Retiree Benefit Guide

Northwest AZ
EMPLOYEE BENEFIT TRUST

Lake Havasu Unified School District

July 1, 2023 – June 30, 2024

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 33 for the Notice of Creditable Coverage for more details.

Benefit Enrollment

May 1 – May 14, 2023

Open enrollment is your opportunity to review your benefits and make changes to your coverage. Open enrollment begins May 1 and ends May 14 at 5:00 PM, for changes effective July 1, 2023. You must enroll even if you are not making changes to your elections. You will receive a Plan letter with rates from the Payroll department. They will enter your insurance selection for you.

The cost of healthcare continues to be a significant concern. To help control healthcare costs, we all need to take an active role in our healthcare options and choose a healthier lifestyle. Better choices include utilizing BlueCare Anywhere and urgent care instead of the emergency room, when appropriate, choosing generic medications and participating in on-site preventive screenings and wellness programs. Making wise choices in how you spend healthcare dollars can make a difference in the future of all our healthcare costs.

About Your Benefits

At Lake Havasu Unified School District, we are committed to providing a comprehensive and valuable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your benefits. If you have any questions, feel free to reach out to Cheri Tropple or Kari Dunlop by contacting Cheri at 928.505.6930 or email Cheri.Tropple@lhusd.org or Kari Dunlop at 928.505.6944 or email Kari.Dunlop@lhusd.org.

Eligibility and Enrollment

You are eligible to participate in the District's Retiree benefits if you qualified under the District's eligibility guidelines. If you are eligible, you may also cover your:

- Legal spouse, if spouse was covered on your active employee plan the day before you became a retiree.
- Children up to age 26 through the last day of the month of their 26th birthday of your children were covered on your active employee plan the day before you became a retiree.
- Unmarried children of any age who are mentally or physically disabled if they were covered on your active employee plan the day before you became a retiree.

Please refer to the Summary Plan Document (SPD) for each benefit to confirm whether you, your spouse and dependents are eligible.

Select Your Benefits Carefully

To get the most value from your benefits, carefully consider which options are right for you and your family. Because premiums for certain benefits are deducted on a pre-tax basis, IRS regulations may prohibit you from making enrollment changes until the end of the plan year, unless you experience a qualified election change.

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during Annual Open Enrollment. Any pre-tax benefit elections made during open enrollment must remain in effect until the following Annual Enrollment period, unless you experience a qualifying event which may allow for an election change. Examples of qualified life events include:

- Marriage, legal separation, divorce, annulment, or death of a spouse
- Birth, adoption of a child, legal guardianship, or death of dependent child
- Change of an employee's or spouse's employment
- Change in a dependent's eligibility status
- Loss of eligibility for group health coverage, health insurance coverage, or Medicaid/CHIP
- Becoming eligible for a state premium assistance subsidy

If you believe you have a qualifying event please notify Cheri Tropple or Kari Dunlop immediately. You have 31 days from a qualified change in status to make changes. However, note that if you lose eligibility for Medicaid/CHIP, or become eligible for a state premium assistance subsidy, you have 60 days from that qualified change in status to make changes.

Keep in mind, the changes you make must be directly related to the event and you may not add dependents to your plan.

What's New for the 2023-24 Plan Year

Exclusive Provider Organization (EPO) Changes

	2022-23 Plan Year	2023-24 Plan Year
Skin Cancer Screenings	Covered only at on-site screenings	Covered in Provider's office and On-site
Prescriptions	Copay Max Program	Implement Copay Max Plus, adding certain Brand name medications to the eligible list. See page 11 for additional information.

Health Savings Plan (HSP) Changes

	2022-23 Plan Year	2023-24 Plan Year
Skin Cancer Screenings	Covered only at on-site screenings	Covered in Providers Office and On-site
Deductible	In-Network and Out-of-network deductible $1,400/$2,800	In-Network and Out-of-network deductible $1,500/$3,000

Dental Changes

	2022-23 Plan Year	2023-24 Plan Year
Cleanings	Two cleanings per year	One additional cleaning for expectant mothers.
Orthodontics Age Limit	Child age limit 17 for Ortho banding	Increase child age limit to 19 for Ortho banding.
Orthodontics Maximum	Ortho Lifetime Maximum $1,000	Increase Ortho Lifetime Maximum to $2,000 including those in-process.

Vision Changes

	2022-23 Plan Year	2023-24 Plan Year
Retinopathy Screening	Not Covered	Add coverage for a provider Retinopathy Screening.
Network Coverage	Wal-Mart not covered	Add Wal-Mart to Network
Glasses and Contacts	Glasses - $105.00 Contacts - $150.00	Glasses - $200.00 Contacts - $200.00 One each per 12 month period

PATIENT ADVOCACY PROGRAM

NAEBT is adding a new program to assist members in navigating their medical care.

SEE PAGE 13 FOR MORE INFORMATION

American HEALTH Group

Medical Coverage

Terms to Know

- **Copay** - A set dollar amount you pay for a covered healthcare service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for healthcare services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered healthcare services after you reach the deductible. You pay a percentage of the cost, and the medical plan pays the rest.
- **Out-of-pocket Maximum** – The maximum amount of copays, deductible and coinsurance you are responsible for in a plan year before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide healthcare services. In-network providers typically provide services at a lower negotiated rate. If you receive services from a provider that is **In-Network** it will cost you significantly less than going to a provider that is **Out-of-Network.**
- **Formulary Drug List:** A drug formulary is a list of generic and brand-name drugs that have been evaluated for safety and effectiveness, and that your insurance company considers "best choices."
- **Generic Drugs**: FDA-approved, and shown to be just as safe and effective as their more expensive brand-name counterparts.
- **Brand Name Drugs:** Carriers regularly review the latest prescription drugs on the market and maintain a list of brand name drugs that are clinically effective and not cost-restrictive.
- **Specialty Drugs:** Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using the carrier's mail-order pharmacy. You can register for mail-order pharmacy by logging on to **www.navitus.com**.

How the Plans Work

All plans use the Blue Cross Blue Shield of Arizona (BCBSAZ) network and cover 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you pay for care is different with each plan.

Health Savings Plan (HDHP): You pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible. . If you meet the deductible, you and the plan share the costs (coinsurance) until you reach the annual out-of- pocket maximum, then plan will cover 100% of the approved charges until the end of the plan year.

EPO: These Plans have set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays and coinsurance until you reach your annual out-of-pocket maximum.

Telemedicine

Getting to the doctor when you're sick is never easy. That's why telemedicine is offered for non-emergency medical care and behavioral health. You can connect with a U.S. board-certified medical professional by phone or video chat. For further details , visit **www.BlueCareAnywhereAZ.com**.

Medical and Prescription Coverage Highlights – EPO Plan

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind.

	EPO Plan	EPO Plan
	IN-NETWORK	NON-NETWORK
Deductible (Individual/Family)	$750/$2,250	No Coverage
Coinsurance	20%	No Coverage
Out-of-Pocket Maximum (Individual/Family)	$8,700/$17,400	No Coverage
BASIC & PHYSICIAN CARE		
Preventive Care	$0	No Coverage
Primary Care Office Visit	$30 copay	No Coverage
Specialist Office Visit	$50 copay	No Coverage
Virtual Visits	$30 PCP $50 Specialist	No Coverage
Diagnostic Testing Lab/X-ray	Independent Lab - $0 Imaging/Hospital owned Lab – Deductible + 20%	No Coverage
Advanced Imaging and diagnostic lab or x-ray over $500	Deductible plus 20%	No Coverage
Maternity	Deductible plus 20%	No Coverage
SICK AND QUICK CARE		
BlueCare Anywhere General Health or Behavioral Health	$0	N/A
Urgent Care Facility	$50 copay	No Coverage
Emergency Room – True Emergency	$500 plus 20% coinsurance after deductible	$500 plus 20% coinsurance after deductible
HOSPITALIZATION		
Inpatient Hospital	Deductible plus 20%	No Coverage
Outpatient Surgery over $500	Deductible plus 20%	No Coverage
BEHAVIORAL HEALTH		
Outpatient Mental Health	$30 PCP $50 Specialist	No Coverage
Inpatient Mental Health and Substance Abuse	Deductible plus 20%	No Coverage
PHARMACY		
Retail (up to 30 days)	Generics $10 copay Formulary Brand Name $30 copay Non-Formulary Brand Name 75% of the actual cost	
Retail or Mail Order (90 days)	Generics $20 copay Formulary Brand Name $60 copay Non-Formulary Brand Name 75% of the actual cost	
Specialty Drugs	20% up to $150	
Non-network pharmacy reimbursements will be determined according to the Network price of the prescription.		

Certain procedures, treatments, services and products require precertification or prior authorization through American Health Group (AHG) or Navitus. Please contact AHG at 800.847.7605 for medical and Navitus at 855.673.6504 for prescriptions.

Medical and Prescription Coverage – Health Savings Plan

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind.

	Health Savings Plan	Health Savings Plan
	IN-NETWORK	NON-NETWORK
Deductible (Individual/Family)	$1,500/$3,,000	$1,500/$3,000
Coinsurance	20% after Deductible	50% after Deductible
Out-of-Pocket Maximum (Individual/Family)	$3,000/$6,000	Unlimited
BASIC & PHYSICIAN CARE		
Preventive Care	$0	Not Covered
Primary Care Office Visit	20% after Deductible	50% after Deductible
Specialist Office Visit	20% after Deductible	50% after Deductible
Virtual Visits	20% after Deductible	50% after Deductible
Diagnostic Testing Lab/X-ray Under $500	20% after Deductible	50% after Deductible
Advanced Imaging and diagnostic lab or x-ray over $500	20% after Deductible	50% after Deductible
Maternity	20% after Deductible	50% after Deductible
SICK AND QUICK CARE		
BlueCare Anywhere General Health or Behavioral Health	0% after Deductible	N/A
Urgent Care Facility	20% after Deductible	50% after Deductible
Emergency Room – True Emergency	20% after Deductible	20% after Deductible
HOSPITALIZATION		
Inpatient Hospital	20% after Deductible	50% after Deductible
Outpatient Surgery	20% after Deductible	50% after Deductible
BEHAVIORAL HEALTH		
Outpatient Mental Health (30 visit Max)	20% after Deductible	50% after Deductible
Inpatient Mental Health and Substance Abuse (Limited to 2 inpatient confinements per lifetime and max of 30 days per plan year)	20% after Deductible	50% after Deductible
PHARMACY		
Expanded Preventive List Medications	Formulary medications appearing on the Expanded Preventive list are covered with $0 member cost-sharing	
Retail (up to 30 days)	Generic Drugs 20% after Deductible Formulary Brand Name Drugs 20% after Deductible Non-Formulary Brand Name Drugs 75% after Deductible	
Mail Order (90 days)	Generic Drugs 20% after Deductible Formulary Brand Name Drugs 20% after Deductible Non-Formulary Brand Name Drugs 75% after Deductible	
Specialty Drugs	20% after Deductible	

Certain procedures, treatments, services and products require precertification or prior authorization through American Health Group (AHG) or Navitus. Please contact AHG at 800.847.7605 for medical and Navitus at 855.673.6504 for prescriptions.

Telemedicine

Administered by BlueCare Anywhere

Avoid expensive emergency room visits by using BlueCare Anywhere. The average cost of an E.R. visit is $2,283. You may be responsible for a copayment, deductible and coinsurance depending on which plan you are enrolled in so it may cost you between $500 to $2,283. Compare this to $55 for HDHP members or $0 for EPO members.

BlueCare Anywhere℠

Connect with a Provider 24/7

Discover the convenience, comfort, and savings of BlueCare Anywhere℠

If you don't have a regular doctor, or if your primary care provider isn't available, you can visit with a board-certified doctor in the privacy and comfort of home. See a doctor, counselor, or psychiatrist from your phone, computer, or tablet. So you can get the care you need—from wherever you are. Plus, BlueCare Anywhere visits often cost less than an urgent care visit.

What services are offered?

MEDICAL
Get treated for minor injuries and illnesses and non-emergency health issues like cold and flu symptoms, fevers, rashes, and stomach bugs. Doctors can also prescribe medications from your pharmacy of choice, if needed.

COUNSELING
You can get the benefits of an in-person counseling session online. Schedule an appointment with a board-certified counselor or psychologist to get help for depression and anxiety, as well as stress caused by grief, divorce, parenting challenges, job loss, and other major life changes.

PSYCHIATRY
A board-certified psychiatrist is available by appointment. Experienced psychiatrists can help you address common behavioral health challenges, and provide assessments and treatments, as well as assist with medication management.

Connect with a provider in two ways:

1. Download the BlueCare Anywhere app from the Apple® App Store® or Google Play™ online marketplaces.
2. Visit BlueCareAnywhereAZ.com.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Prescription Drug Information

The prescription drug program is administered by Navitus. You are automatically enrolled in the prescription drug plan when you enroll in the medical plan.

Formulary Facts

A formulary is a comprehensive list of preferred drugs chosen based on quality and efficacy by a committee of physicians and pharmacists. The drug formulary serves as a guide for the provider community by identifying drugs which are covered. It is updated regularly and includes both generic and brand name medications.

Checking your Formulary

You can find the Northwest Arizona Employee Benefit Trust (NAEBT) formulary on the Navitus member portal. You can browse by category of use or look up alphabetically. Also included is information about which drugs need prior authorization or have quantity limits. The coverage or tier for each drug product is noted but the dollar amount you pay for each medication is not listed on the site. See the Pharmacy Benefit Schedule on pages 7-8 for cost-sharing information.

Preventative Medications

Certain preventive care prescription drugs mandated under Healthcare reform are covered at 100% with no participant cost-sharing when obtained in-network. An expanded list of 100% covered preventive medications is available to HSP members.

Customer Service

You can find additional information about your prescription drug plan at **www.navitus.com**, or contact Navitus Customer Service at 855.673.6504. Both resources are available 24 hours a day, 7 days a week.

Mail Order

Getting your medications through mail order is simple and convenient. Costco Mail order Pharmacy will service your mail order needs. You do not need to be a Costco member to utilize the mail order service or to pick up a prescription in person.

It is easy to enroll:

Step 1 – Register online at www.costco.com/home-delivery. Select “Sign In/Register” to create an account. Enter all the required information.

Step 2 – Fill your prescription. Request your new prescription online at www.costco.com/home-delivery. Your provider can provide the prescription by calling 800.607.6861 or e-prescribing it to Costco.

Step 3 – Obtain refills online at www.costco.com/home-delivery, or by calling 800.607.6861 or by enrolling in the auto refill program.

Reducing Drug Costs with Copay Assistance

Many high-cost specialty and HIV drugs have copay assistance programs. With these programs, manufacturers pay for part of the drug cost. This may help reduce what you pay. If you are using a drug that is eligible for copay assistance, you must enroll in the program.

Navitus is here to help you enroll to take advantage of these savings.

Getting Started is Easy!

1. A patient representative from your specialty pharmacy will reach out to you to help you enroll. If you already use copay assistance, your out-of-pocket cost will not change.
2. After enrolling, make sure your pharmacy has your copay assistance processing information.
3. Only the amount you have paid out-of-pocket will apply to your annual deductible and/or out-of-pocket maximum.

Frequently Asked Questions

How do I know if my drug has a copay assistance program?

Visit the drug manufacturer's website to see if they have a program for your medication. Many high-cost brand and specialty drugs are eligible for copay assistance. Most generic drugs are not eligible.

Will I have to reenroll in copay assistance?

Some copay assistance programs require reenrollment annually. Please contact the drug manufacturer or your specialty pharmacy provider to confirm your continued enrollment.

Where can I find out more information about copay assistance?

You can find additional details in your Summary Plan Description (SPD) document, which is typically provided in your benefit enrollment information.

What if I am not eligible for my drug's copay assistance program?

If you are not eligible, call Navitus Customer Care at 866.333.2757 to discuss your options. There may be other assistance programs available.

EPO Plan Only

NAVITUS HEALTH SOLUTIONS

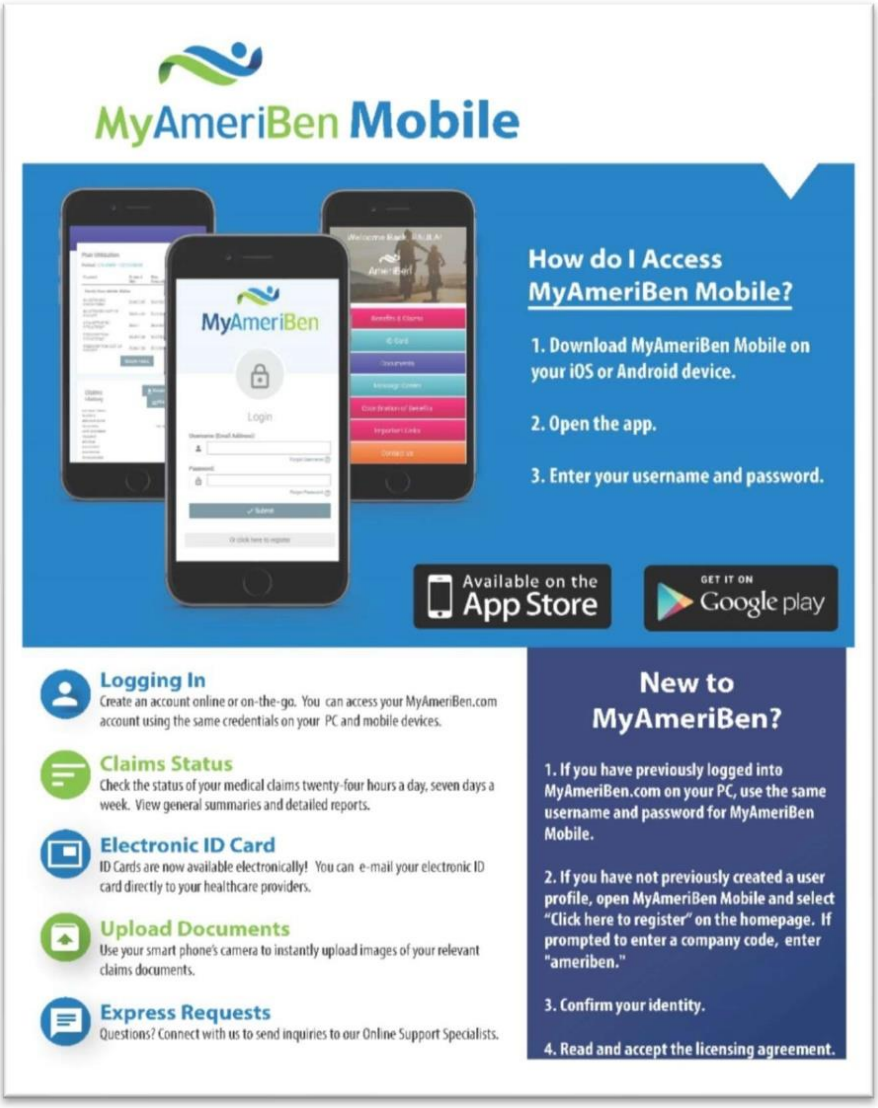
Medical Network

Access the Find A Doctor tool for lists of doctors, other healthcare professionals, hospitals, and facilities. Search for a provider in your plan's network by provider name, type of provider, or within a certain distance of your location. It's important to verify providers are in your plan's network before you see them. If you have an HSP, providers who are not in your plan's network will cost you more. If you have an EPO plan, providers who are not in your plan's network will not be covered by your plan. When talking with a provider, always ask, "Do you take my BCBSAZ plan?" Most providers are in a BCBSAZ network – but not all providers are in every BCBSAZ plan's network. That is why it is important to ask if they take your plan. You can also call the number on the back of your member ID card to determine providers are in your network.

Log in to www.azblue.com ,
choose Arizona PPO as your plan then
click on "Find a Doctor."

Medical Claims Administration

After you visit the doctor, in-network providers send the claim to BCBSAZ for repricing. BCBSAZ discounts it based on the agreement they have with that provider. Once repriced, it is sent to AmeriBen for processing and payment. AmeriBen compares the billing codes to the Summary Plan Description to verify the charges are for covered services. If approved, it is processed for payment. The provider will receive a check, and the participant will receive an Explanation of Benefits (EOB) explaining how the claim was paid. If you receive a bill from your provider and do not receive and EOB from AmeriBen, you should call AmeriBen at 1.877.635.2909 to inquire if they have received the claim or you can contact your provider to verify they have your correct insurance billing information. Non-network providers send their claims directly to AmeriBen for processing or payment. If you have questions or would like assistance with understanding the plan, please call AmeriBen toll-free at 1.877.635.2909.



Patient Advocacy Program

American HEALTH Group

Patient Advocacy: Navigating the Healthcare Maze

American Health Group's (AHG) Patient Advocacy program is provided by specialists who have years of healthcare insurance experience. They serve as your personal coach and will help support you throughout your healthcare journey. Our Patient Advocates will save you time, money, and frustration. You will feel more empowered and in control of your healthcare which results in a greater peace of mind.

AHG will be conducting a raffle of a **$1,000 gift certificate** for those members who have participated by the end of the first plan year. However, there are multiple tangible benefits for you when you collaborate with a Patient Advocate.

- Understand the ins and outs of how health insurance works and how to reduce your out-of-pocket costs
- How to talk with your provider to get more out of the visit
- Help translate medical jargon and provide you with user friendly health education and video clips to better understand your health condition
- Know what services/procedures require prior authorization
- Understand the schedule of benefits and the difference between deductibles and in and out-of-network out of pocket costs
- Secure in-network, high-quality providers close to your home who will listen to your needs and answer questions
- Recognize the cost differences between hospital-based and free-standing diagnostic and surgical centers and how to research and compare care options
- Know when to visit an urgent care center or emergency room
- Uncover avenues of financial assistance for high cost drugs
- Understand your explanation of benefits (EOB) and what your real responsibility is
- Locate care that is not provided by the plan, such as private in-home care and assisted living homes
- Best of all, Patient Advocacy is a voluntary program and there are no charges to you!

Patient Advocacy is a benefit provided by your employer and health insurance plan. If you would like more information, please call **602-265-3800 or 800-847-7605** and ask for a Patient Advocate.
We look forward to serving **YOU**!

2023-24 Retiree Rates and Contributions

EPO PLAN	Annual Cost of Insurance	70% District Contribution	District/ASRS Contribution	Retiree Annual Premium	Retiree Monthly Premium
Retiree Only					
Medical	$13,306.20	$8,887.79	$0.00	$4,418.41	$368.20
Dental/Vision	$594.84	$416.39	$0.00	$178.45	$14.87
Life	$48.00	$33.60	$0.00	$14.40	$1.20
Combined	$13,949.04	$9,337.78	$0.00	**$4,611.26**	**$384.27**
Retiree + Spouse					
Medical	$26,425.08	$8,887.79	$0.00	$17,537.29	$1,461.44
Dental/Vision	$1,168.92	$416.39	$0.00	$752.53	$62.71
Life	$48.00	$33.60	$0.00	$14.40	$1.20
Combined	$27,642.00	$9,337.78	$0.00	**$18,304.22**	**$1,525.35**

HSP (HDHP) PLAN	Annual Cost of Insurance	70% District Contribution	District/ASRS Contribution	Retiree Annual Premium	Retiree Monthly Premium
Retiree Only					
Medical	$12,696.84	$8,887.79	$0.00	$3,809.05	$317.42
Dental/Vision	$594.84	$416.39	$0.00	$178.45	$14.87
Life	$48.00	$33.60	$0.00	$14.40	$1.20
Combined	$13,339.68	$9,337.78	$0.00	**$4,001.90**	**$333.49**
Retiree + Spouse					
Medical	$25,194.84	$8,887.79	$0.00	$16,307.05	$1,358.92
Dental/Vision	$1,168.92	$416.39	$0.00	$752.53	$62.71
Life	$48.00	$33.60	$0.00	$14.40	$1.20
Combined	$26,411.76	$9,337.78	$0.00	**$17,073.98**	**$1,422.83**

Dental Coverage

Administered by Ameritas

Good oral care enhances overall physical health and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the dental benefit plan.

Preferred Provider Organization (PPO) Dental		
	In-Network	**Out-of-Network***
Annual Deductible (Individual/Family)	$50/$150	No Maximum
Annual Maximum (Per Person)	$3,000	No Maximum
Preventive Care (Routine Cleaning and X-rays)	$0 deductible waived	Not Covered
Basic Services (Fillings, Basic Root Canals, Periodontics, Extractions)	20% after deductible	Not Covered
Major Services (Bridges, Dentures Crowns, Implants, Endodontics)	20% after deductible	Not Covered
Orthodontia (Children up to age 19)	50% after deductible	Not Covered
Orthodontia Lifetime Maximum (Per Person – Banded by age 19)	$2,000	Not Covered

Coinsurance rates reflect the member responsibility percentage.

PPO Dentist: Payment is based on the PPO Dentist's allowable fee or the actual fee charged, whichever is less.

Out-of-Network Dentist: Payment is based on the non-participating Table of Allowance.
Members are responsible for the difference between the non-participating dentist Table of Allowance and the full fee charged by the dentist.

Finding a Network Dentist
1. Go to **www.ameritas.com** and click **Find a Health Provider** in the top menu.
2. Select **Find a Network Dental Provider Online**
3. Enter your search criteria and choose **Classic (PPO)** network. Click **Search**.
4. A list of results will display. If necessary, you can also narrow the results by name, distance, or specialty.
5. Or call 800.659.2223

Vision Coverage

VSP administered by Ameritas

Lake Havasu Unified School District's vision plan covers routine eye exams and helps you pay for glasses or contact lenses. Dependents are eligible until their 26th birthday. Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages.

Find a VSP Provider

1. Register and log in to the member vision portal at **www.VSP.com.**
2. Review your vision benefit information.
3. Find a provider near you and schedule an appointment.

Just log in to the vision portal and select Find A Doctor. Search by location, office, or doctor.

Vision Plan Benefits

	VSP Signature Network	Out-of-Network
Annual Eye Exam	Covered in full	Up to $47
Single Vision Lenses	Covered in full	Up to $48
Bifocal Lenses	Covered in full	Up to $69
Trifocal Lenses	Covered in full	Up to $85
Lenticular Lenses	Covered in full	Up to $125
Progressive Lenses	See lens options	NA
Frames	$200	$45
Contacts (elective)	Up to $200	Up to $105
Contacts (medically necessary)	Covered in full	Up to $ 210

Deductible

Annual (applies to first service received)	$0	$0
Eyeglass Lenses or Frames	$0	$0

Benefit Frequencies (months)

	Based on Date of Service
Exam/Lens/Frame	12/12/12

Member cost for lens options (May vary by prescription, options chosen and retail location)

Progressive Lenses	Up to provider's contracted fee for lined Trifocal Lenses. The patient is responsible for the difference between the base lens and the progressive lens charge.	Up to Lined Trifocal allowance
Std. Polycarbonate	Covered in full for dependent children $25 adults	No benefit
Solid Plastic Dye	$13 (except Pink I & II)	No benefit
Plastic Gradient Dye	$15	No benefit
Scratch Resistant Coating	$15-$29	No benefit
Anti-Reflective Coating	$39-$75	No benefit
Ultraviolet Coating	$14	No benefit

Life and Accidental Death & Dismemberment Insurance

Administered by The Standard

Lake Havasu Unified School District provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance to eligible retirees with a shared cost.

	BASIC LIFE
Retiree Benefit	Each retiree will be offered $20,000 Basic Term Life coverage.
Accidental Death & Dismemberment	Each Retiree will be offered $20,000 Accidental Death and Dismemberment coverage.
Premiums	Retirees will contribute $1.20 monthly for this coverage
Benefit Reductions	Benefit reduces by 50% at age 70.
Please see the full certificate for additional information, options, and restrictions.	

Keep Your Beneficiaries Up to Date

- ❖ Make sure to keep this information updated so your benefit is paid according to your wishes.
- ❖ This may be done by contacting Cheri Tropple or Kari Dunlop.

Wellness Calendar

L.I.F.E Wellness Program

Northwest Arizona Employee Benefit Trust offers a comprehensive Wellness Program for all participants. L.I.F.E. Wellness focuses on three key categories: Early Detection, Lifestyle Modification, and Disease Management.

Goals of L.I.F.E. Wellness

- Help improve the quality of life for employees and dependents
- Prevent disease and disability or catch it in the early stages
- Reduce the amount of money spent on medical claims
- Improve productivity by reducing absenteeism and increasing presenteeism

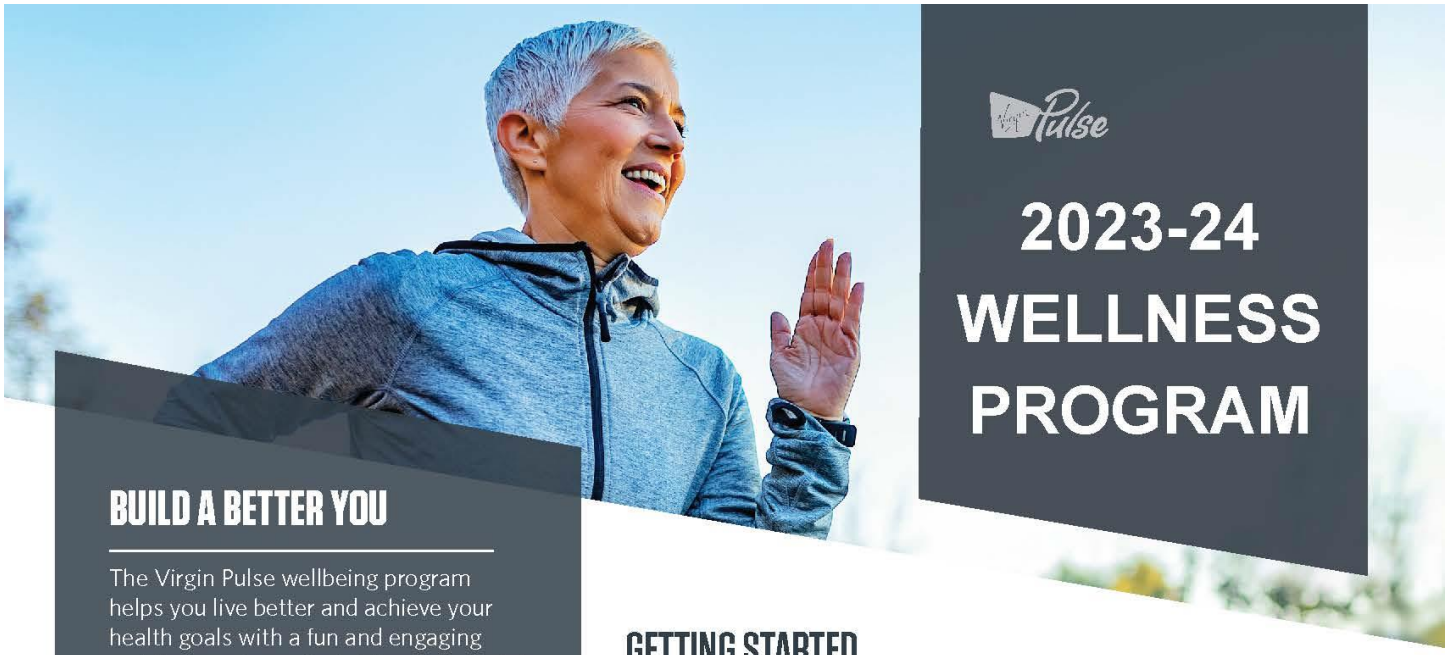
NAEBT'S Wellness Benefit - ALL wellness services required by Health Care Reform are covered at 100% for NAEBT medical/Rx benefit plan participants. ***The only coverage for off-site preventative screenings are those that are mandated by healthcare reform.***

Wellness/preventive services are all services intended to prevent illness or disease of which you have no signs or symptoms. Your provider must bill the services using a wellness code, NOT a diagnostic code.

Virgin Pulse

Virgin Pulse is a wellness portal designed to help you reach a variety of health goals, learn about health topics that interest you, and all while having fun doing it. Take advantage of the vast array of expertise that Virgin Pulse has to offer in nutrition, fitness, financial wellness, mindfulness, and more all at your fingertips. Feel like you need some extra guidance? You also have access to one-on-one telephonic coaching where a health expert can help you reach your goals in all of the subjects mentioned above.

And it gets even better – all employees, spouses, and dependents (18+) enrolled in the medical plan are eligible to participate in the program. Your family and members in your household will have access to the tools and resources in the portal right along with you!



2023-24 WELLNESS PROGRAM

BUILD A BETTER YOU

The Virgin Pulse wellbeing program helps you live better and achieve your health goals with a fun and engaging mobile experience that delivers powerful resources right to your fingertips.

Who can participate?
Employees, spouses and dependents (18+) are invited to sign in to **join.virginpulse.com/NAEBT**
Retirees are able to participate, but unable to redeem for rewards.
Anyone up for a personal challenge? Once you're signed in, be sure to invite your coworkers to join in on the fun!

HOW TO REGISTER

- New members: visit **join.virginpulse.com/NAEBT**
- Existing members: sign in at **member.virginpulse.com**
- Accept the terms and conditions
- Download the Virgin Pulse mobile app by searching "Virgin Pulse" in the App Store or Google Play

Download on the App Store | GET IT ON Google Play

PERSONALIZE YOUR EXPERIENCE

- Set your interests to get personalized wellbeing tips
- Choose your email preferences
- Connect an activity tracker
- Upload a profile picture and add friends

GETTING STARTED

You're registered and signed in—now what? Begin by completing program activities and building healthier habits one day at a time. Here are a few options to help you get started.

Health Check Survey
The Health Check Survey asks questions about your current health status and wellbeing habits. Once completed, your responses will be analyzed to generate a health score, show your health risks, and provide practical tips to help you improve. Complete your survey by visiting Programs.

Pillars and Topics
Looking to reduce stress, increase your energy throughout the day or find the motivation to continue progress toward your wellbeing goals? The Pillars and Topics section can point you in the right direction, providing quick access to many helpful tools and resources.

FREQUENTLY ASKED QUESTIONS

Is my health information confidential?

The Virgin Pulse wellbeing program is confidential and in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Any information shared with Virgin Pulse will not be disclosed, except in accordance with HIPAA laws. Your Protected Health Information (PHI) will not be shared with your employer.

Who can I contact with questions?

- Visit **support.virginpulse.com**
- Email us at **support@virginpulse.com**
- Give us a call at 888-671-9395 (Monday—Friday 8 am – 9 pm ET)
- Join us on live chat on **member.virginpulse.com** (Monday—Friday 2 am – 9 pm ET).

NAEBT L.I.F.E. Lifestyle Improvement For Everyone

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your Payroll/Benefit department.

Benefit	Vendor	Phone	Website or Email
Medical Claims Administrator	Ameriben	1.877.635.2909	www.MyAmeriBen.com
Medical Review	American Health Group	1.800.847.7605	
Medical Network	Blue Cross Blue Shield of Arizona	1.888.472.4352	www.azblue.com
Telemedicine	BlueCare Anywhere		www.BlueCareAnywhereAZ.com
Prescription	Navitus	1.855.673.6504	www.navitus.com
Dental	Ameritas	1.800.487.5553	www.ameritas.com
Vision	Ameritas (VSP Network)	1.800.877.7195	www.vsp.com
Life and AD&D	The Standard	1.800.447.3146	www.standard.com
Voluntary Benefits	Aflac	1.928.208.8526	Wendy_Milacki@us.Aflac.com

Legal Notices & Disclosures

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

All states of reconstruction of the breast on which the mastectomy was performed;
Surgery and reconstruction of the other breast to produce a symmetrical appearance;
Prostheses; and
Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Northwest Arizona Employee Benefit Trust Plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Lake Havasu Unified School District is committed to the privacy of your health information. The administrators of the Northwest Arizona Employee Benefit Trust (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Cheri Tropple at 928.505.6930 or email Cheri.Tropple@lhusd.org or Kari Dunlop at 928.505.6944 or email Kari.Dunlop@lhusd.org.

HIPAA SPECIAL ENROLLMENT RIGHTS

Northwest Arizona Employee Benefit Trust Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Northwest Arizona Employee Benefit Trust Plan. To actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction.

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Cheri Tropple at 928.505.6930 or email Cheri.Tropple@lhusd.org or Kari Dunlop at 928.505.6944 or email Kari.Dunlop@lhusd.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete a form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Northwest Arizona Employee Benefit Trust About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Northwest Arizona Employee Benefit Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Northwest Arizona Employee Benefit Trust has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Northwest Arizona Employee Benefit Trust coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Northwest Arizona Employee Benefit Trust coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Northwest Arizona Employee Benefit Trust and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Northwest Arizona Employee Benefit Trust changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1 800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: July 1, 2023
Name of Entity/Sender: Northwest Arizona Employee Benefit Trust
Contact—Position/Office: Gallagher Benefit Services, Trust Administrator
Office Address: 333 East Osborne Road, Ste. 270
Phoenix, AZ 85012
Phone Number: 602-374-4495

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Summary does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

This document is an outline of the coverage provided by the Northwest Arizona Employee Benefit Trust. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The Summary Plan Description and Plan Document must be read for those details.

Northwest Arizona Employee Benefit Trust, July 1, 2023 – June 30, 2024

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting