FAQs

If you have a specific question, see if it's in the list below and click on the link to be taken directly to the answer you're looking for. Otherwise, feel free to browse and scan the FAQs at your own pace.

The Aon Active Health Exchange™

1. What is an exchange?

An exchange is an online insurance marketplace where buyers like you can shop for coverage from multiple medical, dental and vision insurance carriers who are competing for your business. An exchange merges the best of both worlds: group rates with more individual choice and price competitiveness that comes from free market competition.

The Aon Active Health Exchange is America's first national, large-employer, multi-insurance carrier exchange. Its website is easy to navigate and, just like other online stores, you'll be able to see all your options and sort by the features that are most important to you. By the time you complete your enrollment, you should feel confident that you've selected the right coverage options for your circumstances and budget.

2. Is Aon's exchange sponsored by the government?

No. The Aon Active Health Exchange is a private exchange. It is unrelated to the government-run state and federal health insurance exchanges, or marketplaces. It does, however, provide benefits consistent with the law and guarantees coverage for those eligible, regardless of pre-existing conditions.

3. What are the advantages of the exchange?

The medical and prescription drug, dental and vision benefits available through the exchange offer you:

- **Lots of choices.** Traditionally, you got to choose from the health plan options offered by the company. Through the exchange, you're able to choose from several coverage levels, a variety of insurance carriers and a range of costs.
- **Competitive pricing.** The insurance carriers are competing for your business, so it's in their best interest to offer their best prices. Plus, Penn National Gaming, Inc. will provide a credit to use toward the cost of medical and dental coverage.
- **You also have help when you need it.** There are great tools and resources to help you every step of the way. See question #5 for details about tools and resources.

4. What benefits are included in the exchange?

You can enroll in medical, dental and vision coverage through the exchange. In addition, you can enroll in voluntary benefits through the exchange, including accident injury insurance, critical illness insurance, hospital indemnity insurance, group legal coverage, pet insurance and identity theft protection.

Outside of the exchange, available through Penn, you can enroll in voluntary life insurance for yourself, your spouse and your children, optional short-term disability and long-term disability benefits. In addition, you can enroll in tax-advantaged accounts to pay for eligible health and dependent care expenses, including the Health Savings Account, two types of Health Care Flexible Spending Accounts and the Dependent Care Flexible Spending Account.

5. Where can I get more information?

There are lots of resources available to help before, during and after enrollment.

	Before you enroll	When you enroll	After you enroll
Make It Yours website *(available on September 27)*	pngaming.makeityoursource.com Learn how the exchange works and what coverage options you may have—and get tips for choosing the right coverage for you. You can also watch videos and access the insurance carrier preview sites here.		Visit year-round for practical tips that help you to get the most out of your benefits. Get "The Inside Scoop" on how to work the health care system, be a savvy shopper and even save some money.
Your Carrier Connection *(available through the Make It Yours website)*	**Carrier preview sites:** Get up to speed on provider networks, prescription drug information and other carrier resources. And you can contact insurance carriers directly with specific questions.		**Once you're a member:** Take advantage of all the tools, resources and information offered through your insurance carrier. For questions about your coverage, always start with your carrier. They know their plans best and have the final authority on all claims, billing disputes, etc. (contact information is available on the Make It Yours website).
The enrollment website	Access your current, personalized coverage details and manage your benefits.	Log on to the enrollment website at **mypngamingbenefits.net**, where you can compare your options, get helpful decision support and enroll. You'll also see the credit amount from Penn and prices by option. If you still have questions, you can reach a customer service representative by calling the Penn Benefits Center at **1-866-238-9995**, from 9:00 a.m. to 6:00 p.m. ET, Monday through Friday. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available.	**Once coverage begins:** Access your personalized coverage details and manage your benefits throughout the year. If you need help with more complex issues, call **1-866-300-6530** and ask to be connected to a Health Pro. Health Pros can explain how benefits work and help resolve issues.

Enrollment

6. When is enrollment?

The enrollment period for your 2022 benefits will take place from October 11 through October 22, 2021.

7. What will I need to do?

Between October 11 and October 22, 2021, you must take action to have the coverage you need in 2022, including:

- Medical and prescription drug coverage
- Dental coverage
- Vision coverage
- Health Savings Account (HSA) contributions to start the year, if eligible
- Flexible Spending Account (FSA) participation
    - Health Care FSA (HCFSA)
    - Limited Use Health Care FSA (LUFSA)
    - Dependent Care FSA (DCFSA)
- Critical illness, hospital indemnity accident injury
- Identity theft protection
- Pet insurance (enrollment available year-round as of January 1)
- Student Loan Refinancing (access available year-round as of January 1)
- Group legal coverage
- Optional life, spouse life, dependent life and disability coverage

To enroll, log on to the enrollment website at **mypngamingbenefits.net** during the enrollment period. Over the course of the enrollment process, you'll need to:

- Enroll the eligible dependents you want to cover in 2022. Remember that if you are adding any new dependents to your coverage, you will have to prove their eligible dependent status (more information regarding the Dependent Verification process can be found on the enrollment site at **mypngamingbenefits.net** or in the Benefits Enrollment Guide).
- Choose the insurance carriers and coverage levels you want for your medical, dental and vision benefits.

Existing life, disability, critical illness, hospital indemnity, accident injury, group legal and identity theft protection elections will carry over into 2022 unless you make a change during Open Enrollment.

You can get information about enrollment on the Make It Yours website at **pngaming.makeityoursource.com**.

8. What happens if I don't enroll?

You must review your options. If you don't review your enrollment selections, you may not have the coverage you need for the correct dependents (if any) through Penn next year.

Keep in mind:

- If you don't elect medical coverage, you won't have prescription drug coverage.
- If you don't attest to your tobacco-use status, you will not receive the Wellness Credit that may reduce your medical premiums by up to $100.
- You must make an active election every plan year if you want to contribute to a Health Savings Account (HSA) (if eligible) and/or Health Care or Dependent Care Flexible Spending Account.

9. Who's eligible for benefits?

Full-time Team Members are eligible for Penn's benefits. Full time means that you are regularly scheduled to work 30 hours or more per week.

Eligible dependents include:

- Your eligible spouse;
- Your eligible children under age 26 (eligible children must be unmarried to enroll in dental coverage); and
- Your eligible children of any age who became handicapped or totally disabled before age 26.

Dependent Child Life Insurance is only available for children under age 19, or 26 if a full-time student. It is your responsibility to drop this coverage if you no longer have a dependent that meets the eligibility requirements.

My Options

10. What are my options for medical and prescription drug coverage?

You have several coverage levels to choose from, including Bronze, Bronze Plus, Silver, Gold and Platinum. Each coverage level is available from multiple insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your medical options.

11. What happens if I enroll in the Bronze or Bronze Plus medical option and have expenses early in the plan year?

If you enroll in a high-deductible medical option, you should be prepared to pay the full cost of your medical and prescription drug expenses up to your medical plan's deductible amount—in case you have significant medical expenses shortly after the plan year begins. Even if you start contributing to your HSA right away, your HSA may not yet have enough money to cover costly services early in the plan year. One option is to pay for those early qualified expenses out of your own pocket and then, when your HSA balance has enough funds in it to cover the expense, reimburse yourself from your HSA. This is a good reason to make sure you're saving enough in your HSA. You may also be able to negotiate with the service provider to set up a payment schedule that will allow you to pay for services over time as the money becomes available in your HSA.

12. Am I required to designate a primary care physician?

You must designate a primary care physician to coordinate your medical care if you:

- Choose Kaiser Permanente as your insurance carrier;
- Live in Northern California and choose Health Net as your insurance carrier; or
- Live in Southern California and choose Health Net as your insurance carrier and Gold as your coverage level.

13. Is one coverage level better than another?

No. Don't let the names of the coverage levels fool you—one option isn't better than another. They're designed to give you choice so that you can find the option that makes the most sense for your situation. Remember to take your total costs into consideration, which includes what you pay out of your paycheck (before-tax premiums) *and* what you pay out of your own pocket (deductibles, coinsurance, copays) when you get medical care and use prescription drug coverage.

For example, the Gold and Platinum coverage levels will cost you more each paycheck, but less when you receive care. These coverage levels have copays for some services and lower deductibles compared to the Bronze, Bronze Plus and Silver coverage levels.

The Bronze, Bronze Plus and Silver coverage levels come with lower paycheck costs (before-tax premiums) and higher deductibles. If you don't need a lot of medical care, you'll spend less overall because you're not paying premiums for coverage you don't need. These plans may also cost you less overall if you need enough care that you will meet your deductible and perhaps your out-of-pocket maximum by the end of the plan year.

14. What's the difference between a traditional PPO and a high-deductible PPO?

A Preferred Provider Organization, or PPO, is a type of medical option that uses a network of preferred physicians, hospitals and other health care providers that have agreed to provide care at negotiated prices. You can also go to out-of-network providers, but you'll pay more.

When you enroll in a traditional PPO, like the Gold option, you have to meet a deductible before the insurance carrier starts paying a percentage of the costs. For example, the Gold option deductible is $800 for Team Member only coverage and $1,600 for family coverage. In exchange for a lower deductible, you will pay more each paycheck.

A high-deductible PPO operates the same, but as the name suggests, you have a higher deductible before your medical and prescription drug coverage kicks in. To balance the cost of the high deductible, you will pay less each paycheck. Once you meet your deductible, you get the protection of a traditional PPO and pay a percentage of your ongoing expenses, up to the out-of-pocket maximum. See question #41 for more details about the deductible.

15. Can each family member choose a different medical coverage level or insurance carrier?

No. All family members must be enrolled in the same coverage level with the same insurance carrier.

16. Which medical insurance carriers will I be able to choose from?

Most of the largest insurance carriers are participating in the exchange. Keep in mind that carriers may vary by region. If your insurance carrier's name includes a state, this refers to the location the carrier operates from. In general, it isn't a reference to the network—many offer coverage nationally.

Your specific options are based on where you live. You'll be able to see the options available to you when you enroll.

Before you're a member, you can visit specially designed carrier sites to get a "preview" of their services, networks and more. You should check out the carrier preview sites to get a closer look at the carriers you're considering. You can get to the carrier preview sites through the Make It Yours website at **pngaming.makeityoursource.com**. Once you enroll and become a member of a carrier, you'll be able to register and log on to the carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers and online experience. These consumer ratings and comments can help you with your choices. They're available through the enrollment website at **mypngamingbenefits.net**.

17. Will I be able to use the same providers as I do today?

It depends. Each insurance carrier has its own network of preferred providers (e.g., doctors, specialists, hospitals). If you want to keep seeing your current doctors, select an insurance carrier that includes your preferred providers in its network. If you are comfortable changing doctors, select an insurance carrier whose network includes providers critical to your care.

Even if you can keep your current insurance carrier through the exchange, the provider network could be different and can change, so **always** check the provider directories before making a decision.

Do not rely on your provider's office to know the carriers' network(s). To see whether your doctor is in network:

- **Check out the insurance carrier** preview sites at **pngaming.makeityoursource.com**, or
- When you enroll, check the networks of each insurance carrier you're considering on the enrollment website. For the best results:
    - Search for your provider by name—not medical practice.
    - Check only the office location(s) you are willing to visit.
    - When searching for a facility, use the complete facility name and confirm whether the specialty of the facility is covered in-network.

Important! If you have any uncertainty (for instance, covering an out-of-area spouse or child) or you need the network name, you need to call the insurance carrier.

18. Why should I use in-network providers?

Seeing out-of-network providers typically costs substantially more than seeing in-network providers. For example, there is a higher deductible and higher coinsurance on out-of-network care. You'll also have to pay the entire amount of the out-of-network provider's charge that exceeds the maximum

allowed amount, even after you've reached your annual out-of-network out-of-pocket maximum. Certain Platinum options won't cover out-of-network services at all.

19. How should I choose a medical carrier if my dependents and I live in different states?

Because you and your dependents must enroll in the same option, you may want to consider one of the national insurance carriers that offer national provider networks so that your dependents have access to in-network providers in most locations. Regional insurance carriers *may* offer in-network coverage outside of their regional service area through partnerships with other carriers. You can contact the insurance carrier for details.

Do not rely on your provider's office to know the carriers' network(s). You need to call the insurance carrier to confirm whether an out-of-area provider participates in a carrier's network.

If your insurance carrier's name includes a state, this refers to the location the carrier operates from. In general, it isn't a reference to the network—many offer coverage nationally.

20. How do I decide which medical option is right for me?

You'll have access to a number of resources to help you make smart decisions. You should start by visiting the Make It Yours website at **pngaming.makeityoursource.com** on or after October 1 to access videos, details about your options, comparison charts and more.

Then, when you enroll between October 11 and October 22, you'll be able to see the credit amount from Penn and your price options on the enrollment website at **mypngamingbenefits.net**. You can also access tools that give you a personalized suggestion, help compare the details of your options, let you see insurance carrier ratings and more.

If you still have questions, you can reach a customer service representative by calling Penn Benefits Center at **1-866-238-9995**, from 9:00 a.m. to 6:00 p.m. ET, Monday through Friday. If you don't connect with a representative right away, you will be given the option to save your place in line and be called back once a representative is available. Additionally, you can call the **insurance carriers** with specific questions about the options they offer.

21. Will pre-existing conditions be covered?

Yes. When you and your eligible dependent(s) (if any) enroll in medical coverage through the exchange, coverage is guaranteed, regardless of pre-existing conditions.

22. What's included in the preventive care that's covered at 100% by all medical options?

Recommendations from the U.S. Preventive Services Task Force are used to determine which services are considered preventive services. In general, the following outpatient preventive care services are 100% paid by the insurance carrier when you see an in-network provider, without needing to meet the deductible. Limitations vary by carrier, so check with your insurance carrier if you have any questions.

Examples of preventive care that could be covered at 100% include:

- Annual physical exam
- Pediatric exam
- Well-woman exam (includes Pap test)
- Digital rectal exam
- High blood pressure screening (adult)
- Depression screening (adolescent)

- Mammogram
- Bone density screening
- Cancer screenings
- Cardiovascular screenings
- Colorectal screening
- Prostate screening
- Depression screening (adult)
- Diabetes screening
- Immunizations (child)
- Immunizations (adult)
- Influenza, shingles and pneumonia vaccinations (adult)

23. How will my prescription drugs be covered?

Your prescription drug coverage will be provided through your medical insurance carrier's pharmacy benefit manager—which could be a separate prescription drug company. Team Members who enroll under Aetna, Cigna, Highmark or UnitedHealthcare will have pharmacy benefits managed by CVS Caremark. Each pharmacy benefit manager has its own rules about how prescription drugs are covered. That's why you need to do your homework to determine how your medications will be covered before choosing an insurance carrier.

If you or a covered family member regularly takes medication, it is strongly recommended that you call CVS Caremark (if you're considering coverage under Aetna, Cigna, Highmark and UnitedHealthcare) or the medical insurance carrier (for other carriers) before you enroll to better understand how your particular prescription drug(s) will be covered. Do not assume that your generic or brand name medication will be covered the same way by each carrier each year. Visit the Make It Yours website beginning October 1, for a **list of questions** to ask.

24. What is "prior review" and when is it required?

Before getting certain types of care, you or your doctor may be required to run it by your insurance carrier first. Getting "prior review" (also referred to as prior authorization or precertification) allows the carrier to make sure you're eligible for the services, ensure you're getting care that makes sense for your condition and confirm how the bill is going to be paid.

Where you get care determines who completes the process:

- When you stay in network, your doctor usually completes the process on your behalf when it's required. But you should always confirm with your doctor to be sure he or she is handling it.
- If you go out of network, you are usually responsible for completing the process. You may have to work with your doctor or directly with your insurance carrier to fill out paperwork and receive the appropriate approval before getting care.

When prior review is required and you don't get preapproval, you could get stuck paying most or **all** of the bill or a penalty. For that reason, it's always in your best interest to ask your doctor whether you need to do anything in advance and confirm that services you need will be covered by your insurance carrier.

25. I am considering a national medical carrier for 2022. Can I go to any pharmacy to fill my maintenance medication prescription?

With limited exceptions, CVS Caremark will cover maintenance medications only if you have 90-day supplies filled through mail order or at a CVS pharmacy. To set up mail order with a new medical

insurance carrier, you'll likely need a new 90-day prescription from your doctor. And, because mail order can take a few weeks to establish, it's a good idea to ask your doctor for a 30-day prescription to fill at a retail pharmacy in the meantime. Prescriptions that are not classified as maintenance medications can be filled at any retail pharmacy.

26. Will I receive new medical or prescription drug ID cards?

If you keep your current medical coverage and insurance carrier for 2022, you can continue to use your current ID card(s) unless you are mailed a replacement(s).

If you enroll with Aetna, Cigna, Highmark Blue Shield or UnitedHealthcare for the first time, you'll receive separate medical and prescription drug ID cards before January 1. If you enroll for the first time with a different carrier, you'll receive one ID card for both medical and prescription drug coverage.

27. What are my options for dental coverage?

You have several coverage levels to choose from, including:

- **Bronze:** A PPO option that covers in- and out-of-network care (you'll receive a discounted rate with in-network providers), but does not cover major services or orthodontic expenses
- **Silver:** A buy-up to the Bronze PPO option that covers in- and out-of-network care (you'll receive a discounted rate with in-network providers), including coverage for major services and, for children up to age 19, orthodontic expenses
- **Gold:** An enhanced PPO option that covers in- and out-of-network care (you'll receive a discounted rate with in-network providers), including coverage for major services and orthodontic expenses for children and adults
- **Platinum:** A copay driven DHMO option that covers *in-network care* only, including coverage for major and orthodontic expenses for children and adults. This plan is not available in all areas and has a very narrow network of in-network providers

Each coverage level is available from different insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your dental options.

28. Am I required to designate a primary care dentist?

If you are considering a Bronze, Silver or Gold option, you will not need to designate a primary care dentist. Keep in mind that you'll receive the highest benefit by seeing a dentist who participates in your carrier's network.

If you are considering a Platinum dental option:

- It may cost less than some of the other options, but you **must** get care from a dentist who participates in the insurance carrier's DHMO network. The network could be considerably smaller, so be sure to check the availability of local in-network dentists before you enroll.
- The Platinum dental option does **not** provide out-of-network benefits. So if you don't use a network dentist, you'll pay for the full cost of services.

29. Which dental insurance carriers will I be able to choose from?

You'll be able to choose from Aetna, Cigna, Delta Dental, MetLife and UnitedHealthcare.

Before you're a member, you can visit specially designed carrier sites to get a "preview" of their services, networks and more. You should check out the carrier preview sites to get a closer look at the carriers you're considering. You can get to the carrier preview sites through the Make It Yours

website at **pngaming.makeityoursource.com**. Once you're a member, you'll be able to register and log on to the carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. They're available through the enrollment website at **mypngamingbenefits.net**.

30. What do I need to know about dental networks?

Just like the medical insurance carriers, each dental carrier has its own provider networks that can vary by the coverage level you choose. If it's important that you continue using the same dentist, you should check to see whether your dentist is in the network before you choose a carrier.

Do not rely on your provider's office to know the carriers' network(s). To see whether your dentist is in network:

- Check out the **insurance carrier** preview sites, or
- When you enroll, check the networks of each insurance carrier you're considering on the enrollment website.

31. What are my options for vision coverage?

You have three coverage levels to choose from, including:

- **Bronze:** Exam-only option that provides in-network discounts for materials (e.g., lenses, frames, contacts)
- **Silver:** A PPO option that covers in-network and, for certain services, out-of-network care
- **Gold:** An enhanced PPO option that covers in-network and, for certain services, out-of-network care

Each coverage level is available from different insurance carriers at different costs. When you enroll, you'll be able to compare benefits and features across your vision options.

32. Which vision insurance carriers will I be able to choose from?

You'll be able to choose from EyeMed, MetLife, UnitedHealthcare and VSP.

Before you're a member, you can visit specially designed carrier sites to get a "preview" of their services, networks and more. You should check out the carrier preview sites to get a closer look at the carriers you're considering. You can get to the carrier preview sites through the Make It Yours website at **pngaming.makeityoursource.com**. Once you're a member, you'll be able to register and log on to the carrier's main website for personalized information.

During enrollment (and throughout the year), you can see how other people have rated the insurance carriers on a variety of measures, such as customer service, network of providers, and online experience. These consumer ratings and comments can help you with your choices. They're available through the enrollment website at **mypngamingbenefits.net**.

33. What do I need to know about vision networks?

Each vision insurance carrier has its own provider network. If it's important that you continue using the same eye doctor or retail store, you should check to see whether your eye doctor or retail store is in the network before you choose a carrier.

Do not rely on your provider's office to know the carriers' networks. To see whether your eye doctor or retail store is in network:

- Check out the **insurance carrier** preview sites, or
- When you enroll, check the network of each insurance carrier you're considering on the enrollment website.

34. What other benefit options are available to me through the exchange?

You can choose to supplement your medical coverage with:

- **Critical illness insurance:** Pays a benefit if you or a covered family member is treated for a major medical event (such as a heart attack or stroke) or diagnosed with a critical illness (such as cancer or end-stage kidney disease)
- **Hospital indemnity insurance:** Pays a benefit in the event you or a family member covered under this plan is hospitalized
- **Accident insurance:** Pays a benefit in the event you or a family member covered under this plan is in an accident

You can also choose to enroll in:

- **Legal services:** Covers attorney fees for things like wills, real estate matters and more
- **Pet insurance:** Helps pay veterinary expenses for your sick or injured pet
- **Identity theft protection:** Monitors your personal information and takes steps to protect you from fraud

Through Penn, you can also enroll in:

- **Supplemental life insurance:** Protects your family financially in the event of a death
- **Supplemental short-term and long-term disability:** Provides you with income if you are unable to work due to an illness or non-work-related injury
- **A Health Savings Account:** To save pre-tax dollars for health care expenses now and in the future
- **A Health Care Flexible Spending Account:** To save pre-tax dollars for eligible health care expenses for you and your family during the plan year
- **Limited Use Health Care Flexible Spending Account:** To save pre-tax dollars for eligible dental and vision expenses during the plan year when you elect to also contribute to a Health Savings Account

- **Dependent Care Flexible Spending Account**: To save pre-tax dollars for eligible dependent day care, elder care and after-school program expenses during the plan year

You can get more details on the Make It Yours website at **pngaming.makeityoursource.com**.

35. Is pet insurance available for pets other than cats and dogs?

Yes. If you want coverage for your bird, rabbit, reptile or other exotic pet, you'll find it with Nationwide. Enrolling non-exotic pets, such as a cat or dog, can be done via the Nationwide website. However, to enroll in the Avian & Exotic Pet Plan, please call **1-888-899-4874**.

36. How does student loan forgiveness work for parents?

If you have Parent Plus loans for your children or even grandchildren, Fiducius will help you determine how these loans can be aligned as Direct loans to qualify for forgiveness.

37. Are my loan payments entered as payroll deductions?

No, you are required to make payments directly to the loan servicer.

38. Do all student loans qualify for forgiveness?

No, only Direct federal student loans qualify for the program. Federal student loans must be aligned correctly to be eligible for loan forgiveness. Private student loans are not eligible for forgiveness.

39. What if I have questions about the Student Loan Refinancing benefits?

If you have questions about this benefit, you can email **loginassistance@getfiducius.com**, put "Penn National Gaming" in the subject line, and provide a brief explanation of the issue in the email.

Paying for Coverage

40. When will I find out the cost of coverage?

During the enrollment window (October 11 through October 22), you'll be able to see the credit amount from Penn and your price options when you enroll on the enrollment website at **mypngamingbenefits.net**.

Penn is committed to helping Team Members pay for health coverage through a credit. Since the amount of the credit will not change during the year, our health care spending will be much more predictable. Offering a credit ensures our benefits remain affordable to you.

41. Do I get to keep the Penn credit if I don't enroll in coverage?

No. The credit you get from Penn is for the medical/prescription drug, dental and vision coverage you purchase through the exchange. A cash refund or credit for other benefits is not available.

42. How do I earn the Wellness Credit?

The Wellness Credit lowers your monthly medical premiums by as much as $100 per month ($50 for you and $50 if you cover your spouse). However, the amount will be reduced if either or both of you use tobacco or nicotine products:

- You ***or*** your spouse is a tobacco or nicotine product user:
    - You will not be eligible for the Wellness credit of $50 per month

- You ***and*** your spouse are tobacco or nicotine product users:
    - You will not be eligible for the Wellness Credit of $100 per month

Tobacco products include cigarettes, cigars, pipes, chewing tobacco, all forms of smokeless / electronic devices, vaping and any other form of tobacco or nicotine.

Even if you and/or your covered spouse are tobacco users, you can earn the Wellness Credit by completing one of the following smoking cessation programs:

1. A program offered at CVS Caremark Minute Clinic available at no cost for covered members,
2. A program monitored by your physician,
3. An Alternative Standard agreed to by Penn, you/your spouse and your physician, or
4. A program through your medical carrier.

The CVS Caremark MinuteClinic Smoking-Cessation Program is available to you free of charge. You or your spouse can contact CVS Caremark customer service at 1-866-788-3977.

To receive the credit, you must contact the Penn Benefits Center after completing one of these programs and complete the necessary Affidavits located under Tools and Resources, then Tobacco Information no later than thirty days after the plan year ends.

You are expected to provide accurate and truthful statements on all employment forms. Providing false information or failing to notify Human Resources if your tobacco use status changes during the plan year may lead to disciplinary action up to and including termination of employment and possible legal action.

Note: If you do not take action during Open Enrollment and attest to your tobacco-use status, you will not receive the Wellness Credit for 2022.

43. Will I have to pay the spousal surcharge?

In order to manage plan costs, Penn has a bi-weekly spousal surcharge of $75, which is applicable if your spouse is covered on our medical plan but is eligible for coverage from another employer's medical plan or through self-employment.

When you enroll your spouse in a Penn-sponsored medical plan, you will be required to complete a spousal surcharge attestation. You will attest to whether your spouse is eligible for other medical coverage. If your spouse does have access to medical coverage elsewhere and you choose to cover your spouse through Penn, you will pay the surcharge shown here.

A spouse is considered to have access to other coverage if the spouse is employed and the employer offers medical insurance coverage or your spouse is self-employed and offers medical coverage to his or her employees. Your spouse is not considered to have access to other coverage if your spouse is also a Penn Team Member or his or her other coverage is Medicare.

If you are attesting that you are not required to pay the spousal surcharge and your spouse's eligibility for other medical coverage changes during the plan year, it is your responsibility to notify the Penn Benefits Center immediately at 1-866-238-9995 that you have become responsible for paying the spousal surcharge.

44. What will I have to pay when I need medical care?

Other than in-network preventive care, which is paid 100%, how much you have to pay when you need medical care primarily depends on your medical coverage level. Find the details for all coverage levels on the Make It Yours website at **pngaming.makeityoursource.com**.

45. What's a deductible and how does it work?

The deductible is what you pay out of your own pocket before your insurance carrier begins to pay a share of your costs. If you have a deductible, you pay the full "negotiated" costs of all in-network services until you meet your deductible. The "negotiated" costs are the payments providers (doctors, hospitals, labs, etc.) have agreed to accept from the insurance carrier for providing a particular service.

How the medical deductible works depends on your coverage level:

- **The Bronze, Silver, Gold and Platinum medical coverage levels have a traditional deductible.** Once a covered family member meets the *individual* deductible, your insurance will begin paying benefits for that family member. Charges for all other covered family members will continue to count toward the family deductible. Once the family deductible is met, your insurance will pay benefits for all covered family members.
- **The Bronze Plus medical coverage level has a "true family deductible."[1]** This means that the entire family deductible must be met before your insurance will pay benefits for any covered family members. There is no "individual deductible" in this coverage level when you cover more than yourself on this medical coverage level.

To clarify, if you choose a Bronze Plus coverage level, the individual deductible only applies if you cover just yourself. If you choose to cover dependents too, you must satisfy the family deductible before coinsurance will kick in, even if only one family member has expenses.

The annual deductible doesn't include copays or amounts taken out of your paycheck for health coverage.

Do you use out-of-network providers? Out-of-network charges do **not** count toward your in-network annual deductible; they only count toward your out-of-network deductible.

[1] **Exception:** If you live in California, cover dependents and enroll under Health Net or Kaiser Permanente at the Bronze Plus coverage level, you will have a *traditional* annual deductible. No member in the family will pay more than $2,800 toward the family deductible.

46. What's an out-of-pocket maximum and how does it work?

The annual out-of-pocket maximum is the most you and your covered family members would have to pay in a year for health care costs. The annual out-of-pocket maximum doesn't include amounts taken out of your paycheck for health coverage or certain copays under the Silver, Gold and Platinum coverage levels. How the medical out-of-pocket maximum works depends on your coverage level.

- **The Bronze, Silver, Gold and Platinum coverage levels have a traditional out-of-pocket maximum.** Once a covered family member meets the *individual* out-of-pocket maximum, your insurance will pay the full cost of covered charges for that family member. Charges for all covered family members will continue to count toward the family out-of-pocket maximum. Once the family

out-of-pocket maximum is met, your insurance will pay the full cost of covered charges for all covered family members.

- **The Bronze Plus coverage level has a "true family out-of-pocket maximum."** This means that the entire family out-of-pocket maximum must be met before your insurance will pay the full cost of covered charges for any covered family member. There is no "individual out-of-pocket maximum" in this coverage level when you cover more than yourself on this medical coverage level.

Do you use out-of-network providers? Out-of-network charges do **not** count toward your in-network annual out-of-pocket maximum; they only count toward your out-of-network out-of-pocket maximum.

47. What's a Health Savings Account (HSA)?

An HSA is a special bank account that you can use when you enroll in the Bronze or Bronze Plus medical coverage level. It allows you to set aside tax-free money to pay for qualified health care expenses, like your medical, dental and vision copays, deductibles and coinsurance. Because you'll be responsible for 100% of your medical and prescription drug expenses until you meet your deductible in the Bronze or Bronze Plus medical coverage level, an HSA is a great way to pay less for those out-of-pocket expenses because you're using tax-free money.

Just make sure you use money in your HSA only for qualified health care expenses. If you use money in your HSA for unqualified expenses, you'll pay income taxes on that money and an additional 20% penalty tax if you're under age 65. Keep careful records of your health care expenses and withdrawals from your HSA, in case you ever need to provide proof that your expenses were qualified.

You can decide whether to enroll in an HSA and how much (if any) money you want to contribute. And if you don't have a lot of health care expenses, your money can stay in your account year over year and earn tax-free interest. If you have questions about the use and appropriateness of an HSA as it applies to your specific situation, you should consult a tax professional.

48. Why would I want to use an HSA?

An HSA lets you set aside money to pay for qualified health care expenses, like your medical, dental and vision copays, deductibles and coinsurance. You decide how much money you want to contribute, and you can change your contribution election at any time. If you don't have a lot of health care expenses, your money can stay in your account year over year.

The HSA offers triple tax savings:

- Your contributions to an HSA are tax-free, meaning that they are deducted from your paycheck before taxes are taken out.
- Interest earnings on your HSA balance are not taxed.
- You are not taxed on HSA dollars when you use them to pay for eligible health care expenses.

49. How is an HSA different from a Health Care Flexible Spending Account (FSA)?

While both accounts offer a tax-free benefit when you pay for eligible medical, dental and vision expenses, they differ in several key ways. Compare their differences on the Make It Yours website at **pngaming.makeityoursource.com/medical/hsa-vs-fsa**.

50. Can I enroll in both an HSA and one of the available Health Care FSAs?

It depends. If you enroll in the Bronze or Bronze Plus coverage level, you can make contributions to an HSA and a Health Care FSA only if you elect the Limited Use Health Care FSA. The HSA would be used to pay for your eligible medical and prescription drug out-of-pocket expenses, and the Limited Use Health Care FSA would be used for your eligible dental and vision out-of-pocket expenses. You can't contribute to an HSA **and** participate in the traditional Health Care FSA at the same time to pay for eligible out-of-pocket eligible medical and prescription drug out-of-pocket expenses. You would need to select one or the other, not both.

51. Can I contribute to an HSA if I am covered under my spouse's Health Care FSA?

No. If your spouse's Health Care FSA covers your medical expenses, it would be considered other health coverage and you would not be eligible to contribute to an HSA.

52. Can I contribute to an HSA?

In order to continue to contribute to an HSA, you need to meet the following criteria:

- You must be enrolled in a high-deductible option at the Bronze or Bronze Plus coverage level;
- You cannot be enrolled in Medicare or a veterans medical plan (TRICARE);
- You cannot be claimed as a dependent on someone else's tax return; and
- You cannot be covered by any other health insurance plan, such as a spouse's plan, that is not a high-deductible option.

You can use money from your HSA to pay your dependents' health care expenses as long you claim them as your dependents on your federal income taxes (generally children up to age 19 or under age 24 if they are full-time students).

Life Insurance and Disability

53. Will the exchange be managing my life insurance and disability benefits?

No. Your life insurance, accidental death and dismemberment (AD&D), short-term disability (STD) and long-term disability (LTD) will continue to be administered separately from the exchange. However, if you wish to enroll in any Team Member-paid "buy-up" coverage, you will do this as part of the exchange enrollment process on the enrollment website. You can also review, add or change your beneficiaries on the enrollment website.

54. How do I enroll in the wellness program?

Virgin Pulse will send you a link to your preferred email address on file with instructions on how to register your Virgin Pulse account. Once registered, you can begin earning points and participating in company-wide wellness challenges. Additionally, a user guide will be made available once the program launches on January 1, 2022.

55. What happens to my wellness program points at the end of the year?

Unused points roll over into the next plan year. Those points remain available for your use as long as you are still enrolled in a Penn-sponsored medical plan. If you do not remain enrolled in a Penn-sponsored medical plan or leave the company, you have 30 days from the last day of coverage under the medical plan to redeem all accrued points.