI measurements**
- **Hematocrit or Hemoglobin screening**
- **Hemoglobinopathies or Sickle Cell screening** *(Newborns)*
- **HIV screening**
- **Hypothyroidism screening** *(Newborns)*
- **Immunization vaccines**
- **Iron supplements** *(Children ages 6 to 12 months at risk for anemia.)*
- **Lead screening**
- **Medical History throughout development** *(0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)*
- **Obesity screening and counseling**
- **Oral Health Risk assessment** *(0 to 11 months, 1 to 4 years, 5 to 10 years)*
- **Phenylketonuria (PKU) screening**
- **Sexually Transmitted Infections prevention**
- **Tuberculin testing** *(0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years)*
- **Vision screening**

FreedomMD+RX

Included with MEC plans!

FreedomMD+RX, powered by MeMD and RXValet, combines the benefits of both the FreedomMD program and the FreedomRX program to create a valuable benefit.

FreedomMD

Call a doctor whenever, wherever you are at no cost. FreedomMD gives you unlimited access to a doctor 24 hours a day, 7 days a week, 365 days a year.

Common conditions treated by FreedomMD include:

- Flu Like Symptoms
- Sprains & Strains
- Bronchitis
- Contusions
- UTI's
- Allergies
- Insomnia
- Respiratory & Sinus Infections
- Skin Infections
- Earache

Unlimited 24/7 access to a doctor.

Don't wait until you are sick.
Set up your accounts today!

Visit: www.freedomcarebenefits.com

FreedomRX

Prescription costs are high. FreedomRX has tackled the problem of high prescription costs and provides a one of a kind solution. We have negotiated an affordable program that allows access to hundreds of prescriptions drugs for less than $10. Other drugs are also available at deeply discounted rates.

These commonly prescribed drugs cover a wide variety of ailments.

Hundreds of prescriptions under $10.

"Late one Sunday night, my 4 year old, Lily, woke up drenched in sweat, coughing and crying. I tried giving her plenty of fluids but she couldn't keep anything down and kept vomiting. She just kept getting worse and I started to panic. The urgent care in our area was already closed for the night.

Instead of going to the emergency room I got online and signed into our FreedomMD account. Within 5 minutes, they called me to let me know I would get a call from the doctor shortly. The doctor called in less than 20 minutes, was very patient and listened to all of my concerns. She gave me some advice to make sure Lily stays hydrated and called in a prescription for amoxicillin to the closest 24 hour pharmacy. With FreedomRX, we paid 5 dollars for the prescription. Lily was fine and bouncing around in just a couple of days."

- Marie - Las Vegas, NV

Total cost for Telehealth visit: $0
Total cost for prescriptions: $5
Potential savings: $140 - $400

MEC Elevate

MEC Elevate provides much needed benefits and desired coverages at a reasonable price. In addition to preventative and wellness, MEC Elevate coverages include emergency room services, primary and urgent care services, labs, x-rays and imaging. See the MEC Elevate Plan Summary on the following page for additional details of covered services.

Doctor Visits

Primary Care $20 Copay

Urgent Care $50 Copay

Benefit Amount $1,000

Above the initial plan benefit, the deductible is applied. After the maximum out of pocket is reached, the plan pays continued benefits.

Emergency Room Care

Emergency Room Visit $250 Copay

Emergency Room Transport $150 Copay

Benefit Amount $2,500

Above the initial plan benefit, the deductible is applied. After the maximum out of pocket is reached, the plan pays continued benefits.

Diagnostic Tests & Imaging

X-Ray/Lab $75 Copay

Imaging $250 Copay

Benefit Amount $1,000

Above the initial plan benefit, the deductible is applied. After the maximum out of pocket is reached, the plan pays continued benefits.

These benefits include minimal copays, immediate benefits up to $4,500 before meeting your deductible, and unlimited benefits after your deductible at a reasonable price.

Unlimited 24/7 access to a doctor and hundreds of prescriptions under $10 through the FreedomMD+RX program.

MEC Elevate is designed to satisfy your obligations under the ACA and avoid individual tax penalties.

MEC Elevate Summary

MEC Elevate	
Network	First Health
Deductible (Individual)	
In Network	$7,150
Out of Network	No coverage
Coinsurance	
In Network	0% after deductible
Out of Network	Not Covered
Out-of-Pocket Limit (Individual)	
In Network	$7,150
Out of Network	No coverage
Preventative Care	$0 Copay
Primary Care/Urgent Care Visit	$20/$50 copay[1]
Specialist Visit	No coverage
Mental/Behavioral & Substance Abuse	No coverage
Emergency Room Visit/Emergency Transport	$250/$150 copay[2]
Rehabilitative Speech/Occupational/Physical Therapy Visit	No coverage
Alternative Medicine Visit	No coverage
X-ray/Diagnostic Imaging/Laboratory	$75/$250/$75 copay[3]
Inpatient Admission	No coverage
Outpatient Surgery	No coverage
Prescription Drug	
Generic	No coverage
Preferred	No coverage
Non-preferred	No coverage
Specialty	No coverage

1 *Plan pays first $1000 benefit per year, after $1000 the employee deductible is due until maximum out of pocket is reached, then the plan pays unlimited.*

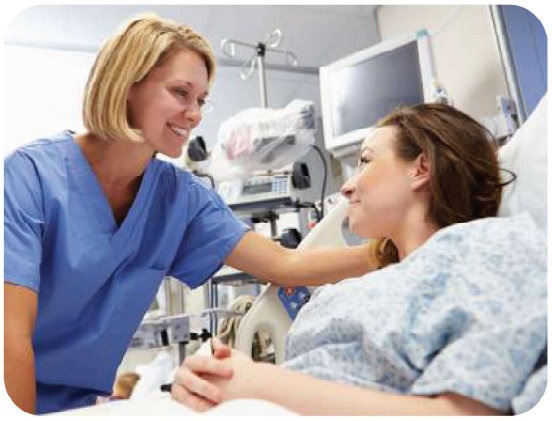
2 *Plan pays first $2500 benefit per year, after $2500 the employee deductible is due until maximum out of pocket is reached, then the plan pays unlimited.*

3 *Plan pays first $1000 benefit per year, after $1000 the employee deductible is due until maximum out of pocket is reached, then the plan pays unlimited.*

Minimum Value Plan

The Minimum Value Plan (MVP) offers major medical coverage. As an eligible employee, the MVP is offered at a cost for which you will be charged no more than 9.56% of your Box 1, W-2 wages for employee-only coverage (cost will vary for dependents).

If you would like to learn more about the Minimum Value Plan benefits or enroll, simply call our Enrollment Center and speak to a knowledgeable representative.



Minimum Value Plan	
Network	Cigna PPO
Deductible (Individual)	
In Network	$7,150
Out of Network	Not Covered
Coinsurance	
In Network	100%
Out of Network	Not Covered
Out-of-Pocket Limit (Individual)	
In Network	$7,150
Out of Network	Not Covered
Physician/Specialist/Chiropractic Office Visit	Deductible
Urgent Care Visit	Deductible
Emergency Room Visit	Deductible
Therapy Visit	Deductible
Alternative Medicine Visit	Deductible
X-ray/Lab Services	Deductible
Inpatient Admission/Outpatient Surgery	Deductible
Prescription Drug	
Generic	Deductible
Preferred	Deductible
Non-preferred	Deductible

FreedomDental + Vision

FreedomDental+ Vision is a direct reimbursement combination plan that pays for dental and vision expenses. The tiered reimbursement structure begins at the first dollar and allows you to maximize your potential benefits.

Reimbursement Schedule	
Procedure cost	**Reimbursement**
Up to $150	**100%**
$151 - $250	**75%**
$251 - $1,800	**50%**

You can choose to go to any dentist or vision specialist.

Examples of covered benefits include:

- **Annual eye exam**
- **Frames**
- **Lenses**
- **Contact lenses**
- **Teeth cleaning**
- **Fillings**
- **Root canal**
- **Dental x-rays**

Reimbursement begins with your first dollar of expenses on dental and vision services.

FREEDOMCARE

ENROLLMENT WORKSHEET

Initial Enrollment (New Hire): ☐	Open Enrollment: ☐	Group ID#:

Type of Coverage Applying For: ☐ Single ☐ Employee & Spouse ☐ Employee & Children ☐ Family

SSN:	**Last Name:**	**First Name:**	**M.I.:**

Address:

Street City State

Zip Code County

Date of Birth:	**Sex:**	**Marital Status:** ☐ Married ☐ Single ☐ Legally ☐ Widowed ☐ Divorced Separated	**Phone**	**Email:**

Name of Employer: **Type of Employment:** ☐ Full-Time ☐ Part-Time:

LIST ELIGIBLE FAMILY MEMBERS TO BE COVERED (PLEASE PRINT)
A certified copy of the court order must be attached for dependents in court-ordered custody or guardianship of the certificate holder. If more space is required, attach a separate page with additional information.

Relationship To You	Sex	First Name, Middle Initial, & Last Name (if not the same)	SSN	Date of Birth
Spouse	☐ Male ☐ Female			
Dependent 1	☐ Male ☐ Female			
Dependent 2	☐ Male ☐ Female			
Dependent 3	☐ Male ☐ Female			

Supporting documentation required.

Are you or any member of your family covered by any other health plan or health insurance that will be in effect concurrently with the coverage you are applying for? Yes No
If yes, complete the appropriate section(s) below. If more space is needed, attach a separate sheet with additional information.

OTHER HEALTH PLAN INSURANCE	**MEDICARE**	
Insured Member's Name: **Date of Birth:**	**Beneficiary Name:**	**Beneficiary Name:**
Employment Status: ☐ Active ☐ Retired **Name of Employer:** _____	**Entitlement Reason:** ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability	**Entitlement Reason:** ☐ Age 65 or Older ☐ End Stage Renal Disease ☐ Other Disability
Type of coverage: ☐ Single ☐ Family		
Policy #: **Effective Date:**	**Medicare #:**	**Medicare #:**
Name of Insurance Company: **Phone:**	**Part A Effective Date:**	**Part A Effective Date:**
Does the above insurance cover "all" family members including yourself? ☐ Yes ☐ No **If no**, please list dependents not covered on a separate sheet.	**Part B Effective Date:**	**Part B Effective Date:**

ACCEPTANCE OF COVERAGE/MEMBERSHIP:
I have read and understand the Acceptance of Elected Coverage/Membership on the reverse side of this form.

Signature of Applicant/Employee: Date:

Employee's Proposed Coverage Effective Date:

Your employer-sponsored plan options

Employer: Technical Needs North, Inc.

Group ID#: C002312

Minimum Essential Coverage (MEC) plan:

☐ Elect single coverage	**Monthly Rate:**	**$46.00**
☐ Elect spouse coverage	**Monthly Rate:**	**$101.20**
☐ Elect child(ren) coverage	**Monthly Rate:**	**$82.80**
☐ Elect family coverage	**Monthly Rate:**	**$138.00**

☐ I decline to enroll in the Minimum Essential Coverage plan.

MEC Elevate plan:

☐ Elect single coverage	**Monthly Rate:**	**$175.75**
☐ Elect spouse coverage	**Monthly Rate:**	**$386.65**
☐ Elect child coverage	**Monthly Rate:**	**$316.35**
☐ Elect family coverage	**Monthly Rate:**	**$527.25**

☐ I decline to enroll in the MEC Elevate plan.

Minimum Value Plan (MVP):

Please call 1.844.300.6497 to enroll.

☐ I decline to enroll in the Minimum Value Plan.

FreedomDental+ Vision:

☐ Elect single coverage	**Monthly Rate:**	**$39.99**
☐ Elect spouse coverage	**Monthly Rate:**	**$87.98**
☐ Elect child coverage	**Monthly Rate:**	**$71.98**
☐ Elect family coverage	**Monthly Rate:**	**$119.97**

☐ I decline to enroll in the FreedomDental+Vision plan.

By signing below, I acknowledge that this is an offer of employer-sponsored coverage. I acknowledge the terms and conditions of the plans I have elected or declined. I verify that all information I have provided is accurate to the best of my knowledge.

Employee Signature

First and Last Name *(Type or Print clearly)*

Date