LAKE HAVASU UNIFIED SCHOOL DISTRICT

Open Enrollment 2022-23

Retiree

Notes:

Lake Havasu Unified School District Open Enrollment Guide

For plan year July 1, 2022 – June 30, 2023

Elections you make during open enrollment will become effective July 1, 2022.

This booklet contains important information regarding your benefits for the plan year beginning July 1, 2022. We believe you will find it very helpful in understanding your benefit options.

Every retiree must enroll for coverage by completing the plan selection document and returning it to Cheri Tropple or Kari Dunlop by 5:00 p.m. on Sunday, May 15, 2022. If you do not enroll before the deadline, you will not have Medical/Rx, Dental/Vision or Life Insurance as of July 1, 2022.

Retirees may not add dependents during open enrollment. Dependents that are on the plan the day before the employee becomes a Retiree are eligible for coverage on the retiree plan. Once a dependent is removed, they cannot be added back on the plan.

If you need assistance with understanding your benefit options, please schedule an appointment to meet with Cheri.Tropple@lhusd.org 928.505.6930 or Kari Dunlop Kari.dunlop@lhusd.org 928.504.6944.

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Contact Information:

Medical Claims Administrator:

AmeriBen will be the Medical Claims Administrator. They can be contacted at 1.877.635.2909 or by visiting www.myAmeriBen.com. More information on AmeriBen can be found on page 10.

Arizona and National Provider Network:

Blue Cross Blue Shield of Arizona will continue to be the Arizona provider network. A list of in-network AZ providers can be found by visiting this link www.azblue.com/chsnetwork and selecting Arizona PPO as your Network. Enter the location, then search. The Mayo Clinic in AZ is not an in-network for NAEBT. You also now have access to the BCBS Blue Card Nationwide Network for medical care outside of Arizona. To search outside of AZ, go to www.azblue.com. For step-by-step instructions on how to find an in-network provider refer to page 10. You may also use the link from www.MyAmeriben.com or by calling AmeriBen at 1.877.635.2909.

Prescription Benefit Plan:

Navitus will be the prescription benefit manager. To register, access your claim information and view the formulary visit www.Navitus.com. Customer service by telephone is available 24/7 except Thanksgiving and Christmas day at 855.673.6504. For more information on Navitus and how your current prescriptions may be affected see page 12.

Dental Coverage:

Ameritas will continue to be your dental coverage provider. You can find in-network dental providers by calling 1.800.487.5553. For an outline of plan highlights see page 23.

Vision Coverage:

VSP will continue to be the vision provider and will be administered by Ameritas. You can find in-network vision providers at www.vsp.com. See page 21 for highlights.

BlueCare Anywhere:

BlueCare Anywhere will provide telephonic/video consultations with a board-certified doctor any time, night or day. Use your computer, tablet, or smartphone to start a visit today. Download the BlueCare Anywhere mobile app or visit www.BlueCareAnywhereAz.com. See page 18 for more information.

Medical Review (Pre-certification):

American Health Group (AHG) will continue to handle all pre-certification. To contact AHG about pre-certification or case management call 1.800.847.7605 or 1.602.265.3800. Please see page 9 of this book for additional information.

Basic Life, Voluntary Life, and AD&D:

The Standard Insurance Company will be your Basic Life, Voluntary Life (VTL) and Accidental Death & Dismemberment benefits provider. You may contact Standard Insurance at 1.800.447.3146 or www.standard.com. See page 27.

NAEBT Trust Administrator:

Gallagher Benefit Services provides Trust Administration services to the Trust as well as assistance with member questions, concerns, or issues. You may contact Stephanie Moore at 928-753-4700 Ext. 6 stephanie_moore@ajg.com or Jenise Dimmick at 928-753-4700 Ext. 3 or jenise_dimmick@ajg.com.

Benefit Enrollment:

Open enrollment will be from May 2, 2022, through 5:00 PM on May 15, 2022, for changes effective July 1, 2022.

Mid-Year Changes to Your Benefit Elections

You will not be allowed to change your benefit elections or add/delete dependents until the next open enrollment period unless you have a Life Event as outlined below:

- Marriage
- Legal Separation
- Adoption or placement for adoption
- Obtainment of other coverage
- Divorce
- Birth
- Loss of other coverage

For a full list of qualifying events, please refer to your Summary Plan Document (SPD). A copy of the SPD can be requested from Cheri.tropple@lhusd.org or Kari.dunlop@lhusd.org. You MUST contact Cheri.tropple@lhusd.org at 928.505.6930 or Kari.dunlop@lhusd.org at 928.505.6944 within 31 days of the Life Event.

Medical/Rx Cards:

Participants will receive new medical/Rx cards. If you need an additional card:

- Log on to www.myAmeriBen.com to request additional cards or to print a copy of your card.
- Utilize the MyAmeriBen app on your smartphone to request additional cards or to view your card.
- Contact Cheri Tropple 928.505.6930 cheri.tropple@lhusd.org or Kari Dunlop 928.505.6944 Kari.Dunlop@lhusd.org to request.

Dental/Vision Cards:

Participants will not receive new dental and vison cards. If you need an additional card:

- Log on to www.ameritas.com to view, print or save your cards.
  - Contact Cheri Tropple 928.505.6930 cheri.tropple@lhusd.org or Kari Dunlop 928.505.6944 Kari.Dunlop@lhusd.org to request.

Dependent Eligibility:

Qualified dependents include the spouse and/or child of a retiree if the dependent was covered on the Plan as of the day before the eligible retiree's retirement. Once a dependent is removed from the plan, they may not be reenrolled. Eligible dependents can be covered on Medical/Rx, Dental/Vision plans through the last day of the month of their 26th birthday.

Disabled Children: Disability must have occurred prior to age 26 and be a covered dependent on the plan prior to age 26 to continue coverage after age 26.

Renewal Changes At-a-Glance:

Exclusive Provider Organization (EPO) Changes

Telephonic or Virtual Visits with local providers continue to be covered subject to normal cost-sharing
Add coverage for Genetic Testing for treatment (diagnosis still excluded) subject to precertification
Add coverage for offsite preventative 3D Mammograms
Increase deductible to $750/$2,250
Increase ER copay to $500 then 80% coinsurance after deductible
Increase max out of pocket to $8,700/$17,400
Discontinue Teladoc and offer telemedicine through BlueCare Anywhere

Health Savings Plan (HDHP) Changes

Telephonic or Virtual Visits with local providers continue to be covered subject to normal cost-sharing
Add coverage for Genetic Testing for treatment (diagnosis still excluded) subject to precertification
Add coverage for offsite preventative 3D Mammograms
Discontinue Teladoc and offer telemedicine through BlueCare Anywhere

Prescription Drug Plan (Rx) Changes

No Changes

Dental Plan Changes

No Changes

Vision Plan Changes

No Changes

Life Insurance Changes

No Changes

General Medical Plan Information:

Medical/Rx Benefit Terms & Billing

What is a co-payment? A co-payment is the fee charged by a provider for a covered medical expense or a covered prescription drug expense at the time the service/prescription is received for those on the EPO plan.

What is a deductible? The deductible is the amount of covered medical expenses the participant pays each plan year before benefits are paid by the plan. For example, if the deductible is $750, then you must pay the first $750 of the covered medical costs before the plan will pay. The deductible amount must be met first before coinsurance applies.

The Health Savings Plan has a $1,400 per participant and $2,800 per family deductible for in-network providers and a separate $1,400 per participant and $2,800 per family deductible for out-of-network providers. The Health Savings Plan deductible is non-embedded meaning that when enrolled in any tier other than employee only, you must meetthe family deductible before claims are paid. The EPO Plan has a $750 per participant and $2,250 per family deductible for in-network providers. The EPO deductible is embedded. This means that participants satisfy the $750 deductible individually even if they are in a tier other than employee only.

What is coinsurance? Coinsurance is generally shown as a percentage of covered expenses over and above the deductible. For example, doctor and facility visits may be covered on an 80/20 coinsurance. This means the plan covers 80%, or $4,800, of a $6,000 facility bill, and the participant is responsible for the remaining 20%, or $1,200, up to the maximum out-of-pocket amount.

How does my maximum out-of-pocket work? Each plan specifies an out-of-pocket maximum. Once this amount is met for the plan year, the plan covers all eligible charges at 100%. Co-payments and deductibles accumulate toward the maximum out-of-pocket amount.

The Health Savings Plan has a $3,000 per participant and $6,000 per family maximum out-of-pocket for in-network providers, and there is no maximum out-of-pocket for out-of-network providers. The maximum out-of- pocket is non- embedded. This means that employees enrolled in any tier other than employee only will need to meet the family maximum out-of-pocket of $6,000.

The EPO Plan has a $8,700 per participant and $17,400 per family maximum out-of-pocket. The maximum out of pocket on the EPO plan is embedded. This means the plan will cover 100% of the approved charges for a participant once the individual participant meets $8,700. The plan will cover 100% of approved charges once employee plus children, spouse or family reaches $17,400 in the plan year.

How does a facility bill for medical services? Is this my only bill for these medical services, or can I expect to receive others? When you receive a facility bill for services, it includes many costs: facility charges, equipment, supplies, laboratory/radiology services, and other support services. You may expect to receive bills for medical services from the facility, as well as from the physician, and/or other providers who supplied medical services. As a result of government regulations, most facility-based physicians and specialists separately bill their services from the facility. The separate bill will be from your physician, surgeon, anesthesiologist, or other independent supplier of medical services. The chart below gives examples of medical services that require the attention of a physician who will send a separate bill for payment.

If you have:	You will also receive a bill from:
X-rays taken	The radiologist
Certain lab tests	The pathologist
Surgery	The anesthesiologist, surgeon, and pathologist
A visit by your personal physician	Your personal physician
An EKG	The Cardiologist

Eligibility, Pre-Certification Requirements, and Case Management:

Verification of Eligibility

Contact AmeriBen at 1.877.635.2909 or log on to www.MyAmeriBen.com. Be sure to verify eligibility and plan benefits before the charge is incurred.

Medical Benefits

An emergency room visit for a life-threatening or limb-threatening situation is a covered benefit. Always consider BlueCare Anywhere, Teladoc, urgent care, or a visit to your Primary Care Physician (PCP) if the condition is not life or limb threatening; this could mean significant savings for you and your family.

Pre-Certification Requirements

American Health Group (AHG) must be notified for all non-emergency hospital admissions at least 72 hours in advance or within 48 hours for emergency admissions. Please refer to your summary plan document for additional services that require pre-certification. Failure to pre-certify may result in a reduction or denial of benefits. To pre-certify services, or if you have any questions regarding pre-certification, contact American Health Group (AHG): 1.800.847.7605 or 1.602.265.3800

Case Management

Case Management through American Health Group (AHG) is available to participants that are experiencing significant medical issues, having difficulty navigating the medical maze or need assistance finding an in-network provider for a serious medical condition. To request services, or if you have any questions regarding case management, contact American Health Group (AHG): 1.800.847.7605 or 1.602.265.3800.

NAEBT Vendor Information

BCBSAZ – Arizona Network

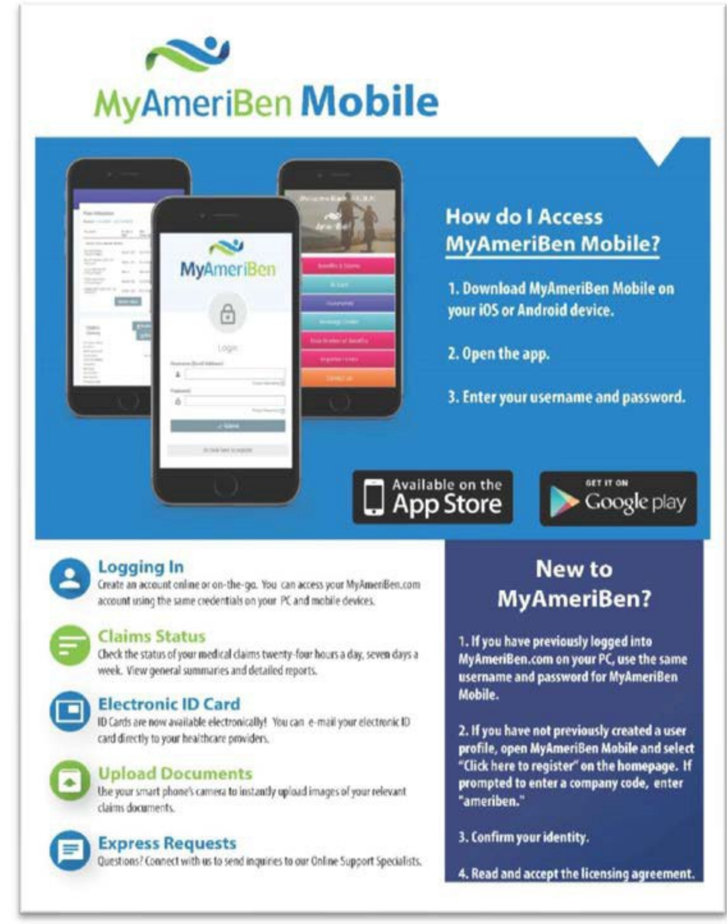
You can search for in Arizona BCBS providers www.azblue.com/chsnetwork select Arizona PPO and "Find a Doctor" Choose the location you would like to search in Arizona. You can locate doctors and hospitals, along with maps and directions to find them. Always use a BCBSAZ provider or facility to ensure you receive the highest level of benefits. Mayo Clinic providers or facilities are not in-network with NAEBT. If you are on the HDHP, your plan has out-of-network coverage available. Approved out-of-network claims for HDHP members are processed at usual and customary rates and are subject to out-of-network cost sharing levels. There is no out-of-network coverage on the EPO plan.

Blue Card Network

Blue Card will be the non-AZ network. With the Blue Card Program, you can locate doctors and hospitals quickly and easily. You can search outside of Arizona BCBS providers from www.azblue.com select "Find a Doctor/Rx", then "Find a Doctor" from the drop-down list. Select "I am a BCBSAZ Member who has a health plan through my employer." On the right- hand side of the screen under "SEARCH A NETWORK", choose PPO or EPO under medical. Add your location and search. You can locate doctors and hospitals, along with maps and directions to find them. Always use a BlueCard PPO doctor or hospital to ensure you receive the highest level of benefits. We do recommend verifying with the provider that they are still contracted with BCBS prior to receiving services.

AmeriBen

AmeriBen, located in Boise, Idaho, has over 50 years of experience administering benefits. It is a privately held company that was founded in 1958. They have over 800 employees located throughout the country and office locations in Boise, Salt Lake City, Phoenix, and Plano. AmeriBen operates with a core purpose of "Changing lives by developing great leaders in family, business, community and the world" and core values of "Integrity," "Initiative," "Good Judgement," and "Teamwork."



Our health plan is a "self-funded" plan, which means NAEBT assumes the financial risk for providing healthcare, vision, and dental benefits to employees and their dependents. In practical terms, self- insured employers pay for claims as they are incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully insured plan. Most self- insured employers subcontract this service to a Claims Administrator.

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 then authorizes BCBSAZ to process the 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 or an electronic payment, 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 log into your personal MyAmeriBen account or 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. AmeriBen uses a vendor that has access to multiple contracts to obtain a discount on the claim if possible. If it is a large claim (Over $5,000), AmeriBen will attempt to negotiate with the facility or provider for a discount. Many times, they are successful, and this saves money for both the Trust and the Participant. If you have questions or would like assistance with understanding the plan, please call AmeriBen toll-free at 1.877.635.2909.

Navitus

Since 2003, Navitus has been helping groups like NAEBT manage their pharmacy benefit plan. They are dedicated to making prescriptions more affordable for both members and the plan. The main office is in Madison, WI and regional offices are located in Austin, TX and Phoenix, AZ. The expanded preventive medications list with $0 member cost-sharing is available on the Health Savings Plan. This means if you are on the Health Savings Plan and you are prescribed one of the medications on the approved list the Trust will pay 100% for these medications.

Pharmacy Benefit F.A.Q.

What is a Pharmacy Benefit Manager (PBM)? A PBM directs prescription drug programs and processes prescription claims by negotiating drug costs with manufacturers, contracting with pharmacies, and building and maintaining formularies. Cost-Saving strategies help lower drug costs and promote good health.

How do I find out about my benefits online? You can sign up to access the portal at www.Navitus.com. Whether it is helping you to find a local pharmacy or reviewing your medication profile, the member portal will provide you with the information to take control of your health.

Where can I find my formulary? The list of drugs covered by your benefit is available on our website at www.navitus.com then select “Members” at the top of the page. In the middle of the page, you will see the Member Portal Login.

How do I get additional Pharmacy ID Cards? You can request additional Medical/Rx ID cards through the AmeriBen portal. All cards are in the name of the employee and are used for both medical and Rx.

When can I refill my prescription? Your prescription can be refilled at a retail pharmacy when approximately 75% of the prescription has been taken.

What if I am going to be traveling away from home? If you are traveling for less than a month, any Navitus Network Pharmacy can arrange in advance for you to take an extra one-month supply. If you are traveling for more than a month, you can request your pharmacy transfer your prescription to another network pharmacy located in the area you are traveling to.

Can prescriptions be mailed to me if I am outside of the United States? Prescriptions cannot be legally mailed from the mail-order pharmacy or any pharmacy in the U.S. to locations outside the U.S.

Co-Pay Max Program

Applies only to specialty medications obtained through the Navitus Specialty Pharmacy Lumicera. If your medication is included in the program, you will be automatically enrolled. If you are on the EPO plan, instead of paying 20% up to $150, your co-pay will be $0. If you are on the Health Savings Plan, instead of paying the full cost of your prescription until you have met your deductible/Max out-of-pocket, your cost-sharing will be $0.

Share a Clear View®

The Navi-Gate® for Members portal includes a wealth of information and is available 24 hours a day, seven days a week. This site offers secure access to your personal pharmacy benefit information.

You can access your member portal via the Navitus website at www.navitus.com > Members > Member Login, or at your plan's website.

We hope this tool is useful to you in managing your health and benefits.

Please note: This portal is for active members only.

Using the Costco Mail-Order Pharmacy

Mail Order

Getting your medications through mail order is simple and convenient. It saves you and the plan money too. Costco will continue to be your Mail Order Pharmacy. 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/pharmacy/home-delivery. Select "Sign In/Register" create an account. Enter all the required information.

Step 2: Fill your prescription. Request your new prescription online at www.costco.com/pharmacy/home-delivery. Your provider can provide the prescription by calling 1.800.607.6861, faxing it to 1.888.545.4615 or e-prescribing it.

Step 3: Obtain refills online at www.costco.com/pharmacy/home-delivery by calling 1.800.607.6861 or by enrolling in the auto- refill program.

If you have questions, click Customer Service. There is detailed information on all the aspects of the process.

Health Savings Plan (HDHP)

Outline of Benefits

MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
Plan-Year Deductible per participant Enrolled in Employee Only (EE)	$1,400	$1,400
Plan-Year Deductible per family Enrolled in any tier other than EE Only	$2,800	$2,800
Out-of-Pocket Maximum per participant per family	 $3,000 $6,000 (Includes Deductible)	 Unlimited Unlimited (Includes Deductible)
Inpatient Hospital	80% After Deductible	50% After Deductible
Outpatient Facility	80% After Deductible	50% After Deductible
Office Visits	80% After Deductible	50% After Deductible
Urgent Care Facility	80% After Deductible	50% After Deductible
Preventive Services (as mandated by the federal law)	100% Deductible Waived	Not Covered
Chiropractic Care (limited to 40 visits)	80% After Deductible	50% After Deductible
Diagnostic testing, X-ray and Lab Services (outpatient)	80% After Deductible	50% After Deductible
Maternity	80% After Deductible	50% After Deductible
Emergency Room Non-Emergency Medical Condition	80% After Deductible Not Covered	80% After Deductible Not Covered
Mental Health & Substance Abuse Inpatient	80% After Deductible	50% After Deductible
Mental Health & Substance Abuse Outpatient	80% After Deductible	50% After Deductible

Please see the Summary Plan Description for the full schedule of benefits and associated precertification requirements.

Exclusive Provider Organization (EPO)

Outline of Benefits

MEDICAL PLAN FEATURES:	IN-NETWORK	OUT-OF-NETWORK
Plan-Year Deductible per participant per family	 $750 $2,250	 Not Covered Not Covered
Out-of-pocket Maximum per participant per family	 $8,700 $17,400	 Not Covered Not Covered
Inpatient Hospital	80% After Deductible	Not Covered
Outpatient Facility	80% After Deductible	Not Covered
Office Visits Primary Care Specialist	 $30 Co-pay $50 Co-pay	 Not Covered Not Covered
Urgent Care Facility	$50 Co-pay (Deductible	Not Covered
Preventive Services (as mandated by the Federal law)	100% No Deductible	Not Covered
Chiropractic Care (limited to 40 visits)	$30 Co-pay (Deductible waived)	Not Covered
Maternity	80% After Deductible	Not Covered
Emergency Room Non-Emergency Medical Condition	$500 Co-pay then 80% After Deductible Not Covered	True Emergencies are covered at in-network benefit level Not Covered
Mental Health & Substance Abuse Inpatient	80% After Deductible	Not Covered
Mental Health & Substance Abuse Outpatient	$30 Co-pay PCP/$50 Co-pay Specialist. No Deductible	Not Covered
Free-standing Laboratory Facility	100% No Deductible	Not Covered
Free-standing Radiology Facility	80% After Deductible	Not Covered
All Other Locations (except office visit)	80% After Deductible	Not Covered

Please see the Summary Plan Description for the full schedule of benefits and associated precertification requirements.

Prescription Plan

Outline of Benefits

	HDHP	EPO
30-day supply at a Retail Pharmacy		
• Prescribed preventive medication as required by federal law	$0 Deductible Waived	$0 Co-pay
• Prescribed medication from the Preventive List	$0 Deductible Waived	Subject to applicable Co-pay
• Tier 1 Generic Drug	20% After Deductible (in-network)	$10 Co-pay
• Tier 2 Preferred Drug	20% After Deductible (in-network)	$30 Co-pay
• Tier 3 Non-Preferred Drug (non-formulary)	75% After Deductible/25% Plan	75% Participant/25% Plan
• Specialty	20% After Deductible	20% max of $150
90-day supply at a Retail or Mail Order		
• Prescribed preventive medication as required by federal law	$0 Deductible Waived	$0 Co-pay
• Tier 1 Generic Drug	20% After Deductible (in-network)	$20 Co-pay
• Tier 2 Preferred Drug	20% After Deductible	$60 Co-pay
• Tier 3 Non-Preferred Drug	75% After Deductible/25% Plan	75% Participant/25% Plan

Expanded Preventive Medications List - Medications listed on the Expanded Preventive Medications are provided to members on the HDHP without member cost-sharing. The list is available from Navitus. See page 13 for registration information.

2022-23 Monthly Retiree Rates

2022-23 LHUSD Retiree Benefit Plan Rates				
EPO	Monthly Premium	District Contribution	ASRS or District Contribution	Retiree Contribution
Retiree Only	$1,168.81	$759.68	$75.00	$334.14
Retiree + S	$2,295.59	$759.68	$130.00	$1,405.92
Retiree +1C	$1,829.11	$759.68	$130.00	$939.44
Retiree + C	$2,226.52	$759.68	$130.00	$1,336.85
Retiree + F	$3,192.46	$759.68	$130.00	$2,302.79
Health Savings Plan (HDHP)				
Retiree Only	$1,085.25	$759.68	$75.00	$250.58
Retiree + S	$2,126.89	$759.68	$130.00	$1,237.22
Retiree +1C	$1,699.06	$759.68	$130.00	$809.38
Retiree + C	$2,063.58	$759.68	$130.00	$1,173.91
Retiree + F	$2,948.28	$759.68	$130.00	$2,058.61
Dental/Vision				
Retiree Only	$48.67	$34.07	$0.00	$14.60
Retiree + S	$95.71	$34.07	$0.00	$61.64
Retiree +1C	$70.76	$34.07	$0.00	$36.69
Retiree + C	$97.26	$34.07	$0.00	$63.19
Retiree + F	$139.78	$34.07	$0.00	$105.71
Life	$20K Retiree			
Retiree Only	$4.00	$2.80	$0.00	$1.20

What is BlueCare Anywhere?

With **BlueCare Anywhere**, Blue Cross Blue Shield of Arizona (BCBSAZ) members can see a board-certified doctor, counselor or psychiatrist on a computer or mobile device. It's the easy way to get immediate care—any day, any time. Why wait to start feeling better? Just sign in and connect to your live virtual visit.

What services are offered?

MEDICAL

You don't have time to be sick. And whether you're at home, work or on vacation, a board-certified doctor is ready to connect with you whenever and wherever you need help. For common health issues like headaches, fevers, rashes and stomach bugs, simply click to select a provider and start feeling better.

COUNSELING

Sometimes you just need to talk things out. When life's challenges get too heavy, a certified counselor or psychologist is a click away. From concerns such as depression and anxiety, to stress caused by grief, divorce, parenthood, or other major life changes.

PSYCHIATRY

Psychiatric care is here whenever and wherever you need it. Connect with a board-certified psychiatrist face-to-face via video visit or by phone from the privacy and comfort of your own home to address common behavioral health challenges. Experienced psychiatrist provide assessments, evaluations and treatment.

All consultations are $0 through December 31, 2022

An Independent Licensee of the Blue Cross and Blue Shield Association

How does it work?

One of the key benefits is convenience. Virtual doctor visits* are available 24/7 and can be conducted anywhere members have access to a smartphone, tablet or computer with internet access, using these simple steps:

1. Enroll online by providing your name, email address and password.
2. Fill out a questionnaire about your symptoms, medications and health history
3. Select a provider type: medical, counseling, psychiatry
4. Pay the cost share with a credit card, flexible spending account (FSA) or health savings account (HSA)
5. Choose a pharmacy (if medication is required)
6. See the doctor or schedule an appointment
7. Receive a visit summary and share with your primary care provider

How much does it cost?

Your **BlueCare Anywhere** telehealth visit copay is listed on your Summary of Benefits and Coverage (SBC). Go to your online member account at **azblue.com/member** to review your SBC.

When would I use BlueCare Anywhere?

- I want to see a doctor, but can't fit it into my schedule
- My doctor's office is closed
- I feel too sick to drive
- I have children at home and don't want to bring them with me
- It's difficult for me to get a doctor's appointment
- I'm on business travel and not able to get to care

Can I use BlueCare Anywhere when I'm traveling?

Yes. Providers are available and licensed in all 50 states.

What computer requirements are needed?

High-speed Internet access and a webcam or computer with a built-in camera and audio capability are required.

Can the doctor prescribe medication?

Yes, doctors can consult, diagnose, and prescribe medication.

Who are the doctors?

Medical doctors available on **BlueCare Anywhere**:

- Are U.S. board-certified, licensed, and credentialed
- Have an average of 10-15 years experience
- Have profiles, so you can see their education and practice experience

How do I add a spouse or other family member?

If your spouse or other family member is on your health plan, they are eligible for BlueCare Anywhere. They will need to sign up on BlueCareAnywhereAZ.com or download the BlueCare Anywhere mobile app. If your child is on your health plan, they are eligible for BlueCare Anywhere. Parents and guardians can add children who are under age 18 to their account and have doctor visits on their behalf. Enroll yourself first and then add your child or dependent to your account.

What if my child is over 18 and still on my health insurance?

They should sign up as an adult and create their own separate account.

SIGN UP AT **BlueCareAnywhereAZ.com**
OR DOWNLOAD THE **BlueCare Anywhere** APP NOW.

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*Virtual visits do not provide emergency care. In an identified or probable emergency, the virtual visit provider will direct the patient to seek emergency care.

D15180 11/17

TEL-0200-122317

BlueCare Anywhere™

Quick Tips

BlueCare Anywhere puts you face to face with a board-certified doctor any time, night or day. These tips can help you start a visit in minutes using your computer, tablet, or smartphone.

1 Sign up to get started. It's easy!

(It's a good idea to do this before you need to see a doctor.)

- Download the BlueCare Anywhere mobile app or visit **BlueCareAnywhereAZ.com.**
- Fill in your contact information.
- Set up your username and password.
- Add your insurance, provider, health history, and payment information.
- Test your connection to make sure it works.
- You're ready to use BlueCare Anywhere!

2 Know when to use it

Visit with a doctor, counselor, or psychiatrist for help with:

- Cold, flu, fever
- Cough, bronchitis
- Diarrhea, vomiting
- Headache
- Pink eye
- Rashes
- Insomnia
- Anxiety
- Depression
- And more!

Headache

This is not a complete list. BlueCare Anywhere should not be used for burns, wounds, broken bones, or life-threatening conditions. For more information, visit BlueCareAnywhereAZ.com.

Virtual visits do not provide emergency care. In an identified or probable emergency, the virtual visit provider will direct you to seek emergency care.

3 See a doctor or make an appointment

- Open the app or go to **BlueCareAnywhereAZ.com** and sign in.
- Follow the steps to choose a doctor or make an appointment. Some doctors are available right away. Others might have a short wait time.
- You can see the fees and add or change your payment information.

If you are traveling out of state, you'll need to change your profile setting to show the state you're visiting. That way, you can choose a doctor who is licensed to practice in that state.

4 Get treated

You will see when the doctor dials into the video chat session.

The doctor will talk with you about your health concern just like during a regular office visit.

You can use the camera on your computer or mobile device to provide close-up views.

The doctor will give you treatment options and may send a prescription to the pharmacy you've selected, if needed.

Need a sick slip or documents to go back to work or school? The doctor can provide this, if medically appropriate.

5 After your visit

- You'll receive a report that you can share with other healthcare providers.
- You'll also receive an email with a link to a satisfaction survey. Your answers will help us make BlueCare Anywhere the very best it can be.

Share

CARE IS AVAILABLE NOW.

VISIT **BlueCareAnywhereAZ.com**
OR DOWNLOAD THE APP TODAY.

An Independent Licensee of the Blue Cross and Blue Shield Association

App Store is a service mark of Apple Inc., registered in the United States and other countries. Google Play and the Google Play logo are trademarks of Google Inc.

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TEL-0236-072518

Vision Plan Highlights

NORTHWEST ARIZONA EMPLOYEE BENEFIT TRUST

Policy #: 010-301339

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	$105	$45
Contacts (elective)	Up to $150	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

NORTHWEST ARIZONA EMPLOYEE BENEFIT TRUST

Policy #: 010-301339

VSP Network

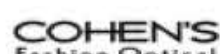
With access to the largest network of independent doctors, VSP members receive services at rates well below walk-in prices at more than 36,000 doctors nationwide. Find a provider at https://www.vsp.com

36,000

VSP is accepted by more than 36,000 doctors nationwide

4,500

retail chain affiliates such as



The largest network of **independent doctors**

94% of VSP doctors offer early morning or evening appointments and access to 24-hour emergency care

94%

No claim forms to complete when you see a VSP doctor

Out-of-network benefits can be used at

Online In-network Options

Eyeconic.com is in-network online eyewear store - which means you won't have to pay the full price now, then wait to be reimbursed later. Your vision benefits will be applied directly to your online order. Eyeconic FAQ:
https:www.vsp.com/eyewear-question.html

Customer Service

VSP 800-877-7195 www.vsp.com
Mon-Fri 5am-8am, Sat 7am-8pm, Sun 7am-7pm (PST)

Additional Savings

Find More VSP exclusive member savings offers at
https://www.vsp.com/optical-discounts.html

When you visit a VSP network provider you'll save:

20% off remaining frame balance

20-25% off non-covered lens options such as UV coating & polycarbonate

20% off non-covered complete prescription glasses

15% off LASIK and PRK laser surgery retail price or

5% off promotion price

Based on applicable laws, reduced costs may vary by doctor location.

Laser Vision Surgery

Your vision plan provides an average discount of 15% on LASIK and PRK. Your maximum out-of-pocket per eye is $1,800 for LASIK, $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP Provide must coordinate the procedure. Getting started is simple; just follow the steps at https://www.vsp.com/lasik.html

Based on applicable laws, reduced costs may vary by doctor location.

Rx Savings

Save on Prescription medications at 60,000 Pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. Just Present your Rx savings card. To access and print your Rx savings cards, visit ameritas.com, register/sign in to your secure member account and select member savings. This discount is offered at no additional cost and is not insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Dental Plan Highlights

NORTHWEST ARIZONA EMPLOYEE BENEFIT TRUST
Policy #: 010-301339

Dental Plan Benefits

	In-Network	Out-of-Network
Type 1 Preventive No Waiting Period	100%	Not Covered
Type 3 Major No Waiting Period	80%	Not Covered

Deductible

Type 1	$0	$0
	$50 per person, per calendar year	$$0
Family Maximum	When 3 family members satisfy their Deductible Amounts for this Plan Year, no additional Deductibles will apply to any family members for the rest of this Plan Year.	No family maximum

Plan Year Maximum

Type 1, 2, and 3 (per person, per benefit period)	$3,000	$0

Orthodontia Benefits (children under age 17) In Network Only

No waiting period		
Plan Benefit	50%	NA
Lifetime Deductible	$50	NA
Lifetime Maximum (per person)	$1,000	NA

Claims Allowance

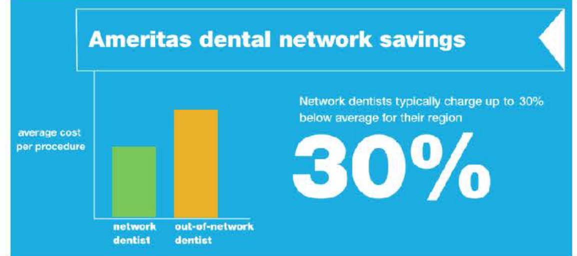
Type 1, 2 and 3	Discounted Fee	0th U&C

Open Enrollment

If you do not elect to participate when initially eligible, you may elect to participate at the policyholder's next enrollment period, which normally coincides with the policy anniversary date.

Provider Flexibility and Network Savings

Members aren't limited to one particular dentist, or a small group of providers, who may or may not be taking new patients. Each plan member is free to visit any provider they choose, including your current dentist, regardless if they are in- or out-of-network. And family members do not have to see the same dentist. When you visit an in-network dentist there are no claim forms to complete. For a list of network dentists in your area, go to Find A Provider at ameritas.com.



The Ameritas dental network is one of the **5 largest networks** in the nation for access points. Source: NetMinder 2016

Ameritas Network: These plans give you more than 428,000 access points across the nation for dental care.

Late Entrant

We strongly encourage you and/or your dependents to sign up for coverage when you are initially eligible. If you choose to enroll after initially declined, you and/or your eligible dependents will be considered a Late Entrant. Covered expenses will not include and benefits will not be payable in the first 6 months that a person is insured if the person is a Late Entrant; except for Type 1 and Type 2 procedures.

Member Savings

Prescription savings

Just for participating in our dental, vision or hearing care plans, members can save big on prescription medications through one of the world's largest retailers. **No additional cost. Only savings.**

Extra Value

Our plan members, their covered dependents can **save on prescription medications at over 60,000 pharmacies across the nation** including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

60,000

Participating pharmacies will give Ameritas plan members their normal health care pharmacy benefit, or the prescription discount, whichever saves them more. Even if the employees already have health insurance pharmacy benefits, they are welcome to check out this Rx discount.

Find a pharmacy near you – http://www.emsmed.com/vendors/pharmacy.aspx

Look up a price – http://www.emsmed.com/vendors/rxpricing.aspx?groupid=Ameritas

Rx Savings

Members can receive up to 65% savings on generic prescriptions, and overall average savings of 40% across brand name and generic prescription combined.

Save on frames and lenses

Save up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. This is available to you without any additional cost to your plan premium.

You may receive savings on the following vision care products at Walmart Vision Centers:

- top quality frames for the entire family including today's most popular brands.

- wide selection of lens options; all lenses come with scratch resistant coating for no additional charge.

- safety eyewear.

Guarantees

Walmart Vision Centers stand behind their products and workmanship by offering:

- 60-day frame and lens satisfaction guarantee.
- 12-month replacement guarantee on broken or damaged frames or lenses.
- lifetime adjustments and cleanings.

Customer Service

Customer Connections 800-487-5553 www.Ameritas.com
Monday - Thursday 7am-12am CST, Friday 7am-6:30pm CST

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

Health Savings Account (HSA)

Qualified HDHP enrollees may open HSA account **at their banking institution** or through **HSA Bank**. Contributions will generally be post-tax contributions with a deduction taken when filing for taxes. Please consult with your tax professional from additional details and qualification information. See below in bold for some general qualifications.

What is an HSA?

An HSA is an individual savings account that can be used to pay for qualified medical, Rx, dental or vision expenses. The High Deductible Health Plan (HDHP) option allows you to open an HSA and take advantage of terrific tax savings. The money in your account accumulates on a tax-deferred basis and can be rolled over from year to year. You can save your money for future medical, Rx, dental or vision expenses, and as long as you use the money for a qualified medical, Rx, dental or vision expense, your funds are never taxed. **This account is only available if you select the HDHP. A participant cannot contribute to an HSA if they are covered on any other non-qualified plan, are covered as a dependent on another person's tax return (excluding spouses), are enrolled in an FSA, or are enrolled in Medicare, TRICARE or TRICARE for life.**

How Does an HSA Work?

An HDHP offers a lower monthly premium in exchange for a higher deductible. The money you would normally spend on monthly premiums can now be contributed on a pre-tax basis to your HSA account. You will receive a debit card to use for qualified medical expenses, which will draw from your HSA. Distributions from your HSA are tax-free when used to pay for qualified medical expenses. The 2021 maximum contribution for single coverage is $3,600, and family is $7,200. HSA participants who are 55 or older can contribute an additional $1,000, or $4,600 for single coverage and $8,200 for family coverage. Please note, HSA contribution limits operate on a calendar-year basis. A participant can elect to contribute the maximum amount from July 1, 2021 - December 31, 2021; however, to avoid tax issues, the individual must remain on the HDHP through the full plan year following elections.
How can I save money with an HDHP & HSA?

- HDHP premiums are lower than traditional plans.
- HSAs have a tax-favored status.
- Interest earned on the money in an HSA is tax deferred.
- Using HSA dollars to pay for qualified medical expenses is tax-free.

What is considered a "Qualified Medical Expense"? A full list of qualified expenses for an HSA is identified in IRS Section 213D.*

Some of the most common expenses include:

Deductible	Contact	Eyeglasses	Over-the-counter
LASIK	Office visit	Dental	Out-of-pocket
Prescription	Chiropractor	Vaccinations	

*You should refer to www.irs.gov/pub/irs-pdf/p502.pdf for a full list of qualified expenses. If HSA funds are used for non-qualified medical expenses, those purchases are subject to a 10% penalty tax and will be considered income for tax purposes.

What are the benefits of having an HSA account?

The eligibility requirements to open and contribute to a Health Savings Account (HSA) are mandated by the Internal Revenue Service (IRS), not by your employer. Individuals who enroll in an HSA but are later determined to be ineligible for that account are subject to financial penalties from the IRS. It is an individual's responsibility to ensure that he/she meets the eligibility requirements to open an HSA and to have contributions made to that HSA, as outlined below: To be eligible to open an HSA and have contributions made to the HSA during the year, an individual must be covered by an HSA-qualified health plan (an HDHP) and must not be covered by other health insurance that is not an HSA-qualified plan. Certain types of insurance are not considered "health insurance" and will not jeopardize an individual's eligibility for an HSA, including automobile, dental, vision, disability, and long-term care insurance. **IMPORTANT: Individuals enrolled in Medicare are not eligible to open an HSA or have contributions made to the HSA during the year. If you think you may become eligible for Medicare in the next 12 months, you should consider whether enrolling in the medical/Rx plan that is paired with a health savings account is a wise choice.** You may not be claimed as a dependent on someone else's tax return. Individuals may not open an HSA, or have contributions made to the HSA during the year if a spouse's health insurance, Health Care Flexible Spending Account (Health Care FSA) or health reimbursement arrangement (HRA) can pay for any of the individual's medical expenses before the HSA-qualified plan deductible is met. This means that a standard general-purpose Health Care FSA may make you ineligible to open an HSA and have contributions made to the HSA during the year. If an individual received any health benefits from the Veterans Administration (or one of its facilities)—including prescription drugs— in the three (3) months prior, he or she is not eligible to open an HSA and have contributions made to the HSA during the year.

Most accounts offer a debit card for convenient access to your money and online banking tools.

- The contributions are 100% tax-deductible.
- The fund grows tax-deferred.
- The money withdrawn for qualified medical expenses is tax-free.
- The money you put in can reduce your taxable income.
- You can roll the savings over from year to year.
- Your HSA is portable and can move with you from job to job.
- After age 65, you can use your HSA account to pay Medicare premiums, deductibles, co-pays, and coinsurance under any part of Medicare.

How do I pay the bill at my doctor's office with an HSA?

If you have an HSA, it is important not to overpay for medical, Rx, dental or vision expenses. Since you're paying "cash" from your HSA, if you pay the entire bill up front, you may be paying too much, since network discounts would not have been applied. For example, most claims must be re-priced before you know what you owe. If you pay cash at the time of service, you will pay before the network discounts are applied. This may pose a problem if you are reimbursed by your physician's office because you have technically made an unqualified withdrawal from your HSA. We strongly suggest you wait until you receive your Explanation of Benefits (EOB) before paying the provider.

NOTE: If you enroll in the EPO the IRS prohibits you from enrolling in an HSA.

For questions, contact HSA Bank at 1.800.357.6246 or online at www.hsabank.com.

Basic Life Insurance/Accidental Death and Dismemberment (AD&D)

Basic Life Insurance

Basic Life Insurance will be administered by The Standard Insurance Company. Each Retiree employee will be offered $20,000 in life insurance and $20,000 in Accidental Death and Dismemberment*

* Retirees will now contribute $1.20 to this coverage per month. See rate chart on page 19.

L. I. F. E. Wellness

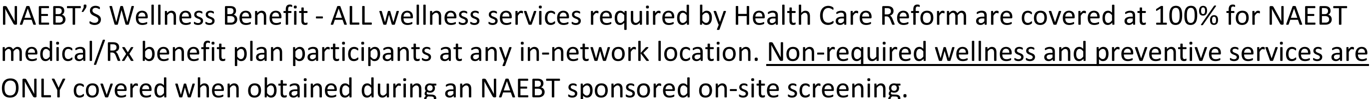
The NAEBT Wellness Program

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 at any in-network location. Non-required wellness and preventive services are ONLY covered when obtained during an NAEBT sponsored on-site screening.



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.

Screenings and Services

Recommended screenings and services are specific to your age and gender which include, but are not limited to:

Adults – Blood Pressure, Cholesterol, Diabetes, HIV and Colorectal Screenings and Immunizations

Women – Mammograms, Cervical Cancer and HPVtesting, as well as some prenatal care and breast-feeding supplies

Children – Immunizations and newborn screenings

Certain Prescription Drugs – Contraceptives, Low Dose Aspirin, Folic Acid, and Iron Supplements

For a list of all services and prescription drugs required for coverage by Health Care Reform, please visit the following website: U.S. Preventive Task Force

On-Site Screenings

As a part of NAEBT's Wellness Program, some preventive screenings are brought on-site to provide participants a convenient and timely way to protect their health.

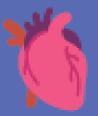
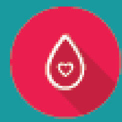
The following screenings are provided on an annual basis:

- Health Risk Assessments
  - Lifestyle Questionnaire
  - Biometric Data
    - Optional BMI
  - Fasting Blood Draw
    - Full Lipid Panel (Cholesterol)
    - Blood Sugar (Diabetes)
    - Optional Thyroid Screening
    - Optional Prostate Specific Antigen (PSA)
- Skin Cancer Screenings
- Cardiac & Organ Screenings
- Mammograms
- Flu and Pneumonia Vaccinations
- Colon Cancer Screening with Colorectal Kits
- Comprehensive Eye Screenings

Please look for wellness emails and flyers throughout the year for screening dates and additional information.

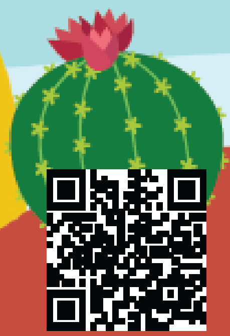
IMPORTANT NOTE: Your Personal Health Information will not be released to your Human Resources/Benefits Department or your employer unless you request so. Individual data is never used to determine your insurance coverage.

2022-2023 WELLNESS CALENDAR

JULY	AUGUST	SEPTEMBER	OCTOBER
Cardiac & Organ Screenings 	Cardiac & Organ Screenings	Flu & Pneumonia Vaccinations Cardiac & Organ Screenings	Mammography Screenings Flu & Pneumonia Vaccinations
NOVEMBER	**DECEMBER**	**JANUARY**	**FEBRUARY**
Wellness Survey Mammography Screenings Comprehensive Eye Screenings	Stress Management Program with Chair Massages	Health Risk Assessment Screenings 	Health Risk Assessment Screenings
MARCH	**APRIL**	**MAY**	**JUNE**
Health Risk Assessment Screenings	Skin Cancer Screenings	Colon Cancer Program with Colorectal Kits Skin Cancer Screenings	Stress Management Program with Chair Massages

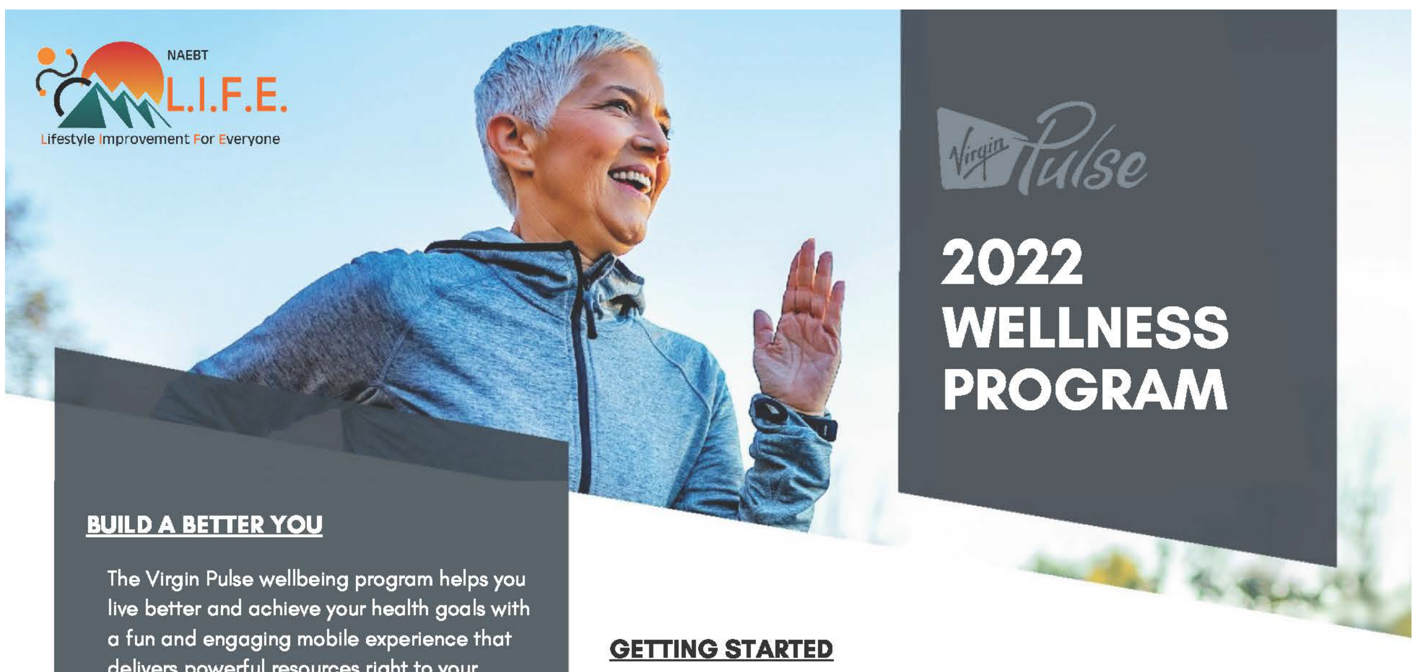
A wellness portal designed to help you reach a variety of health goals and have fun doing it! Earn rewards for actions completed in the portal and for attending wellness events. Use these points to redeem gift cards or shop in the Virgin Pulse Store.

join.virginpulse.com/NAEBT or Scan the QR code!



Preventive screenings and services are subject to change. Watch for emails and flyers with more details. Preventive screenings and services brought onsite through the NAEBT Wellness Program are covered 100% for eligible NAEBT Medical Benefit Plan Members.

Questions? Contact Kari Dunlop at Kari.Dunlop@lhusd.org



2022 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 fingetips.

Employees, spouses and dependents (18+) are invited to sign in to:

join.virginpulse.com/NAEBT

Retirees are able to participate in the fun but unable to redeem for rewards.

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

PERSONALIZE YOUR EXPERIENCE

- **Set your interests to get personalized well-being 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.

VP + Partners

New to the portal in 2022 is access to a variety of new health partners. Take advantage of their expertise and take charge of your health!

- **Whil** – Mindfulness focused partner offering audio meditation and lessons
- **Aaptiv** – Fitness focused partner offering a wide variety of fitness and nutrition courses
- **FoodSmart** – Nutrition focused partner offering recipes, tips to healthy eating, and education.
- **Enrich** – Financial wellness focused partner offering resources to help you manage your finances, learn to tackle debt, and prepare for the future.

Questions? Contact your Human Resources Department or your NAEBT Wellbeing Consultant, Dominique Heidt, at dominique_heidt@ajg.com

Special Notices

Medicare Notice of Creditable Coverage Reminder

If you or your eligible dependents are currently Medicare-eligible or will become Medicare-eligible during the next 12 months, be sure you understand whether the prescription drug coverage that you elect through the pool is or is not creditable with (as valuable as) Medicare's prescription drug coverage. NAEBT has determined that the prescription drug coverage under the EPO plan and the Health Savings Plan are creditable coverage.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

You or your dependents 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 stages 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. Plan limits, deductibles, co-payments, and coinsurance apply to these benefits.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or http://www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at http://www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

COMPLIANCE WITH HIPAA PRIVACY STANDARDS

A. Compliance with HIPAA Privacy Standards

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

Certain members of the employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the Privacy Standards), these employees are permitted to have such access subject to the following:

1. General. The Plan shall not disclose Protected Health Information to any member of the employer's workforce unless each of the conditions set out in this Compliance with HIPAA Privacy Standards section is met. 'Protected Health Information' shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present, or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. Permitted Uses and Disclosures. Protected Health Information disclosed to business associates and members of the employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms 'payment' and 'health care operations' shall have the same definitions as set out in the Privacy Standards, but the term 'payment' generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. 'Health care operations' generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training, or accreditation of health care providers; underwriting, premium rating, and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management, and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

3. Authorized Employees. The Plan shall disclose Protected Health Information only to members of the employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this Compliance with HIPAA Privacy Standards section, members of the employer's workforce shall refer to all employees and other persons under the control of the employer.

   a. Updates Required. The employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

   b. Use and Disclosure Restricted. An authorized member of the employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his/her duties with respect to the Plan.

   c. Resolution of Issues of Noncompliance. In the event that any member of the employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

      i. investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and whether the Protected Health Information was compromised

      ii. applying appropriate sanctions against the person(s) causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment

      iii. mitigating any harm caused by the breach, to the extent practicable

iv. documentation of the incident and all actions taken to resolve the issue and mitigate any damages

v. providing notification in accordance with HIPAA requirements

4. Certification of Employer. The employer must provide certification to the Plan that it agrees to all of the following:

a. not use or further disclose the Protected Health Information other than as permitted or required by the plan documents or as required by law

b. ensure that any agent or subcontractor to whom it provides Protected Health Information received from the Plan agrees to the same restrictions and conditions that apply to the employer with respect to such information

c. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the employer

d. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law

e. make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards

f. make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards

g. make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards

h. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards

i. if feasible, return or destroy all Protected Health Information received from the Plan that the employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible

j. ensure the adequate separation between the Plan and member of the employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards

5. The following members of Northwest Arizona Employee Benefit Trust's workforce are designated as authorized to receive Protected Health Information from Northwest Arizona Employee Benefit Trust (Plan) in order to perform their duties with respect to the Plan:

a. HR/Risk Manager

b. HR Director

c. Benefits Specialist

d. HR Technician

e. HR Administrator

f. Client Wellbeing and Engagement Consultant

g. Client Financial Accounting Manager

h. Account Executive

i. Account Manager

j. Account Assistant

B. Compliance with HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the Security Standards), the employer agrees to the following:

1. The employer agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the employer creates, maintains, or transmits on behalf of the Plan. Electronic Protected Health Information shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards, provisions Authorized Employees and Certification of Employers described above

Claims Administrator:

AmeriBen IEC

AmeriBen processes medical plan claims and can answer questions about eligibility, medical benefits, and network providers.

1.877.635.2909 www.MyAmeriBen.com

Medical Review:

American Health Group (AHG) Medical plan pre-certification, case management, and second opinions. 1.800.847.7605 or 1.602.265.3800

Nationwide Provider Network:

Blue Cross Blue Shield of Arizona (BCBSAZ)
www.azblue.com/chsnetwork
Blue Card National Network www.azblue.com
1.888.472.4352

Telemedicine:

BlueCare Anywhere:
24/7 Access to healthcare
1.844.606.1612
www.bluecareanywhereaz.com

Prescription Drug Program:

Navitus 1.855.673.6504

www.navitus.com

Dental & Vision Coverage:

Ameritas Dental

Dental eligibility, benefits, claims, and ID Cards.
1.800.487.5553 www.ameritas.com

VSP - Vision

Vision eligibility, benefits, claims, and ID Cards.
www.vsp.com

Basic Life Insurance, Voluntary Life Insurance and AD&D:

The Standard Insurance Co.
1.800.447.3146
www.standard.com

Health Savings Account (HSA):

HSA Bank administers the Health Savings Accounts and can be reached by calling Client Assistance Center: 1.800.357.6246

www.hsabank.com

NAEBT Wellness:

Gallagher Benefit Services Wellness
Dominque_Heidt@ajg.com
Virgin Pulse Wellness Portal 1.888.671.9395
support@virginpulse.com

NAEBT Trust Administrator:

Gallagher Benefit Services provides administration services to NAEBT.
1.928.753.4700 Ext. 6
Stephanie_Moore@ajg.com